
The Community Resource Guide to Address Tobacco-Related Health Disparities



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Executive Summary & Introduction



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TEXAS HEALTH AND HUMAN SERVICES COMMISSION

December 28, 2011

THOMAS M. SUEHS
Executive Commissioner

In September 2010, the Texas Health and Human Services Commission Executive Commissioner Thomas Suehs created the Center for Elimination of Disproportionality and Disparities (CEDD or the Center). CEDD is the first of its kind in the nation to address disproportionality and disparities and ensure racial equity in the delivery of services to clients across all health and human services (HHS) agencies and programs. CEDD is charged with achieving equity through partnership with HHS agencies (Department of State Health Services, Department of Aging and Disability Services, Department of Family and Protective Services, and Department of Assistive and Rehabilitative Services), external stakeholders, systems, and communities to identify and eliminate disproportionality and disparities impacting vulnerable populations. In May 2011, the 82nd Legislature passed Senate Bill (SB) 501, establishing CEDD's work in state statute and expanding responsibilities to include developing health initiatives to eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations experiencing a disproportionate burden of disease, disability, and death.

CEDD uses a cross systems approach and serves as a vehicle in addressing disproportionality and disparities in HHS and other systems that serve Texas' most vulnerable citizens. CEDD is actively engaged in projects and initiatives that improve health outcomes, equity, and access for vulnerable populations. Moreover, I am pleased to announce the completion of one such project—the *Community Resource Guide to Address Tobacco-Related Health Disparities*.

Individuals, advocates, coalitions, and organizations play critical roles in influencing the development of social and environmental policies to address health disparities within their communities. The *Community Resource Guide to Addressing Tobacco-Related Health Disparities* provides evidence-based, user-friendly content, tools, and resources that will allow you to tailor your tobacco prevention and control initiatives in order to effectively address tobacco-related health disparities within your communities in a culturally appropriate manner. Tobacco use has negatively impacted each and every one of us, but through collaborative and tailored initiatives and interventions, we can improve the health of Texas communities.

To learn more about the CEDD, please feel free to contact us at 877-316-2822.

Sincerely,



Joyce James
Associate Deputy Executive Commissioner
Health and Human Services Commission
Center for Elimination of Disproportionality and Disparities

Executive Summary

The state of Texas has a growing and diverse population. Through the work of the Center for the Elimination of Disproportionality and Disparities (CEDD), the Texas Health and Human Services Commission (HHSC) is committed to addressing disproportionality and health disparities in a way that improves the health of all Texas residents. The CEDD is especially focused on optimizing the health and wellness of Texas residents by developing and strengthening systems and services to monitor, analyze, and assess the health needs of underserved populations throughout the state.

Concerted efforts have been made to raise awareness about tobacco related health disparities in regions and communities across the state. Health disparities are often referred to as the disproportionate burden of disease, illness and mortality associated with personal characteristics, such as race, ethnicity, age, and gender. Other characteristics that are associated with adverse health conditions and contribute to health disparities may include financial circumstances or place of residence, functional

or developmental status, and sexual orientation. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Every American, according to the Health and Human Services (HHS) Office of Minority Health, must have the opportunity to live a healthier, more prosperous and more productive life, regardless of who they are and where they live. This resource guide helps to build the capacity of local and regional tobacco prevention and intervention programs and services and encourages systematic planning and activities to address tobacco-related health disparities by connecting community groups, faith-based organizations, public health practitioners, business leaders, public officials, and others aligned with this goal.

Introduction

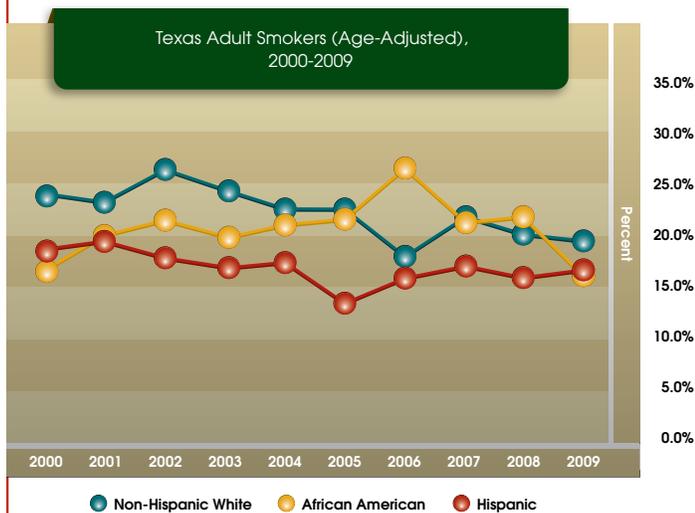
Burden of Tobacco Use

An estimated 46 million adults in the U.S. reported being current smokers in 2010. Smoking affects every part of the body and causes cancer, heart disease, lung diseases (including emphysema, bronchitis, and chronic airway obstruction)¹, premature birth, low birth weight, stillbirth, and infant death. Annually there are approximately 443,000 deaths nationally tied to the adverse health effects from cigarette smoking.² This staggering number equates to nearly one in every five deaths caused by tobacco, which is more than all of the deaths caused by HIV, illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined.³

In Texas, approximately 18.5% of the adult population, which equates to over 3,257,000 individuals, are smokers, with non-Hispanic whites having the highest smoking prevalence.⁴

Every year more than 24,100 Texans die from a smoking-related illness such as cancer or cardiovascular and respiratory disease. More than 27,000 Texans are diagnosed with tobacco-related cancers. Lung cancer is the leading cause of death among men and women diagnosed with cancer in Texas.⁵ Economically, tobacco use is a burden to Texans, costing taxpayers nearly \$11 billion annually in medical care and productivity losses.⁶

Even for non-smokers there are harmful effects — there is no risk-free level of exposure to secondhand smoke. Secondhand smoke contains more than 4,000 chemicals, including 69 chemicals proven to cause cancer.⁷ Secondhand smoke causes heart disease and lung cancer in adults and kills thousands of Texans annually. Young children are especially vulnerable to secondhand smoke because their lungs are not fully developed. Secondhand smoke causes a number of health problems in infants and children, including severe asthma attacks,



¹ US Department of Health and Human Services (HHS), Public Health Service, Office of the Surgeon General. The health consequences of smoking: A report of the Surgeon General. Rockville, MD: HHS; 2004.

http://www.cdc.gov/tobacco/data_statistics/sgg/2004/index.htm

² Centers for Disease Control and Prevention. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004 (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm57445a3.htm>). *Morbidity and Mortality Weekly Report* 2008; 57(45):1226–8 [accessed 2011 March 11].

³ Mokdad AH, Marks JS, Stroup DF, Gerberding JL. *Actual Causes of Death in the United States*. *JAMA: Journal of the American Medical Association* 2004; 291(10): 1238–45 [cited 2011 March 11].

⁴ Center for Health Statistics. *Texas Behavioral Risk Factor Surveillance System data*. Austin, TX: Texas Department of State Health Services, Center for Health Statistics 2007–2008.

⁵ American Cancer Society, High Plains Division, Inc. *Texas Facts & Figures 2008*. Austin, TX: American Cancer Society, High Plains Division, 2008.

⁶ Fellows, J.L. (2006). *Final Report: The Financial Returns from Community Investments in Tobacco Control*. The Center for Health Research: Kaiser Permanente Southwest. (50555 1/06 Center for Health Research).

⁷ U.S. Environmental Protection Agency. *Respiratory health effects of passive smoking: Lung cancer and other disorders*. U.S. EPA office of Research and Development Publication No. EPA/600/6-90/006F, 1992.

⁸ Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General. Atlanta: CDC; 2006. http://www.cdc.gov/tobacco/data_statistics/sgg/2006/index.htm

respiratory infections, ear infections, and sudden infant death syndrome (SIDS).⁸ The workplace is a major source of secondhand smoke exposure for adults, and exposure in the workplace has been linked to an increased risk of heart disease and lung cancer among adult nonsmokers. Smokeless tobacco and cigars also cause a number of serious oral health problems, including cancer of the mouth, gums, larynx, esophagus, and lung, periodontitis, and tooth loss.

Tobacco Use Prevention Is Vital

Tobacco use remains the single most preventable cause of death and disease in both the U.S. and Texas. Tobacco prevention and control would save lives and money in addition to improving the quality of life for many Texans.

Healthy People is a national strategy that provides a framework for action to improve the health of all Americans through the launch of a 10-year agenda targeting specific health objectives. *Healthy People* establishes benchmarks and monitors progress over time to encourage collaboration across all sectors, guide individuals to make informed health decisions, and measure the impact of health activities. Several objectives of *Healthy People 2020* pertain to tobacco use. The goals are to reduce illness, disability, and death related to tobacco use and secondhand

smoke exposure to the point that tobacco use is no longer a public health problem for the nation. *Healthy People 2020* tobacco use objectives are organized into three key areas:

1. **Tobacco Use Prevalence:**
Implementing policies to reduce tobacco use and initiation among youth and adults.
2. **Health System Changes:**
Adopting policies and strategies to increase access, affordability, and use of smoking cessation services and treatments.
3. **Social and Environmental Changes:**
Establishing policies to reduce exposure to secondhand smoke, increase the cost of tobacco, restrict tobacco advertising, and reduce illegal sales to minors.⁹

These objectives, along with sustainable and culturally competent practices, will be addressed in this *Community Resource Guide to Address Tobacco Related Health Disparities*. The guide will also focus on using community engagement strategies in order to mobilize communities toward social and environmental change.

Although tobacco is an equal opportunity killer, some populations disproportionately suffer from the health and economic hardships associated with tobacco use. An emphasis on eliminating tobacco-related disparities is necessary to close the gap between different populations in tobacco prevalence and tobacco-related health outcomes.

⁹ Healthy People 2020 Topics & Objectives: Tobacco Use. <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=41>

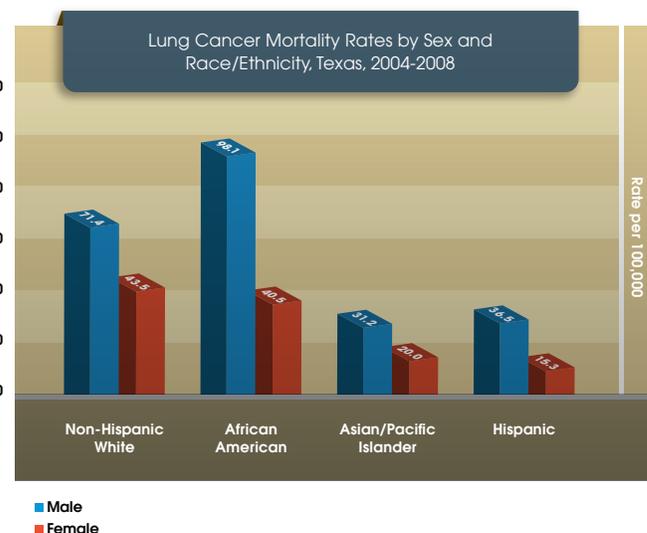
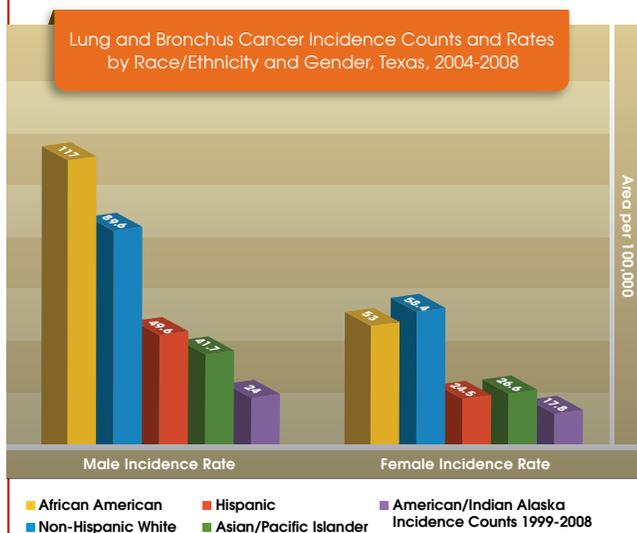
Tobacco-Related Health Disparities

Tobacco is a powerful and pervasive cause of health disparities. The National Conference on Tobacco Health Disparities (NCTHD) defines tobacco-related health disparities as:

“Differences in the patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in capacity and infrastructure, access to resources, and environmental tobacco smoke exposure.”¹⁰

Studies have demonstrated disparities in the prevalence of tobacco use, access to smoking cessation services, and tobacco-related cancer incidence and mortality based on racial/ethnic and socioeconomic status (SES).¹¹ The differences in patterns of tobacco use, exposure, prevention,

and treatment result in poorer health outcomes, and higher morbidity and mortality rates among specific populations. Factors influencing health disparities are barriers to access of health services, social and economic inequities, age, gender, race, sexual orientation, language, and inequitable distribution of health-care resources. Racial and ethnic groups are more likely to work in services and hospitality industries where smoking is allowed and, therefore, suffer disproportionately from health risks of tobacco and secondhand smoke.¹² More than 10 million African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Latinos smoke cigarettes. In Texas, African Americans, particularly African American men, currently bear the greatest health burden from tobacco use.



¹⁰ Fagan P, King G, Lawrence D, Petrucci SA, Robinson RG, Banks D, Marable S, Grana R (2004). *Eliminating Tobacco-Related Health Disparities: Directions for Future Research*. American Journal of Public Health. February 2004, Vol 94, No. 2.
¹¹ Irvin Vidrine J, Reitzel LR, & Wetter DW. Department of Health Disparities Research. *The role of tobacco in cancer health disparities*. *Curr Oncol Rep*. 2009 Nov; 11(6): 475-81.
¹² Texas Workforce Commission

Community interventions are effective in addressing population-specific tobacco-related health disparities. The state of Texas is working alongside health-care professionals and community stakeholders to reduce tobacco-related disparities throughout the state — and you are key to that plan.

Overview of the Community Resource Guide to Address Tobacco-Related Health Disparities

The *Community Resource Guide to Address Tobacco-Related Health Disparities* is designed to provide tobacco coalitions, as well as organizations, health professionals, community groups, and other community stakeholders with steps to address tobacco-related health disparities through community implementation of a tobacco control plan. The purpose of this guide is to provide culturally competent methods to eliminate exposure to secondhand smoke, promote cessation, and identify and eliminate disparities among population groups through population-based community interventions, counter-marketing, policy implementation, and evaluation.

Each section of this guide should help to educate and assist your tobacco coalition in

organizing, planning, engaging communities and media, ensuring sustainability, implementing a tobacco control plan, and heightening awareness about the burden of tobacco use and the need for prevention via a culturally sensitive approach.

In addition, the resource guide provides tobacco coalitions multicultural outreach tools, resource and communication tools, data resources, and funding guidance and resources.

Effective community programs influence the social norms of a community, and those norms are driven by culture. Culture shapes how people see their world and participate in their community. Culture can include geography, lifestyle, age, disabilities, religious affiliation and any other characteristics that affect attitudes and beliefs toward tobacco use. To operate effectively and respectfully for the benefit of the entire community, your tobacco coalition will need to focus community outreach efforts to influence and reach the people in the community at their homes, jobs, schools, places of worship, places of leisure, health-care settings, community organizations, and other public places in a culturally competent manner. Therefore, your coalition and community partners should work collaboratively to develop a culturally sensitive and comprehensive tobacco prevention and control plan.

It is our hope that the *Community Resource Guide to Address Tobacco-Related Health Disparities* will assist your Tobacco coalition in

developing successful and culturally competent intervention plans for your community.



Guiding Principles



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Guiding Principles

The *Community Guide to Address Tobacco-Related Health Disparities* was developed to complement the Community Tobacco Prevention and Control Toolkit located on the Texas Department of Health Services (DSHS) website.¹ The Community Tobacco Prevention and Control Toolkit provides strategies and a framework for addressing the DSHS Tobacco Prevention and Control Strategic Plan for 2008-2013. Strategies include the following:

1. Prevent tobacco use among young people.
2. Ensure compliance with state and local tobacco laws with adequate enforcement.
3. Increase cessation among young people and adults.
4. Eliminate exposure to secondhand smoke.
- 5. Reduce tobacco use among populations with the highest burden of tobacco-related health disparities.**
6. Develop and maintain statewide capacity for comprehensive tobacco prevention and control.

The *Community Guide to Address Tobacco-Related Health Disparities* guiding principles are based on Goal #5, to reduce tobacco among populations with the highest burden of tobacco-related health disparities. The guiding principles to achieve health equity through environmental and social changes include:

1. Engaging the community
2. Developing partnerships
3. Community collaboration in all stages and processes of tobacco prevention and control programs
4. Developing culturally competent organizations and programs
5. Sustainable practices in community tobacco prevention and control initiatives

¹ Department of State and Health Services website <http://www.dshs.state.tx.us/tobacco/>



Strategic Prevention Framework



The Strategic Prevention Framework

The Strategic Prevention Framework (SPF) is a five-step planning process guide developed by The Substance Abuse and Mental Health Services Administration (SAMHSA) to address substance abuse and prevention through the selection, implementation, and evaluation of culturally competent and sustainable interventions. This five-step process includes:

1. Assessment
2. Capacity Building
3. Planning
4. Implementation
5. Evaluation

This five-step planning framework focuses on



outcome-based prevention, population-level change, prevention across a lifespan, and data-driven decision-making.

Outcome-based prevention provides evidence as to whether or not your prevention goals were achieved. It is important to include specific and measurable outcomes expected through the prevention program for the success and continued funding of the program.

Population-level change requires prevention programmers to look at all of the factors influencing health across all systems and population groups within a community to more than adequately influence tobacco prevention and control.

Prevention across the lifespan requires practitioners to look at the effects of tobacco use and exposure across all ages within a population for prevention purposes.

Data-driven decision-making is used to describe the community and the community's capacity to address identified gaps.

1. Assessment¹

The first of the five components of the SPF is assessment. Assessment will enable you to figure out what is going on in your community. It allows you to identify and understand the community's needs, resources, and readiness to address tobacco prevention. The assessment should include community demographics, the cultural and ethnic make-up of the community, how tobacco use is perceived, and who has historically been involved in community efforts against tobacco. Any existing barriers should be identified during this time as well. It is imperative to have key stakeholders within the community involved in all aspects. Including key stakeholders will ensure community buy-in as well as increase the likelihood of producing sustainable initiatives.

2. Capacity Building²

Communities must have capacity – that is, the resources and readiness – to support tobacco prevention and control programs. Well-supported programs and community initiatives are more likely to succeed. Capacity takes into account the organizations, programs, resources, and infrastructure that exist in a community, and how well these groups work with each other. The challenge is to then leverage those resources to build upon the existing strengths and address the areas needing strengthening within a community.

Looking at the results of the assessment data will allow coalitions to recognize and address any gaps identified through the data in order to build capacity.

Key components of capacity building include:³

- **Improving awareness of tobacco prevalence problems and readiness of stakeholders to address these problems.** Stakeholders, as representatives of the community, often have competing priorities. It is important to make a strong, compelling case as to why stakeholders should commit their time, energy, and resources to tobacco prevention and control initiatives.
- **Strengthening existing partnerships and/or identifying new opportunities for collaboration.** It is essential to build upon existing partnerships to maximize capacity through the sharing of resources and information. This involves including stakeholders from various sectors of the community in the early planning stages and throughout the intervention process. Community champions can be non-traditional and traditional partners from the local media, legislature, faith, school and business communities.
- **Improving organizational resources.** At the community level, this often means engaging or building planning groups, ensuring that planning groups reflect the ethnic make-up of the community, and/or enhancing how the group does the work.
- **Developing and preparing the prevention workforce.** The success of tobacco prevention control initiatives greatly depends on the knowledge and tenacity of the people delivering the intervention. Workforce development

¹ For more information on Assessment please see the Community Needs Assessment section of this Guide.

² For more on Capacity Building please see the Capacity Building section of this Guide

³ Substance Abuse and Mental Health Services Administration, Strategic Prevention Framework. <http://captus.samhsa.gov/access-resources/about-strategic-prevention-framework-spf>

includes creating or enhancing systems to support development activities and making sure that community members can access the services provided.

Sustainability and cultural competence are essential to capacity building. Sustaining efforts for the long term depend heavily upon broad cultural representation.

3. Planning⁴

Planning is essential to program success and sustainability and ensures that the focus of the staff and stakeholders is on reaching the same goals.

Planning at the community or tribe level typically includes the following activities:

- **Prioritizing the risk and protective factors** associated with the tobacco-related health disparities you are trying to address. Establish criteria such as changeability and importance to determine which factors are having the greatest impact in the community.
- **Select prevention interventions** that are evidence-based and in-line to address the priority problems identified. Before selecting a prevention intervention, “map” the cultural landscape of the community. Create an inventory of commonly spoken languages, socio-economic issues, neighborhood allegiances, and key leaders and their cultural connections. Involve representatives from across the cultural landscape in the selection of your prevention approaches.
- **Develop a comprehensive, logical, and data-driven plan** that includes

a logic model, plans for addressing identified resource and readiness gaps, and how issues of cultural competence are being addressed. Good planning requires a group process. Whether this process happens in a formal coalition or among a more informal group of partners, it cannot represent the thoughts and ideas of just one person. Decisions must reflect the ideas and input of individuals from across community sectors.

4. Implementation⁵

Implementation is when the action starts – when communities and coalitions do what they say they are going to do. Fidelity and adaptation are important components to consider throughout implementation. Fidelity refers to the degree to which a program is implemented as intended. Adaptation takes into account that the plan that was originally conceptualized may need to have a few elements changed in order to better meet local circumstances. There is a delicate balance between fidelity and adaptation because any time you change an intervention, you may affect the desired outcomes. Implementation will require some degree of adaptation in order to ensure efficiency, effectiveness, and cost-effectiveness.

5. Evaluation⁶

⁴ For more information on Planning please see the Developing Your Strategic Plan section of the Guide.

⁵ For more information on Implementation please see the Implementation section of this guide

Evaluation is the systematic collection and analysis of information about program activities, characteristics, and outcomes to reduce uncertainty, improve effectiveness, and make decisions. Evaluations improve efficiency in that evaluation results can be used to determine what efforts should be sustained, and what efforts need to be improved. The SPF evaluation includes evaluation of the five-step planning process. To evaluate the SPF process the following questions need to be included:

- How successful was the community in selecting and implementing appropriate strategies?
- Were these the “right” strategies, given the risk factors the community identified?
- Were representatives from across the community involved in program planning, selection, and implementation? In what ways were they involved?
- Was the planning group able to identify potential new partners with which to collaborate?
- What was the quality of the data used in decision-making?

Communicating the evaluation results to the community is important to maintain relationships and increase sustainability. Think about how the findings are reported, including layout, readability, and user-friendliness. Coalitions and organizations should be ready to provide

technical assistance after findings are reported.

Sustainability and Cultural Competency

The SPF steps are guided by the principles of *cultural competence*⁷ and *sustainability*.⁸

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. In order to effectively address tobacco related health disparities, you must understand the cultural context of the community and draw from community-based values, traditions, and customs, and work with knowledgeable people from the community to plan, implement, and evaluate tobacco prevention and control activities. Cultural competence helps to ensure that the needs of all community members are identified and addressed.

Sustainability is the ongoing processes that ensure the success and continuity of tobacco prevention and control programs. Sustainability needs to be taken into account at the beginning of planning, and ownership among stakeholders needs to be developed. Sustainability depends on:

- Community support
- Funding
- Community champions
- Training
- Best practices

The SPF is an effective, evidence-based

⁶ For more information on Evaluation please see the Evaluation section of this guide

⁷ See Cultural Competency section of the Guide for more information

⁸ See Sustainability section of the guide for more information

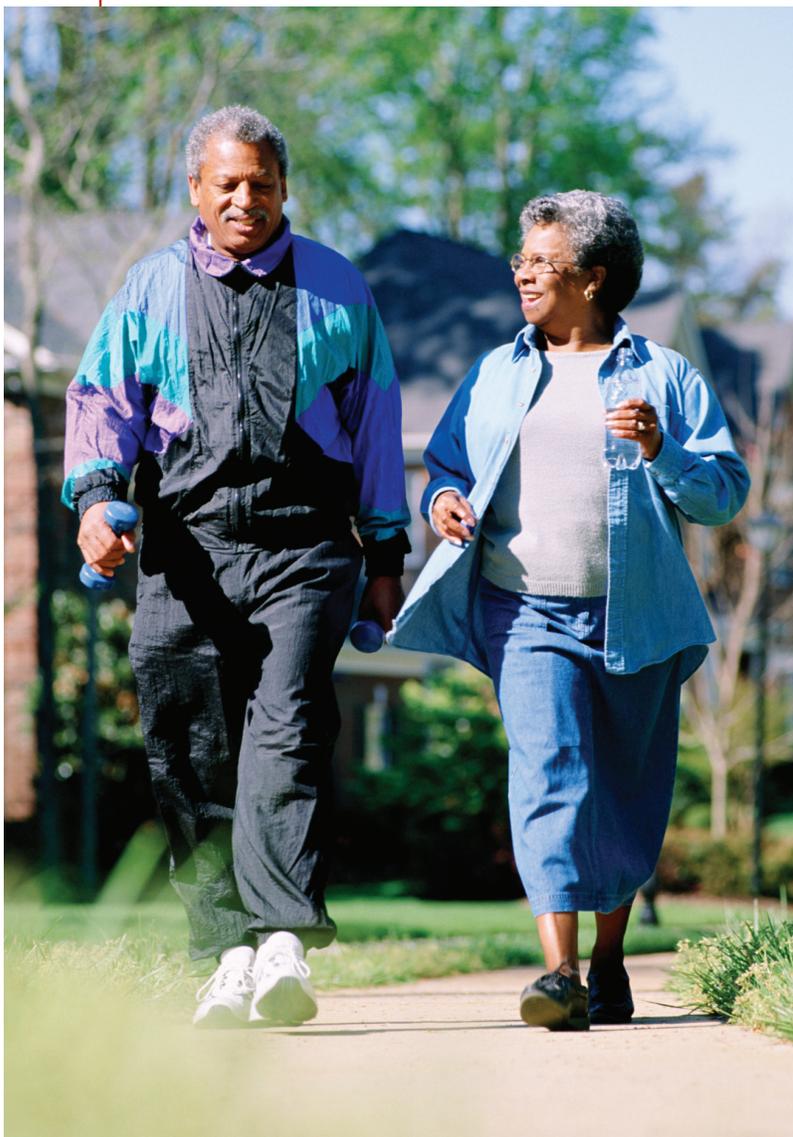
approach used in community efforts to address tobacco prevention and control. Communities free from tobacco and health disparities do not magically appear. It takes a continued and comprehensive effort from committed stakeholders to develop and sustain a successful tobacco prevention and control program. The five-step process, in conjunction with the underlying principles of cultural competency and sustainability, provides the infrastructure necessary to support community-based health interventions.

Section 1: Engaging the

Community

Community engagement is a process of working collaboratively with people associated with one another either by interests, geographic proximity, or similar circumstances to address issues affecting quality of life. Community engagement is an effective method to bring about environmental and social changes that improve the health of the community and its members. The following three chapters of the guide provide valuable information, resources, and tools needed to effectively engage communities in addressing tobacco-related health disparities.

- V. Coalition Building
- VI. Working with Priority Populations
- VII. Cultural Competency



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Coalition Building



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Coalition Building

The Prevention Institute defines a coalition as “a union of people and organizations working to influence outcomes on a specific problem. Coalitions are useful for accomplishing a broad range of goals that reach beyond the capacity of any individual organization.”¹ The knowledge and expertise of all members in a coalition can be put to use in seeking solutions. Together, individuals and organizations can maximize available resources to accomplish the task at hand.

Dynamic coalitions are effective and sustainable. In order to be dynamic, coalitions must have the ability to build capacity. Coalition building is and has been an effective strategy in accelerating tobacco control efforts to alter social norms through tobacco related policy change.² Coalitions provide organizations and individuals the opportunity to have a voice in community and statewide issues, and to participate in the strategic planning of tobacco control programs. Community outreach is essential to engaging disparate communities affected by tobacco-related health disparities when building or extending coalition membership. Strong coalitions cultivate relationships through engaging members in disparate communities.

Historically, coalitions and tobacco initiatives addressed mainstream communities. The positive

outcomes associated with tobacco initiatives in mainstream communities were not apparent in communities primarily composed of members belonging to priority populations. Coalition member recruitment must be ongoing, and an emphasis must be placed on recruiting members from disparate communities in a culturally competent manner to address the gap seen in health outcomes. Cultural competency is an influential component of building cohesive and inclusive coalitions. Cultural competency is imperative to influencing social norms to advance communities experiencing the disproportionate impact and burden of tobacco and tobacco-related diseases.

There are several steps or principles listed below that begin within your coalition and expand outward once engaging members within the community.

1) Recruit

The first step of engagement starts within the coalition. A core team of coalition members needs to be developed to recruit new members. The composition of the core team should reflect the ethnic and racial backgrounds of the community that you are trying to engage.

The National Partnership for Action to End Health Disparities (NPA) was established by the U.S. Department of Health and Human Services

1 Cohen L, Baer N, Satterwhite P. Developing Effective Coalitions: and eight step guide. In: Worsback Me, ed. Community Health Education and Promotion: A Guide to Program Design and Evaluation. 2nd ed. Gaithersburg, MD: Aspen Publishers Inc; 2002: 161-178.
2 Glantz SA, Begay ME. Tobacco industry campaign contributions are affecting tobacco control policymaking in California. *Journal of the American Medical Association* 1994; 272(15): 1176-1182.

Office of Minority Health in 2011 to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and move the nation toward achieving health equity. The NPA developed criteria for establishing partnerships. These criteria could aid your coalition in assigning job roles to effectively engage and connect with optimal community partners when conducting community outreach initiatives.

Establishing Partnership Criteria in Alignment NPA

Awareness Partner:

Primary goals are to collaborate at the local level to improve outreach efforts for community members; assist in identifying necessary steps for decreasing the number of community health disparities related to tobacco; offer assistance in providing media support (new campaigns, public relations work, community event support, and other health education opportunities); work to create new resources based on tobacco control and prevention goals based on what the community has identified.

Leadership Partner:

Primary goals are to work with local community members to identify and implement realistic steps (community-specific and

community-driven) that will strengthen local leadership, build capacity at the local, state, and national levels; assist local community organizations in taking advantage of funding opportunities available for improving community health and supporting local research efforts to eliminate tobacco related health disparities; assist local community members in forming strong, active coalition members for decreasing disparities; mentor youth and recruit them for leadership roles in the community to improve community wellness across the lifespan.

Life Experience Partner:

Primary goals are focused on holistic wellness/healthy living choices by improving access for community members; identifying barriers to healthy living in the community; and improving awareness of the importance of healthy lifestyle choices across the wellness spectrum (social wellness, physical wellness, emotional wellness, spiritual wellness, etc.). Special focus is on children and elders across all social service systems:

- For improvements in the quality of care in the local aging network
- For the development of youth programs, and institutions that support lifespan initiatives and planning (e.g., short & long term educational goals such as high school graduation rate, college planning, work life planning and other healthy lifestyle choices)

Cultural Connection Partner:

Primary goals are to actively work to improve diversity appreciation, particularly for cultural appreciation and understanding in the workforce; support increases in translation and bilingual support services for all service providers; assist in raising awareness of the importance of cultural education in the workplace for community members.

Research and Development Partner:

Primary goals are to support entities providing action-oriented plans to incorporate a true community-based research and evaluation process on all community research initiatives; invest in effective community intervention planning through knowledgeable health-care partners committed to reducing health disparities and strengthening community health; identify ways to expand and enhance community information for larger collaborations to improve health outcomes and sustain a high level of wellness for all community members.

Once the core team has been recruited and roles assigned, the first task of the core team is to develop the criteria for coalition membership. The next task is to map the community. Mapping the community will allow you to become knowledgeable about the community's culture, economic conditions, social networks, political and power structures, norms and values, demographic trends, history, and experience with efforts by outside groups to engage it in various programs. In these introductory settings and meetings, it is important to not only make a good impression, but to also be able to communicate to that community why its participation is worthwhile. Please utilize the Community Mapping template in the appendix section of this guide section. This community mapping exercise will allow your coalition to review various organizations across community sectors and rank importance, feasibility, and involvement.

HELPFUL TIP

It may be helpful to schedule a meeting with external entities/organizations that have engaged stakeholders within the community of interest in past projects. They may be willing to set up a few introductory meetings with contacts they have within the community. These organizations could also provide your coalition with tips and/or ideas on how to engage the community based on their past experiences.

It is important to be comprehensive and inclusive across community sectors. The Substance Abuse and Mental Health Services Administration (SAMSHA) identifies 12 sectors as critical to the initiatives on the community level. The 12 identified sectors are as follows:

1. Youth
2. Parents
3. Law Enforcement
4. Business
5. Media
6. Youth-serving organizations
7. Religious or fraternal organizations
8. State, local, or tribal agencies
9. Civic and volunteer groups
10. Schools
11. Health-care organizations
12. Other

When establishing relationships and building coalition membership, you should consider how you will invite potential members. Consider extending personal invitations, and careful consideration should be given to who extends the invitation from your coalition's core team. Try to schedule a meeting where community stakeholders are located. Holding a meeting in familiar surroundings will put the potential community partner at ease, build trust, and relay the message that your coalition values their participation and input. In these introductory settings and meetings, it is important to not only make a good impression through personalized introductions, but also to be able to express why participation is worthwhile to the community.

2) Identify and Mobilize Community Assets

It is also a good time to identify and assess community assets in introductory meetings. Community assets include interests, skills, experiences of individuals and organizations, and social networks. Institutional resources such as facilities, materials, skills, and economic power within the community can be assessed and mobilized. Coalitions need to be prepared to bring their resources to the table. As mentioned in the previous paragraph, coalitions need to make community participation worthwhile. Community members need to know that they stand to gain more than they lose.

(Please see appendix for coalition membership templates. Templates can be tailored to your coalition's information, and given to potential members.)

3) Build an Initial Framework for Working Together

Your coalition and its newest members need to build an initial framework for working together. The first order of business should be to create an appropriate decision-making and governing process. Determining how decisions are made, whether motions are passed by majority, unanimous, or any other type of vote, requires careful, deliberate discussion. Throughout this whole process, you must remember and accept

that collective self-determination is the right of the community. External entities cannot assume that new information will coerce or provide the impetus for communities to act in their own self-interest. Share power from the beginning. Plans for development, implementation, and evaluation should be conducted as a group. Value each member and what they contribute to the coalition. Included in the appendix of this chapter is an effective tool and exercise developed by the Prevention Institute to strengthen collaborative efforts across diverse fields.

4) Build Trust

Building trust is an ongoing process when expanding your coalition to include members within disparate communities. Avoid identifying with one organization or group within a community. Reaching out to the fullest range of formal and informal leaders and organizations will decrease the chances of alienating potential community partners by failing to engage and include them in coalition activities. One way to build rapport and trust among new coalition members is to plan events and activities where members can work together directly. If ownership and power are not shared throughout the engagement process, communities may feel as though they are being used for their connections or as a means to legitimize the work of external

entities. People in a community are more likely to participate in tobacco initiatives if they can identify with the issue, are respected, and are able to make a meaningful contribution.

5) Organize around a Vision, Mission, and Goals

As an established coalition, you most likely already have a Vision, Mission, and Goals statement. Your Vision, Mission, and Goals may not reflect what the community sees as their reality. As a group, organize, discuss, and identify areas of consensus. Establish an action agenda with achievable goals and objectives to mirror the updated Vision, Mission, and Goals. *(See appendix for template.)*

6) Effective Communication

Communication should be frequent. Frequent communication serves to reinforce commitment and shows new members that the coalition is active. Make sure the information communicated is relevant. Do not overburden new members with irrelevant information. Overburdening new members with irrelevant information may only serve to increase the chances of having your emails moved to junk mail.

Keep messages simple. The best communicators make it easy for other people to understand their messages. Structure your messages in a way that allows for and encourages

feedback from other group members. Be aware that informal modes of communication may be more effective with your new members. There are communities where traditional communication methods are not as effective. In these communities the spoken word is more effective than the written word.

7) Build on Success

The morale and vigor of a coalition is enhanced when success can be celebrated. Agendas that address tobacco-related health disparities and quality of life can be overwhelming. It is important to break down the big issues into smaller and more manageable pieces. Celebrations do not have to be elaborate or expensive in order to be considered a celebration. Taking a moment at the beginning of each meeting to recognize the efforts of coalition members can boost morale and energize coalition efforts. Focus on the strengths of the community and coalition efforts. Weaknesses need to be addressed, not as weaknesses, but rather as areas of improvement.

The tool kits below will provide more information on coalition building. There are also templates included to help map community assets and develop new visions, goals, and assets. Templates are also included in the appendices section of the Tobacco Guide.

Toolkits for Coalition Building

Best Practices User Guide: Coalitions – State and Community Interventions was developed to provide tobacco control program managers with information on the best practices of utilizing coalitions as a part of a comprehensive program that can lead to important policy changes. <http://www.cdc.gov/tobacco>
800-CDC-INFO (800-232-4636)
TTY: (888) 232-6348.

Beyond Targets: Communities of Color Making a Difference in Tobacco Control focuses on tools for building broader support for tobacco control as a larger agenda of community health through providing resources designed to help you think through policy development, advocacy, and leadership. www.ThePraxisProject.org (202) 234-5921.

Building Coalitions Among Communities of Color: A Multicultural Approach is a resource primarily for people of color, who are building coalitions in which representatives from communities of color predominate. This document offers guidance in coalition building, strategic planning, inter-group relations, organizational development, group maintenance, and evaluation. <http://minorityhealth.hhs.gov> 1-800-444-6472.

Developing Effective Coalitions: An Eight Step Guide provides structure to the coalition building process through eight specific steps. www.preventioninstitute.org 510-444-7738.

Mobilizing for Action: Building Capacity in your coalition provides tips and tools on how to start a coalition, expand a coalition, create shared goals and infrastructure, determine community readiness, identify key leaders/stakeholders, engage in youth prevention, and create a healthy, culturally inclusive environment to address the prevention of substance abuse. www.marshfieldclinic.org 1-866-520-2510.



COMMUNITY MAPPING

Directions: The coalition may break up into groups or work together in a large group to complete this checklist. If desired, use the Recruitment Planning Sheet in the workbook to move this listing of potential members from paper to reality.

Coalition Membership Checklist

Please rate the participation of the following organizations in the areas of their importance to the work of the coalition, the feasibility of getting them involved, if they already participate and the level of their involvement. A 1 indicates less and a 5 indicates most.

Education	Importance	Feasibility	Involvement
<i>Education (K-12)</i>			
School Superintendent(s)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Principal	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Drug Free Schools Coordinators	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
High Schools	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Middle & Junior High Schools	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
PTA Organizations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
School Resource Officer	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
<i>Colleges & Universities (if they are present in the community)</i>			
Administration	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Student Affairs	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Resident Managers	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Substance Abuse Prevention	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Judicial Review	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Campus Police	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Fraternities and Sororities	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Government	Importance	Feasibility	Involvement
Elected Official (national, state, and local)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Mayor or City/County Council	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Substance Abuse Prevention and Treatment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Department of Public Health	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Local Health Departments	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Community Health Clinics	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Department of Recreation	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Driver's Licensing Agencies	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Public Works Department	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Armed Forces	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
(Army, Navy, Air Force, Marines, Coast Guard, National Guard and Reserve Units)			
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Judicial Community	Importance	Feasibility	Involvement
Prosecutors/County/City Attorneys	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Judges:			
Juvenile Court Judges	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
District/Adult Court Judges	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Juvenile Justice System	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Admission/Intake			
Family/Parent Education Program			
Probation			
Probation and Parole (18 to 20 year olds)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Law Enforcement Community	Importance	Feasibility	Involvement
Chief's Office	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Local and State Police/Sheriff's Departments	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Alcohol Unit/Traffic Safety Unit			
Community Relations/Affairs			
Alcohol Beverage Control Agency/Dept	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Businesses/Employers	Importance	Feasibility	Involvement
Businesses That Employ Underage Youth	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Fast Food	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Movie Theaters	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Amusement Parks	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Alcohol Industry	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Bars	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Restaurants	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Liquor Stores/ Beer Distributors	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Liquor and Wine Wholesalers	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Insurance Companies	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Chambers of Commerce	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Labor Unions	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Local Major Employers	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Arenas	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Record and video stores	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Media	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Television Stations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Radio Stations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Newspapers	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Youth & Youth Organizations	Importance	Feasibility	Involvement
MADD YIA Groups	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
SADD Organizations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Boys & Girls Clubs	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Boy Scouts/Girl Scouts	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
YMCA	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4-H Clubs	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Substance Abuse Prevention Groups	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Religious Groups & Faith Organizations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Community	Importance	Feasibility	Involvement
Parent Groups	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Faith Community	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Citizen Activist Groups	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
MADD Chapters	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
RID Chapters	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Civic Groups	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Kiwanis	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Lions	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Rotary	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Junior League	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Minority/Culturally Specific Organizations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
National Urban League	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
NAACP	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
League of United Latin American Countries (LULAC)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Neighborhood Associations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Citizens	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Health Care Community	Importance	Feasibility	Involvement
Hospitals/Trauma Centers	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Physicians	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Pediatricians	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Medical Associations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Nurses	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Emergency Dept. Physicians & Nurses	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Health Maintenance Organizations	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Health Insurance Companies	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Emergency Medical Technicians And Paramedics	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Other _____	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Harsha, B. (2001). *Community how to guides on...Coalition building*. National Highway Traffic Safety Administration (NHTSA). Appendix 1. To view PDF's visit:
http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Guides_index.html

COMMUNITY MAPPING EXERCISE

Coalition reflection on the community: Pass this form out to current and new members of your coalition in order to brainstorm and list as many people within each sector as possible. Please be as inclusive as possible. For example, a school coach may have just as much to contribute to the coalition as the school principal. Please also include key community leaders.

Youth: _____

Parents: _____

Law enforcement: _____

Business: _____

Media: _____

Youth-serving organization: _____

Religious or fraternal organization: _____

State, local and tribal agencies: _____

Civic and volunteer groups: _____

Schools: _____

Health-care organizations: _____

Other: _____

(Adapted from the Marshfield Clinic Building a Solid Foundation)

LETTER INVITATION

Agency Logo/Letterhead
(or coalition logo if developed)

(Date)

Hello,

I am currently coordinating the development of a coalition in (Community/County). A coalition is an alliance of people, groups, agencies, etc. who come together for a specific or common purpose. The focus of this coalition will be to (provide details).

The first step in developing a coalition is to draw together a group of individuals from many sectors of the community who will begin discussing local needs related to this issue. Your expertise would be very valuable as we strive to build a strong coalition.

Our first meeting will be held on (date, time, location).

During this meeting, you will hear more about this opportunity, and you will play a key role by sharing your knowledge and insight with the group. Please note that your attendance at this meeting does not commit you to join the coalition. However, you are more than welcome to do so. The meeting will last for approximately one hour. Feel free to bring a lunch with you. Coffee and treats will be provided.

Enclosed you will find general information on the drug/issue we are attempting to impact. If you have any questions, please call or email me at _____.

Sincerely,
(name)

PS If you are unable to attend, please consider sending another representative from your organization. Concerned individuals representing a variety of professions and interests are what will lead to our success!

Sample Membership Form

**[Name of Coalition]
MEMBERSHIP FORM**

PERSONAL INFORMATION

Name: _____

Address: _____

Phone: _____

Email: _____

Race/Ethnicity: _____

Number of Lived in [Name of Community]: _____

ORGANIZATION INFORMATION

Organization Represented: _____

Type of Organization: _____

Organization Tasks: _____

Major Organizational Success: _____

Are you authorized to officially represent this group? Yes No

GENERAL INFORMATION

What brought you here? _____

On which specific area(s) would you like to see the [name of coalition] focus? _____

Skills/Interests you are willing to share with the coalition? (Examples: designing print media, writing, public speaking, etc.) _____

What would you like to do in addressing community priorities? _____

Is there anyone else you would recommend for coalition membership? Yes No

If “yes,” please provide name(s) and contact information below.

Comments:

(Adapted from Building Coalitions Among Communities of Color: A Multicultural Approach)

SAMPLE AGENDA

(COALITION NAME)

(Location)

(Date)

(Time)

AGENDA

1. Call to order/Welcome and Introductions

2. Review and Approve Minutes

3. Updates

4. Committee Reports

5. Other

- Next meeting
- Member comments

(Standard meeting agenda courtesy of Marshfield Area Coalition for the Youth)

Developing the Vision, Mission, and Goals

Vision

The vision is a state of what the coalition wants to accomplish, create, or achieve. It typically consists of a single sentence that is short and to the point. Questions to ask yourself when constructing your vision include:

- What change does our coalition want to make for our community?
- What we are doing and why are we doing it?

Mission

A mission statement describes what the coalition will do to make its vision a reality. It is the “doing” statement. The statement is clear, concise, and used to hold the coalition accountable. A question to ask yourself:

- What needs to happen to bring our vision into a reality?

Goal(s)

The goals of your coalition should reflect what you want to see accomplished in the community, and should guide decision-making. Goals should be Specific, Manageable, Attainable, Relevant, and Time-bound (SMART).

(Adapted from CDC’s Best Practices for Comprehensive Tobacco Control Programs)

COLLABORATION MULTIPLIER

Enhancing the Effectiveness of Multi-Field Collaboration

Collaboration Multiplier is an interactive tool for strengthening collaborative efforts across diverse fields. A multi-field approach has proven vital for tackling today's complex social challenges. Whether the goal is promoting health equity, strengthening local economies, reducing greenhouse gas emissions, or enhancing community safety, improving our well-being requires community-wide changes that include strengthening government policies and the practices of key organizations. Multi-field collaboration expands available resources, strategies, and capabilities to achieve outcomes that could not be accomplished by one field alone.

Collaboration Multiplier provides a systematic approach to laying the groundwork for multi-field collaboration. The tool guides organizations through a collaborative discussion to identify activities that accomplish a common goal, delineate each partner's perspective and potential contributions, and leverage expertise and resources. Collaboration Multiplier is based on the understanding that different groups and sectors have different views of an issue and different reasons for engaging in a joint effort. For example, a collaborative formed to increase access to healthy food in underserved neighborhoods can more effectively engage partners by recognizing that each has their own goals. A grocery store operator might expand fresh food offerings to enhance sales and profits, a health department would support the effort to improve health, and the Mayor might

see enhanced food retail as fundamental for a flourishing community. Collaboration Multiplier helps surface these perspectives and forge strategies that advance their objectives simultaneously.

Collaboration Multiplier can be used in different stages of collaboration. It can be used by a newly formed or established partnership that wants to strengthen its collective effort, or it can be used by an individual or small set of organizations that recognize the value of a diverse partnership and want to think strategically about whom to invite to the table.

The Collaboration Multiplier Process

Collaboration Multiplier occurs in two phases: 1) Information Gathering and 2) Collaboration Multiplier Analysis.

In the first phase, the key sectors and fields that can contribute to a solution are identified. Then key information from the perspective of each field (or prospective field) is collected according to a common set of categories. Specific categories vary based on the particular collaboration, but typical examples include:

- **Importance:** Why is this issue important?
- **Organizational Goals:** What are the goals related to this issue?
- **Audience:** Who is the primary audience/constituency?
- **Expertise:** What unique expertise does this field bring to the collaborative?

Partner	Importance	Organizational Goals	Expertise	Assets & Strengths	Key Strategies	Desired Outcomes	Partnership	Organizational Benefit

- **Assets/Strengths:** What resources (skills, staff, training capacity, funding) can be brought to the table?
- **Key Strategies:** What key strategies/activities are currently implemented relevant to this issue?
- **Desired Outcomes:** What specific results/outcomes are desired as a result of this collaboration? What does success look like?
- **Data:** What data is collected, and how?
- **Partnership:** Which partners/participants can be brought to the table to enhance outcomes?
- **Organizational Benefit:** What is the benefit of participating in this collaborative?

Compiling this information can provide a “big picture” snapshot for partners and lays the groundwork for a collaborative discussion.

In the next phase, the collaborative engages in a “collaboration multiplier analysis” to discuss the implications based on the information collected. Some key areas of discussion can include:

- What partner strengths can the collaborative utilize? How do you leverage each partner’s expertise?
- What results and outcomes can be achieved together?
- What strategies/activities can two or three partners work together on?

Collaboration Multiplier serves as a starting point for appreciating what different fields can bring to the table and for building effective interdisciplinary efforts through partnership. After completing the two-phase process, partners can begin developing a comprehensive strategy to achieve their shared vision. To support strategic efforts, Collaboration Multiplier is designed to complement and inform Prevention Institute’s Spectrum of Prevention, a tool for developing multifaceted activities for effective prevention, and The Eight Steps to Effective Coalition Building, a step-by-step guide for coalition development and sustainability. Effective collaboration can be a powerful force for mobilizing individuals to action, bringing health and safety issues to prominence, forging joint solutions, and developing effective policies. By working through Collaboration Multiplier, partners will see the fruits of their efforts grow exponentially.

For more information, visit Prevention Institute’s website at www.preventioninstitute.org or e-mail virginia@preventioninstitute.org.

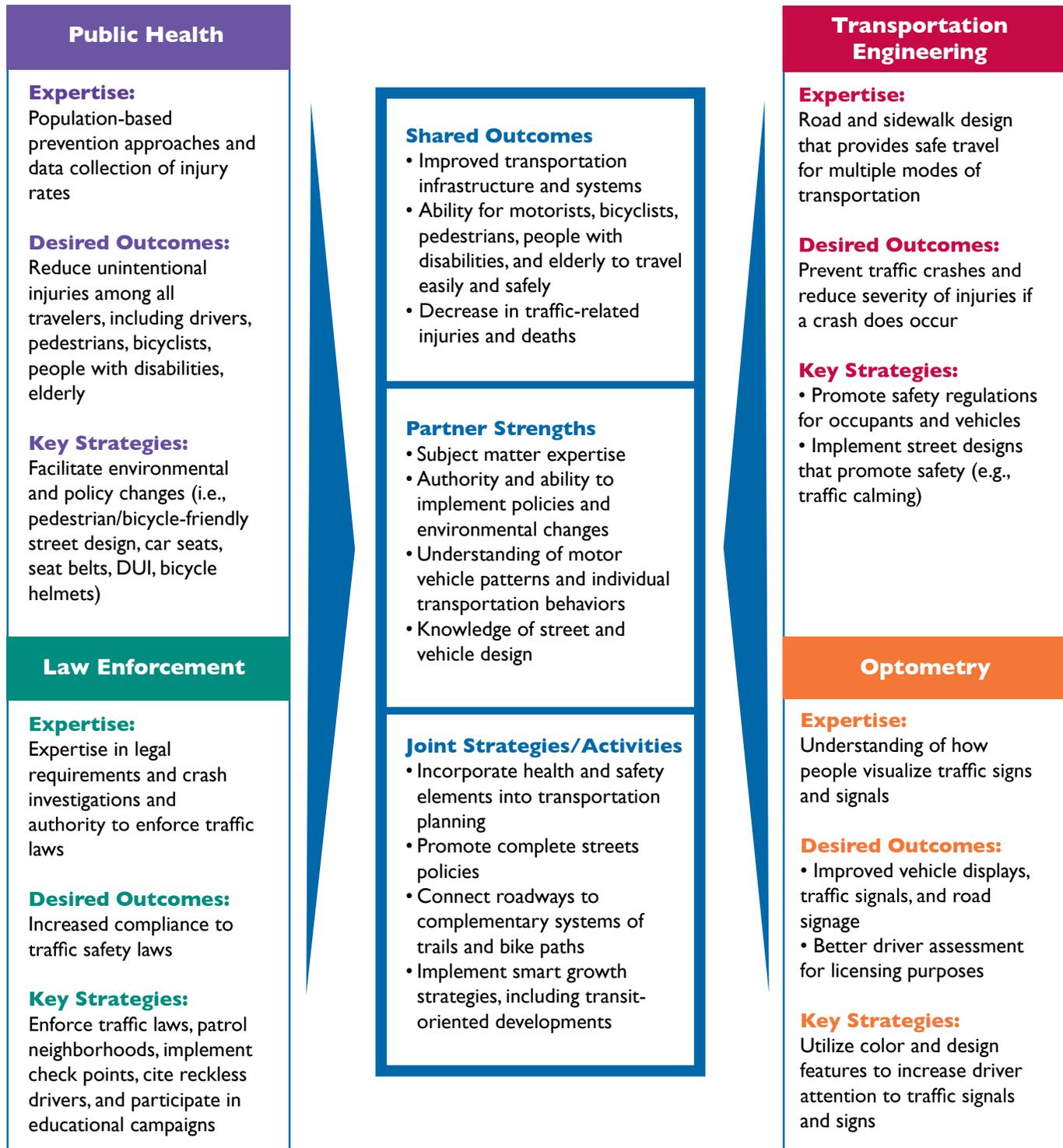
COLLABORATION MULTIPLIER EXAMPLE: TRAFFIC SAFETY COALITION

Goal: Decrease traffic-related crashes and fatalities Phase I: Information Gathering

(This is a sample; expected levels of detail would be greater)

	Expertise	Desired Outcomes	Strategies
Public Health	Population-based prevention approaches and data collection of injury rates	Reduce unintentional injuries among all travelers, including drivers, pedestrians, bicyclists, disabled, elderly	Facilitate environmental and policy changes (i.e., pedestrian/bicycle-friendly street design, car seats, seat belts, driving under the influence, bicycle helmets)
Law Enforcement	Expertise in legal requirements and crash investigations and authority to enforce traffic laws	Increase compliance with traffic safety laws	Enforce traffic laws, patrol neighborhoods, implement check points, cite reckless drivers, and participate in educational campaigns
Transportation Engineering	Road and sidewalk design that provides safe travel for multiple modes of transportation	Prevent traffic crashes and reduce severity of injuries if a crash occurs	Promote safety regulations for occupants and vehicles; implement street designs that promote safety
Optometry	Understanding of how people visualize traffic signs and signals	<ul style="list-style-type: none"> • Improve vehicle displays, traffic signals, and road signage • Better driver assessment for licensing purposes 	Utilize color and design features to increase driver attention to traffic signals and signs

Phase II: Collaboration Multiplier Analysis



Phase II: COLLABORATION MULTIPLIER ANALYSIS

Goal: _____

COLLABORATOR
Expertise:
Desired Outcomes:
Key Strategies:
COLLABORATOR
Expertise:
Desired Outcomes:
Key Strategies:

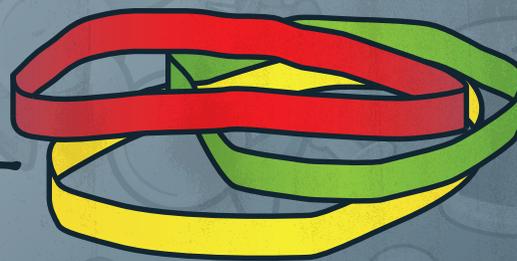
WHAT RESULTS/OUTCOMES CAN BE ACHIEVED TOGETHER?
WHAT PARTNER STRENGTHS CAN THE COLLABORATIVE UTILIZE?
WHAT STRATEGIES/ACTIVITIES CAN 2+ PARTNERS WORK TOGETHER ON?

COLLABORATOR
Expertise:
Desired Outcomes:
Key Strategies:
COLLABORATOR
Expertise:
Desired Outcomes:
Key Strategies:

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Working with Priority Populations



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Priority Populations

Although tobacco is an equal opportunity killer, certain communities bear a disproportionate burden of tobacco-related health disparities. The National Conference on Tobacco Health Disparities (NCTHD) defines tobacco-related health disparities as

“Differences in the patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in capacity and infrastructure, access to resources, and environmental tobacco smoke exposure.”¹

The differences in patterns of tobacco use, prevention, and treatment result in poorer health outcomes, and higher morbidity and mortality rates among specific populations. Factors influencing tobacco-related health disparities are social and economic inequities, age, gender, race, sexual orientation, language, and inequitable distribution of healthcare resources.

Priority populations are identified by the Centers for Disease Control and Prevention (CDC) as groups that experience significant tobacco-related health disparities. Priority populations typically are defined by demographic factors such as age, gender, race/ethnicity, income level, education attainment or grade level, marital status, or health care coverage status; a geography such as a region of

a state or specific community; or a location in which the priority population may be reached such as a workplace, school, or church. The CDC has identified African Americans, American Indian/Alaska Native, Asian American/Pacific Islander, Hispanic/Latino, Lesbian, Gay, Bisexual, Transgender, and Low Socio-Economic Status people as priority populations. Descriptions of how tobacco use affects each priority population are included within this guide section.

In 2004, Texas became a “majority-minority” state, meaning that its racial and ethnic minority population is now greater than the White population. Racial and ethnic minority groups have been shown to experience disproportionality at a greater rate. Potential reasons for disparities may include interrelated factors such as genetics, the environment, lifestyle choices, differences in cultural beliefs, linguistic barriers, social determinants of health, and trust in health-care providers. This is a complex problem and requires significant consideration when working with priority populations. The message that is delivered through your program and/or tobacco coalition is the key to success, particularly in reaching out to priority populations. Educational messages and programs need to be tailored to your audiences’ different ages, cultural backgrounds, beliefs, educational level and economic status. The increasing population growth of racial and ethnic communities and linguistic

¹ Fagan P, King G, Lawrence D, Petrucci SA, Robinson RG, Banks D, Marable S, Grana R (2004). *Eliminating Tobacco-Related Health Disparities: Directions for Future Research*. American Journal of Public Health . 94;2.

groups, each with its own cultural traits and health profiles, presents challenges for tobacco coalitions in Texas.

Listed below are tools and resources based on working with priority populations. These tools and resources will aid your coalition to engage priority populations in tobacco prevention and control initiatives.

Resources and Toolkits to Address Priority Populations

Agency for Healthcare Research and Quality provides the National Healthcare Disparities Report which is a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and within priority populations and tracks the progress of activities to reduce disparities. www.ahrq.gov 301- 427-1104.

American Medical Association hosts a Doctors Back to School program which aims to encourage children from under represented minority groups to look at medicine as a career option, and ultimately work toward eliminating racial and ethnic health disparities. <http://www.ama-assn.org> 800-621-8335.

Department of Health and Human Services (DHHS) website on specific populations links to information on topics related to priority populations including immigrants, rural health, disabilities, and racial and ethnic minorities. www.hhs.gov/specificpopulations/index.shtml 1-877-696-6775.

Families USA provides an Action Kit to community leaders with information, tools, and resources necessary to engage in health advocacy and improve the health and well-being of their communities. <http://familiesusa.org> 202-628-3030.

Gay Data allows user to access health data on LGBT populations and learn how to collect sexual orientation data effectively in scientific surveys, questionnaires, and studies. <http://www.gaydata> 215-762-8785.

Health Research and Educational Trust provides a disparities toolkit to help health-care organizations educate staff and implement a systematic method of collecting race, ethnicity, and primary language data. <http://www.hretdisparities.org> 312-422-2600.

HHS Offices of Minority Health federal, regional, and state minority health offices dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. <http://minorityhealth.hhs.gov> 1-800-444-6472.

HHSC Center for the Elimination of Disproportionality and Disparities addresses disproportionality and disparities to ensure racial equity in the delivery of services to clients across all health and human services agencies and programs as well as other systems that serve vulnerable populations by providing technical assistance through use of the Texas Model for Addressing Disproportionality and Disparities and data analysis. www.hhsc.state.tx.us/ceed 1-877-316-2822.

National Conference of State Legislatures allows user to access articles, technical assistance, maps, charts, and briefs on minority health, health disparities, and health reform for states. <http://www.ncsl.org> 202-624-5400.

National Partnership for Action to End Health Disparities provides a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities reach their full health potential. <http://minorityhealth.hhs.gov/npa/> 1-855-JOIN-NPA 1-855-564-6672.

Southwest Rural Health Research Center on the health challenges of the rural population in the US. Some of the distinctive cultural, social, economic, and geographic characteristics that define rural America place rural populations at greater risk for a myriad of diseases and health disorders. www.srph.tamushsc.edu 979-862-4238.

Think Cultural Health offers the latest cultural competency tools and online learning to promote cultural and linguistic competency in health care for health professionals and tools for health-care organizations from the HHS Office of Minority. Offers the latest resources and tools to promote cultural and linguistic competency in health care. You may access free and accredited continuing education programs as well as tools to help you and your organization provide respectful, understandable and effective services. <http://www.thinkculturalhealth.hhs.gov> 1-800-444-6472.

The Commission to Build Healthier America accesses data and resources related to the social factors that influence health from the Robert Wood Johnson Foundation. <http://www.commissiononhealth.org> 877-843-7953.

Unequal Treatment is a landmark study from the Institute of Medicine that explores the inequality in health care, and provides recommendations for reducing racial and ethnic disparities in health care. <http://www.iom.edu> 202-334-2352.

Unnatural Causes...is inequality making us sick? presents a video documentary series with accompanying discussion, policy guides, handouts, and planning events in exploring racial and socioeconomic inequalities in health [in English, Spanish and Asian languages]. <http://www.unnaturalcauses.org> 415-284-7800.

National Standards on Culturally and Linguistically Appropriate Services (CLAS) provides principles and activities of culturally and linguistically appropriate services should be integrated

throughout an organization and undertaken in partnership with the communities being served. <http://minorityhealth.hhs.gov> 1-800-444-6472.

Hispanic Population

“Hispanic” or “Latino” refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture regardless of race. According to the 2010 Census, 50.5 million or 16% of people residing in the United States identified themselves as Hispanic. In Texas, the Hispanic population comprises approximately 38% of the total population.²

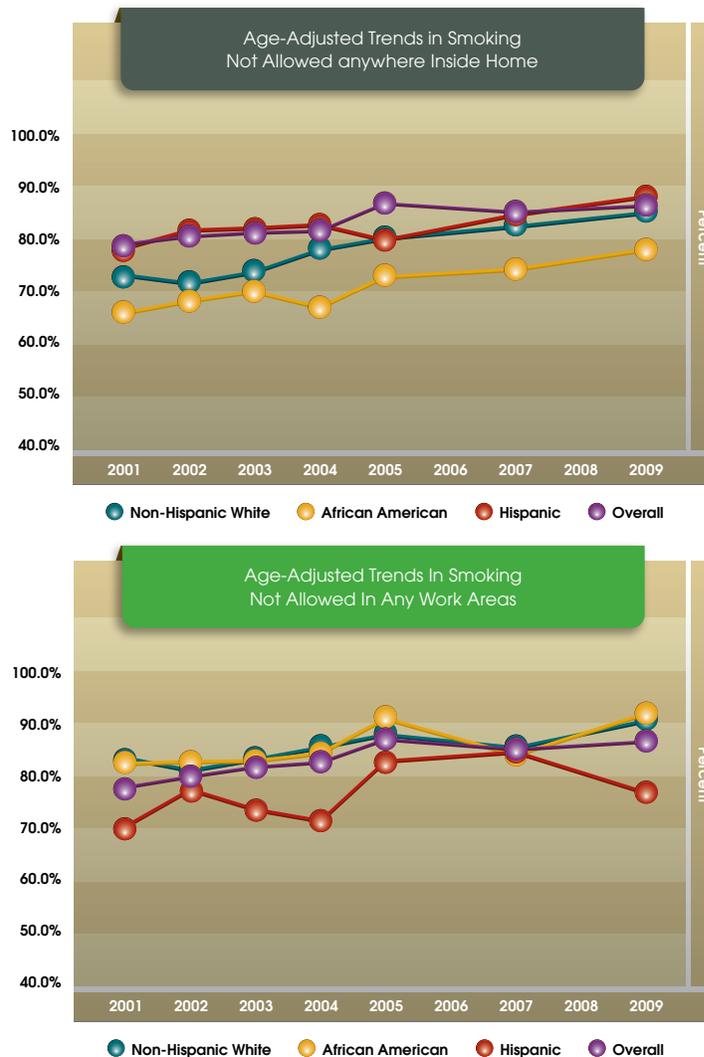
The prevalence of smoking among Hispanics is lower than that of whites, African Americans, and American Indians/Native Americans. Despite the lower prevalence of cigarette smoking, lung cancer is the leading cause of cancer among Hispanics. Secondhand smoke is linked to lung cancer as well as other tobacco related cancers, and although Hispanics have the lowest exposure to secondhand smoke at home, they have the highest rates of exposure to secondhand smoke at work.³ The susceptibility of Hispanic workers to unsafe or hazardous working environments is greater compared to other Texans. Hispanics are less likely to be covered by workplace smoking policies and exposure to secondhand smoke. Hispanics comprise about 10.5% of the food industry, and workers in the service industry are less likely to be

² United States Census Bureau. Census Brief: The Hispanic Population. Washington, DC: United States Department of Commerce, United States Census Bureau, 2011. Available from <http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>
³ Center for Health Statistics. Texas Behavioral Risk Factor Surveillance System data. Austin, TX: Texas Department of State Health Services, Center for Health Statistics, 2001-2009.

covered by smoke-free workplace ordinances.⁴ This may indicate that occupations dominated by non-Hispanic whites are more likely to have workplace regulations for smoking. These startling numbers highlight the importance of workplace regulations banning smoking at the worksite.

It is important to note that Hispanics born in America are more likely to smoke than their counterparts born elsewhere (19.1% vs 11%).⁵ Acculturation and tobacco industry targeting are prominent influences to this difference in prevalence. Acculturation is the process whereby the attitudes and/or behaviors of people from one culture are modified as a result of contact with a different culture.⁶ The tobacco industry has profited from its research and understanding of Hispanic culture, and has used acculturation in methods to promote tobacco use among the Hispanic population. The tobacco industry influence the Hispanic community through contributions to Hispanic cultural events, and through targeted promotions including the introduction of cigarette brands with names such as “Rio” and “Dorado” to advertise to the Hispanic community.

The development and support of smoke free policies are imperative to combat and reduce tobacco use and secondhand smoke in Hispanic communities. Your coalition’s tobacco control



and prevention efforts should address the specific tobacco-related situations that are relevant to Hispanic communities. For instance, there is a high percentage of Latino smokers who do not identify themselves as smokers if they only occasionally smoke cigarettes. Messages about smoking and quitting should focus on the behavior of smoking and/or the situations in which the smoking takes place. Messages that focus on “smokers” may miss a large percentage of the people they are trying to reach.

⁴ American Community Survey, 2006-2008, www.census.gov/acs

⁵ Centers for Disease Control and Prevention. 2008. *Cigarette Smoking Among Adults-United States, 2007*. Morbidity and Mortality Weekly Report. 57(45):1221-1226. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a2.htm>

An emphasis on how light smoking or smoking primarily in social situations places still people at risk for disease and other negative consequences. It is also important to recognize why people smoke. In many cases, Latino smokers associate some benefits with smoking such as providing pleasure and relieving stress.

Listed in the resources section for the Hispanic/Latino populations are tools to address tobacco use in this community in a culturally competent manner.

Hispanic Toolkits

Sabemos: Por respeto – Aquí no se fuma is a community outreach toolkit designed to help community leaders heighten awareness among Hispanic/Latino parents who have recently arrived in the United States about secondhand smoke and how it can affect them and their children. This kit also includes an interactive CD-ROM that contains electronic versions of the Sabemos print and media materials providing guidance on practical steps for creating smoke-free environments in the home, workplace, and community. <http://www.cdc.gov/tobacco/> 800-CDC-INFO or 800-232-4636 TTY: 888-232-6348.

Train the Trainer Smoking Cessation Tool-Kit: Help Someone Quit Today toolkit provides the knowledge and information to health educators, case managers, and others so that they can make system changes in their organizations and provide the necessary assistance to their Latino clients.

<http://www.indianalatin.com>
626-457-6606 or 626- 457-4189.

African-American Population

In the early 20th century African Americans smoked at a fraction of the rate of whites. The tobacco industry identified this population as an untapped market, and began to target the African American community using specific marketing strategies to influence the purchasing of tobacco products. For instance, the tobacco industry noticed that menthol cigarettes were popular in African American communities, and began to market menthol cigarettes heavily through advertisements, promotions, and discounts in predominately African American neighborhoods.⁷

Today, 21.3% of all adult African Americans smoke, and approximately 83% of African American smokers aged 12 and over smoke menthol cigarettes as compared to 24% of Whites.^{8,9} In Texas African-Americans have lower smoking rates than whites, but the highest rates of secondhand smoke in the home.¹⁰ The highest mortality rates from lung cancer are also found in black males, with rates approximately 30% higher than white males, who have the next highest rate.¹¹ African American smokers in Texas bear a disproportionate burden of tobacco-related

⁶ Encyclopedia of Public Health: <http://www.enotes.com/public-health-encyclopedia>

⁷ Connolly, G. (2007). Testimony before the U.S. Senate Committee on Health, Education, Labor and Pensions. Retrieved from <http://www.tobaccofreekids.org/reports/tda/Connolly022707.pdf>. Cited in National African American Tobacco Prevention Network. African Americans and Menthol. www.naatpn.org

⁸ Centers for Disease Control and Prevention. Vital Signs: Current Cigarettes Smoking Among Adults Aged > 18 years—United States, 2009. *MMWR* 2010; 59(35): 1135-1140.

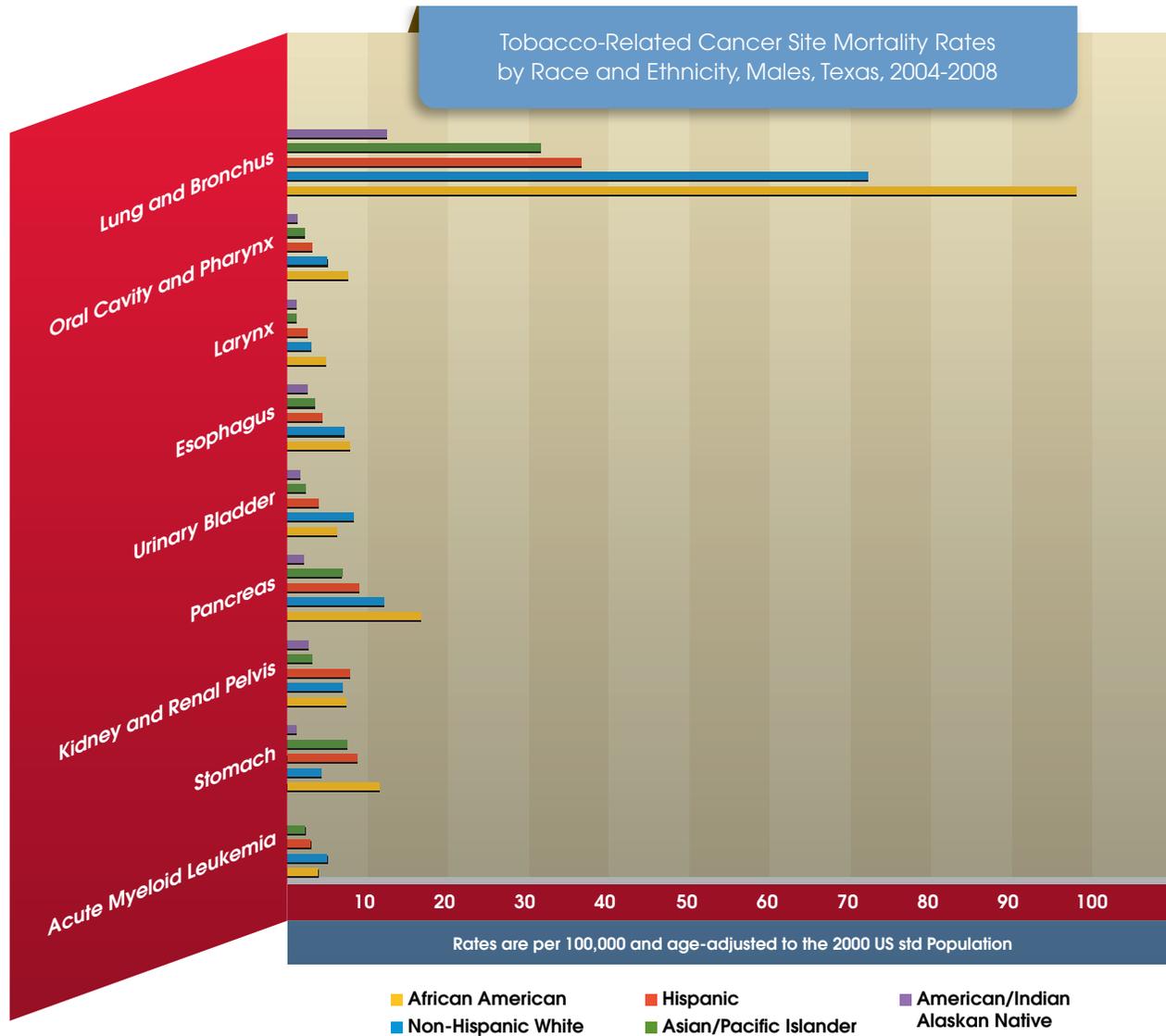
⁹ Substance Abuse and Mental Health Services Administration. The NSDUH Report: Use of Menthol Cigarettes. Rockville, MD; 2009.

¹⁰ Center for Health Statistics. *Texas Behavioral Risk Factor Surveillance System Data*. Austin, TX: Texas Department of State Health Services, Center for Health Statistics, 2001-2009.

¹¹ Risser DR, Bowcock CL, Miller EA, Magid R, Garcia R. Cancer in Texas, 2011. Austin, TX: Texas Cancer Registry, Texas Department of State Health Services; Cancer Prevention Research Institute of Texas, 2011.

cancers, experiencing the highest incidence for six of the ten tobacco-related cancers (Lung & bronchus, oral cavity and pharynx, larynx, esophagus, pancreas, and stomach).¹²

perceived racial discrimination.¹³ There have been several studies that reveal perceived race-based discrimination as the best predictor of smoking behavior among African Americans



There are several reasons as to why tobacco-related health disparities exist in the African American community. For many African Americans, smoking is a coping mechanism used to manage the stress associated with

over other smoking predictors such as education, gender, income, and age.¹⁴ Perceived and actual discrimination increase the amount of everyday stress, and contributes to tobacco-related health disparities seen in African Americans. Also it

¹² Texas Department of State and Health Services. Cancer Epidemiology and Surveillance Branch, Texas Cancer Registry, Incidence- Texas 1995-2008.

¹³ Bennett GG, Wolin, K.Y., Robinson E.L, Fowler, M.S, Edwards, C.L. Perceived Racial/Ethnic Harassment and Tobacco Use Among African American Young Adult. AM J Public Health 2005; 95(2): 238-240 as cited in Legacy for Longer Lives. African Americans and Smoking www.legacyforhealth.org

¹⁴ Landrine H, Klonoff EA. 2000. Racial Discrimination and Cigarette Smoking among blacks: finding from two studies. Ethnicity Dis. 10: 195-202.

is important to note that in the years following the Surgeon General's report on tobacco and its harmful effects in 1966, many nationwide organizations focused cessation efforts to target mainstream communities, and have failed to address and/or have little affect on lower income and racial and ethnic minority populations.

Adopting a community-based approach in your coalition to undertake tobacco-related health disparities within the African American community is essential to addressing tobacco control and prevention. Developing relationships and partnerships within African American communities is an important component in using a community-based approach. Partnerships should include organizations not typically associated with tobacco control such as faith-based organizations, fraternities, and sororities. Increasing the awareness and knowledge of the impact the tobacco industry on the African American community will motivate members to take action. The tobacco industry has been very successful in using culturally specific marketing strategies in the African American communities, and it is important for tobacco coalitions to also use culturally specific strategies in order to eliminate tobacco-related health disparities.

Listed below are toolkits that have been effective in addressing tobacco-related health

disparities in the African American community. There are also handouts geared toward increasing awareness and knowledge of tobacco in the African American community from the National African American Tobacco Prevention Network in the resources section of this guide.

African American Toolkits

FightKool: Operation Storefront Activity provides activities that encourage young people to take a closer look at tobacco advertising and promotions at stores that sell tobacco products. <http://aacoh.org/> (888) 4-NAATPN.

Pathways to Freedom: Winning the Fight Against Tobacco addresses issues specific to African Americans, such as targeted advertising campaigns and historical, cultural, and socioeconomic influences. <http://www.cdc.gov/tobacco/> 800-CDC-INFO or 800-232-4636 TTY: 888-232-6348.

Ujima: An Action Guide, African-Americans Building Stronger, Healthier, Tobacco Free Communities Together is designed for communities, organizations, and individuals that seek to address the toll of tobacco-related problems in African American communities. <http://www.tobaccopreventionnetworks.org> 919-855-4800.

American Indian/Alaskan Native Population

The health disparities in the American Indian/Alaskan Native (AI/AN) communities are largely attributed to tobacco use. Tobacco use is associated with heart disease and cancer, which are the two leading causes of death in AI/AN adults. The disproportionality in health status can also be attributed to high levels of poverty, lower educational attainment, lack of health insurance, and lack of access to medical care.¹⁵ Tobacco historically and presently has a sacred role in American Indian cultures. Traditional tobacco uses in the AI/AN culture include burning tobacco during prayer and other ceremonies as well as for medicinal and healing rituals. The Native American Rehabilitation Association of the Northwest (NARA) lists the following ceremonial uses of tobacco:

- To honor and welcome guests
- To bless food crops
- To communicate with the Creator or the Spirit World
- To ensure the welfare of the people
- To bless a hunt
- To bind agreements between tribes
- As payment to a healer

Today, the traditional use of tobacco is overshadowed by the abuse of commercial tobacco. AI/AN have the highest smoking rate (23.2%) compared to any other racial/ethnic minority population in the U.S.¹⁶ The tobacco industry has targeted the AI/AN community through sponsorship as well as advertisements at pow-wows, rodeos, and other cultural events. The tobacco industry uses American Indian imagery and cultural symbols such as warriors and feathers. An example of this is the American Spirit brand, which features an American Indian smoking a pipe.

Texas ranks fourth in the U.S. in the AI/AN population, which is a significant increase from being ranked eighth in 1990.¹⁷ There is a general lack of trust in the U.S. government amongst the AI/AN community due to how the AI/AN population was treated historically. Tobacco coalitions need to be mindful of this when engaging the AI/AN community. The Tobacco Control Evaluation Center recommends the following:

- Set up communications with tribal councils and tribal IRBs
- Create an advisory committee with local AI/AN members to guide discussions
- Share resources with non-tobacco entities that work in the same AI/AN communities
- If you are invited to visit a reservation,

¹⁵ Satter D.E. Roby, D.H., L.M. and Wallace, S.P. (2010). *Costs of Smoking and Secondhand Smoke Exposure in California American Indian Communities*. Los Angeles, CA: UCLA Center for Health Policy Research.

¹⁶ CDC. "Vital Signs: Current Cigarette Smoking Among Adults Aged > 18-Years United States, 2009" *MMWR* 59(44), September 7, 2010 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5935a3.htm?ts_cid=mm5933a3_w.

¹⁷ U.S. Census Bureau. 2010. Facts for Features: American Indian and Alaska Native Heritage Month. November 2010. U.S. Census Bureau News. www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb10ff22.html

first ask what is socially acceptable before you begin your interviews (e.g. customs on addressing one another, phrasing questions, and eye contact)

- Be agreeable with AI/AN customs
- If the community you are visiting has casinos, familiarize yourself with the history and economic role of casinos in the community

The toolkits listed below will further help your coalition address tobacco related-health disparities in a culturally sensitive manner in the AI/AN communities.

American Indian/Alaskan Native Toolkits

Indian Community Health Profile Project Toolkit was designed to be a proxy for overall health. Rather than the usual collection of morbidity and mortality rates, the toolkit provides tribes a concise, comprehensive, and user-friendly set of indicators with which to assess community health. www.npaihb.org 503-228-4185.

Tribal Tobacco Policy Workbook remains among the most comprehensive guides for achieving tobacco policy change in tribal communities. With step-by-step guidance, this workbook has served as a resource for tribes throughout North America to write, pass, and enforce tobacco-related policies. www.npaihb.org 503-228-4185.

Asian American/Pacific Islander Population

The United States Census Bureau (2010) defines Asians as persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Pacific Islander is defined as persons with ancestors native to the Hawaiian Islands, Polynesia, Melanesia, and Micronesia. AAPIs comprise approximately 5% of the population in the U.S. and Tobacco use is the number one preventable cause of death among Asian Americans and Pacific Islanders in the U.S.¹⁸ The overall smoking prevalence of AAPIs is relatively low at 11.6%, but there are certain subgroups within this population in which the smoking rate is much higher. For instance, the prevalence of smoking among Native Hawaiian or other Pacific Islander adults is 16.5%.¹⁹ The AAPI community bears a disproportionate impact from tobacco-related diseases. Root causes such as socioeconomic and political inequities have an adverse effect on the health status of the AAPI population. The tobacco industry further compounds this problem through targeting marketing of tobacco products in AAPI communities.

¹⁸ Asian Pacific Partners for Empowerment and Leadership

¹⁹ CDC. Vital and Health Statistics – Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009. Available at http://www.cdc.gov/nchs/data/series/sr_1/sr10_249.pdf

Tobacco companies target AAPI populations using culture specific media messages that portray smoking as a way to become more Americanized. Research show that Asian men with low acculturation have higher smoking rates compared to those with high acculturation. The same cannot be said for Asian American women in that Asian American women with high acculturation have higher smoking rates compared to those with low acculturation.²⁰ This difference in acculturation and smoking rates among men and women can be attributed to the tobacco industry specifically targeting AAPI women and girls to portray smoking as glamorous and “Western” (APPEALS 2002).

AAPIs also experience disproportionality in exposure to secondhand smoke. Many AAPIs work in the service industry such as in restaurants, bars, casinos, and hotels. Texas municipalities have passed smoke-free ordinances (45% municipal population is protected), but many of these bans do not encompass service industry workplaces. As a result, AAPIs in the service industry are exposed to and experience the harmful effects of secondhand smoke.

Currently, the AAPI comprise approximately 4% of the Texas population, but they have experienced the fastest population growth

compared to other racial/ethnic groups in Texas from the 2000-2010 Census. Knowing and understanding the cultural issues impacting the AAPI population is essential to a tailored approach to engaging members of this community. For instance, tobacco takes many forms in the AAPI community. Listed below are different types of smoked and smokeless tobacco used by Asian Americans typically of South Asian descent:

- *Bidis* – small, thin hand rolled cigarettes wrapped in a tendu or temburni leaf and smoked without a filter²¹
- *Zarda* – a tobacco mixture with betel nut, lime, and other spices which are usually chewed²²
- *Paan Masala* – chewable, smoke-less tobacco consisting of sweet tobacco, betel nut and other flavoring ingredients, wrapped together in a betel-leaf and chewed as a quid²³

Typical or mainstream smoking and/or tobacco cessation programs may not reach the AA/PI population due to the lack of tailored programs for various types of tobacco, and lack of information regarding the cultural implications that may be associated with use.

The Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) recommend the following tailored, culturally competent, and community-effective approaches to tobacco

²⁰ Kim SS, Ziedonis D, Chen K. Tobacco Use and Dependence in Asian Americans: A Review of the literature. *Nicotine and Tobacco Research*. 2007; 9(2): 169-184 as cited in *Legacy for Longer Lives: Asian Americans, Native Hawaiians, and Pacific Islanders and Smoking*. www.legacyforhealth.org

²¹ Robbins, LT. Flavored Cigarettes (Bidis) Popular Among Youth. *Legislative Brief* 9(45), National Conferences of State Legislatures; November/December 2001 as cited in *South Asian Network, Tobacco and South Asians*, www.southasiannetwork.org.

²² Puttaiah R, Carley K, Holvanahalli R. Tobacco, betel-quid chewing, and oral health. In: Bedi R, Jones P.(eds) *Tobacco and betel-quid chewing among the Bangladeshi community in the United Kingdom*. Centre for Transcultural Oral Health, London, 1995 as cited in www.southasiannetwork.org.

²³ Wasnik KS, Ughade SN. Tobacco consumption practices and risk of oro-pharyngeal cancer: a case-control study in Central India. *Southeast Asian J Trop Med Public Health* 1998; 29(4): 827 – 834 as cited in www.southasiannetwork.org

control within the AA/PI population:

- Fund and conduct surveillance and needs assessments of AA/PI populations; separate data by ethnicity, gender, and language
- Fund culturally competent research, evaluation, and intervention studies on AA/PI population groups
- Provide funding for development of AA and PI tobacco control leaders within the community
- Fund culturally-tailored tobacco prevention and cessation programs for youth and young adults to focus on broad youth/young adult issues, advocacy, and empowerment
- Fund policy change initiatives that assist AA/PI blue-collar industry workers and promote clean indoor air
- Promote sustainability programs to assist AA/PI small merchants and restaurant owners with compliance to current smoking ordinances and legislation
- Develop culturally-tailored media and communication campaigns on the impact of secondhand smoke on AA/PI communities
- Increase access to free language-appropriate and culturally competent tobacco cessation services
- Increase representations of AA/PI community stakeholders in tobacco coalition activities
- Increase and improve grant making opportunities, resources and support for AA/PI community based organizations to work on tobacco prevention and control²⁴

It is imperative for Texas tobacco coalitions to develop capacity to work with diverse AAPI communities. This is a great opportunity for tobacco coalitions to work with communities which could not only benefit the communities, but also the overall tobacco movement. Listed below are toolkits to aid in efforts to address culturally specific issues in the AAPI population.

Asian American/Pacific Islander Toolkits

Conducting Needs Assessment for Tobacco Control in Asian American and Pacific Islander Communities was designed to help those who work with Asian American and Pacific Islander (AAPI) communities on tobacco prevention and control to better design and implement their activities and programs. www.appealforcommunities.org 510-272-9536.

Enhancing Cultural and Community Competence for Tobacco Control for Asian Americans and Pacific Islanders toolkit designed to assist in the initial assessment of institutional cultural and community competency and to encourage agencies to engage in the on-going process of developing cultural competence while working with Asian American and Pacific Islander (AAPI) communities. www.appealforcommunities.org 510-272-9536.

Implementing Community Readiness Approach to Tobacco Control consists of compilations of case studies highlighting how five regional coalitions or networks from across the continental U.S. and Hawaii took up the challenge of reducing tobacco use in their local Asian American and Pacific Islander (AAPI) communities using a community capacity building approach. www.appealforcommunities.org 510-272-9536.

²⁴ Asian Pacific Partners for Empowerment, Advocacy and Leadership. *A Policy Framework for Preventing and Reducing Tobacco Use, Obesity, Cardiovascular Diseases and Cancer in Asian American, Native Hawaiian and Pacific Islander Community*. June 2011; www.appealforcommunities.org

Integrating Evaluation into Tobacco Programs for Asian American and Pacific Islander Communities evaluation kit is designed to help people who are developing or implementing tobacco control programs for Asian American and Pacific Islander (AAPI) communities. www.appealforcommunities.org 510-272-9536.

Making Tobacco Relevant for Asian American and Pacific Islander Communities kit is designed to aid those working in tobacco prevention and control within the Asian American and Pacific Islander (AAPI) community. www.appealforcommunities.org 510-272-9536.

Project and Event Planning for Tobacco-Free Asian American and Pacific Islander Communities action kit provides you with strategies to plan and implement tobacco control projects in Asian American and Pacific Islander (AAPI) and other diverse communities. www.appealforcommunities.org 510-272-9536.

Tobacco Cessation Among Asian American and Pacific Islanders: A Community Approach kit assists Asian American and Pacific Islander (AAPI) communities in implementing tobacco cessation programs and policies. www.appealforcommunities.org 510-272-9536.

Lesbian, Gay, Bisexual, and Transgender (LGBT) Population

The Lesbian, Gay, Bisexual, and Transgender (LGBT) community comprises about 3% of the U.S. population.²⁵ Although this population is typically excluded from research, studies, and surveys capturing smoking prevalence, the number of reports are increasing to convey that the LGBT community has significantly higher smoking prevalence rates when compared to the

general population of the U.S. A large information gap exists due to the exclusion of questions addressing sexual orientation; however, based on the data that is available, it is determined that the LGBT community experience the negative impact of tobacco related health disparities. The high smoking rates and impact of tobacco related health disparities may be a result of variety of influences such as peer pressure, stresses of social stigma, targeting by the tobacco industry, and limited access to effective tobacco and medical treatment.

Research shows that stress caused by actual or perceived stigma can influence negative health behaviors that result in tobacco use and the associated negative health consequences.²⁶ The bar culture also has a huge influence on the smoking rates in the LGBT community. Bars provide an important role in the LGBT community in providing a safe and social environment to meet and socialize. The disadvantage is that without smoke-free ordinances, bars are often establishments that enable social tobacco use, and increase the exposure to secondhand smoke.

The tobacco industry recognized the LGBT community as an untapped population that is typically ignored by other companies, and use culturally specific and tailored methods to successfully promote cigarettes. Tobacco

²⁵ Census Snapshot: United States. 2007, The Williams Institute, University of California, Los Angeles.

²⁶ Health Care Needs of Gay Men and Lesbians in the United States. Council Report. 1996, Journal of the American Medical Association, Vol 275(17), pp.1254-1359.

companies advertise in LGBT focused publications, and often provide funding to LGBT organizations. Some of the tobacco related health disparities in the LGBT population are a result of the lack of access to treatment. Lack of health insurance, and perceived and actual discriminatory healthcare practices increase the avoidance to seeking treatment.

Although Texas does not have data to depict the prevalence of tobacco use in the LGBT, or even the size of the LGBT population for that matter, it is important for tobacco control programs to include this population. Keep in mind that the LGBT community is a diverse community comprised of people from various race/ethnicities. In order to include the LGBT population in your coalition's tobacco control and prevention initiatives to address the tobacco related health disparities associated with this population, the American Lung Association recommends:

- Including sexual orientation and gender identity questions in the core demographic questions in local and state surveillance systems and surveys
- Recognize LGBTs as a priority population and engage as well as include representatives from LGBT organizations in intervention development and implementation
- Increase cultural competence and knowledge related to interests, issues, and concerns of the LGBT population

- Providing targeting media materials regarding tobacco use and prevalence
- Providing tailored cessation services. The Last Drag is an example of a promising, tailored and culturally competent cessation service

There is a belief in the research community that people would be uncomfortable with answering questions about their sexual orientation. This assumption is false. States that have included questions on sexual orientation have had excellent response rates. In fact, responses to questions on sexual orientation were at times greater than questions about household income.²⁷

Examples of questions provided by the LGBT Network to incorporate in surveys include:

Example 1: Do you consider yourself to be:

- Heterosexual or straight
- Gay or lesbian
- Bisexual

Example 2: Do you consider yourself to be one or more of the following:

- Straight
- Gay or lesbian
- Bisexual
- Transgender
- Other _____

The toolkits listed below will provide further instruction as to how to adequately and successfully address tobacco-related health disparities in the LGBT population.

²⁷ Vankim N. & Padilla J. 2010. *New Mexico's Process in Collecting Lesbian, Gay, Bisexual, and Transgender Health Data and its Implications for Addressing Health Disparities*. New Mexico Department of Health. Available online: www.nmtupac.com/reports/new/2010_LGBT_Report.pdf. As cited in American Lung Association Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community. www.lungusa.org

LGBT toolkits

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals serves as both a reference tool and program guide to inform administrators and clinicians on successful program development and implementation strategies for effective lesbian, gay, bisexual and transgender sensitive programs. www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727) TTY: 1-800-487-4889.

Best Practices for Asking Questions about Sexual Orientation on Surveys guide with a multi-disciplinary expert panel in order to identify and provide the best scientific approaches and methodology in capturing sexual orientation on surveys. <http://www.lgbttobacco.org> 617-927-6451.

Low Socioeconomic Status Population

Nationally, the overall smoking prevalence has decreased. Although the smoking prevalence has decreased, it still remains relatively high among low socioeconomic (SES) status individuals. Low SES populations are defined as sociodemographic groups of individuals with low income, people with fewer than 12 years of education, individuals with limited or no medical insurance, the unemployed or underemployed, and the working poor. The prevalence of smoking is greatest among Low SES adults. In 2009, 31% of adults below the federal poverty level smoked, compared with 19% of those at or above the poverty level.²⁸

Tobacco-related health disparities affect the low SES population for a variety of reasons. Low SES individuals are more likely to experience exposure to secondhand smoke at home as well as the workplace. Approximately half of blue collar workers are not covered by smoke-free policies at their worksites, whereas 76.3% of white collar workers are protected by worksite smoke-free policies.²⁹ Moreover, low SES individuals are less likely to be insured and have access to the smoking cessation services provided by health insurance. Studies conducted within the CDC Office of Smoking and Health reveal that coverage of smoking cessation services increases the success rate of quitting smoking as well as increase the number of quit attempts.³⁰ Low SES individuals typically smoke to relieve stress, and often relapse due to stress and low efficacy.³¹ Tobacco advertisements often glamorize tobacco use through portraying tobacco users as successful and powerful. The reality is most smokers are poor and have limited education, and the tobacco industry is preying on the low SES population through a message that smoking gives you status.

Well over 4 million Texans live below the poverty level. That is 17.1% of the population in Texas.³² Families and persons are classified as below poverty if their total income or unrelated

²⁸ Centers for Disease Control and Prevention. Vital Signs: Current Cigarette Smoking Among Adults Aged > 18 years – United States, 2009. *MMWR Morb Mortal Wkly Rep* 2010; 59(35): 1135-1140 as cited in Legacy. *Socio-Economic Status and Smoking*. www.legacyforhealth.org

²⁹ Campaign for Tobacco-Free Kids. 2010. *Tobacco and Socioeconomic Status*. Available at: <http://www.tobaccofreekids.org/research/factsheets/pdf/0260.pdf>

³⁰ DHHS, CDC, Office of Smoking and Health, "What is the Role of Health Insurance Coverage in Tobacco Use Cessation?" [Washington, DC: CDC] 22 June 2010 http://www.cdc.gov/tobacco/quit_smoking/cessation/coverage/page2/index.htm

³¹ Prevention Research Center and National Network on Tobacco Prevention and Poverty. 2004. *Smoking Habits and Prevention Strategies in Low Socioeconomic Status Populations*. Available at <http://www.healthcouncil.org/breakfreealliance/pdf/preres.pdf> as cited in NALBOH. Tobacco use Prevention Among Low Socioeconomic Status Populations. www.nalboh.org

³² U.S. Census Bureau. (2010 June). Texas QuickFacts from the U.S. Census Bureau. Retrieved August 16, 2011. <http://quickfacts.census.gov/qfd/states/48000.html>

individual income was less than the poverty threshold specified for the applicable family size, age of the householder, and the number of related children under 18 present. While non-Hispanic whites are currently the largest single group of impoverished in the U.S., ethnic minority groups are overrepresented among those living in poverty. Low-income populations from all races and ethnicities tend to be in poorer health than others. According to the Office of Minority Health, poverty is associated with a lack of resources, information, and knowledge; substandard living conditions; risk-promoting lifestyle; and diminished access to health care. Poor health decreases people's capacity to work, which reduces their ability to better their socio-economic status, thus continuing the cycle of poverty to subsequent generations.

The economic downturn has widened the gap between the rich and the poor, making it crucial for tobacco coalitions to address tobacco-related health disparities in the low SES population. The American Legacy Foundation, a foundation dedicated to the development of programs to address the health impacts of tobacco use, recommends the following strategies to address tobacco-related health disparities in low SES populations:

- Engage non-traditional, community based partners
- Integrate tobacco control into multiple

services provided by governmental and non-profit organizations

- Empower members and leaders in the low SES population to address tobacco control issues in their communities as part of their social-justice and quality of life agenda
- Engage and empower low SES youth
- Implement culturally tailored, place-based interventions
- Develop the capacity of non-traditional organizations to implement integrated tobacco control programs
- Educate health-care providers such as community health centers about the cessation interventions focused on low SES populations
- Implement public media campaigns specifically designed to reach low SES populations

The toolkit listed below will further guide your tobacco coalition toward addressing tobacco related health disparities.

Low SES Toolkit

Tobacco Control in Low SES Populations explores promising, evidence-based policies to address tobacco related health disparities in the low SES population. www.legacyforhealth.org 202-454-5555.

Youth Population

Tobacco use is typically initiated during adolescence. There are approximately 850 youth that become daily smokers every day in the U.S.³³ It is also during adolescence that lifetime smokers first develop their smoking habit.

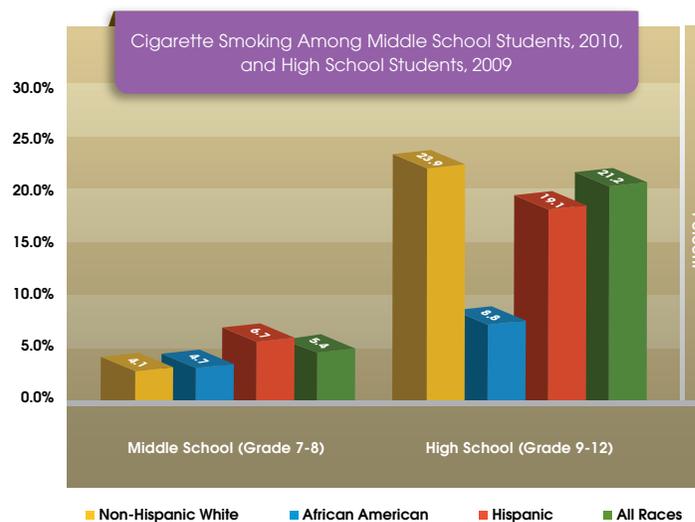
Factors associated with youth tobacco use include:

- Low socioeconomic status
- Use and approval of tobacco use by peers or siblings
- Lack of skills to resist influences of tobacco use
- Smoking by parents or guardians and/or lack of parental support or involvement
- Accessibility, availability, and price of tobacco products
- Perception that tobacco is the norm
- Low level of academic achievement
- Low self-image or self esteem
- Aggressive behavior (adapted from CDC Youth and Tobacco Use 2011)³⁴

The trend of tobacco use among middle and high school students has decreased steadily over the past decade, but that trend has recently slowed in the past few years. It is important to remain vigilant in tobacco control policies for youth. Lifetime smokers typically begin smoking

in their youth. The tobacco industry recognizes the importance of targeting adolescents and spends millions in order to develop more lifetime smokers or a future generation of smokers.³⁵

The overall 2009 youth prevalence of tobacco use was 15.1%. Prevalence rates vary regionally, with some regions of Texas reporting up to 19.7% use rates among middle school and high school students. In 2009, the rates of cigarette smoking among high school students were highest among non-Hispanic whites and Hispanics (23.9 and 22.5 percent).³⁶ For middle school, smoking rates were highest for Hispanics (6.7%).³⁷



The success in decreasing the trend of tobacco use is exigent on youth engagement. Tobacco control organizations and coalitions need to engage the youth in order to challenge

³³ Substance abuse and Mental Health Services Administration. *Results from the 2009 National Survey on Drug Use and Health*, detailed tables.

³⁴ Centers for Disease Control and Prevention. *Best Practices Users Guide: Youth Engagement – State and Community Interventions*. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

³⁵ *Best Practices for Comprehensive Tobacco Control Programs*, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, October, 2007.

³⁶ Center for Health Statistics. *Texas Youth Risk Behavior Survey data*. Austin, TX: Texas Department of State Health Services, Center for Health Statistics, 2001-2009.

³⁷ Mental Health and Substance Abuse Division. *Texas School Survey of Substance Abuse data*. Austin, TX: Texas Department of State Health Services, Mental Health and Substance Abuse Division, 1998-2010.

conventional thinking, advocate for policies, and change the social norms on tobacco use. The CDC's Best Practices User Guide for Youth Engagement list the following as important reasons to include the youth tobacco control:

- **Advocate for Policy Change.** Youth can be effective in garnering support for policy development and change, and can capture the attention of political leaders and the media.
- **Project a Powerful Voice.** Youth have credibility with peers and community members. This allows them to help educate the community to reduce pro-tobacco influences and increase healthier norms and behaviors.
- **Expose tobacco industry tactics.** Young people can be effective partners in the fight against the tobacco industry by exposing its manipulative tactics and undermining its efforts.
- **Offer energy and vitality.** Youth bring energy to activities and events. Tobacco control programs should work to channel action, resulting in increased awareness and policy change.
- **Reflect genuine concern.** Youth generally volunteer their time to be involved in tobacco control efforts. They do this because of the stake they have in their own future.

- **Bring diverse representation and provide generational insight.** Youth can provide important insight about their generation. Involving youth in tobacco control efforts ensures the design of effective, population-specific policies.
- **Invoke creativity and innovation.** Young people naturally challenge the traditional attitudes that may restrict and limit how adults think and act. They add innovation and creativity to any program, making it more attractive to other youth and policy makers.
- **Mobilize their peers.** Youth have the ability to mobilize their peers for activities and facilitate access to many arenas. These actions add strength to tobacco control policy efforts while also broadening the type and number of venues involved in message delivery.

To further understand how to engage the youth in tobacco, please review the CDC's Best Practices User Guide for Youth Engagement listed below.

Youth Toolkit

Best Practices User Guide: Youth Engagement – State and Community Interventions focuses on the role youth play in advancing policy as part of a comprehensive tobacco control program.
<http://www.cdc.gov/tobacco>
1-800-232-4636 TTY: 1 (888) 232-6348.

Rural Populations

According to Rural Healthy People 2020, rural areas report a higher prevalence of chronic diseases that has been attributed, in part, to a rural population that is older, poorer, and less educated than urban populations. Differences also exist between urban and rural populations in that rural populations tend to be older, less educated, and poorer than urban residents and have limited access to quality medical care facilities. Smoking and excessive alcohol use are among the number of behavioral and social factors that have been identified as related to an increased risk of a variety of diseases in the rural population. Tobacco-related health disparities exist among rural populations in terms of the prevalence of tobacco use, and the related consequences that result. The smoking prevalence in rural areas is

higher than urban areas, and the rural setting has significantly higher smokeless tobacco use rates as well. According to the 2007 National Survey on Drug Use and Health, the use of smokeless tobacco in rural areas is about three times as high as the rates in metropolitan regions.

The tobacco industry also influences the rural population through sponsorship of sporting events such as rodeos, bull-riding, and car racing.³⁸ Familiar advertisements such as those who feature the Marlboro man often provide a bucolic image that is often appealing to many individuals in the rural population.

The U.S. Census Bureau defines rural as any area that is not urban, with urban being defined as a settlement with 1,000 persons per square mile. This definition is very limiting in that rurality is multidimensional with many



economic, demographic, and geographic sociologic aspects. Rural populations are linguistically and ethnically diverse, and therefore need a culturally competent approach to addressing tobacco prevalence and policy change.

Rural areas, especially along the Texas-Mexico border, contain many newly immigrated Hispanics/Latinos with cultural roots on both sides of the border. Four of the seven poorest cities and five of the poorest counties in the U.S. are located in Texas along the Mexican border in rural areas. In order to effectively address tobacco-related health disparities in rural areas, tobacco coalitions and or tobacco control programs need to identify rural areas as well as the unique social, economic, cultural, and geographic conditions unique to that area. Many rural areas consist of tight-knit communities that are connected to their faith-based institutions. There are strong, informal social networks in rural communities that, once tapped, could be very influential in gaining support and mobilizing stakeholders.

The toolkits listed below will help your tobacco coalition address tobacco use in a culturally competent manner for rural populations.

Toolkits for Rural Populations

Tobacco Control in Rural America examines tobacco-related health disparities facing

rural areas in presented creative approaches to facilitating the enforcement of tobacco-free policies, reshaping norms and public opinion around tobacco use, or connecting rural tobacco users with cessation services. <http://www.americanlegacy.org> 202-454-5555 .

Atlas of Rural and Small-Town America is an internet-based information system that allows you to manipulate various socioeconomic data series used in many Economic Resource Service (ERS) products. Use the interactive tools to create and manipulate charts, maps, and tables including multidimensional tables, such as poverty rates by urban/rural status. <http://www.ers.usda.gov/Data/Ruralindex.htm> 202-694-5050.

Mental Illness and Tobacco Use

There are tobacco-related health disparities that exist among people with mental illness when compared to the general populations. People with mental illnesses live twenty-five fewer years on average due to the association of preventable and treatable causes of disease, disability, and death that result from tobacco use.³⁹ Approximately 200,000 of the 443,000 people who die prematurely from smoking each year are people with mental illness or substance use disorders.⁴⁰

There are several contributing factors to the tobacco-related health disparities among people with mental illnesses. Often people who have problems coping with stress, anxiety, and depression are more susceptible to nicotine

³⁹ Colton, C.W. and Manderscheid, R.W. (2006). Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*, 3(2). Retrieved from http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.

⁴⁰ Schroeder, S.A. (2009). A 51-year-old woman with bipolar disorder who wants to quit smoking. *JAMA*, 301, 522-531.

dependence, and they use cigarette smoking as a coping mechanism. Another important factor is the limited training mental health providers have in addressing tobacco use, and also the attitude many mental health workers have that addressing tobacco use and cessation is not important. Psychiatrists are less likely as compared to other health professionals to ask about a patient's smoking status and provide advice to quit due to the commonly held belief that their patients have more pressing issues to address.⁴¹ Smoking is often viewed as the social norm in mental health and substance abuse centers.

Approximately one in five Texas adults has a mental illness.⁴² This is a vulnerable population due to the high morbidity and mortality rates associated with smoking and access to smoking cessation services. Studies have shown that you do not need to be free of mental illness in order to quit smoking (Schroeder 2009). It is important for tobacco control organizations and coalitions to recognize the high prevalence of tobacco use in this population in order to work toward promoting prevention and cessation.

Several key strategies include:

- Training mental health-care providers in evidence-based tobacco cessation strategies
- Develop policy to support tobacco-free environments at mental health service campuses

- Enforce smoke-free policies at psychiatric hospitals and clinics
- Raise awareness among partners regarding disparate smoking rates among people with mental illness
- Partner with follow-up agencies and resources, including outpatient programs, case managers, consumer-operated services, private psychiatric facilities, state tobacco programs and quit lines to broaden efforts

The toolkits listed below will further help guide you in addressing tobacco-related health disparities for people with mental illnesses.

Toolkits for Mental Illness

A Hidden Epidemic: Tobacco Use and Mental Illness seeks to call attention to the issue of the high prevalence of tobacco use and nicotine dependence among people with mental illnesses and to highlight barriers to effective tobacco-cessation efforts to help people with mental illnesses quit. www.Legacyforhealth.org 202-454-5555.

Bringing Everyone Along Resource Guide aims to be a practical resource based on existing research, insights and advice obtained through key informant surveys of professionals, and the interpretation and recommendations of an Expert Advisory Committee. www.tcln.org 503-418-1659.

Tobacco-Free Living in Psychiatric Settings: A Best Practices Toolkit Promoting Wellness and Recovery includes practical tools to create a tobacco-free psychiatric setting. www.Nasmhpd.org 703-739-9333.

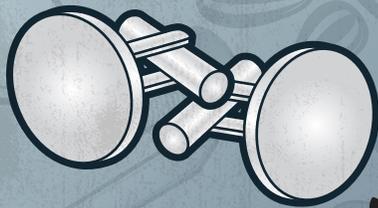
⁴¹ Association of American Medical Colleges, "Physician Behavior and Practice Patterns Related to Smoking Cessation, Summary Report" (Washington, D.C.: American Association of Medical Colleges, 2007), 69.

⁴² Morningside Research and Consulting (2005). *Mayor's Mental Health Task Force Final Report*, Austin, TX.

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Cultural Competency



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Cultural Competency

The growth of racially and ethnically diverse communities has presented new challenges for public health practitioners in addressing health equity. The divisions of race, ethnicity, and culture are apparent in disproportionate health outcomes. In order to address health disparities, health practitioners must understand the attitudes and health seeking behaviors of the individuals and communities disproportionality experiencing negative health outcomes. Cultural competency is imperative to closing the gap in health disparities. When taken apart, cultural and competency have two very different meanings. *Culture* refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. *Competence* implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.¹ *Cultural Competency* is defined as a collection of skills that support understanding and appreciation of cultural differences. Cultural competency is achieved through willingness and ability to recognize community-based values, traditions, and customs, and to work with people from the community in assessing, planning, implementing, and evaluating programs to address

tobacco-related health disparities.

Cultural competency is one of the two underlying components of the five steps in the Strategic Prevention Framework (SPF).² The *Actions to ensure cultural competence for your coalition* planning checklist was developed by Community Anti-Drug Coalitions of America (CADCA) to help coalitions navigate through the five steps in the SPF while incorporating cultural competency. This checklist will assist your coalition in ensuring that cultural competency is evident in the SPF. A copy of this checklist can be found in templates section.

Cultural competency is essential in addressing and eliminating tobacco-related health disparities. Tobacco disparities continue to exist for communities of color and other priority populations. These disparities have been linked to an increased exposure to secondhand smoke in several priority population subgroups within minority communities. An excess burden of tobacco-related diseases such as heart disease, stroke, lung cancer, oral cancers, and other respiratory illnesses results in the disproportionate mortality rates experienced by vulnerable populations. Lack of access to health care, as well as the inequities in treatment patients from priority populations experience, adds to the overall negative outcomes in tobacco-related diseases. Despite the greater need, priority populations receive inadequate and unequal funding to address tobacco issues. As

¹ The Office of Minority Health U.S. Department of Health and Human Services. What is Cultural Competency. Adapted from Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards A Culturally Competent System of Care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

² See Strategic Prevention Framework (SPF) section in guide to reference

a result of this inadequacy, priority populations have lower institutional capacity, funding, and infrastructure to develop comprehensive and culturally competent approaches to addressing tobacco-related health disparities. Data and research for subgroups of priority populations need to be examined in order to better understand and address tobacco issues. Informal community assessments, in addition to rigorous and validated research, need to be conducted as well.

Tobacco coalitions must work toward becoming culturally competent in order to adequately address tobacco-related health disparities within Texas communities. Tobacco control works to alter social norms and/or environments by changing public policies, which makes cultural competency imperative to addressing diverse communities in order to make headway and sustain initiatives against the disproportionate impact and burden of tobacco. A culturally competent organization has diversity within its workforce as well as the capacity to incorporate many different behaviors, attitudes, and policies and work effectively in cross-cultural settings to produce better health outcomes.

As a tobacco coalition serving the community, it is important to acknowledge the diversity in your community. Sustainable and effective tobacco prevention and control programs depend on community engagement, and successful community

engagement is dependent on cultural competency. In planning your program to address tobacco health disparities in priority populations, one of the key steps will be to identify your audience/community. A thorough understanding of community diversity will assist your coalition to engage communities in a culturally competent manner. Any community planning should reach all the members of the community, especially those most impacted by tobacco. Research studies provide evidence that empowerment achieved through effective community engagement can improve community efficacy and influence outcomes.³ It will be important to understand the social, economic, and cultural aspects of the chosen group in order to tailor your activities, messages, and educational components to effectively reach the target audience and ensure success. Race and ethnicity are important indicators of community diversity, but other components include:

- Geographic location
- Population stability (rates of in-migration, out-migration, interstate migration, and immigration)⁴
- Age distribution
- Social, political, and economic climate
- Language
- Nationality
- Acculturation
- Gender
- Sexual orientation
- Education
- Socio-economic status (SES)
- Religious beliefs

³ Kouzes, J.M. & Posner, B.Z. (1990). *The Leadership Challenge*. San Francisco: Jossey-Bass as cited in Goode, T. (2001). Policy brief 4: Engaging communities to realize the vision of one hundred percent access and zero health disparities: a culturally competent approach. Washington, D.C.: National Center for Cultural Competence, Georgetown University Child Development Center.

⁴ Campbell P., U.S. Census Bureau (1996). *Population Projection: States, 1995 – 2025*, published May 1997, <http://www.census.gov/population/www/projections/stproj.html> as cited in Goode, T. (2001). Policy brief 4: Engaging communities to realize the vision of one hundred percent access and zero health disparities: a culturally competent approach. Washington, D.C.: National Center for Cultural Competence, Georgetown University Child Development Center.

Many Texans do not use English as their primary language, which means that your coalition may need to have meetings conducted in another language or the information/material translated. Messages must be tailored to meet individual cultural, age, literacy, and language needs. For instance, people with lower than average literacy levels may require pictorials. People with mental and physical disabilities, who are often overlooked in the development of special programs, will need interventions tailored to meet their particular needs. Once your program messages have been tailored, care must be taken to ensure that the messages are communicated

effectively, by testing with the target population via focus groups and or dialogue sessions.

The following checklist adopted from the National Center for Cultural Competence (NCCC) will aid your coalition in determining its cultural competency when engaging the community in health promotion and disease prevention initiatives. The NCCC is an organization that provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations.

Does your Agency reach out and engage the following individuals, groups, or entities?⁵

	Never	Seldom	Sometimes	Regularly
Places of worship (e.g., churches, synagogues, mosques, kivas), and clergy, ministerial alliances, or indigenous religious or spiritual leaders?				
Traditional healers (e.g., medicine men or women, curanderas, espiritistas, promotoras, or herbalists)?				
Mental health providers, dentists, chiropractors, or licensed midwives?				
Providers of complimentary and alternative medicine (e.g., homeopaths, acupuncturists, or lay midwives)?				
Ethnic publishers, radio, cable or television stations or personalities, or other local and/or ethnic media sources?				
Human service agencies?				
Tribal, cultural, or advocacy organizations?				
Local business owners such as barbers/cosmetologists, sports clubs, restauranteurs, casinos, salons, and others?				
Social organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic associations)?				

Instruments developed by the NCCC to use in assessing the cultural competency of your organization or coalition's policies and practices are included in the toolkits portion of this guide section.

⁵ National Center for Cultural Competence – Georgetown University Center for Child and Human Development (2006). *Cultural and Linguistic Competence Policy Assessment*. <http://guccdc.georgetown.edu/nccc>

Cultural competence plays an important role in sustaining tobacco program initiatives within communities. A strong and culturally competent coalition is able to unite all sectors of a community to bring about population-level changes. Involving the community in every phase of the tobacco coalition work will give community members a sense of ownership, and increase the likelihood of producing population level social and environmental change.

Resources for Cultural Competence

The following are resources and toolkits available to review, use, and practice in working toward becoming more culturally competent.

A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials provides guidance on how to assure that health promotion materials reflect the principles and practices of cultural and linguistic competence. <http://gucdc.georgetown.edu/nccc> 202-687-5387 or 800-788-2066 TTY: 202-687-5503.

A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument is designed to examine cultural and linguistic competence in four dimensions: values, policy, structure, and practice. <http://gucdc.georgetown.edu/nccc> 202-687-5387 or 800-788-2066 TTY: 202-687-5503.

A Planner's Guide...Infusing Principles, Content and Themes Related to Cultural and Linguistic Competence into Meetings and Conferences is designed to assist meeting and conference planners infuse principles, content, and themes related to cultural and linguistic competence. <http://gucdc.georgetown.edu/nccc> 202-687-5387.

Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan is designed to provide anti-drug coalitions with a basic understanding of cultural competence and its importance in achieving substance abuse reduction that is both effective and sustainable. www.cadca.org/ www.coalitioninstitute.org 703-706-0560, ext 240.

Cultural and Linguistic Competence Policy Assessment is intended to support community health centers in improving health care access and utilization, enhancing the quality of services within culturally diverse and underserved communities, and promoting cultural and linguistic competence as essential approaches in the elimination of health disparities. <http://gucdc.georgetown.edu/nccc> 202-687-5387 or 800-788-2066 TTY: 202-687-5503.

Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach is designed to provide health-care organizations with the rationale for engaging communities in a culturally and linguistically competent manner. <http://gucdc.georgetown.edu/nccc> 202-687-5387 or 800-788-2066 TTY: 202-687-5503.

Priority Populations Initiative: Breaking New Ground and Building Capacity in Cultural Tailoring explores strategies used by Legacy grant recipients to tailor tobacco control programs to meet the unique cultural needs of the target population. <http://www.legacyforhealth.org> 202-454-5555.

The Community Tool Box: Multicultural Collaboration tool to points out and provides descriptions of recurring causes of cross-cultural communication difficulties. <http://ctb.ku.edu> 785-864-0533

Toolkit for Community Action toolkit has been developed to help individuals, organizations, and policy makers raise awareness about health disparities, engage others in conversations about the problems and solutions, and take action for change. <http://minorityhealth.hhs.gov/npa> Toll Free: 1-855-JOIN-NPA (1-855-564-6672)

Templates

Actions to Ensure Cultural Competence for Your Coalition⁶

Every coalition's planning for cultural competence will look different because each community is unique. When you develop your coalition's plan for incorporating cultural competence into every phase of the Strategic Prevention Framework (SPF), ask DOES OUR COALITION...

Assessment

- Include diverse populations, cultures, ethnicities, gender, sexual orientation, disability and age groups in data gathering?
- Encourage participation of bilingual community members to support the development and implementation of our assessment?
- Use multiple forms of data collection; both qualitative and quantitative (key informant interviews, focus groups, listening sessions and surveys)?
- Recognize that diverse communities view tobacco use differently and that culture influences how they should be addressed (i.e. the ceremonial use of tobacco in American Indian communities)?
- Recognize and include formal and informal community leaders in all aspects of building your coalition?
- Consider how community "institutions" and history-keepers can contribute to prevention efforts?

- Involve community in all aspects of data analysis (impacts buy-in prevention strategies)?
- Incorporate community strengths as well as problems in our assessment?

Capacity

- Ensure that coalition staff reflects composition of community?
- Train staff and members on concepts of cultural competence?
- Establish principles and strategies that lead to diverse community leadership?
- Encourage participation of members that represent the cultural, linguistic and ethnic composition of the community?
- Meet in different community settings and ask local cultural organizations to host at their site?

Planning

- Ensure broad community participation in planning process?
- Review and discuss planning process with community to increase understanding of planning?
- Broaden work and action plans to reflect input and outreach by diverse populations, cultures, ethnicities, and age groups to include data gathering?
- Incorporate community in selection of strategies and seek methods to assure buy-in is present?

⁶ Community Anti-Drug Coalitions of America (CADCA) National Community Anti-Drug Coalition Institute. Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan (2009). www.cadca.org

Implementation

- ❑ Ensure activities include members of impacted communities
- ❑ Seek unique and creative methods to ensure all communication materials reflect “community” – brochures and posters, reports, etc.?
- ❑ Continuously review, assess, and select strategies for implementation that reflect local environments and problems?
- ❑ Ensure all communication materials are reviewed (tested) for appropriateness by target community prior to distribution (content, reading level, visual and distribution method)
- ❑ Conduct appropriate prevention programs for the composition of the community

Evaluation

- ❑ Involve community in collection, interpretation, and dissemination of information (including youth)?
- ❑ Ensure evaluation process and products are relevant to diverse communities?
- ❑ Consider applying awareness of race and culture specific linguistic and community attributes and relevance to measure all coalition prevention efforts?
- ❑ Include various qualitative methods in your evaluation (e.g. interviews informal/formal)?
- ❑ Select an evaluation team with experience and expertise working in diverse communities?
- ❑ Disseminate data to community

Section 2: Planning for, Developing, and Implementing Your Tobacco Prevention and Control Plan

The following seven chapters of the Community Guide provide the steps, information, resources, and tools necessary to plan, develop, and implement your tobacco prevention and control initiatives in your community.

- VIII. Community Needs Assessment
- IX. Data Resources
- X. Capacity Building
- XI. Developing Your Strategic Plan
- XII. Media Outreach
- XIII. Implementing Your Tobacco Control Plan
- XIV. Conducting an Evaluation



Community Needs Assessment



stamp holder



Community Needs Assessment

What Is a Community Needs Assessment?

As community planning action teams and organizations meet to discuss community change, there is often a realization among members in the lack of sufficient knowledge of a community's needs. A community needs assessment is a constructive strategy for obtaining a transparent picture of your community. It will help you identify local assets as well as areas that need strengthening. A community needs assessment is a systematic process put into place in order to gather data for decision making regarding community needs and resources, and to then set priorities based on the community-level data gathered. It is essential to gather data relating to tobacco issues within a community prior to the development and implementation of a tobacco control initiative or program. A community needs assessment on tobacco use defines and describes the:

1. Geographic area and population
2. Epidemiology of tobacco use
3. Infrastructure, training needs, and history of tobacco prevention and control
4. Baseline measures of tobacco-related attitudes and practices in different community sectors
5. Current Community resources/services (templates included in appendix)

6. Additional information needed to address gaps in the understanding of local tobacco use.

(Adapted from Texas Department of State Health Services Community Best Practices Toolkit)

As a funded program in tobacco control (or as a program seeking funding), a tobacco component is essential if not mandatory to include in a community needs assessment. It is a good idea to include other issues as components of your needs assessment such as housing, economics, crime, health services, etc. as components of your needs assessment. Tobacco may not be a priority in some communities. If, for example, childhood asthma or housing are identified as priorities in the community by community members, then it is important to link tobacco to these priorities.

Preparing for the Needs Assessment

The first step for coalitions in preparing for a community needs assessment is to form a team/committee to organize, obtain, review, and compile information across all sectors of the needs assessment process. The needs assessment team/committee should include a diverse group of individuals and organizations from the community in addition to members within the coalition with previous experience with data collection and analysis. Members from the community who do not have a background in research still play an

important role in the assessment by contributing their knowledge of the community and social/cultural practices and norms.

Developing a Timeline

Develop a reasonable timeline to conduct these activities. Planning can take 3-6 months depending on the experience level of your coalition. Projects have failed in the past due to the lack of time, resources, and commitment. It is important to not only involve other organizations in the assessment, but to also spread out the division of labor/tasks. This will ensure inclusion and increase the amount of time, resources, and commitment.¹

Designing and Planning the Needs Assessment

The following steps are key to designing a needs assessment:

1. Determine the purpose and objectives of the needs assessment
2. Identify available resources
3. Understand and agree upon roles and responsibilities
4. Determine the questions to be answered
5. Develop the methodology for collecting and analyzing data
6. Establish a realistic timeline and work plan

Define the scope and the major areas that need to be assessed in the needs assessment. Successful community assessments begin with well-defined objectives. Objectives must be clearly defined in order to involve the necessary stakeholders, and ensure that community priorities can be clearly identified. With the increase in availability of information due to the widespread use of the internet, planning groups may find a large amount of information, little of which is applicable to the coalition's vision. Identifying questions that will be answered by the community assessment permits group members to be more selective in collecting useful data. A preliminary list of questions will also provide a framework for collection of new information through surveys, focus groups, or public meetings.²

Next, determine your methods for gathering data information. Listed below are several methods of data collection with descriptions:

Using existing data. This is research information typically found in census and other public records or you can locate information gathered by others. Examples of this would be the Texas Cancer Registry and the Behavioral Risk Factor Surveillance System (BRFSS).

Listening sessions and public forums. Listening sessions are forums you can utilize to learn about

¹ Adapted from the Community Tool Box <http://ctb.ku.edu>

² Community Development-Data Information and Analysis Laboratory (CD-DIAL), Iowa State University. (2001). *Preparing for a Collaborative Community Assessment*. <http://www.extension.iastate.edu/communities/communitydata.html>

the community's perspectives on local issues and options. They can help you get a sense of community members' knowledge and feelings regarding issues. Public forums tend to be larger, well-publicized, and allow people to discuss issues in the community during at certain location and time.

Interviews and focus groups. These are conducted using small, informal groups composed of community members to discuss and reflect on issues affecting a community. You will have a perspective of what is important to members of the community through your attendance to public forums. Your focus groups or interviews should emphasize community identified issues and how they are connected with tobacco control and prevention.

Direct, and sometimes participant, observation. Spend a few weekends within the community, watching and talking to people. Windshield surveys are one form of observation in which an individual drives through a neighborhood to gain information. These observations focus on the physical aspects of a neighborhood such as types of housing, physical conditions of housing, street conditions such as the number of cigarette butts on sidewalk curbs, locations of tobacco outlets, the number of people smoking in public, and other observable characteristics.

Surveys. Surveys are a good source of feedback and may be sent to people in the mail, given at

community events or meetings, handed out on the street, and/or given over the phone.

When developing a survey:

- Have members of the needs assessment team/committee check each item for accuracy and completeness.
- Have various stakeholders check the wording of the items. Is it user-friendly? Is it clear and simple? This includes pilot testing the survey with a few participants.
- Make sure all key areas are covered (e.g. education, health, safety, housing, etc.)
- Make sure that you have accurate translations of the survey when needed.
- Check the list of items yielded from the focus groups.
- Write affirmative simple statements.
- Make sure each item is asking only one question.
- Delete repeated items that are worded differently.
- The demographics page is placed at the end of the survey and it provides a descriptive profile of the individual responses.

It is also effective to include several open-ended questions in your survey as part of the qualitative portion. The qualitative portion gives community members a voice to say what is important in their community. These type of questions could include:

- What are 3 things you like most about living in your community?

- What are 3 things you would like to improve about your community?
- What is an effective way to get residents involved in their community?³

(See appendix for templates. Resources listed at the end of this section will also provide survey templates)

Collect and Compile Information for the Needs Assessment

Collecting and compiling information for the needs assessment involves gathering quantitative and qualitative data. In addition to tobacco-related data, it is also important to map the assets of the community as well as use community indicators in order to reflect the environmental or community-level measures and equity. Community level indicators, also known as quality of life indicators, are specific to community demographics, economics, education, environment, health, and public safety. Asset mapping focuses on the strengths of the community rather than the areas that need improvement. Focusing on assets gives the power back to the community members directly affected by the issue.

Together with qualitative and quantitative data, community indicators and asset mapping will aid coalitions in developing community profiles. A community profile is a useful tool and resource for the coalition as well as community members. It informs both coalition and

community members of the available resources in the community, and may enable members of the community to take ownership of the resources available to them to improve their health and quality of life.

Quantitative Data – provides systematic and standardized method to gathering data. Quantitative methods produce hard data expressed in numbers, such as the percentage of high school students who currently use tobacco in your area and scores about the attitudes toward tobacco use.

Qualitative Data – method utilized to record feelings, concerns, experiences, and impressions according to the subjects’ own words, either spoken or written. Qualitative methods use open-ended questioning techniques in focus groups, survey questions, critical incident surveys, staff feedback, and interviews.

Do’s and don’t’s of data collection:

- *Avoid information bias.* Who you ask for information, where you ask it, and when you ask it will all introduce a bias to the results. To ensure this doesn’t happen, make sure the information received is from a cross-section of the community, and not just one part. Also, make sure questions are asked in neutral tone so as to not encourage a person to answer one way or another. Also be cautious of who you choose to be an interviewer or facilitator. This too can affect interviewee responses.
- *Don’t rely on only one source.* Obtain

³ Sharma A., Lanum M., and Suarez-Balcazar Y. 2000. A Community Needs Assessment Guide: A Brief Guide on How to Conduct a Needs Assessment. Center for Urban Research and Learning and the Department of Psychology, Loyola University, Chicago.

relevant information from a wide variety of sources in order to avoid information bias. The accuracy and validity of your research will be improved by reviewing several sources of information.

- *Respect Confidentiality* Confidentiality and trust are important in building and sustaining relationships with community members.
- *Credit the source information.* Always credit data from where it is taken. When data is taken from secondary sources, the original source should be fully referenced as the owner of the data.

Analyze and Interpret Information and Data with Group/Coalition

After data collection, the next step is to figure out what the numbers mean and how to use this information. The information collected must be organized and analyzed in order to be used to plan, implement, and evaluate tobacco program initiatives.

What is the information telling you?

- Compare your population with a larger group to ascertain whether a health issue or disease rate is higher or lower than expected. Compare the community data with national and state sources in order to benchmark the data.
- Compare current information with that collected in previous years to identify trends over time.
- Identify significant gaps in the information.

- Compare and contrast different types of information (e.g. statistics, surveys, questionnaires, focus groups, public forums, etc.)
- Look for strengths as well as weaknesses. Even the most disadvantaged communities have strengths that can be further expanded when building capacity to address the identified gaps and problems within the community.

Ask yourself the following questions when analyzing the data:

- How many people are affected by tobacco use?
- What is the data telling you about equity?
- What is the impact on people's lives?
- Are there appropriate and effective interventions?
- Are there adequate services and resources?
- Do the health needs identified by the community coincide with your coalition's priorities?⁴

After analyzing the data, you will be able to determine what the priorities are in the community and how to link those priorities to tobacco control initiatives. The table listed below provides examples of linkages between tobacco control and other health and social issues.

⁴ Adapted from the Community Health Needs Assessment: An Introductory Guide for Family Health Nurses in Europe, World Health Organization, 2001

Examples of Linkages between Tobacco Control and Other Priority Issues⁵	
Community Priority	Link to Tobacco Control
Youth Violence Prevention	Youth employment and resiliency programs increase young people’s abilities to make healthy decisions, including the choice not to use tobacco.
Quality Housing	Tenants seeking to improve the quality of their living environments and property owners seeking lower maintenance and liability costs may support clean indoor-air policies.
Family Support Services for Those of Low Income	Family support services work to protect limited family budgets by reducing the purchase of drugs (including tobacco) and alcohol and increasing income by reducing sick days.
Parks and Recreation	Safe, clean parks that promote healthy activities and are free of tobacco related litter improve a community’s livability.
Literacy	Literacy helps individuals build skills to understand and protect themselves and others from the harmful effects of tobacco.
Asthma	Childhood and adult onset asthma are linked to secondhand smoke exposure. Constituency groups addressing asthma may support secondhand smoke educational efforts and the establishment of smoke-free multi-unit housing policies.
Cervical and Breast Cancer Prevention	Smoking is a risk factor for developing cervical cancer, and breast cancer is linked to secondhand smoke exposure among pre-menopausal women. Constituency groups addressing these women’s health issues may promote cessation services and secondhand smoke policy efforts.
Prenatal Care and Childcare Service Providers	Smoking during pregnancy increases the risk for pre-term birth and low birth weight babies. After a baby is born, exposure to secondhand smoke increases risk for Sudden Infant Death Syndrome and the development of respiratory illnesses and asthma in children. Providers serving pregnant women and families may promote cessation and secondhand smoke prevention education as well as support efforts to improve secondhand smoke protection in single family homes, multi-unit housing, and cars.

Planning on What to Do with Needs Assessment Results

Planning and implementing are the next step to addressing the priorities identified by the needs assessment. It will be helpful to consider the following suggestions when planning your interventions:

Be Creative

Think outside of the box when creating an action plan. For instance, if you want to address the number of people affected by chronic illnesses associated with tobacco, you may need to consider not only their tobacco use, but also the environment in which they live and the social norms that affect tobacco use and exposure.

⁵ Tobacco Technical Assistance Consortium. 2004. *Communities of Excellence Plus in Tobacco Control: Training and Resource Manual*. Atlanta, Georgia.

Think about issues that the community prioritized in your needs assessment. There may be housing and economic needs that are related to and affect tobacco use.

Involve the Community

Include people from the community to which the community needs assessment was administered. The same people you included in the planning, development, and evaluation of the needs assessment will want to continue to participate in future programs developed to address identified gaps and priorities within their community.

Collaborate

It is difficult or unfeasible for a single organization or entity to bring about social and environmental change. Collaborate, plan, and distribute roles and responsibilities among you, coalition as well as community stakeholders.

Health Promotion

The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system, defines health promotion as “the process of enabling people to increase control over and improve their health.” It is a model of empowerment for individuals and communities. Health promotion covers a range of activities:

- Creating healthy public policies
- Building supportive environments
- Strengthening community action
- Developing personal skills
- Reorganizing health services
- Addressing inequalities

If undertaken with local people, community health needs assessment can be a way of practicing health promotion. It is important to gauge whether your proposed actions are meeting the range of activities noted above.

Prevention

Actions to improve health include the treatment of those who are ill, as well as the activities to keep a community healthy.

Primary prevention aims to stop the onset of a disease or a condition. An example of primary prevention is the prevention of coronary heart disease through smoking cessation at work or passing workplace smoking bans.

Secondary prevention works by early detection and treatment of a disease or conditions usually through screening. An example of secondary prevention is a referral to smoking cessation treatment for a patient who has suffered from a heart attack. People who quit smoking after a heart attack reduce their risk of death by at least one third.⁶

Tertiary prevention targets the person who already has the symptoms of the disease. Tertiary

⁶ Critchley JA, Capewell S. Smoking cessation for the secondary prevention of coronary heart disease. Cochrane Database of Systematic Reviews 2004, Issue 1. Art. No.: cd003041.D01:10.1002/14651858.CD003041.pub2

prevention is the management of a disease to control symptoms and prevent the disease from causing other problems.

Measuring Success

It is necessary to monitor and record the changes in the implemented action plan in order to evaluate successes and failures. There are a few helpful guidelines regarding what to record:

- Where you are now (baseline measurements)
- Where you are going (aim and objectives)
- How to get there (action plan)
- How you will know you have arrived (evaluation/outcome measures)

Aim for small, achievable, and measurable goals. This increases the chance of success. Measure your progress against your goals regularly. Share and celebrate success with others in your group regularly. If certain aspects of your plan are not meeting your objectives or goals, consult others and address the necessary changes.

The resources listed at the end of this section will provide more guidance for your community needs assessment. Remember to review the templates referenced in this section.



Needs Assessment Toolkits

A Community Needs Assessment Guide: A Brief Guide on How to Conduct A Needs Assessment is intended to facilitate the work of community leaders, agency staff, and university practitioners in identifying the concerns and strengths of a community and to develop initiatives to address the needs brought forth by the assessment process.

<http://www.luc.edu> 312-915-7760.

Communities of Excellence in Tobacco Control, Module 2: Conducting a Communities of Excellence Needs Assessment provides detailed instructions on how to complete a community needs assessment.

<http://www.cdph.ca.gov/programs/tobacco>
916-558-1784.

Community Assessment Tools: Communities in Action provides detailed guidelines and tools for conducting effective community assessments to ensure that your project will meet community needs and make the best use of available resources.

www.rotary.org 847-866-3000.

Community Health Needs Assessment: An Introductory Guide for Health Nurses in Europe describes the ways in which health needs assessments can identify priority health needs, target resources to address inequalities, and involve local people.

<http://www.euro.who.int> +45 39 17 17 17.

Community Tobacco Prevention and Control Toolkit Community Needs Assessment provides information and tools for conducting effective tobacco needs assessments.

<http://www.dshs.state.tx.us/tobacco/bestpractices/assessment.shtm> 512-206-4729.

Needs Assessment Workbook provides actions to consider and goals to obtain when going through a needs assessment process, and provides tools that can be followed for additional support.

www.rpscolorado.org 303-839-9422.

The Community Tool-Box contains information about how to assess community needs and resources, how to get issues on the public agenda, and how to choose broad strategies to promote community health and development.

<http://communityhealth.ku.edu> 785-864-0533.

The New Brunswick Community Health Needs Assessment is intended to be a resource base to assist in the process of carrying out a community health needs assessment.

<http://www.gnb.ca/0051/index-e.asp>
506-457-4800.

Additional Resources

Carter, K.A. and Beaulieu, L.J. (1992). **Conducting a Community Needs Assessment: Primary Data Collection Techniques.**

<http://edis.ifas.ufl/pdffiles/HE/HE06000.pdf>

Community Development-Data information and Analysis Laboratory (CD-DIAL), Iowa State University (2001). Preparing for a Collaborative Community Assessment.

<http://www.extension.iastate.edu/Publications/CRD334.pdf>

Guy, S.M. **Community Needs Assessment Survey Guide.** Utah State University Extension.

www.Extension.usu.edu

Needs Assessment Guidelines provides guidelines and examples of needs assessments surveys for schools from the state of North Dakota.

<http://www.dpi.state.nd.us/grants/needs.pdf>

School Capacity Building Tool-Kit

provides a methodology to assess a school's capacity to implement alcohol, tobacco, and other drug programs.

<http://scbtoolkit.coe.uh.edu> 713-743-9843.

Texas Tobacco Prevention and Control Coalition Needs Assessment

provides TPCC sites with data collection tools, services, and reporting forms for data collection.

<http://www.dshs.state.tx.us/tobacco/bestpractices/assessment>

Tips for Conducting a Needs Assessments

provides helpful tips to keep in mind as you organize, conduct, and evaluate your community needs assessment.

<http://beabridge.org> 215-731-6150.

Community Opinion Survey

1. Overall, how satisfied are you with your neighborhood as a place to live?
1 Very unsatisfied 2 Unsatisfied 3 Satisfied 4 Very Satisfied
2. What are the three things you like the most about your neighborhood?
 - 1.
 - 2.
 - 3.
3. What are three things you would like to change/improve about your community?
 - 1.
 - 2.
 - 3.
4. What is an effective way to get residents involved in their community?

Demographics

1. Gender: Male Female
2. Age: 18-24 25-40 41-65 65+
3. Put an "X" on the line next to your race/ethnicity:
 African American Hispanic/Latino
 American Indian White
 Asian American/Pacific Islander Other: (Please specify: _____)
4. Number of adults living in the household _____
Number of children living in the household _____
5. Highest level of education completed:
 Some education (grammar school/high school) Associate's Degree
 High School/GED Bachelor's Degree
 Some College Graduate/Professional School
6. How many years have you lived in this community? _____

(Adapted from A Community Needs Assessment Guide: A Brief Guide on How to Conduct a Needs Assessment, Loyola University Chicago, 2000)

Utilizing the Results from a Community Assessment

To be useful, the information gathered from interviews, focus groups, or questionnaires in a community assessment should be analyzed to help set an agenda for outreach goals and objectives. To know what the results mean might not be a straightforward matter. Identifying “what is” in a community assessment does not automatically make clear “what should be.”

When examining results, organize the data to fill in answers to the following questions:

1. What is the targeted community (as specific as possible)?
2. What does the community need (or what are they lacking) according to your perspective?
3. What does the community need (or what are they lacking) according to their perspective?
4. Are outreach resources adequate to deal with the problem?
5. Will outreach make a difference in the problem?
6. Is the group responsive to solutions or ready for change?
7. What work is already underway?
8. What is the political landscape of the problem in this group?

(Adapted from the National Network of Libraries of Medicine Conducting a Community Assessment)

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Data



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Resources for Data

Data Resources

The Data Resources in this guide will support coalitions addressing tobacco-related health disparities within communities. Historically, data collection was limited in identifying health disparities. Section 4302 of the Affordable Care Act contains provisions to strengthen federal data collection efforts by requiring that all national federal data collection efforts include information on race, ethnicity, sex, primary language, and disability status. Please see the examples of proposed data standards provided by the Office of Minority Health in the templates section on race, ethnicity, language spoken, and disability status. The Affordable Care Act provisions do not mention questions regarding sexual orientation. It is important to include the Lesbian, Gay, Bisexual, and Transgender population in federal, state, and local data collection and surveillance systems.

The Affordable Care Act recognizes the need to standardize our methods in data collection in order to improve our understanding of health disparities. Health disparity data will provide coalitions with the necessary information needed to identify existing gaps to then develop culturally competent and tailored evidence-based interventions to address tobacco-related health

disparities. Once the gaps are identified and your tobacco control initiatives are tailored to your community's needs, data can then be used to monitor and evaluate your program objectives. Analyzing and publishing tobacco-related health disparities data could leverage support for programs designed to prevent or address those disparities.

It is important to utilize multiple data sources, but be careful to only review what you know you can use. There are thousands of data resources available, and you will run the risk of decreasing the quality of your data by increasing the quantity of data collected. The resources listed below can help you identify data and trends in order to track objectives and measure the success of your projects aimed at changing health outcomes in your community. Risk factor data can assist in determining the types of intervention strategies and trends in health behaviors. These data also may suggest barriers to consider when developing and implementing tobacco initiatives. Some of the resources provided are available only at the national or state level. Coalition members/stakeholders may utilize these resources on the national and state level to benchmark and determine where the gaps are within your community.

Data Collection Methods

Using Quantitative and Qualitative Data

Quantitative data provides information that is measured and expressed with numbers. For example, surveys can show the percent of participants who respond to a question in a certain way. Quantitative data can be presented as numbers or percents, ranges or averages, and in tables or graphs. It can also be used to compare different groups of participants – men and women, adolescents and adults – with non-participants.

Qualitative data expresses progress and impact in words rather than numbers. Qualitative data are usually collected by document review, observations, and interviews and can provide descriptions about program activities, context, and participants' behaviors. Qualitative data can also be expressed in numbers. For example, interview responses can be tallied to report the number of participants who responded a certain way.

There are a number of factors that need to be considered in reaching a decision regarding the method that will be used, including the questions being addressed, timeframe available, and the type of data that will be credible to stakeholders.

Data sources

Written documents and records can provide information about community participants and

about the evolution of your plan over time. These records may already exist, but creating your own may ensure that you get the information you want about your participants and the impact of your tobacco plan. However, records and documents provide only a piece of the evaluation picture, suggesting only possible conclusions.

Interviewing participants, coalition members, and stakeholders is a great way to get information about the impact of your tobacco plan. Interviews can provide in-depth information about behaviors, attitudes, values, and knowledge before, during, and after the tobacco plan implementation. As with observations, being clear and focused about the information you want is important. It is also important to get a range of perspectives so as not to end up with a biased interpretation of the outcomes. Structured interviews following your prepared questions will be most effective. Since interviews require participants to reveal their thoughts, it is wise to keep in mind having a good fit between interviewer and participants.

Group interviews or focus groups are a good way to talk to more people in a shorter period of time. However, you will want to keep the group on track and make sure that everyone gets involved in the discussion. Interviews can help clarify and expand what you learn through document review and direct observations. It is possible to get

enough detailed information about your tobacco plan by interviewing a sample of participants instead of all.

A *survey* is a way to collect information via mail, phone, or in person. A questionnaire is used to collect information as part of a survey. Participants can be surveyed via mail or phone; however, you may choose to have participants complete a written questionnaire in person during events your coalition hosts. This may result in a better response rate, which can give way to more accurate information about the group as a whole. As with interviews, surveying a sample of the group may be more effective than surveying all your participants. However, you need to be sure to choose a sample that is representative of the entire group. Surveys can include close-ended questions and open-ended questions. People who complete a close-ended survey would be asked to select the answer that best matches their beliefs or feelings. Open-ended questions provide no answer categories. They allow the participants to reflect and respond to a question in their own words. See the appendix of this section for tips on developing questionnaires in your evaluation.¹

Please see the RAND Data Collection Planning Tool in the templates portion of this section. This tool will help you track factors for assessment and data collection.

Data Analysis and Interpretation

There are three steps in data analysis.²

1. Enter the data into a database and check for errors. If you are collecting data with your own instrument, you will need 1) to select the computer program you will use to enter and analyze the data, and 2) to determine who will enter, check, tabulate, and analyze the data.
2. Tabulate the data. The data need to be tabulated to provide information for each indicator.
3. Analyze and stratify your data by various demographic variables of interest, such as participants' race, sex, age, income level, or geographic location.

Make comparisons. Use statistical tests to show differences between comparison and intervention groups, between geographic areas, or between the pre-intervention and post-intervention status of the target population.

Reporting Your Findings

Formal evaluation reports can provide information to your stakeholders, the community, and your funders about your coalition's progress and success. In your evaluation report, you will want to include: the objectives of your plan and your targeted audience, what data you collected for your evaluation and how, the evaluation results in terms of plan goals and objectives, and the plan for using the evaluation to improve the plan.

¹ Horizon Research Inc., *Taking Stock: A Practical Guide to Evaluating Your Own Programs* <http://www.horizon-research.com/reports/1997/stock.pdf>

² Centers for Disease Control and Prevention, *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs* http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

Presenting your data simply and concisely can help your audience get a clear and accurate picture of your program. Blending your qualitative data, such as quotes from interviews or descriptions from observations with your quantitative data from surveys is a useful way to report your evaluation results.³

Data Resources

Health Disparities Calculator is a statistical software designed to generate multiple summary measures to evaluate and monitor health disparities. HD*Calc was created as extension of SEER*Stat that allows the user to import SEER Data or other population-based health data such as National Health Interview Survey, California Health Interview Survey, Tobacco Use Supplement to the Current Population Survey, and National Health and Nutrition Examination Survey.
<http://seer/cancer.gov/hdcalc> 301-496-8510.

National Data

American Cancer Society tracks cancer occurrence, including the number of deaths, cases, and lifespan after diagnosis. The American Cancer Society also tracks data regarding behaviors that influence the risk of developing cancer and the use of screening tests.
www.cancer.org 1-800-ACS-2345.

American Legacy Foundation Rigorous builds effective initiatives and contributes to and expands upon the body of knowledge about tobacco control. The foundation's research and evaluation team conducts the Legacy Media Tracking Survey (LMTS) to document the tobacco-use beliefs, attitudes and behaviors of American youth, and the effectiveness of the truth® campaign.
www.americanlegacy.org 202-454-5555.

Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest telephone survey, and tracks health risks in the United States. Scientific research has clearly shown that personal health behaviors play a major role in premature morbidity and mortality.
www.cdc.gov/brfss 800-CDC-INFO 800-232-4636
TTY: 888-232-6348.

Cancer Control Planet Cancer was developed by LIVESTRONG for control planners, program staff, and researchers with the same goals: to reduce cancer risk, the number of new cancer cases, and the number of deaths from cancer, as well as enhance the quality of life for cancer survivors. Yet, all do not have easy access to resources that can facilitate the transfer of evidence-based research findings into practice.
www.cancercontrolplanet.cancer.gov 866-673-7205.

Centers for Disease Control (CDC) The CDC is a leader in nationwide health disparities prevention and control resources. They include the estimated number of new disease-causing deaths, and the age-adjusted mortality rates for cancer deaths by race and ethnic minorities.
www.cdc.gov 800-232-4636 TTY: 888-232-6348.

CDC Wonder (Wide-ranging Online Data for Epidemiology Research) allows you to access statistical research data published by the CDC; public-use data sets about deaths, cancer incidence, HIV and AIDS, tuberculosis, vaccinations, births, census data, and many other topics are available for query.
<http://wonder.cdc.gov>
800-232-4636 TTY: 888-232-6348.

CHARTing Health Information for Texas, was developed by the University of Texas School of Public Health at Houston to provide a comprehensive collection of links to publicly available, geographically discreet health data for the state of Texas.
www.sph.uth.tmc.edu/charting 713-500-9000.

³ Horizon Research Inc., Taking Stock: A Practical Guide to Evaluating Your Own Programs <http://www.horizon-research.com/reports/1997/stock.pdf>

Community Health Data Initiative (National Center for Health Statistics, CDC, NCHS) is a collaborative effort among government and non-government partners to establish a network of suppliers and demanders of community health data, indicators, and interventions. Its purpose is to help Americans understand health and health-care system performance in their communities, thereby sparking and facilitating action to improve performance value.

<http://www.hhs.gov/open/>. 1-877-696-6775.

Forum on Child and Family Statistics provides access to federal and state statistics and reports on children and their families, including: population and family characteristics, economic security, health, behavior, social environment, and education. www.childstats.gov 202-502-7300.

Health Indicators Warehouse serves as the data hub for the HHS community Health Data Initiative by providing a single source for national, state, and community health indicators.

<http://healthindicators.gov> 800-232-4636.

Health Resources and Services Administration provides information and links to data, statistics, and resources. The organization contains publications, resources, and referrals on health-care services for low-income, uninsured individuals and those with special health-care needs; as well as data on medically underserved areas. www.hrsa.gov/data.htm 888-ASK-HRSA or 888-275-4772, TTY: 877-489-4772.

National Cancer Data Base was established to serve as a comprehensive clinical surveillance resource for cancer care in the United States. The NCDB was the first national database used to track and compare the treatment of most types of cancers.

www.facs.org/cancer/ncdb/index.html
312-202-5085.

National Cancer Institute Cancer Control and Population Sciences provides augmented data collection on risk factors; health behaviors, such as tobacco use, diet, and physical activity; cancer screening; treatment; and quality of life. www.appliedresearch.cancer.gov
1-800-4-CANCER or 1-800-422-6237.

National Cancer Institute provides data and information on cancer for use by cancer control planners and cancer care providers. www.cancer.gov 1-800-4-CANCER.

National Center for Health Statistics (NCHS) looks at outcomes, access, literature synthesis, public reporting, underserved, quality, data collection methods, etc. Access data, reports, surveys, and tools. <http://www.cdc.gov>
800-232-4636 TTY: 888-232-6348.

Spit Tobacco Prevention Network Information Resource Center's comprehensive, electronic information is to maintain and disseminate scientific data and resources on spit tobacco education, epidemiology, health effects, user identification, risk groups and prevention and cessation strategies and services. www.nospit.com/IRC.html 214-828-8100.

Surveillance, Epidemiology, and End Results (SEER) provides an authoritative source of information on cancer incidence and survival in the United States, covering 26% of the U.S. population. Data query tools for both SEER cancer incidence and U.S. mortality, statistical tables, graphs, maps, special reports, state cancer profiles, and cancer statistical software. www.seer.cancer.gov 301-496-8510.

The Health Indicators Warehouse is a major new and evolving resource for identifying and selecting performance measures or indicators, launched by Health and Human Services in early 2011 as part of the **Community Health Data Initiative** (CHDI), a public-private effort

to increase understanding by program planners, researchers, policymakers, and others of the health status and health-care performance of their communities, and to inform action to improve performance and, ultimately, improve community-level health outcomes. The HIW currently contains nearly 1200 health indicators derived from over 170 different data sources, including those used to track measures for **Healthy People 2020**.

[www.hhs.gov/open/datasets/
communityhealthdata.html](http://www.hhs.gov/open/datasets/communityhealthdata.html) 1-877-696-6775.

The Intercultural Cancer Council promotes policies, programs, partnerships, and research to eliminate the unequal burden of cancer among racial and ethnic minorities and medically underserved populations in the United States and its associated territories. www.iccnetwork.org 713-798-4614.

Tobacco Information and Prevention Source a CDC Office of Smoking and Health includes research data and reports as well as tobacco control program guidelines, which provides state-based information on the prevalence of tobacco use, health impact, and associated costs for all 50 states.

www.cdc.gov/tobacco
800-CDC-INFO or 800-232-4636
TTY: 888-232-6348.

US Department of Health and Human Services provides general health information and includes cancer data and resources. www.hhs.gov 1-877-696-6775.

Youth Risk Behavior Surveillance System provides monitoring health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. The YRBSS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students. www.cdc.gov/HealthyYouth/yrbs/index.htm 800-CDC-INFO or 800-232-4636 TTY: 888-232-6348.

State Data Sources

County Health Rankings provides county-by-county health rankings in each of the 50 states, explanations of each health factor, and actionable strategies to improve the health of communities across the nation. <http://www.countyhealthrankings.org> 608-265-6370.

Texas Cancer Registry (TCR) is the State population-based cancer registry, collecting approximately 140,000 reports of cancer annually. Publications such as county and regional fact sheets, special reports, links to national cancer statistics and other data resources, as well as information on cancer cluster investigations. www.dshs.state.tx.us/tcr 800-252-8059.

Selectable Cancer Incidence/Mortality Rates and Mapping Web Query Tool. Estimates of Cancer Cases and Deaths for Texas, by Health Service Region, and Counties with at Least 100,000 population. Texas Cancer Registry, Texas Department of State Health Services. <http://www.cancer-rates.info/tx/>
Estimates of Cancer Cases and Deaths for Texas, by Health Service Region, and Counties with at Least 100,000 population. Texas Cancer registry, Texas Department of State Health Services. <http://www.dshs.state.tx.us/tcr/expected2010.shtm>

Estimates of Cancer Prevalence (Number of Persons Living with Cancer) in Texas. Texas Cancer Registry, Texas Department of State Health Services. <http://www.dshs.state.tx.us/tcr/data.shtm>

Texas Cancer Information. The University of Texas M.D. Anderson Cancer Center. [http://www.slehc.org/CHI/CHIS/BreastHealth/
Index.cfm](http://www.slehc.org/CHI/CHIS/BreastHealth/Index.cfm)

The Texas Youth Risk Behavior Surveillance System (YRBSS) Federally funded classroom-based paper survey conducted biennially on odd years to monitor priority health-risk behaviors that contribute substantially to the leading causes of death, disability, and social problems

among youth and adults in the United States.
<http://www.dshs.state.tx.us/chs/yrbs/>
512-458-7111, ext. 2564.

The Texas Behavioral Risk Factor Surveillance System (BRFSS) Federally funded telephone survey conducted on a monthly basis of randomly selected adult Texans to collect data on lifestyle risk factors contributing to the leading causes of death and chronic disease.
<http://www.dshs.state.tx.us/chs/brfss/default.shtm> 512-458-7111, ext 6593.

Texas Cancer Data Center, Texas Cancer Council and M.D. Anderson Cancer Center resource on health professionals, health facilities, demographics and statistics, and community resources via the Internet, dedicated to empowering Texans with the knowledge needed to reduce the human and economic impact of cancer.
www.txcancer.org 713-792-2277.

Texas Department of State Health Services (DSHS) collects and reports data on a number of health issues, including Behavioral Risk Factor Surveillance and cancer incidence and mortality.

www.dshs.state.tx.us/datareports.shtm
512-458-7111 or 1- 888-963-7111.

Texas State Data Center and Office of the State Demographer disseminates population estimates and projections for Texas.
www.txsdcenter.tamu.edu 210-458-6543.

Texas School Survey of Substance Use Among Students Texan students in grades 7-12 are asked to report on their use of alcohol, tobacco, inhalants, illicit drugs, and over-the-counter or prescription-type drugs, as well as attitudes, extracurricular involvement, and other related behaviors.
<http://www.dshs.state.tx.us/sa/recentresearchstudies.shtm> 512-458-7111.

Texas Tobacco Prevention and Control Initiative tracks changes in Texas Ordinances in 2010 and provides comparisons of coverage of the Texas Municipal population by smoke free ordinances.
<http://www.dshs.state.tx.us/tobacco/>
512-458-7111.



RAND Data Collection Planning Tool

Having a clear data collection plan will help to ensure that the data collection process is on track. In general, the key components of a data collection plan are:

- Community conditions or factors that need to be assessed

Examples

- Factors to be assessed could include the absence or strength of smoke-free laws
- Availability of cigarettes to minors
- Favorable attitudes to smoke-free laws

- Indicators to be measured

Examples

- Numbers of sales to minors
- Smoking prevalence in the community

- How and where to get data

- Archival data, observations, community surveys, interviews, focus groups, etc.

- Who is responsible for data collection? Where is this data found?

- Dates by which key tasks are to be completed

You and your coalition will be able to use the planning tool on the subsequent page to input your answers.

RAND Data Collection Planning Tool

Factor to Be Assessed	Indicators to Be Measured	Method for Data Collection	Where Found	Completed by/Person Responsible

From the RAND Corporation Publication Preventing Underage Drinking: Using Getting to Outcomes with the SAMHSA Strategic Prevention Framework to Achieve Result

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Capacity Building



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Community Capacity Building

Capacity building, as mentioned in a previous section within the guide, is the second step in the Strategic Prevention Framework. Building capacity to eliminate tobacco-related health disparities in a community involves the development of resources, skills, organizational structures, and infrastructure. As a principal component of community engagement, capacity building includes sharing knowledge, leadership, and power to equitably represent the community. In order for capacity building to be sustainable, it is essential to include community stakeholders in collaboration and leadership.

Community capacity is the characteristics of a community that affect its ability to identify, mobilize, and address social and public health problems.¹ Outside organizations cannot build community capacity without community partnerships. Community capacity building allows coalitions to work with community members to enable their ability to address and influence what happens in their community. Capacity building

for priority populations requires building cultural competency within your coalition and/or organization. Cultural competency is essential in racial and ethnic communities to address tobacco-related health disparities.

Community Capacity includes:

- *Local residents* – skills, experiences, passions, capacities, and willingness to contribute to the project. Inclusion of all residents is essential to harnessing the community capacity potential. Help members within the community identify their strengths, skills, and resources, and then identify existing gaps. Emphasize people’s abilities to be their own agents of change through collaboration and creating conditions that allow community members to participate and contribute to the community.
- *Local voluntary* – associations, clubs, networks, and religious institutions
- *Local institutions* – public institutions such as schools, libraries, parks, police stations, etc.
- *Physical assets* – the land, buildings, infrastructure, access to health-care, and resources.

There are four key principles that provide a framework for building capacity within a community:

¹ McLeroy K., Norton B., Kegler M., Burdine J.N., Sumaya C. Community-based intervention. *Am J Public Health* 2003; 93: 529-33.

Principles	Description
Sense of Community	A community's strengths, values, history, and level of participation are often related to motivation to improve the health of community members. Focus on the community perspective and needs.
Leadership	Studies have revealed that both formal and informal leadership are important in engaging the community about its strengths, areas of need, and priorities as well as in encouraging participation.
Community Collaboration	In order for a community to develop the capacity for tobacco abuse prevention and control, there must be trust, shared power, and a genuine interest in the community. Help build effective and inclusive organizations through creating navigation routes to involvement and decision making. Collaboration can be achieved through communication, networking, and exchanging information.
Strengthen Community Organizations and Representatives	Ensure that training and technical assistance opportunities are provided for project development, implementation, and evaluation. Include information on how to access and attract funding and resources. Emphasize people's abilities to be their own agents of change through collaboration and creating conditions that allow community members to participate and contribute to the community.

Community capacity is a key determinant of a community's readiness to collaborate in tobacco control. Strategies to build capacity include:

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

capacity. This is especially the case for volunteers or novice staff in community-based organizations who can use their participation in a working group to develop skills and find mentoring relationships.

2. *Funding:* Mini-grants and other small, short-term funding sources can provide some opportunities for community organization staff to develop capacity in project planning, implementation, budgeting and fiscal management, and evaluation. Mini-grants can also increase community participation as seen in California.
3. *Training and Technical Assistance:* National and statewide programs will often provide training and technical assistance to organizations engaging in tobacco control activities. Be sure to require technical assistance providers to provide services in capacity building that are based on the community needs identified in the community needs assessment. Community specific goals need to be addressed in order to develop capacity and infrastructure.²

² Adapted from *Moving Beyond Data to Making a Difference Implementing Goal Four of CDC Best Practices for Comprehensive Control Programs*

The listed toolkits below will aid you and your coalition/organization in building community capacity in order to address tobacco-related health disparities.

Capacity Building Toolkits

Assist: Shaping the Future on Tobacco Prevention and Control: Building National, State, and Local Capacity and Capability. The coalition model was selected and used as the basic organizational structure for ASSIST because of the potential strength of coalitions to mobilize diverse community organizations and individuals to work together to influence social norms and policies. <http://www.hhs.gov/1-877-696-6775>.

Building Community Capacity: Guidance for Staff Working with Communities is a guide providing practical advice about how to work with communities to build their capacity. It also includes case studies and existing resources to strengthen current work. http://www.safercommunitiesscotland.org/view_policy.php?id=4501312258700/7772.

Capacity Primer: Building Membership, Structure and Leadership is a primer that provides clear guidelines for assisting your coalition build the capacity needed to develop and carry out a comprehensive community plan to reduce substance abuse. www.cadca.org 1-800-54-CADCA.

Community Tobacco Prevention and Control Toolkit Coalition Capacity Building Basics discusses the importance of building coalition capacity in order to mobilize programs to solve local tobacco problems. Tools, resources, and action plans are provided to aid in building coalition capacity.

<http://www.dshs.state.tx.us/tobacco/bestpractices/capacitybuilding.shtm>
512-206-4729.

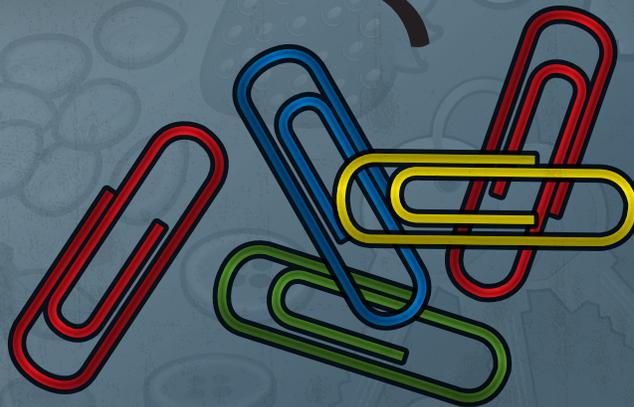
Moving Beyond Data to Making a Difference Implementing Goal Four of CDC Best Practices for Comprehensive Tobacco Control Programs provides the background and theoretical basis for understanding tobacco-related health disparities, and provides a methodology to address these disparities in disparate communities. www.thepraxisproject.org 202-234-5921.

Priority Populations Initiative: Breaking New Ground and Building Capacity in Cultural Tailoring explores strategies to tailor tobacco control programs to meet the unique cultural needs of the target population. www.legacyforhealth.org 202-454-5555.

Developing Your Strategic Plan



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Developing Your Strategic Plan

Developing your strategic plan is the third step in the Strategic Prevention Framework (SPF). Regardless of how an agency conducts its needs assessment, systematically identifying and selecting priorities increases the likelihood of a successful project. Compare your population with a larger group to ascertain whether a health issue or disease rate is higher or lower than expected.

- Compare current information with that collected in previous years to identify trends over time;
- Identify significant gaps in the information;
- Compare and contrast different types of information (e.g. statistics, client and professional views, surveys and questionnaires); and
- Look for positive features as well as problems; even the most disadvantaged communities have strengths that can form the building blocks for change.

It is important to seek the help and views of others as you undertake this process, ensuring that your personal views have not distorted the analysis. At the end, summarize and make a list of the health issues you identify, as these will be the main conclusions to be communicated to others.

Once your coalition has obtained and analyzed the results from the needs assessment, the next step

is to use that information to identify and prioritize critical issues in order to develop a strategic plan using evidence-based environmental strategies to address tobacco-related health disparities. Please review the Assessment Protocol for Excellence in Public Health included in the resources portion of this section to review several methods to identifying priorities.

It is imperative to include community stakeholders in the planning process. Community leaders need to pay considerable attention to the planning process in order to have a successful tobacco control and prevention program within their communities. Active involvement in the planning process can empower disparate communities to address the critical issues they identified within the community needs assessment. Keeping the planning process open to community members who want to participate does not require large numbers of people to be involved with all aspects of the plan; however, it is important to receive input and consensus in order to build trust and support.¹

(Please see the Checklist for Involving Specific Populations in the Development Process in the templates portion of the Developing Your Plan section.)

According to the Community Anti-Drug Coalitions of America (CADCA), a strong plan:

- **Allows** you to wisely allocate current dollars and resources and secure future funding.

- **Defines** “success” in measurable terms.
- **Helps** you select interventions targeted to root causes of substance abuse in your community.
- **Assigns** accountability and timetables.
- **Emphasizes** cultural competence at every stage – involving community members at the coalition table for assessment, capacity building, planning, implementation, and evaluation.²

Developing Logic Models

A logic model is a tool used to provide a visual of your coalition’s strategic plan to address tobacco-related health disparities as well as to determine the effectiveness of the plan. The logic model can portray a coalition’s resources, activities, outputs, audiences, and short-term, intermediate, and long term outcomes related to addressing tobacco prevention and control. The model is an effective tool for strategic planning because it maps the critical issues identified by the community needs assessment with accompanying resources and activities. The elements of the logic model are further described below.

Objective(s):

The objective or objectives are the overarching goals of the tobacco control and prevention program.

Inputs:

Inputs are the resources or what you invest into your program. They include human resources such as staff, volunteers, community members, partners,

and faculty members. Fiscal inputs include funds, grants, donations, and fees. Other inputs include knowledge, materials, facilities, equipment, technical assistance, and research.

Activities:

Activities are what your coalition does with the available resources. Activities include events, tools, and actions your coalition and stakeholders take in order to address tobacco-related health disparities and the priorities identified by the community needs assessment.

Outputs:

Outputs are what your coalition and community partners will produce. Output examples include the creation of no smoking bans, increasing awareness on the dangers of secondhand smoke, and/or stronger enforcement against the sale of tobacco to minors. It is helpful to conduct a process evaluation by measuring the extent to which your program implemented as intended, and whether or not the desired outputs were produced. We will go into greater detail on how to conduct a process evaluation in the Evaluation section of this guide.

Outcomes:

Outcomes are how the participants in your program improve or change as a result of your coalition’s activities. Outcomes are typically categorized as Short-term, Intermediate, or

² Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan. Community Anti-Drug Coalitions of America. 2009.

Long-term. Short-term outcomes may include increasing awareness about the negative effects of tobacco, eliciting community member participation and partnerships, and promoting the use of available resources. Intermediate outcomes are changes in policies, practice, and behavior. Examples of Intermediate outcomes include smoke ban policies adopted by local businesses and/or local government, increasing the number of tobacco prevention programs, and increasing the number of community members accessing available smoking cessation services. Long-term outcomes are typically in the 4-6 year time frame and indicate an overall change in the condition of the target population. A Long-term outcome would be the reduction of tobacco-related morbidity and mortality for populations disproportionately affected by tobacco-related health disparities.

Please refer to the listed toolkits for guidance on developing a logic model. A logic model template will be included in the appendix of this section.

Logic Model Toolkits

W.K. Kellogg Foundation Logic Model Development Guide focuses on the development and use of the program Logic Model. This guide will provide an orientation to the underlying principles to use in program planning, implementation, and dissemination of results. <http://www.wkkf.org> 269-968-1611.

A guide to Developing an Outcome Logic Model and Measurement Plan provides an overview of logic models, and provides instruction on how to develop and tailor a logic model. <http://liveunited.org> 703-836-7112.

Action Steps

Developing action steps when developing your plan will help your coalition stay organized, and help ensure that the critical issues identified by the community are in fact being addressed. Follow the listed action steps below when developing your plan:

- Research existing models and strategic plans from other states
- Create a directory for those models
- Provide funding opportunities for pilot projects based on models researched (tailor these models based on community needs)
- Develop a document to explain the strategic plan and the importance of the models
- Create a plan for the distribution of the strategic plan and information using:
 - Websites
 - List serves
 - Media

(Please see Texans Standing Tall Planning Tool template included in this section.)

Intervention Strategies

An effective strategic plan should encompass the use of educational, policy, and environmental strategies. Educational, policy, and environmental strategies enhance one another, and together, these strategies can be helpful in changing knowledge, attitudes, skills, behavior, policies, and the environment to reduce and eliminate tobacco-related health disparities. For instance, it would be unrealistic to expect a community to enact a tobacco related policy to change the physical and social environment without an understanding of how this would impact the health and wellness of community members.

Examples of activities for each strategy are included below:

Educational Strategies – includes communication and skill building.

- Communication methods: media advocacy, group discussions, educational materials (tailored to community priorities), and audiovisual aids.
- Training methods – classes to develop skills, technical assistance, inquiry learning, trainings, and discussions.

Policy Strategies – Includes policies, regulations, and laws as well as informal rules and understandings of government and local organizations such as schools, non-profit organizations, service organizations, and business.

- Negative policies – designed to restrict or limit unhealthy actions (i.e. restrictions on sale of tobacco products in public buildings, policy to enforce laws against the sale of tobacco products to minors, increasing the tobacco excise tax, and policies to restrict smoking at worksites and public places).
- Positive policies – policies designed to encourage healthful actions: discounts on insurance for nonsmokers and flex time for employees to attend tobacco cessation.

Environmental Strategies – Changes that alter the physical or social environment; includes efforts to make the environment:

- More supportive of health (e.g. creating designated smoking areas away from buildings, limiting the size of cigarette displays at convenient stores, and limiting the number of tobacco advertisement displays).
- More discouraging of actions that are not supportive of health (e.g. removing cigarette vending machines from public buildings).
- More supportive of normative changes in attitudes and behaviors (i.e. community expectations related to the benefits of quitting smoking, and limiting exposure to second hand smoke).

A quality plan has detailed steps and a clear, objective course of action. One way to develop well-written objectives is to use the SMART approach. Developing specific, measurable objectives requires time, orderly thinking, and a clear picture of the results expected from program activities. The more specific your objectives are, the easier it will be to demonstrate success.

SMART stands for:

Specific

Measurable

Attainable/Achievable

Relevant

Time bound

Specific—*What exactly are we going to do for whom?*

The “specific” part of an objective tells us what will change for whom in concrete terms. It identifies the population or setting, and specific actions that will result. In some cases it is appropriate to indicate how the change will be implemented. Coordinate, partner, support, facilitate, and enhance are not good verbs to use in objectives because they are vague and difficult to measure. On the other hand, verbs such as “provide,” “train,” “publish,” “increase,” “decrease,” “schedule,” or “purchase” indicate clearly what will be done.

Measurable—*Is it quantifiable and can WE measure it?*

Measurable implies the ability to count or otherwise quantify an activity or its results – way of defining whether or not your objectives have been completed successfully. It also means that the source of and mechanism for collecting measurement data are identified, and that collection of these data is feasible for your program or partners. Baseline measurements from your community needs assessment should be used to track and measure change.

Attainable/Achievable—*Can we get it done in the proposed time frame with the resources and support we have available?*

The objective must be feasible with the available resources, appropriately limited in scope, and within the program’s control and influence. Sometimes, specifying an expected level of change can be tricky. To help identify a target, talk with an epidemiologist, look at historical trends, read reports or articles published in scientific or other literature, look at national expectations for change, and look at programs with similar objectives. Consult with partners or stakeholders about their experiences. Often, talking to colleagues in other states who have implemented similar programs or interventions

can provide you with information about expected change. In some situations, it is more important to consider the percentage of change as a number of people when discussing impact. Will the effort required to create the amount of change be a good use of your limited resources?

Relevant—*Will this objective have an effect on the desired goal or strategy?*

Relevant relates to the relationship between the objective and the overall goals of the program or purpose of the intervention. Evidence of relevancy can come from a literature review, best practices, or your theory of change. For tobacco prevention and control programs, the objective should accomplish one of the following:

- Directly lead to a desired environmental or educational change identified in your strategic plan.
- Directly lead to a policy or system level change in a priority setting.

Time bound—*When will this objective be accomplished?*

A specified and reasonable time frame should be incorporated into the objective statement. This should take into consideration the environment in which the change must be achieved, the scope of the change expected, and how it fits into the overall work plan.

Strategic planning takes time, effort, and collaboration. Listed below are two toolkits to help identify community needs and prioritize populations in order to develop plans to address tobacco prevention and control.

Toolkits for Developing Your Plan

Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs. the purpose of this tool is to effectively identify, plan, and implement needed policy, systems, and environmental changes as well as to enable communities to be able to assess the current policy landscape and monitor changes over time. www.cdc.gov/HealthyCommunitiesProgram 770-488-6452.

Community Tobacco Prevention and Control Toolkit Strategic Planning to Reduce Tobacco Use provides information on using logic models to identify evidence-based interventions in order to develop a strategic plan to address tobacco control and prevention. Links to existing evidenced-based programs are provided. <http://dshs.state.tx.us/tobacco/bestpractices> 512-458-7111.

Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan focuses on the process of incorporating cultural competence within community coalitions as they work through each stage of the Strategic Prevention framework. www.cadca.org 1-800-54-CADCA.

Planned Approach to Community Health: Guide for the Local Coordinator PATCH is community health planning model used to help communities plan, conduct, and evaluate health promotion and disease prevention programs <http://lgreen.net/patch.pdf> 1-877-696-6775.

Prioritization is part of the Assessment Protocol for Excellence in Public Health workbook to assist in the methodology used to prioritize issues based on community resources and needs. <http://www.cdc.gov> 800-CDC-INFO (800-232-4636).

Resources

The Community Toolbox provides outlines and tools for developing strategic and action plans. <http://ctb.ku.edu> 785-864-0533.

Program: (name) _____ Logic Model



Situation:

Assumptions	External Factors
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Media Outreach



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Media Outreach

Developing positive relationships with local media outlets is essential to the success of your tobacco control and prevention program, grassroots campaign. Building a relationship with the media is not a simple task. Cultivating a relationship with the media takes time, energy, and effort. Learning how to effectively communicate via the media will ensure visibility and promote community outreach for your coalition's message.

Why Local Media?

In order to address, reduce and/or eliminate tobacco related health disparities, your coalition needs to frame messages that are easily understandable and easily relatable to members within the community. Since you are addressing the issues important to the community, you want to be able to make sure those issues are addressed using modes of communication that members of the community have access to and will likely use. Local media can include anything from newspapers, newsletters, local magazines, radio, billboards, and television stations throughout the community.

Using local media is also a cost-effective method of conveying your message. Media outlets will often run releases and cover events free of charge when the messages relate to social change.

Getting Started

You want your coalition to be able to effectively disseminate your message, but where do you start?

Make a Plan

Make a Media Plan before contacting the media. Think about what you would like to see accomplished through contacting the media. What are your goals and objectives in contacting the media? For instance, if one of your coalition's goals is to enact a city wide smoke-free policy, then your media goal or objective would be to have media coverage that supports and reports your coalition activities in working toward enacting a city wide smoke-free policy.

Do Your Homework

Research the different media outlets in the community in which you are trying to convey your coalition's message. Find out which outlets and contacts best suit your coalitions needs. What kind of stories have these media outlets covered in the past? Make a list of the local community newspapers, local publications/magazines, radio, and television stations. The following list provides helpful suggestions to organize your media contact information:

1. Company
2. Contact name, title
3. Type of contact (assignment editor, health care reporter, columnists, editor, producer)
4. Address
5. Phone
6. Fax
7. Email
8. Website
9. Contact preference (phone/email)
10. Language (English/Spanish/etc.)
11. Distribution/Reach (Local/State/National)
12. Focus (general/business/youth/etc.)
13. Audience (age/gender/etc.)
14. Recent stories (articles or stories recently published)

(Adapted from Colorado Nonprofit Association's Working with the Media Nonprofit Toolkit)

Ask your community stakeholders about possible connections to these media contacts within their community at your next coalition meeting. Your community stakeholders are your coalition's key to the community, and could possibly facilitate contact with the local media.

Develop Your Message

What does your coalition want to present to the media? Think about what is newsworthy. Information that is currently on your coalition's website may be seen as newsworthy to you, but the media may not share your same view. Are you developing a new program that will be available to the public soon? This is new and newsworthy. The Colorado Nonprofit Association developed the Five W's to aid coalitions in developing an

effective and concise message.

The Five W's

1. Who are you? Who do you represent?
This should be a clear and concise organization description.
2. What is the news you want reported?
When answering this question think carefully about what you want this story to accomplish. Are you inviting people to an event, are you communicating an important fact, or are you stating a position on an issue?
3. When will the event occur?
4. Where will the event occur?
5. Why is this news report important?
Why should others care about what you are doing?¹

(Please see the template on How to Establish your Message in the appendices portion of this guide.)

¹ Colorado Non-profit Association. *Working with the Media Nonprofit Toolkit*. Long Beach Non-profit Partnership. <http://www.lbnp.org/nonprofit-marketing>

Identify Media Spokesperson

Identify one person within your coalition to be the main point of contact for media. Having one point of contact as a media liaison will make it easier for your coalition, it will keep your coalition's messages consistent, and it will make your coalition more accessible to the media.

Contacting the Media

As previously mentioned, ask your community stakeholders at your next meeting for possible existing contacts with the local media. Your community stakeholders may have existing relationships with local media outlets from previous projects, and could facilitate contact with these outlets.

Set up Informal Meetings

Set up informal meetings with reporters, newspaper columnists, producers, etc. You have done your homework and should be aware of what your media contacts have recently worked on or what they are currently doing. Be sure to comment on your media contact's recent work to build rapport when making initial contact. Try to set up an informal meeting to open up a conversation in order to build a working relationship.

Become a Resource

Become your media contact's source

of relevant tobacco control and prevention information. The media may want to contact an expert (you) for comment on a story that may not be directly related to your coalition. This is a great way for your coalition to receive exposure.

Write an Opinion Editorial (Op-Ed) or Letter to the Editor

An Opinion Editorial (Op-Ed) is an excellent tool to raise public awareness. A good time to send an Op-Ed is when there is an upcoming event, campaign, or issue. Op-Ed pieces should be written in news article format, and in a way that outlines your coalition's position in a persuasive manner. Your Op-Ed should be about 700-800 words and cover the following points:

- Description of your coalition.
- What issue(s) is your coalition addressing in the community?
- How does your coalition help to solve this issue?
- How was this issue(s) being addressed before your coalition?
- What does the community stand to gain? Lose?
- What community groups, leaders, or people are participating in coalition activities?
- Is there opposition to your coalition?
- Why should the community care?

(Modified from Colorado Nonprofit Association's Working with the Media Tool-kit)

Op-Ed examples from the Robert Wood Johnson Foundation are provided in the templates portion of this guide section.

Letters to the editor are typically written in response to a story, article, or previous letter. A 200-300 word letter to the editor should be mailed to the editorial page. It is especially important to write a letter to the editor if there was an article or opinion piece written that opposed your coalition.

Write a Press Release

A press release, also known as a news release, is used to make an announcement about a major event. Press releases should attract the attention of the media and provide all the information to the story in a concise and clear message.

Templates for Op-Eds, letter to the editor, and press release are included in the templates section.

Responding to the Media

Be prompt and prepared when responding to the media when contacted for interviews or inquiries. Know your message and have your main talking points prepared and rehearsed. Your response to any question should somehow relate or tie back to your coalition's message. You cannot always anticipate what the media will ask you; however, avoid saying "no comment" when you are unsure of how to answer a question. Be honest with your answers. If

you are unsure of how to answer a question, tell the interviewer why you are unsure or why you cannot answer their question at that time.

If your coalition initiated an interview with the media, provide your interviewer with information about your coalition. Information should include some background as well as the newest and latest occurrences in your coalition. This courtesy of providing basic information will save your interviewer some time, which is always appreciated.

It is completely normal, if not expected, to be nervous about an upcoming interview. If you are nervous about an upcoming interview, practice interviewing with a colleague. Rehearsing your talking points and conducting a mock interview will help calm any nerves associated with an upcoming interview.

Using Social Media

An increasing number of people are using Facebook, YouTube, Twitter, and other social media tools to receive and disseminate information. Social media has become an effective tool for the dissemination of health messages. Social media and other emerging communication technologies can better connect people to:

- Increase the timely dissemination and potential impact of health and safety information.
- Leverage audience networks to facilitate information sharing.

- Expand reach to include broader, more diverse audiences.
- Personalize and reinforce health messages that can be more easily tailored or targeted to particular audiences.
- Facilitate interactive communication, connection, and public engagement.
- Empower people to make safer and healthier decisions.²

Incorporating social media into your media outreach plan can greatly increase your coalition's reach, without having to directly go through a media contact.

Different Modes of Media

Different modes or channels of media are listed below with brief descriptions of each method.

News/Press Conference: Typically used to release “big” news. A conference is called by your coalition to disseminate new information, or respond to a current event or issue. Media is invited to attend and ask questions after your coalition delivers a statement.

News Release: Typically used to release new reports and/or announcements. It can include quotes from officials, coalition members, or members within the community. A news release can also be used to announce an event you want covered.

Feature Story: Takes an in-depth view of your issue.

Pitch letter/Phone call: A letter that is written or a phone call that is made to a media source in an effort to get your issue or story covered.

RSS Feed: Really Simple Syndication is technology that notifies users of updates to content on a Web site, blog, or Internet TV channel.

Sound Byte: A brief, often shorter part of a longer interview, quote or speech that is considered by the editor or media outlet as the most important.

News Briefing: News that does not deal with serious facts or findings. Also known as a “human interest” story to bring attention to an issue that is interesting but may not necessarily be crucial findings.

Public Service Announcement: A television or radio announcement that disseminates your message to a target audience.

Editorial/Op-Ed: is A brief written reaction to a recent event or news story. An editorial expresses an opinion and is often written to express a point of view.

Media Advisory: Serves as an invitation to the media to attend your event. It is important to provide some notice of an upcoming event. The invitation should answer questions such as: Who, What, When, Where, and Why.

² Centers for Disease Control and Prevention. Office of the Associate Director for Communication. The Health Communicator's Social Media Toolkit. July 2011.

Media Outreach Toolkits

Media Advocacy Tool Kit: Tobacco Policy Change Grantees provides the necessary resources and tools to be an effective communicator. <http://www.rwjf.org> 878-843-7953.

Media Toolkit assists in providing the components needed to engage the media and develop a positive relationship for an effective grassroots campaign. www.qualitygrowth.org

The Health Communicator's Social Media Toolkit was designed to provide guidance to help you get started using social media – from developing governance to determining what channels best meet your communication objectives in creating a social media strategy. <http://www.cdc.gov> 800-CDC-INFO (800-232-4636).

Working with the Media Nonprofit Toolkit provides useful tips, samples, and how-tos to help nonprofits work with the media to advocate for your organization and mission. www.ColoradoNonprofits.org 303-832-5710.

Media Outreach Templates

How to Establish Your Message	
1. Who?	
2. What is your news?	
3. If an event, when will it occur?	
4. If an event, where will it occur?	
5. Why is your news relevant?	
6. What is significant about your project, work or event?	
7. Why is your project, work or event important to the community? Elaborate on question #2.	
8. What kind of change can be expected from your project, work or event?	

(Adapted from Colorado Nonprofit Association)

Template: Letter to the Editor

<Name of Media Outlet or Publication>

<Attention: >

<Address 1>

<Address 2>

<City>, <State> <Zip or Postal Code>

Dear Editor:

<State your reason for writing here. If you are responding to articles or editorials by the media outlet, use the first sentence to reference the title of the article, name of the publication, and date it appeared.>

<State your case here. Include facts, references, or research here to establish credibility. [Keep length in mind though. Acceptable letter length will vary from periodical to periodical. Look at their letters section to get a feel for an appropriate length.]>

< Include a call to action, asking readers to follow up with some activity, such as joining in calling on policymakers to address the issue.>

<End with a strong, positive statement in support of your case.>

Sincerely,

<Writer's Signature>

<Name of Writer>

<Writer's Title>

<Writer's Organization >

Op-Ed Template

Suggested Title

Introduction: [State your opinion and the one to three main points you will argue in your article.]

Body of Article:

[Support the opinion you stated in the first paragraph by developing each of your main points: Cite facts and figures (and your sources).]

[Demonstrate your familiarity - give a brief background on why you are knowledgeable and why you care about this issue.]

[State what is being done to address the problem highlighting what you or your organization are doing.]

[State the other side of the issue and explain why it is wrong, off topic, irrelevant an outlier opinion etc.]

Conclusion: *[End with how the issue can be improved and what actions need to be taken.]*

Personal Information: [Name of Writer]

[Writer's Title]

[Writer's Organization] [Telephone Number]

[E-mail Address]

Organizational Information:

Organization Description] (if applicable)

Press Release Template

FOR IMMEDIATE RELEASE:

CONTACT:

Contact Person

Company Name

Voice Phone Number

FAX Number

Email Address

Website URL

<HEADLINE>

<City>, <State>, <Date>

[The first paragraph] Begin your press release with a two sentence paragraph that provides a quick overview of the news and why it is important. It should read easily and make your news sound exciting to a general audience.

Next, provide some background information on the product or service. Make sure to write your release in terms that readers, consumers, your target audience, and the general public will understand. Do not use industry terminology, and provide definitions for terms that readers might not know about or understand.

Your text should explain the purpose, target market, and benefits of your product or service, and intrigue the reader to find out more, visit your website, contact you for more information, recommend your product to a friend, or sell your product to management.

ABOUT <COMPANY>

The final paragraph should be a brief description of your coalition and services it provides. Include a summary of your coalition's history. Also include "For more information, contact:" as the last sentence.

- END -

Organization

Contact Information

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Implementing Your Strategic Tobacco Control Plan



shell collection



Implementation

Implementation is the fourth step of the Strategic Prevention Framework.¹ This step is all about putting your coalition's plan into action. You are basically doing what you said you were going to do. It is important to hit the ground running, and the great amount of time and effort devoted to developing your strategic plan will pay off in the implementation stage of your tobacco prevention and control efforts.

Cultural Competency in Implementation

As mentioned in the previous steps, it is imperative to continuously include the members of the community. Inclusion of stakeholders in the implementation of your strategic plan will bring credibility and provide community ownership. Some members of the community may want to be more involved than others in program implementation. Regardless of degree of involvement, your coalition must keep the target population informed of all coalition activities in their community. Committed community members and partners are essential to the success of implementation, and are also a valuable resource when it comes to the best methods and modes of implementation. Remember that diversity encompasses more than race and ethnicity it also

includes age, gender, disability, sexual orientation, and socioeconomic status.

Cultural adaptation is especially important when it comes to implementation. Cultural adaptation refers to program modifications that are culturally sensitive and tailored to a particular group's traditional world views. Too often, people equate cultural adaptation with translation but it is much more than that. Effective cultural adaptation considers the values, attitudes, beliefs, and experiences of the target audience. These considerations are imperative to addressing tobacco-related health disparities.

Getting Started

Strategic plans are typically implemented through coalition members, partners, paid staff, volunteers, and other organizations committed to performing work tasks. Depending on the scope of work, outside contractors may need to be hired to perform activities that cannot be completed by coalition members. The coalition also can issue a request for proposals, which defines the work it wants done and invites community-based organizations or individuals to develop and submit proposals outlining in detail how they plan to carry out specific activities.

¹ Please review the Strategic Prevention Framework section of the tobacco guide as a reference

Implementing Evidence-based Interventions

Your coalition should have selected an evidence-based strategy to use in your strategic plan. It is important to use evidence-based strategies because these methods have been proven to be effective in tobacco prevention and control programs. Please keep in mind that no two communities are alike. An approach or strategy that worked well in one community may not transfer successfully and work as well in another community. Tailor your approaches and strategies to address each unique community.

For information on evidence-based programs and practices, please visit SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP): <http://nrepp.samhsa.gov/>

Monitoring Implementation

Monitoring and documenting program implementation and any changes made to the strategic plan is a “must do.” Funders may ask your coalition to report on the accuracy with which it has implemented its evidence-based interventions. Also, it is good to know what is and is not working with your program while there is still plenty of time for modification. Many wonderfully designed but ineffective programs could have been altered during the

implementation phase if careful monitoring had taken place. If something is not working, then try a different strategy. A process evaluation is an evaluation method used to determine whether or not your program is being implemented as planned. Please review the Evaluation section of this guide for more information on how to conduct a process evaluation.

Generally, within 3-6 months of beginning a new strategy or activity, your coalition staff should use these processes to develop a systematic way to review your logic model and strategic plan to accomplish the following:

- **Document** program components that work well
- **Identify** where improvements need to be made
- **Provide** feedback so strategies are implemented more effectively
- **Make** timely adjustments in activities and strategies to better address identified problems
- **Assess** whether enough resources have been leveraged and where you might find more
- **Engage** stakeholders/sectors so they feel responsible and pride in helping to ensure that the goals and objectives of the coalition are met

Review the toolkits for implementation listed below for more guidance and information on how to effectively implement your strategic plan.

Implementation Tool-kits

Implementation Primer: Putting your plan into Action will assist your coalition in the implementation of comprehensive strategies designed to achieve population-level reductions of substance abuse.

www.cadca.org 1-800-54-CADCA.

Implementation Toolkit provides the information and tools you will need to hit the ground running with strategy implementation and focuses on how to develop solid action plans that set you up to effectively monitor your implementation process.

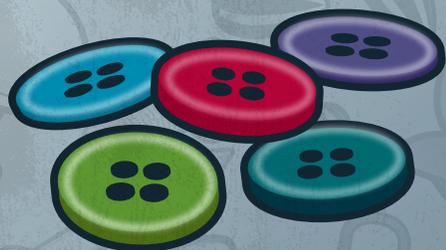
<http://dhhs.ne.gov> (402) 471-3121.

Implementing Comprehensive Community Tobacco Prevention & Control Programs provides you with the necessary information needed to implement comprehensive evidence-based programs.

<http://www.dshs.state.tx.us>

(512) 458-7111 or 1-888-963-7111.

Conducting an Evaluation



{ *button holder* }



Evaluating Your Tobacco Control Plan

Now that your coalition's activities are underway, it is time to determine the effectiveness of your tobacco control plan. Evaluation is the process of collecting, analyzing, and monitoring tobacco-related attitudes, behaviors, and health outcomes at regular intervals to determine the efficiency and vigor of your tobacco prevention and control plan. Evaluations are conducted to improve your tobacco control plan; measure the plan's effectiveness; demonstrate the effective use of resources; and determine accountability. Evaluating your tobacco control plan will provide your coalition with information regarding the fidelity of your goals and objectives, what aspects of the tobacco control plan are working, and what areas need to be improved in order to ensure validity and sustainability.

Evaluation is the final stage of the Texas Strategic Prevention Framework process following Assessment, Capacity Building, Planning, and Implementation.¹ Although it is considered to be the final stage, evaluation needs to be incorporated in all stages of your tobacco prevention and control program. During the evaluation stage, your coalition will assess the implementation and outcomes of the tobacco

control plan to measure what has been done and the effects it has had on the community. The evaluation findings will tell you the effectiveness of your coalition's goals and strategies to reduce tobacco-related health disparities and how the tobacco control plan might be improved to achieve better outcomes.

A comprehensive and participatory approach to evaluation involves engaging the diverse stakeholders within the community. Involving a diverse group of stakeholders ensures reciprocity in that the information gained through the evaluation will benefit all participants. Let participants know that their opinions are important by providing opportunities for them to share their thoughts and views. With community participation you can improve your tobacco plan to better meet local circumstances and increase the likelihood of attaining positive results. For more guidance, please see the "Checklist for engaging stakeholders" developed by the CDC in the appendix of this guide.

It is time to get started! There are three types of evaluations that will be useful in determining the effectiveness of your coalitions' tobacco prevention efforts:²

- Formative evaluation
- Process evaluation
- Outcome or summative evaluation

¹ For more information on the Texas Strategic Prevention Framework please see the Strategic Prevention Framework section of this guide.

² Department of State Health Services, *Community Tobacco Prevention and Control Toolkit Evaluation*. <http://www.dshs.state.tx.us/tobacco/bestpractices/evaluation.shtm>

Formative evaluation

A formative evaluation can be used to test your tobacco coalition's strategy and plan. This type of evaluation is conducted during the development of your tobacco control plan and continues throughout the life of the plan to ensure that the strategies and activities are feasible, significant, acceptable, and culturally appropriate for the priority population. A formative evaluation will provide your coalition with information to improve the tobacco control plan.

Process evaluation

Before your coalition evaluates the outcomes or impact of the tobacco control strategies, it must first make sure the activities are operating according to the plan. A process evaluation is a special type of formative evaluation conducted to determine the fidelity in the implementation of the tobacco control plan and whether or not your coalition is meeting the goals of the plan (e.g. are the people being served members of the priority population?). This type of evaluation should occur several times throughout all program stages in order to review the program processes, determine what is most effective, what needs to be improved, and identify barriers to be addressed so that benchmarks of community progress are being met. Information from a variety of sources (such as participants, coalition members, and

stakeholders) can tell you how a program is progressing. This type of evaluation is essential to determining the impact of your tobacco control plan activities and strategies on the community at various stages of the intervention.

Conducting a process evaluation will allow your coalition to improve and fine tune the plan throughout development and implementation. If your coalition's process evaluation is effective in monitoring progress, it will ensure that there are no unwelcome surprises at the conclusion of the project. Information collected may also form the basis for an outcome evaluation conducted at a later date.

Outcome evaluation

An outcome, or summative evaluation, is used to assess the degree to which the goals of the tobacco control plan were met and determine the impact of the tobacco prevention and control program within the community. Changes in the behaviors, attitudes, tobacco-related morbidity and mortality, and environmental conditions are the outcomes typically examined through an outcome evaluation. Outcome evaluations take place after the plan has been implemented during the timeframe set for change to have occurred.

The outcome evaluation is also an assessment of effectiveness, strength, and scope for use in making decisions regarding expanding

the intervention, continuing or increasing funding, modifying the plan, or discontinuing the intervention. An outcome evaluation may determine continuation of the plan's activities and funding. This type of evaluation is conducted by taking baseline measurements in the areas of interest before implementation in order to measure and compare the baseline to the measurements taken after implementation. Pre-and post-intervention measurements will determine whether or not your coalition was successful in achieving desired outcomes.

All evaluations can be conducted by the coalition itself; however, when conducting an outcome evaluation, it may be wise to get an external evaluator who can be objective and unbiased.

Once your coalition has determined the type(s) of evaluation it will use, it is now ready to begin developing its evaluation plan.

Developing an Evaluation Plan

The first step in developing your evaluation plan is clarifying the purpose of the evaluation, stating exactly what is to be evaluated. The purpose of your coalition's evaluation may be to identify pieces of the plan that need improvement, assess the plan's effectiveness, assess community needs, mobilize community support, or demonstrate

accountability of resources. The purpose of your evaluation will reflect the stage of development of your plan and will determine the type of evaluation to use. With a new plan, your coalition may want to conduct a process evaluation to help improve the program by determining what works and what does not work. With a mature plan, your coalition may want to conduct an outcome evaluation to assess the plan's effectiveness and demonstrate that it is making productive use of resources.

A competent evaluation plan involves:

- Developing a logic model
- Defining goals and objectives
- Developing an evaluation design
- Developing evaluation questions
- Implementing the evaluation plan

Developing a Logic Model

Every project should start with a logic model to provide a framework to which the evaluation design can be applied. Logic models are flowcharts that depict project components and provide a picture of how your tobacco plan works. These models can include any number of project elements, linking the project inputs and activities to outcomes. Your evaluation plan should reflect the framework of the logic model. A typical model begins with the inputs to the project and moves through its processes and activities to program outputs and short-term, intermediate, and long-term outcomes.

- **Project inputs** are the various resources that provide support to your project (i.e. federal funding and local funding, staffing, equipment, materials, partnerships, time, and in-kind contributions).
- **Activities** are the actual events that take place as part of your plan.
- **Short-term outcomes** are the immediate results of these activities. One type of outcome is sometimes called an “output,” which is an accounting of the numbers of people, communities, or organizations your coalition reached. Another type of outcome looks at short-term changes that result from the experience.
- **Intermediate outcomes** include behavior change, normative changes, and changes in policies (e.g. adoption of clean indoor air policies, and establishing voluntary bans on smoking in schools, day care centers, restaurants, and work places).
- **Long-term outcomes** are the broader impacts that might not be expected to emerge until some time after the community has experienced the plan.

The logic model shows the process that flows from inputs to long-term outcomes and can help you determine whether your program activities logically lead to the desired outcome. It also provides a framework for monitoring the flow of work and checking whether required activities are being put in place. An outcome indicator is a specific, observable, and measurable change that will represent achievement of the desired outcome. Outcome indicators are organized by evidence-based logic models. Selecting the right

indicators to measure your plan’s effectiveness is key to a good evaluation.³

When drafting a logic model, first determine your goal, assess project inputs, and then decide on the activities needed to achieve your goal(s). Once you have selected your plan’s activities and decided on the various components of your logic model, arrange them in order, starting at the left-hand side and moving to the right. Examine your model carefully. Does each step logically relate to the other? Are there missing steps that disrupt the logic of the model? Once the model is implemented, can you use it to assess whether your program is doing what it needs to do to implement change?⁴

See the Resources and Toolkits section of this guide for examples and templates of tobacco prevention logic models developed by the Centers for Disease Control and Prevention (CDC). These templates and examples can be tailored to your coalition’s tobacco prevention and control plan.

A visual description helps ensure that all stakeholders understand the tobacco plan’s purpose, resources it will need, activities it will conduct, and its capacity to effect change. Logic models are useful starting places for developing goals and objectives and forming questions to be answered through the evaluation.

³ Centers for Disease Control and Prevention Key Outcome Indicators for Evaluation Comprehensive Tobacco Control Programs http://www.cdc.gov/tobacco_control_programs/surveillance_evaluation/key_outcome/pdfs/key_Indicators.pdf

⁴ Centers for Disease Control and Prevention, Introduction to Program Evaluation for Comprehensive Tobacco Control Programs http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

Defining goals and objectives

Well-written and clearly defined goals and objectives focus the evaluation, set targets for outcomes, and most critically, identify the targets by which you will measure your plan's success (e.g. To be considered successful, what does your plan need to accomplish?).

A goal expresses the overall mission or purpose of your tobacco control plan. The overarching purpose of your tobacco plan is to reduce and eliminate tobacco-related health disparities. The goals of your plan will guide the development of your specific purpose. Objectives are statements describing the results to be achieved and the manner in which the results will be achieved. The objectives of your tobacco plan should flow from the logic model and link to one another. Each evaluation objective should be specific, measurable, and achievable.

There are two general types of objectives: process and outcome. Process objectives describe your plan's activities. They specify actions to be taken and are useful in measuring plan implementation. Outcome objectives are the intended results of your plan's activities. Outcome objectives are often divided into short-term, intermediate, and long-term objectives. They generally state:

- Who will do what?
- How much will they do?
- By when?

“Who” is typically stated as a population; “how much” reflects what your coalition thinks is achievable; and “when” is stated as a month, year, or period after the plan begins.⁵

Think about your goal as a problem to be solved. As you break the problem down, there will be many possible objectives that must be achieved in order to truly accomplish your goals.⁶

Now that your coalition has a clear understanding of your tobacco plan's purpose, goals and objectives, it is time to focus on where the evaluation is headed and what steps will be taken to get there.

Developing an evaluation design

Earlier in this section we discussed the three types of evaluations: formative, process, and outcome. Once your coalition decides on the type of evaluation(s) to use it should then determine the design of the evaluation. The evaluation design should outline which questions you are investigating, the process you will follow, what will be measured, what methods will be used, who will perform each activity, what will be done with the information that is collected, and how the results will be disseminated.

The evaluation design should also accommodate the plan activities and meet the needs of diverse stakeholders. There are typically

⁵ Centers for Disease Control and Prevention, Introduction to Program Evaluation for Comprehensive Tobacco Control Programs http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf
⁶ The 2002 User-Friendly Handbook for Project Evaluation. For assistance with developing goals and objectives please refer to the Goal and Objective Worksheet in the template section of the appendix developed by the National Science Foundation. <http://www.nsf.gov/pubs/2002/nsf02057/nsf02057.pdf>

two types of evaluation designs that are used:

- Experimental
- Quasi-experimental

Experimental designs are defined by using random assignment to compare the effectiveness of an intervention on one or more groups that did not receive the intervention.⁷ This will allow your coalition to attribute change in outcomes to your plan. If you find that having a control group is difficult, one solution is to use a *quasi-experimental* design. These types of designs make comparisons of an equivalent group to the group participating in the target program; this design does not involve random assignment to intervention and control groups.

There are also less traditional designs your coalition can use in its evaluation. These include simple pretest-posttest or posttest only designs. Depending on your program's objectives, resources, and the intended use of the evaluation findings, these less traditional designs may be more suitable for measuring progress toward achieving program goals. These designs are oftentimes the preferred method to compare participant groups and measure the degree of change that results from your plan while being more affordable and expedient. It is important to choose a design that will capture the measurements and data that coincide with your

coalition's immediate and long-term needs. A collaborative approach to focusing the evaluation will provide a practical way to better ensure the effectiveness and validity of your coalition's evaluation designs.

Once your coalition determines its evaluation design, it can begin framing the evaluation questions.

Developing evaluation questions

A focused evaluation gathers information for a specific purpose or use and builds on the logic model. It is important in developing the evaluation questions to identify possible audiences (participants, would-be participants, community members, etc.) and their specific information needs. Identifying who will use the evaluation results and determining what is important to them will help frame and design your evaluation questions to meet their needs. As previously discussed, your stakeholders can be good sources of information with regard to what is feasible and effective in program implementation. You will want to identify these stakeholders early in the design phase and draw upon their knowledge as the plan is shaped. A strong stakeholder group can be useful at various points in the project – shaping the questions addressed, identifying credible sources of evidence, and reviewing

⁷ Centers for Disease Control and Prevention, Introduction to Program Evaluation for Comprehensive Tobacco Control Programs http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

findings and assisting in their interpretation. In most cases, key stakeholders will share a number of information needs; however, there may be audience-specific questions that also need to be considered.

Rather than trying to answer every question that various stakeholders may pose, the evaluation team should focus on those it determines to be most relevant to the tobacco prevention and control intervention. Questions may vary depending on the type of evaluation your coalition uses. Below are some questions that may be considered when conducting the different types of evaluations:⁸

Formative evaluation:

- Are the proposed activities suitable for the priority population?
- Are the proposed plans and strategies likely to succeed?
- When is the best time to introduce the plan to the priority population?
- Are sufficient resources to carry out the plan available?
- Are there beliefs among the priority population that work against the plan?

Process evaluation:

- Was each tobacco plan activity completed as planned?
- To how many people/workplaces/communities was each activity delivered?

- What were participants', workplaces', or communities' perceptions of each activity and/or the plan?
- What were the strengths of the way the plan was implemented?
- What were the difficulties, barriers, or challenges to implementation?
- Is the priority population moving toward the anticipated goals of the tobacco control plan?
- Are the numbers of community members reached in the program increasing?

Outcome evaluation:

- Was there a change in the communities' knowledge, attitudes and beliefs?
- Was there a decrease in the percentage of the priority population that smoked in the past 30 days?
- Were there changes in the number or restrictiveness of clean air policies?

The evaluation questions should help you determine if you are making progress toward your objectives. The questions listed above may be good to consider; however, each specific question should be considered for inclusion based on the following decisive factors:

- The contribution of the information to the goals of the plan's stakeholders
- Who would use the information
- Whether the answer would provide information that is not now available
- Whether the information is important to a major group or several stakeholders

⁸ Department of State Health Services, Community Tobacco Prevention and Control Toolkit Evaluation: Evaluation Types. <http://www.dshs.state.tx.us/tobacco/bestpractices/evaluation.shtm>

⁹ The 2002 User-Friendly Handbook for Project Evaluation. For assistance with developing goals and objectives please refer to the Goal and Objective Worksheet in the template section of the appendix developed by the National Science Foundation. <http://www.nsf.gov/pubs/2002/nsf02057/nsf02057.pdf>

- Whether the information would be of continuing interest
- How the question can be translated into measurable terms
- How it would be possible to obtain the information, given financial and human resources.⁹

The questions your evaluation team and stakeholders agree upon will affect the methods used to gather data. Therefore, your team will need to decide on the questions before choosing a data collection method. Whatever your questions are, grouping them in terms of your goals and objectives will help you to organize your thoughts and identify gaps in your evaluation plan.

Subsequent to your coalition clarifying what it intends to evaluate, determining the type of evaluation(s) it will use and evaluation questions, and defining measurable goals and objectives, it is now time to focus on implementing the evaluation plan.

Implementing the evaluation plan

Once your evaluation plan has been developed, your coalition is ready to implement the plan. Key activities to include when implementing your evaluation plan are:

- Collecting data
- Analyzing and interpreting data
- Reporting the outcomes

Collecting data¹⁰

Data collection is the first step in implementing your coalition's evaluation plan. Measuring your coalition's progress and impact means collecting and interpreting information. You will need to collect baseline data to compare with the cumulative data you collect at the end of the project. Your coalition may want to collect both quantitative and qualitative data.¹¹ Using qualitative and quantitative data can provide a more comprehensive picture of your plan. Before you decide which method to use to collect this information, keep in mind your purpose, as previously discussed, to ensure that data collection is more manageable.

There are four basic ways to collect evaluation data:¹²

- Document review
- Observations
- Interviews
- Surveys

Using a combination of these methods will assist your coalition in checking its findings. Also, your evaluation will have more credibility if you can reference more than one information source and method of data collection to support your conclusions.

Now that you have collected your data, it is time to interpret and report your findings.

¹⁰ Please see the Data section of the guide for more information on data, sources of data, and data collection

¹¹ For more information on quantitative and qualitative data please see the Resources for Data section of this guide.

¹² For details on data collection sources and steps, please see the Resources for Data section of this guide.

Analyzing and interpreting data

Once data is collected it must be analyzed and interpreted. Data analysis is the process of organizing and classifying the information you have collected, tabulating it, analyzing it, comparing the results with appropriate information, and presenting the results in an understandable manner. Evaluation and each data collection activity will tell you about the quality and success of your plan. Reviewing this evidence and considering it in terms of your objectives will help you determine whether or not your plan achieved what it intended.¹³

After analyzing the data, the next step is to determine what the results say about the plan. In some cases, interpreting your data may require additional expertise, someone who can shed light on your results. Data are given voice by those who interpret them. Interpreting your evaluation data for “in-house” use can be done informally; however, making it available to others requires a more polished product.

Reporting the outcomes

Once you have analyzed the data, you must then decide what you are going to do with it. The next stage in implementing your evaluation plan is reporting the outcomes. This includes pulling the data together, distilling and disseminating

the findings. Dissemination and utilization are important components of the evaluation process. It is important to conduct evaluations in such a way that the results will be useful. You want the results to not only be viewed by your audience as useful but also truthful. Keep in mind that the use of evaluation outcomes should be consistent with the purpose of your evaluation.¹⁴

Remember, the ultimate purpose of an evaluation is to use the information to improve your plan. Therefore, once you have analyzed and interpreted your evaluation findings, you will want to use the results to make needed changes in your plan, activities and services. The purpose identified early on in the evaluation planning should guide the use of the evaluation results. Evaluation is a practical tool that your coalition can use to inform its efforts and assess its impact. The right questions, combined with the right data collection methods, can make all the difference between an evaluation that is only designed to meet limited goals of compliance and one that meets the needs of the project and its stakeholders.¹⁵

Listed below are evaluation tools and resources that will aid your coalition to conduct effective evaluations of your tobacco prevention and control initiatives.

¹³ For data analysis steps, please see the Resources for Data section of this guide.

¹⁴ For more information on data reporting, please see the Resources for Data section of this guide.

¹⁵ The 2002 User-Friendly Handbook for Project Evaluation. For assistance with developing goals and objectives please refer to the Goal and Objective Worksheet in the template section of the appendix developed by the National Science Foundation. <http://www.nsf.gov/pubs/2002/nsf02057/nsf02057.pdf>

Resources and Tools to Develop and Implement Evaluations

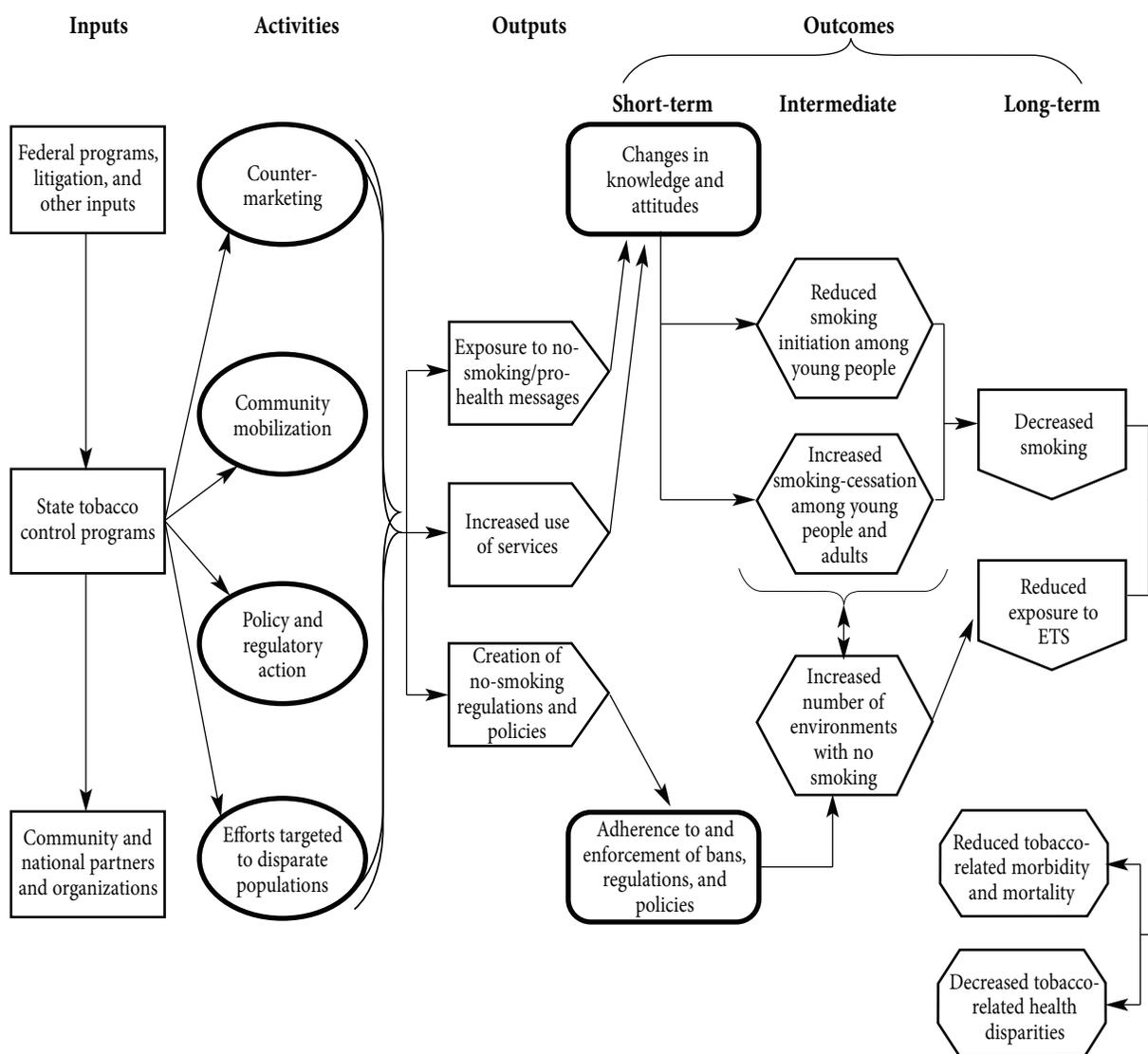
The Centers for Disease Control and Prevention (CDC) developed logic models for prevention, promotion of quitting, elimination of exposure to secondhand smoke, and elimination of tobacco-related health disparities. The CDC logic models are based on strong scientific evidence for what works in tobacco prevention and control. http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/process_evaluation/pdfs/tobaccousemanual_updated04182008.pdf

The CDC Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs provides information on 120 key outcome indicators for evaluation of statewide comprehensive tobacco prevention and control programs. The publication will help programs decide which indicators can be measured within budget or which indicators are likely to carry the most weight with policymakers and provides examples of data sources and survey questions that evaluators can use to gather data from their programs' target populations. http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/key_outcome/pdfs/key_Indicators.pdf

The National Science Foundation (NSF) seeks to increase the capacity of researchers to conduct high-quality, innovative, useful, and credible evaluation or research studies and to communicate the results of their research. The NSF provides various evaluation resources and tools to assist with creating logic models, defining goals and objectives, identifying stakeholders, collecting and analyzing data, and reporting findings. <http://www.nsf.gov/od/lpa/news/publicat/nsf04009/ehr/rec.htm>

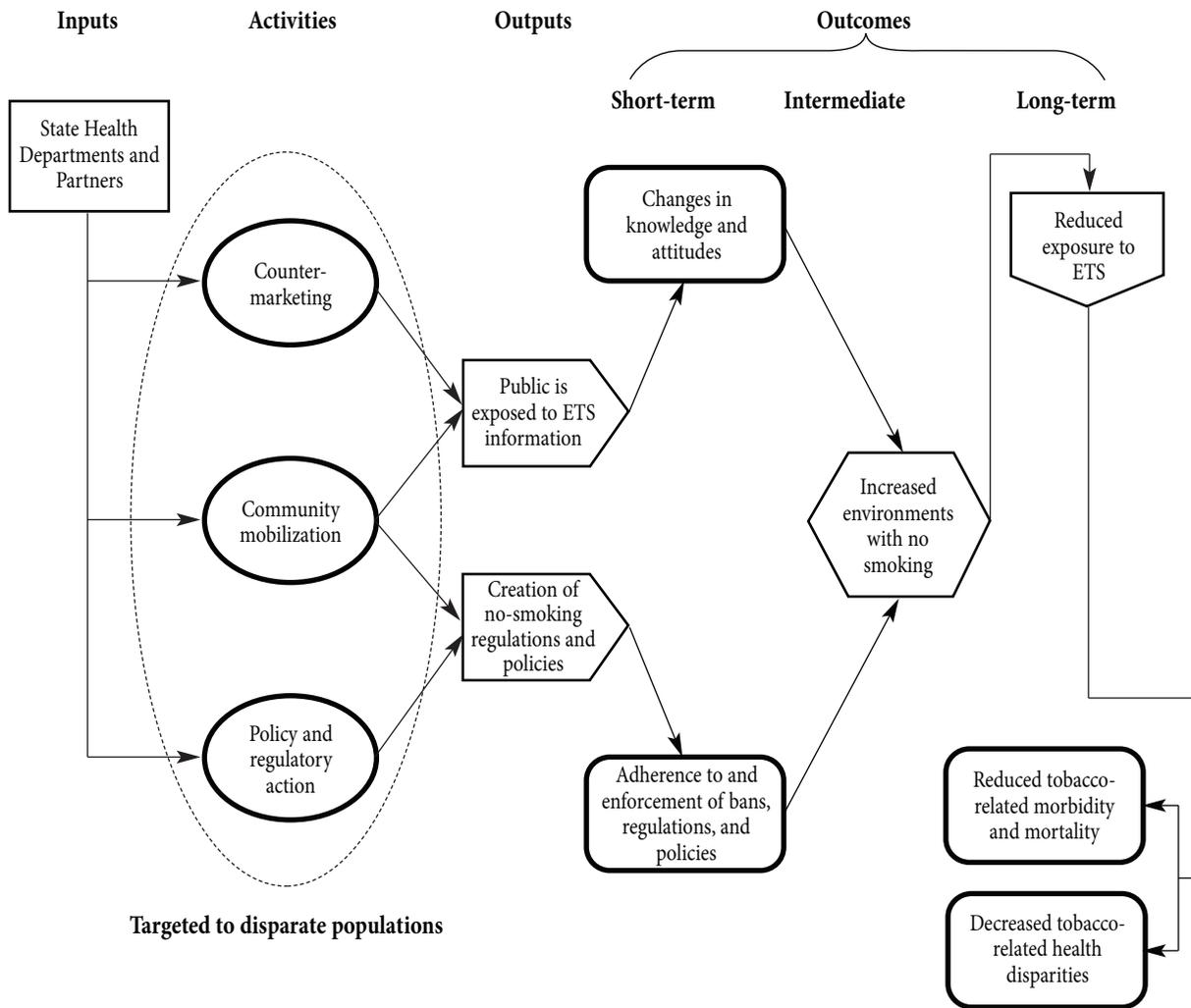
Horizon Research, Inc. (HRI) is a private research firm located in Chapel Hill, North Carolina, specializing in work related to science and mathematics education. HRI's expertise includes diverse areas such as research in science and mathematics education and evaluation of science and mathematics education initiatives. HRI provides templates on developing evaluation plans, evaluation designs, and data collection plans. <http://www.horizon-research.com/reports/1997/stock.pdf>

Tobacco-use prevention and control logic model¹⁶



¹⁶ Introduction to Program Evaluation for Comprehensive Tobacco Control Programs
http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

Logic model for eliminating exposure to environmental tobacco smoke¹⁷



¹⁷ Introduction to Program Evaluation for Comprehensive Tobacco Control Programs
http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

GOAL AND OBJECTIVE WORKSHEET¹⁸

1. Briefly describe the purpose of the project.

2. State the above in terms of a general goal.

3. State an objective to be evaluated as clearly as you can.

4. Can this objective be broken down further? Break it down to the smallest unit. It must be clear what specifically you hope to see documented or changed.

5. Is this objective measurable (can indicators and standards be developed for it)? If not, restate it.

6. Once you have completed the above steps, go back to #3 and write the next objective. Continue with steps 4, 5, and 6.

¹⁸ Introduction to Program Evaluation for Comprehensive Tobacco Control Programs
http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

Checklist for engaging stakeholders¹⁹

- Identify stakeholders.
- Identify stakeholder role(s) in evaluation planning and implementation.
- Review the list of stakeholders to ensure all appropriate stakeholders are included.
- Represent individual stakeholders and stakeholder organizations.
- Understand and respect stakeholders' values.
- Create a plan for stakeholder involvement.
- Identify areas for stakeholder input.
- Bring stakeholders together as needed.
- Target key stakeholders for regular participation.
- Ask stakeholders to suggest evaluation questions.

¹⁹ Introduction to Program Evaluation for Comprehensive Tobacco Control Programs
http://www.dcc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/pdfs/evaluation.pdf

Tips for Developing Questionnaires

Wording Matters!

How you word your questions can influence the response you get. Be precise in your language to help the respondent understand what information you are requesting. For example, an open-ended question that asks participants how many Science and Math Nights they have attended might yield a variety of responses such as, “a lot,” “four,” “can’t remember,” or “most of them.” In this case, to help jog memories and get more accurate information, it might be better to provide the dates of the sessions and the major activity that occurred, and ask respondents to check which ones they attended. With questionnaire items, it’s also important to avoid leading the respondent in a particular direction with your questions or answer categories. For example, a closed-ended item with mostly positive answer choices (“Okay,” “Fun,” “Great”) does not give participants suitable options for expressing a negative opinion.

- Keep your questionnaire short, ideally no more than a page or two. Remember, someone will have to tally or read and analyze all of those responses.
- Keep it simple, with short questions and clear answer categories.
- Make it easy to use—participants will be more likely to complete it.
- Make it anonymous, and participants will probably be more honest.
- Use language appropriate for the audience. The younger the student, the simpler the questions and answer categories need to be²⁰.

Section 3: Sustainability

It takes more than funding to produce sustainable changes. Funding is important to sustaining initiatives; however, producing long-term health improvements takes long term commitment and policy strategies to sustain social and environmental changes. The next two chapters of the Community Guide will provide information, resources, and tools on how to sustain communities’ efforts in tobacco prevention and control to address tobacco-related health disparities.

XV. Policy Development

XVI. Funding Opportunities

²⁰ Horizon Research Inc., Taking Stock: A Practical Guide to Evaluating Your Own Programs <http://www.horizon-research.com/reports/1997/stock.pdf>

Developing and Implementing Smoke-Free Policies



{ key tray }

Policy

In 2006, the U.S. Surgeon General concluded that no risk-free level of secondhand smoke exposure exists.¹ Smoking bans and restrictions are policies, regulations, and laws that limit smoking in workplaces and other public areas such as public buildings, offices, restaurants, and bars. Formal clean air acts enacted by local and state governments are the preferred and Centers for Disease Control and Prevention (CDC) recommended strategy to providing protection from secondhand smoke.² The results from a recent survey indicate that 70% of Texas voters favor a proposed statewide law to prohibit smoking in all indoor workplaces and public facilities.³ On average, smoking bans in workplaces have led to a 72% reduction in exposure to environmental smoke.⁴ Implementing smoke-free policies is a public supported, sustainable, and effective environmental and social change method used to prevent secondhand smoke.

Comprehensive statewide smoke-free legislation has passed in 29 states. Despite public support for clean air laws, the Texas legislature was not able to pass a smoke-free workplace law in the 80th session in 2007, the 81st session in 2009, and the most recent 2011

82nd legislative session. Even with the absence of a comprehensive statewide law, Texans can still protect themselves. Incorporated municipalities can pass local ordinances to protect citizens from exposure to secondhand smoke. There are 33 Texas municipalities that have passed local smoke-free ordinances;⁵ however, approximately 5 million Texans living outside of an incorporated municipality do not have this same protection. Communities outside of an incorporated municipality can only protect their members through a state law. Consequently, there must be coordinated, comprehensive strategies such as state and community interventions to reduce smoking and protect all Texans from exposure to secondhand smoke. These interventions include implementing or changing policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. Because decreasing disparities in tobacco occurs largely through community interventions, these policy changes require the involvement of community partners.⁶

Communities disproportionately affected by tobacco-related health disparities are influenced by policies, or lack thereof, and historically

¹ US Department of Health and Human Services. *The health consequences of involuntary exposure to tobacco smoke*; a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC; 2006. <http://www.surgeongeneral.gov/library/secondhandsmoke/report/fullreport.pdf>

² Centers for Disease Control and Prevention for Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion. <http://www.cdc.gov>

³ BASELICE & Associates, Inc. *Opinion Research for Decision Making in Politics and Public Affairs*. January 2011 as cited in Smoke-Free Texas, www.smokefree.org

⁴ The Task Force on Community Preventive Services. *The Guide to Community Preventive Services: What Works to Promote Health?* New York: Oxford University Press; 2005: 48 <http://www.thecommunityguide.org/tobacco/Tobacco.pdf>.

⁵ Smoke-Free Texas. *Texans covered by comprehensive smoke-free workplace ordinances* – Oct. 2010

⁶ Centers for Disease Control and Prevention for Office on Smoking and Health. *Best Practices for Comprehensive Tobacco Control Programs* – 2007

have had limited access and participation in the policymaking process. Communities must become more involved in the way tobacco is promoted, sold, and used in order to counter the harmful effects of secondhand smoke.

Although disparities in secondhand smoke exposure have decreased over the years, minority and low socio-economic (SES) populations compose a significant portion of the blue-collar workforce, and are less likely to be protected by clean air policies. African American male workers, construction workers, and other blue-collar and service workers continue to experience high levels of secondhand smoke compared to white-collar workers.⁷ In many cases, the people experiencing and affected by tobacco-related health disparities are unaware of or excluded from the decisions that affect health, economic, and social inequities prevalent in their communities. Problems within a community need to be addressed using solutions developed by the community.

In beginning work with the community to develop smoke-free policies, your coalition must first review what current policies, if any, are in place before taking the necessary steps toward working with communities to pass local smoking workplace bans. Visit <http://www.utmb.edu/shsordinances/> to create a report to provide your coalition with information on ordinances

for cities in Texas as well as the strength of the ordinances in place. A scale of 1 to 5 based on the five smoking ordinance focal settings is used to determine the strength of the smoke-free policy in Texas municipalities. Municipalities receiving the highest grade, a five, are considered to have a comprehensive smoke-free policy. The table below provides an in-depth explanation of the smoking protection level ratings for focal settings.

Five Smoking Ordinance Focal Settings:

- Municipal Worksites
- Private Worksite
- Restaurants
- Bars in Restaurants
- Bars Not in Restaurants

⁷ Arheart KL, Lee DJ, Dietz NA, Wilkinson JD, Clark III JD, Leblanc WG, Sendar B, Fleming LE. Declining Trends in Serum Cotinine Levels in U.S. Worker Groups: The Power of Policy. *Journal of Occupational and Environmental Medicine* 2008; 50 (1): 57-63 cited in Centers for Disease Control and Prevention Fact sheet. <http://www.cdc.gov/tobacco>

Ratings of Protection Levels for Focal Setting⁸

RATINGS	DESCRIPTOR	CRITERIA
5	100% Smoke-Free	No smoking allowed in a particular setting
4	Moderate	Designated smoking areas are allowed if separately ventilated. The owner or manager may choose to be smoke free or designate separately or independently ventilated smoking areas.
3	Mixed	Either no smoking is allowed OR designated smoking areas are allowed if separately or independently ventilated, but coverage is partial due to exceptions, ambiguities, or legal issues.
2	Limited	Designated smoking areas allowed or required.
1	No Coverage	No restrictions on smoking in the stated setting, even if an SHS ordinance exists.

The Department of Kinesiology & Health Education at the University of Texas at Austin developed a needs assessment tool, Smoke Free Municipal Clean Air Policies,⁹ for Texas Tobacco Prevention and Control Coalition programs. This tool can be utilized by your coalition to organize and track the strength and status of smoke-free policies for municipalities in Texas. A copy of this tool is included in Tools and Templates section of this guide.

Community Readiness

Once the statuses of smoke-free policies are reviewed for the municipality, conduct a community assessment via a poll or survey to gauge the level of community support for a smoke-free ordinance. This assessment will allow your coalition to better determine what direction

to take in order to effectively engage members of the community toward taking action in the development and implementation of smoke-free policies. If the data reveals that the community is not supportive of a smoke-free policy, then the coalition should focus efforts toward increasing awareness and education regarding the detrimental health effects of secondhand smoke.

Helpful tip: Use information from your needs assessment to determine what issues members of the community are concerned about, and include those issues in your tobacco awareness and education campaign. Boil down educational messages into clear, concise messages, and provide one-page fact sheets to community members.

⁸ Adapted from Texans Standing Tall. *Youth Substance Abuse Issues: Research and Legislation*. Report Card 2010. www.texasstandingtall.org

⁹ Sneden GG, Robertson TR, Batanova M, & Loukas A. *Texas Tobacco Prevention and Control Coalition Needs Assessment*. Department of Kinesiology & Health Education, University of Texas. 2010. <http://www.uttobacco.org/files/2010%20DHS%20Cross%20Comm%20Tab%20Evaluation%20Plan.pdf>

Recruit Local Community Champions

Regardless of community readiness and/or support in passing a smoke-free policy, your coalition should have several local policymakers or community leaders to sponsor and act as a champion for your ordinance. Local champions that reflect the racial and ethnic diversity of the community are essential to the policy development process. A local champion has rapport with the community, experience in getting policies passed, and should be a member or involved in the local government such as the city council or county commission. Your champion may have already partnered with your coalition during the capacity and/or coalition-building stages of addressing tobacco-related health disparities. If there is not a champion amongst your community partners, then efforts need to be focused on recruiting a local champion to endorse your coalition's efforts.¹⁰ Some tips on how to influence your local policymakers include:

- Giving background/history of your tobacco coalition
- Sharing tobacco-related data and statistics for the community
- Providing tobacco-related budget estimates
- Explaining what the proposed changes in the laws would mean

- Telling program success stories
- Inviting the policymaker to a coalition meeting¹¹

Including community leaders in the policy development process does not guarantee change, but their exclusion will delay progression. Inclusion in policy development will increase the likelihood of passing a community relevant and effective smoke-free ordinance.

Drafting a Smoke-free Ordinance

Drafting a smoke-free ordinance is often a complex, legal undertaking. Fortunately, there are many smoke-free ordinances, templates, free legal aid, and guides available to your coalition. Americans for Nonsmokers' Rights (ANR) is a national organization dedicated to nonsmokers' rights, protecting nonsmokers from exposure to secondhand smoke, and preventing tobacco addiction among youth. ANR pursues an action-oriented program of policy and legislation and provides a model that has served as the basis for many smoke-free ordinances across the United States. This model will be included in the appendix of the guide section. It is important to remember when reviewing this model that this is a model, and the circumstances and concessions pertinent to the community should be reflected in the ordinance.

¹⁰ Partnership for Prevention. *Smoke-Free Policies: Establishing a Smoke-Free Ordinance to Reduce Exposure to Secondhand Smoke in Indoor Worksites and Public Places*. April 2009, www.prevent.org

¹¹ Adapted from *Tips for Policymaker Outreach: A Washington State Department of Health Tobacco Prevention and Control Program Toolkit*. Washington State Department of Health, March 2010.

Local legal counsel should be consulted when drafting the ordinance to ensure that the ordinance is compliant with existing local laws. It is also important to develop a relationship with the local agency that will be enforcing the ordinance in order to receive input and identify and remedy any problems that may exist when implementing and enforcing a new ordinance. Your coalition can also receive assistance and resources from the Tobacco Control Legal Consortium at <http://www.wmitchell.edu/tobaccolaw/tclc.html>.

Deal Breakers. Discuss amongst your coalition and community partners what you would be willing to compromise on when negotiating the ordinance. There are “Red Light/Green Light” provisions that could weaken your ordinance. These provisions allow restaurants, bars, clubs, and other businesses to fulfill legal obligations through displaying signs which state their smoking policy and through restricting smoking to certain hours of the day. These types of policies are not only difficult to enforce, but also provide little protection because the harmful chemicals found in secondhand smoke will still be present in room even days after a cigarette is smoked.

To view more provisions to exclude, please review the *Fundamentals of Smoke-free Workplace Laws* document included in the toolkits section of this guide.

Getting a Smoke-free Ordinance Passed

Once the smoke-free ordinance is introduced, mobilize community partners and coalition members to provide support through attending public hearings, contacting the press, and contacting local elected officials via phone calls, e-mails, and letters. It is important to be ready to respond to the opposition. Some opposition claims include:

- Economic Loss
- Not the Government’s Role
- Requires Approval by Planning Commission vs. Local Government
- Employees Can Decide Where to Work
- Smoking Tobacco is Legal
- Smoking Laws Divert Attention from More Critical Issues
- The Dangers of Secondhand Smoke are Based on “Junk” Science

Rebuttals to these common claims made by the opposition have been prepared by the University of Kentucky Clean Indoor Air Partnership, a program whose mission is to provide communities with science-based strategies for promoting clean indoor air through research, education, and policy development. The rebuttals can be found in appendix of this guide section.

Implementation

To support implementation of the ordinance

- Develop enforcement protocols in collaboration with local enforcement agencies.
- Self-enforcement of smoke-free laws are contingent upon public awareness, so your coalition should continue education efforts.
- Ask local officials to include information on the ordinance in business license applications and renewals.
- Collaborate with local businesses to disseminate information for tobacco cessation services for people interested in quitting.¹²

Review a checklist adapted from Americans For Nonsmokers' Rights to assist in your coalition's implementation efforts.

Developing and Implementing Smoke-Free Policy Toolkits

The toolkits provided below will provide your coalition with further instruction and guidance in developing and implementing smoke-free ordinances.

A Toolkit for Implementing and Defending Smoke-Free Ordinances offers a standardized set of tools that can be customized for use in your community to provide information about how to conduct surveillance activities to monitor the effects of ordinances.
www.clearwaymn.org 1-800-782-1878.

Community and State Coalitions for Public Health Policy Change: A Quick-Start Guide is a tool to help improve tactics employed in bringing about a desired policy change.
<http://www.health-outcomes-policy.ufl.edu>
352-265-8035.

Developing Smoke-free Implementation Regulations provides information and resources to help draft and adopt effective smoke-free implementation regulations.
<http://www.rwjf.org> 877-843-7953.

Fundamentals of Smoke-free Workplace Laws contains guiding principles for developing, enacting, and implementing effective smoke-free air laws that protect people from the disease and death caused by secondhand smoke.
www.no-smoke.org 510-841-3032.

Leadership for Policy Change provides specific ways that foundation, government agencies, and other institutions can cultivate community leaders.
www.policylink.org 510-663-2333.

Policymaker Outreach Toolkit includes essential information that can help you be successful in advocating for and developing policies.
<http://www.doh.wa.gov/tobacco/> 360-236-3642.

Smoke-Free Policies: Establishing a Smoke-Free Ordinance to Reduce Exposure to Secondhand Smoke in Indoor Worksites and Public Places – An Action Guide is a tool designed to assist public health practitioners invested in reducing secondhand smoke exposure through effective community-level strategies.
www.prevent.org 202-833-0009.

¹² Partnership for Prevention. Smoke-Free Policies: Establishing a Smoke-Free Ordinance to Reduce Exposure to Secondhand Smoke in Indoor Worksites and Public Places – An Action Guide. April 2009. www.prevent.org

Resources

The **Americans for Nonsmokers' Rights (ANR)** developed *Provisions of Smoke-free Air Laws* to provide a brief overview of the typical sections of a smoke-free workplace/public place law, and related background information useful for drafting these ordinances. This document can be accessed at the following sites, and will also be included in the resources section of the tobacco guide.

<http://www.no-smoke.org/document.php?id=235>

<http://www.no-smoke.org/pdf/provisions.pdf>

The **Americans for Nonsmokers' Rights (ANR)** provides model ordinance language that has been used effectively in hundreds of communities across the country. ANR recommends using this model language in its entirety, when your community is ready to consider a smoke-free policy. This document can be accessed at the following site, and it will also be included in the resources section of the tobacco guide.

<http://www.no-smoke.org/goingsmokefree.php?id=499>

The **University of Kentucky Clean Indoor Air Partnership** developed rebuttals and suggested talking points to use when addressing opposition claims. This document can be accessed at the following site, and will also be included in the resources section of the tobacco guide.

Link and resource is being provided through the **Network for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Equity:**

<http://www.lgbttobacco.org/files/Rebuttals%20to%20Opp%20Claims%202010%20091310%20FINAL.pdf>

The **University of Kentucky** developed a one-pager to address and dispel property, economic, ventilation, and accommodation myths by opposition to smoke-free laws. Your coalition should tailor this handout to each community, and use it to increase awareness, education, and support for smoke-free laws. This document can be accessed at the following site, and it will also be included in the resources section of the tobacco guide.

<http://www.mc.uky.edu/tobaccopolicy/KCSP/OnePagers/SMOKE-FREELAWS-WHATTHEOPPOSITIONSAYS.pdf>

Tools and Templates



Provisions Of Smokefree Air Laws

Americans for Nonsmoker's Rights

Implementation Checklist

IMMEDIATELY AFTER THE LAW PASSES:

Business Education: Educate the business community about the new law.

- Compile a list of all places of employment in the community.
- Send a letter to all employers notifying them of the new law, enforcement date, enforcement procedures, etc. This should be sent by the enforcing agency if possible.
- Create a Business Education Packet containing:
 - Enforcement instructions (in clear, simple to understand language);
 - Frequently Asked Questions (FAQ);
 - “No Smoking” signs and decals for places of employment;
 - Sample pay stub inserts to inform employees about the law;
 - Phone number or website for more information;
 - Information on how to report a violation; and
 - List of cessation resources in the area.
- Send a business kit to every employer in the community.
- Send extra business kits to the Chamber of Commerce, and other business groups in your community.

Public Education: Educate the general public about the new law.

- Set up a phone hotline (and website) for questions about the new law. Include information on effective dates, how to file a complaint, how to comply, and enforcement procedures.
- Generate positive earned media about the law (letters to the editor, radio call in shows, etc.). This is a great way to calm unfounded fears about how the new law will impact business, dispel myths about the “smoking police” writing tickets, etc. Be sure to include the hotline number and web address for additional information.
- Place paid ads in the local daily newspapers and weekly papers.

- Congratulate and thank elected official publicly for passing the law.
- Talk about it! Tell business owners that you are glad the new law passed.

ONE MONTH BEFORE IMPLEMENTATION DAY:

- This is a great opportunity for earned (free!) media. Submit letters to the editor to be printed on, and just before, implementation day.
- Create a “Countdown to Smoke-free Air” buzz in your community. Place a large sign in a public area with the number of days left to implementation, or place paid ads in the local paper noting the countdown.
- Plan an Implementation Day Celebration. The media will be out in full force on implementation day. Be sure that smoke-free supporters will be out supporting businesses, and that the local media knows where to find you.
- Recruit supportive owners and employees, willing to act as spokespeople for interviews on implementation day.

ON IMPLEMENTATION DAY (AND ONE DAY PRIOR):

- Release a positive press statement the day before implementation day, including the hotline number to call for more information and names of spokespeople available for interviews. Make sure your spokespeople are prepared with positive talking points.
- CELEBRATE! Get out and enjoy the smoke-free air. Make sure the local media knows where to find you.
- The opposition will be armed with stories about how businesses will drop. Be prepared to counter their arguments with real solid facts. Smoke-free laws are good for business. See (WEBSITE LINK)
- Visit businesses in person to make sure that signs are up and answer any of the questions they may have.

AFTER IMPLEMENTATION DAY:

- Stay positive and keep the momentum going! Continue meeting with your coalition weekly, and think about new ways you can support your new law.
- Send another thank you letter to your city council for passing the law. This is a time when they may be asked to weaken the law. Encourage them to keep the law intact, and strong.
- Host a one, two or six month birthday party for your new law. Get local media attention and focus on how well the law is going, and how the law is impacting public health.
- Be prepared for the opposition to try to repeal the law or take the law to the ballot. If this happens, call us for additional support.

D. Smoke-Free Municipal Clean Air Policies

When a community develops policies that restrict tobacco use in public places it is easier for residents to live a tobacco-free life. When the community's governing body makes tobacco prevention and reduction a priority through policy decisions, educational programs, and by allocating funding and dedicating personnel, they establish a fundamental foundation for a healthier community. See also <http://goingsmokefree.org/> to see Toolkit for Implementing Smoke-free Laws.

Tobacco program staff or coalition members should complete this form. **Please print one copy of this form for each municipality with at least 5,000 residents.**

Name of Municipality: _____

1. Describe or attach a copy of the municipality's ordinance or policy regulating smoking. If you are not sure if you have an ordinance or what it says, look up your community online through the University of Texas Medical Branch, Texas Smoke-Free Ordinance Database <http://www.utmb.edu/shsordinances/> or contact your community officials.

2. What is the strength of the current municipal policy? (See <http://www.utmb.edu/shsordinances/>)

Setting	Level of Protection (1-5)
a. Municipal worksites	
b. Private worksites	
c. Restaurants	
d. Bars not in restaurants	
e. Bars in restaurants	

3. What is the status of smoke-free policies in other public places?
(optional collect if relevant – requires CEW to conduct telephone survey)

Setting	FY2010 - Name & Number of entities with smoke-free policies
Multi-unit apartments	
Community colleges	
Child Development/Day Care Centers	
Trade & technical schools	
Worksites with over 50 employees	
Parks	
Casinos	
Public arenas	
Entertainment venues (e.g. bowling alleys)	

1. Is this municipality interested in adopting & implementing a smoke-free policy?

(circle one) Yes No

2. Is there a group actively promoting smoke-free policies in this municipality?

(circle one) Yes No

3. List names of groups or individuals advocating for smoke-free policies:

Date Started: _____ Last Updated on: _____

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Funding



Funding

Tobacco-related health disparities result from a variety of environmental and social factors. Lack of infrastructure, resources, and funding contribute to the prevalence of health disparities. Tobacco coalitions are often awarded grants to address tobacco-related health disparities in their affected communities. Therefore, including community members in coalition activities in the development and implementation of programs increases community ownership, positive outcomes, as well as the likelihood of achieving sustainability through continual grant funding.

Your coalition has successfully engaged members of the community to address the issues affecting them, but what happens when the initial funding has been exhausted? Successful community engagement has created the interest and manpower; however, operational costs associated with programs that may not have the ability to be sustained through donations and in-kind donations alone. Sustainability will be heavily dependent on community-led initiatives to seek out and secure funding. Communities must first become aware of what funding opportunities exist, where to locate those opportunities, and how to apply for funding in order to sustain and build upon tobacco prevention and control initiatives.

Grant proposals are written by agencies to receive funding. Larger federal or state grants typically require a team of experienced individuals to write and organize a proposal. Your chances of getting awarded grant funding greatly depend on the duration of the grant, the amount of money being awarded, and whether or not the grant is competitive or non-competitive. For smaller organizations and coalitions, it may be necessary to partner with larger and more experienced organizations in order to compete for the more substantial grants.

Competitive grants – permit the funding organization to exercise judgment or discretion in selecting the applicant/recipient through a competitive grant process. There is a review process to determine funding awards based on which application best addresses the program requirements.

Non-competitive grants – specifically support a designated institution or set of institutions for particular research, education or extension topics of importance to a state or region. Non-competitive grants are approved if the grantee meets the requirements or formula established by the grant program.

The grant proposal process can be overwhelming for many smaller and newer coalitions and/or community-based groups. Mini-grants are an alternative option for coalitions to replace the larger and more cumbersome grants. Mini-grants are an ideal place to start for a

smaller organization seeking funding to sustain existing efforts and initiatives.

Mini-grants are on a smaller scale, and are typically awarded to fund short-term community projects or events. Since the amount of money awarded in mini-grants is small (\$200 - \$2,000), larger agencies are not very likely to apply for this funding. Mini-grants build political and community support, and solidify existing community partnerships as well as bring new partners into the coalition's efforts. The money from mini-grants goes to the grassroots groups continuing the tobacco control and prevention efforts in their communities.

Writing a Grant Proposal

Preliminary steps need to be taken before writing a grant proposal. Find out if there will be pre-applications available prior to the formal program announcement, and whether

a conference or briefing will be held. Research who the decision makers are and what their involvement is in the grant reviewing and decision making processes for awarding funds. Make sure you have enough information to support your proposal. An organization must have data that include target population demographics, client surveys, public opinion polls, etc., in order to have a good combination of raw data and public opinion to solidly support a proposal. It is also important to understand the funding organization. Acquire written materials concerning the mission and goals of the funding organization such as an annual report.

The following table includes the ten components and component descriptions typically included in grant proposals. The components appear in the order in which they are usually organized and appear in the proposal.¹

¹ Table developed based content found in Rinehart E. & Bouie-Scott B. 2003. *Proposal Writing: The Basic Steps in Planning and Writing A Successful Grant Application*. Illinois Department of Commerce and Economic Opportunity, Springfield, IL.

Component	Description
Cover Letter	<ul style="list-style-type: none"> • Include organization letterhead • Summarize need • Propose program • Organization's qualifications
Title Page	<p>Includes:</p> <ul style="list-style-type: none"> Project title Name of applicant Name of agency submitted to Signature Typed name and title of authorized personnel approving the submission
Summary	<ul style="list-style-type: none"> • Synopsis of project objectives, procedures, evaluation • Typically 250 words
Introduction	<ul style="list-style-type: none"> • Tell what needs to be done and why • General theory on which the project is based
Problem Statement	<ul style="list-style-type: none"> • State why this problem needs to be addressed • Provide references to research, statistics, previous projects or other documentation to support the need for the project
Objectives	<p>State the proposed outcome of the project in specified and measurable terms</p> <p>Each objective is usually related to</p> <ol style="list-style-type: none"> 1. a need identified in the introduction section; 2. activities in the methodology section; 3. activities in the evaluation section
Methodology	<ul style="list-style-type: none"> • Describe the problem in terms of the methods you will use • Why you are choosing this strategy • Describe the specific activities and action steps that will be used to achieve objectives
Evaluation	<ul style="list-style-type: none"> • Details how the organization will determine if objectives are met • Include type of evaluation information to be collected • How the data will be analyzed and disseminated
Future Orientation	<ul style="list-style-type: none"> • Discuss topics relevant to the future of the project • How will continuation be done?
Budget	<ul style="list-style-type: none"> • State the proposed project costs in a table or spread sheet format • Every item should be documented • Request as much money as you need to complete the project adequately

It is imperative to be cognizant of grant proposal deadlines. Review the grant proposal deadlines methodically and more than once. Determine whether state deadlines are

postmarked deadlines or "received in office" deadlines. It is a common practice to have proposals sent by overnight commercial carriers, so that the sender can verify its receipt by the

funder. Be aware that some federal agencies will honor a postmarked date only if sent by U.S. mail service. Some funders will accept faxed or emailed submissions and others will not.²

Writing a Mini-Grant Proposal

Determine Compatibility. Read the grant guidelines and determine whether or not the community and/or coalition's goals are compatible with the funding agency. Review the request for proposal (RFP) to determine eligibility and if the grant objectives coincide with the program's goals and objectives. If the proposal is not a good fit, then don't waste time and resources applying for that particular grant. There will be other funding opportunities available. The actual writing of the grant proposal will begin once compatibility has been determined.

Priority Problem/Problem Statement defines the need for the project, and who will benefit from the project. Conduct research to provide evidence to document the problem or need. The community needs assessment conducted by the coalition can also be used to demonstrate need.

Partnerships. Collaboration with multiple community partners will increase the strength of the grant proposal. Make sure a letter of support from each partner is provided to explicitly state the intended contribution.

Project Purpose and Goals. Focus on the purpose and/or objectives of the project, and the projected outcomes one hopes to accomplish as a result of the project. Try to include goals that are quantifiable.

Project Description and Methods. Explicitly state what activities will be performed in order to accomplish the project objectives.

- Be realistic with project plans
- Develop a clear timeline for your objectives
- Clearly define the focus of the project concept
- Describe the connection between the objectives and activities

Evaluation. Provide details as to how the project will be evaluated, when, and by whom. Include the instruments and methods of evaluation to be used in the project. Show on the timeline when the evaluations will occur.

Budget. Determine the amount of money needed to implement the project from the start to end date. Develop a budget that is as accurate as possible and considers all potential costs. Make sure you review the guidelines of the grant once more to determine allowable expenses.

Write an Abstract. Proposals often require an abstract or project summary. This section should be one to two paragraphs in length. Even though this section will appear first, it is best to write this section last to ensure that the abstract reflects the relevant project information based on the written proposal.

² Rinehart E. & Bowie-Scott B. 2003. Proposal Writing: The Basic Steps in Planning and Writing A Successful Grant Application. Illinois Department of Commerce and Economic Opportunity, Springfield, IL.

A mini-grant template is provided in the appendix of this guide section. Please review this template for a better understanding of how a mini-grant proposal is structured.

Please review the resources and toolkits listed below for more information on where to look for funding opportunities as well as how to apply for them.

Websites for Funding Opportunities

Catalog of Federal Domestic Assistance is an online Catalog of Federal Domestic Assistance that gives you access to a database of all federal programs available to state and local governments, private profit and nonprofit organizations and institutions. www.cfda.gov 1-866-606-8220.

Center for Nonprofit Management is one of the nation's leading management support organizations. The Center for Nonprofit Management brings the most current tools for best practices in nonprofit management to thousands of nonprofit boards, staff, and volunteers. www.cnmdallas.org 214-826-3470.

Grants.gov. provides one-stop electronic opportunities with over 900 grant programs offered by the 26 Federal grant-making agencies. www.grants.gov 1-800-518-4727.

Non-profit Resource Center of Texas is a one-stop resource for nonprofit organizations. The Center publishes a directory of Texas foundations. www.nprc.org 210-242-4774.

Office of Minority Health The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. Search the website for funding announcements. www.omhrc.gov 1-800-444-6472.

Rural Information Center provides information and referral services to local, tribal, state and federal government officials; community organizations; rural electric and telephone cooperatives; libraries; and businesses and citizens working to maintain the vitality of America's rural areas. The website includes a listing of funding resources. www.nal.usda.gov/ric/ruralres/funding.htm 1-800-633-7701.

Texas Association of Nonprofit Organizations is the statewide association reflecting and promoting Texas' growing nonprofit community in all its diversity. www.TANO.org 512-381-1490.

Texas Library Association Community Libraries maintains directories of organizations and agencies that offer grant opportunities. www.txla.org 512-328-1518.

Texas NonProfit provides data that facilitates connections between the 80,000+ nonprofit organizations with the 4,000+ charitable foundations in the state of Texas, major philanthropic corporations and sharing individuals. www.txnp.org 210-805-9595.

Grant Writing Toolkits

Proposal Writing: The Basic Steps in Planning and Writing Successful Grant Application

is a guide to help community developers with the basic elements and concepts in planning and preparing winning proposals for project funding.
<http://www.commerce.state.il.us/dceo/>
1-800-252-2923.

Writing a Funding Proposal is a toolkit that deals with planning and researching a funding proposal before you write it; how to write the proposal; and the follow-up required once it is written and sent off.

<http://www.civicus.org> 202-331-8518.

Writing a Successful Grant Proposal

helps prepare you for a competitive grant application through outlining each step that needs to be completed in the proposal process.
www.agecon.purdue.edu/newventures
1-888-398-4636.

Templates

Mini-Grant Application Template

Contact Information

1. First Name:
2. Last Name:
3. a. Organization *(required)*:
b. Organization mailing address:
4. Email:

Collaborating Partners Information

Partnering Organization No. 1

5. Applicant Name:
6. Organization *(required)*:
7. Email:

Partnering Organization No. 2

8. Applicant Name:
9. Organization *(required)*:
10. Email:
11. Title of Proposal *(required)*:
12. Program Format *(required/check all that apply)*:

workshop
panel
teleconference
forum
roundtable discussion
other (please describe): _____

13. Abstract of Proposed activity

14. Goals and objectives of this activity

15. Anticipated outcomes and benefits of the proposed activity.
Describe who will benefit and how.

16. Detailed agenda for the proposed activity

17. Name and background of all presenters/speakers, if different from questions #1, #5, and #8

18. What are your plans for evaluating your project?
How will you conduct your evaluation?

19. Budget - Provide the following information (required):

Budget Item	Cost	How Was the Cost Derived?	Contributions	Mini-grant Request
Total Budget Request				

20. Include additional budget information/comments here.
Be sure to describe any costs listed as “other”:

Section 4: Resources

The next four chapters in the Guide provide valuable resources. The section on Tobacco Coalitions and Organizations will provide you with information on the different local, state, and national organizations as to what services and technical assistance are available. The chapter on the Texas Model provides another framework to use to address tobacco related health disparities. The chapter on Health Education Messages

provides you with one-pagers on various tobacco-related issues for dispersal amongst various sources in the community as a way to quickly disseminate information.

XVII. Tobacco Programs, Organizations, and Coalitions

XVIII. The Texas Model

XIX. Health Education Messages

XX. Definitions



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Tobacco Programs in Texas



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National Networks for Tobacco Control and Prevention

Asian Pacific Partners for Empowerment, Advocacy, and Leadership (APPEAL)

APPEAL is a national network of over 500 organizations and individuals working towards a tobacco-free Asian American, Native Hawaiian and Pacific Islander community.

APPEAL PROMISE Network
300 Frank H. Ogawa Plaza, Suite 620
Oakland, CA 94612
Ph: 510-272-9536
www.appealforcommunities.org

Break Free Alliance

Break Free Alliance engages states and key organizations serving low SES populations in tobacco control efforts and assists them with resource development and assessments, technical assistance, capacity building and evaluation to prevent and reduce use in low-income communities.

Break Free Alliance
Health Education Council
3950 Industrial Blvd., Ste. 600
West Sacramento, CA 95691
Ph: 916-556-3344
www.breakfreealliance.org

National African American Tobacco Prevention Network (NAATPN)

The NAATPN strives to address tobacco challenges in African American communities through providing technical assistance, training, community competent organizational development, grassroots organization, and tobacco control advocacy expertise.

NAATPN
400 West Main Street
Suite 415
Durham, NC 27701
Ph: 919-680-4000 or 1-888-7NAATPN
<http://naatpn.org>

The National Latino Tobacco Control Network (NLTCN)

NLTCN is an open information and support system that promotes information exchange, collaboration, and personal and institutional linkages among tobacco control and health disparities advocates and experts who want to become more effective in changing policies and social norms around tobacco control to achieve health equity for Latinos.

National Latino Tobacco Control Network
1869 Park Road, NW
Washington, DC 20010
Ph: 202-328-1313
www.latinotobaccocontrol.org

The Network for LGBT Health Equity

The Network for LGBT Health Equity is a community-driven network of advocates and professionals looking to enhance LGBT health by eliminating tobacco use, and other health disparities within our communities.

The Network for LGBT Health Equity
1340 Boylston Street, 8th Floor
Boston, MA 02115
Ph: 617-927-6451
www.lgbttobacco.org

National Native Commercial Tobacco Abuse Prevention Network (NNCTAPN)

The National Native Commercial Tobacco Abuse Prevention Network was established to provide a forum for Tribes and Tribal organizations to obtain and disseminate evidence-based and culturally appropriate information in order to identify and eliminate health disparities related to commercial tobacco abuse.

National Native Commercial Tobacco Abuse Prevention Network
2956 Ashmun Street, Suite A
Sault Ste. Marie, MI 49783
<http://www.itcni.org>

Texas Tobacco Coalitions and Resources

American Cancer Society

The American Cancer Society is a nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. The ACS helps you take steps to prevent and treat cancer as well as researches cures.

1-800-227-2345

<http://www.cancer.org>

American Lung Association

The American Lung Association is dedicated to the prevention, control, and cure of lung disease. ALA works to prevent, control, and cure lung diseases such as asthma, lung cancer, emphysema, chronic bronchitis, influenza, and pneumonia, and fight for tobacco control and clean air through education, research, and advocacy.

8150 Brookriver Drive, Suite S102,
Dallas, TX 75247

Phone: 214-631-5864

<http://www.lungusa.org>

ACTIVE Life

ACTIVE Life's mission is to create and sustain a healthy community by promoting healthy lifestyles. They have been awarded a two-year grant through the City of Austin in order to combat tobacco consumption using three different strategies: Target Marketing, Workplace Policies, and Environmental Impact.

911 West Anderson Lane, Ste. 101
Austin, TX 78757

Phone: 512-533-9555

<http://www.activelifehq.org>

North Texas Clean Air Coalition

The North Texas Clean Air Coalition is a nonprofit organization in the region dedicated to encouraging voluntary efforts to improve the air quality in North Texas through educating, engaging, and recognizing the business community.

P.O. Box 610246

DWF Airport, Texas 75261

Phone: 817-690-1921

<http://www.workingforcleanair.org>

Coordinated Training Services

Coordinated Training Services provides evidence-based prevention training for prevention programs and coalitions to strengthen and expand prevention infrastructure as well as train with the latest prevention technology, research, and best practice approaches.

4115 Freidrich Lane

Suite 100

Austin, Texas 78744

<http://www.statewidetraining.org>

Live Tobacco-Free Austin

The mission of the Austin/Travis County Health and Human Services Department (HHSD) is to work in partnership with the community to promote health, safety, and wellbeing.

1106 Clayton Lane

Austin, TX 78767

Ph: 512-972-6464

www.livetobaccofreeasutin.org

Texans Standing Tall (TST)

Texans Standing Tall (TST) is the statewide coalition working to support and create healthier and safer communities for youth. Their vision is to make alcohol, tobacco, and other drugs irrelevant in the lives of youth. TST consists of community coalitions, individual adults and youth, state agencies, and other organizations.

2211 South IH-35, Suite 201

Austin, TX 78741

Ph: 512-442-7501

www.texansstandingtall.org

Texas Statewide Education and Prevention

Texas Statewide Education and Prevention provides training for law enforcement in tobacco compliance and education in order to reduce the amount of sales to underage youth.

P.O. Box 1328
San Marcos, TX 78667
Ph: 512-245-3841
www.Texas-STEP.org

Austin Tobacco Prevention and Control Coalition (TPCC)

Austin Tobacco Prevention and Control Coalition (TPCC) helps those who want to live tobacco-free by preventing youth from starting, helping those who want to quit, and protecting everyone from the dangers of secondhand smoke.

Austin/Travis County Health and Human Services Department
Chronic Disease Prevention and Control Program
P.O. Box 1088
Austin, TX 78767
Ph: 512-972-6465
<http://www.livetobaccofreeaustin.org/atpcc>

Greater Dallas Council on Alcohol and Drug Abuse

The Greater Dallas Council on Alcohol and Drug Abuse works to improve community health through, safety and productivity by lowering the incidence of alcohol and drug abuse.

1349 Empire Central Drive, Ste 800
Dallas, TX 75247
214-522-8600
<http://www.gdcada.org/>

The Coalition

The Coalition works to reduce the impact and frequency of youth substance abuse in Angelina County.

The Coalition
104 S. Bynum
Lufkin, TX 75904
Ph: 936-634-9308
<http://www.angelinacoalition.org>

Serving Children and Adolescents in Need, Inc. (S.C.A.N.)

Serving Children and Adolescents in Need, Inc. (S.C.A.N.) provides individuals with access to a variety of evidence-based prevention, intervention, and treatment services that are delivered by highly trained and caring staff members.

2387 E. Saunders St.
Laredo, Texas 78041
Ph: 956 -724-3177
<http://www.scan-inc.org>

Smoke-Free Texas

Smoke-Free Texas is a broad coalition of organizations who believe all Texas employees and customers have the right to breathe clean indoor air, and is working diligently to get a comprehensive smoke-free workplace law passed in legislation.

2433 Ridgepoint Drive
Austin, Texas 78754
<http://smokefreetexas.org>

**Tobacco Prevention and Control Program
DSHS Mental Health and Substance Abuse
Division**

The mission of DSHS Tobacco Prevention and Control is to reduce the health effects and economic toll tobacco has placed on the citizens of Texas.

Mail Code 2081
909 W. 45th St., Bldg. 552
Austin, TX 78751
Phone: (512) 419-2108
<http://www.dshs.state.tx.us/tobacco/>

Texas Model for Addressing Disproportionality and Disparities



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Introduction

The causes of tobacco-related health disparities are often multi-layered, long-standing, and result in devastating public health consequences. Essential to reducing the prevalence of tobacco-related illness and death is effective tobacco prevention and intervention programs, services, supports, and policies.

This document describes a set of strategies in a practice model, the Texas Model for Addressing Disproportionality and Disparities (the Model), that has achieved significant gains and national recognition in creating fundamental and transformational systemic change.

Developed under the leadership of Joyce James, a Licensed Master Social Worker and former Assistant Commissioner for the Texas Child Protective Services Program and current Associate Deputy Executive Commissioner of the Texas Health and Human Services Commission (HHSC), the Model serves as the conceptual framework for the elimination of disproportionality and health disparities across the five Health and Human Services (HHS) agencies, programs, and services.

Key Components

- **Data-driven Strategies** All data is collected, researched, evaluated, and reported by race and ethnicity. Data is compared to the racial and ethnic populations of a defined area. An examination of the data indicators leads to an examination of why the data is what it is and what systemic factors contributed to the data outcomes, with a context and understanding of poverty and poor communities. The data is examined from a systemic and cross-systems perspective and shared transparently with systems and the communities affected by the data outcomes.
- **Leadership Development** Growing leaders that are grounded in the anti-racist principles; are courageous; understand and are addressing their own internalized racial oppression; know why people are poor; are accountable to the people they serve, their staff, and their institutions; recognize that they are gatekeepers and therefore they are the system; strive to be good gatekeepers through transparency and humility; and are willing to support internally and externally individuals within the same leadership framework.
- **Culturally Competent Workforce** Develop a workforce where everyone is trained in the anti-racist principles, whose humanity demonstrates best practices through service delivery and access to programs and services, who reviews and examines their work through an anti-racist lens, and whose focus is to ensure equity while improving outcomes in partnership with community.

- **Community Engagement** Methods of engaging the grass roots community through transparency in communication that is respectful, recognizes the community's strengths, hears their ideas, and includes them (parents, youth, vulnerable citizens) in dialogues, discussions, planning and decision-making on efforts that will impact them and their communities.
- **Cross Systems Collaborations** Identify and build relationships in partnership with communities, other systems, institutions, and agencies whose services, programs, policies, and practices impact the same or similar populations. Share data transparently, develop and implement cross-systems training, ongoing dialogues, and methods to transfer learning that includes the populations affected into these processes.
- **Training Defined by Anti-Racist Principles** Training defined by learning from history; sharing culture; undoing racism; networking; analyzing the manifestations of racism; understanding the processes and affects of militarism; undoing internalized racial oppression, inferiority and superiority; developing others internal and external to the institution as leaders; maintaining accountability; and reshaping gate-keeping.
- **An understanding of why people are poor, the history of Institutional racism, and the impact on poor communities and communities of color** Develop a common definition of racism and an understanding of its different forms: individual, institutional, linguistic, and cultural; develop a common language and analysis for examining racism in the United States; understand one's own connection to institutional racism and its impact on his/her work; understand the role of institutions in exacerbating institutional racism, particularly for people and communities of color; understand the historical context for how racial classifications in the United States came to be and how and why they are maintained; understand the historical context for how U.S. institutions came to be and who they have been designed to serve; understand how all of us are adversely impacted by racism every day and everywhere; address surface assumptions about how work is (or is not) affected by racism; develop awareness and understanding about ways to begin undoing racism; gain knowledge about how to be more effective in working with constituencies, organizations, communities, vulnerable populations; understand the role of community organizing and building effective multiracial coalitions as a means for undoing racism.

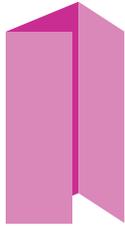
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Resources for Health Education Messages



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TO ORDER MORE BROCHURES, PLEASE VISIT:
<http://webds.dshs.state.tx.us/mamd/litcat/default.asp>

- 1** Find the brochure you would like to order through our search engine on the website.
- 2** Add the brochure to your shopping cart and specify the quantity.
- 3** Fill out contact and shipping information.

Definitions



spools of thread

Definitions

Cultural competency – describes the ability of an individual or organization to interact effectively with people of different cultures.

Culture – refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Disparity – is the condition or fact of being unequal and refers to the difference in outcomes and conditions that exist among specific population groups as compared to other groups due to unequal treatment or services.

Disproportionality – is the overrepresentation of a particular group or race in a system compared to their representation in the general population.

Health disparity - is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical

disability, sexual orientation, geography, or other characteristics historically linked to discrimination or exclusion.

Health equity – Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Secondhand smoke – Secondhand smoke is a mixture of gases and fine particles that includes smoke from a burning cigarette, cigar, or pipe tip, smoke that has been exhaled or breathed out by the person or people smoking. More than 7,000 chemicals, including hundreds that are toxic and about 70 that can cause cancer.

Smoking Cessation – is the process of discontinuing the practice of inhaling a smoked substance.

Socioeconomic status - is an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education, and occupation.

Tobacco-related health disparities – differences in the patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in capacity and infrastructure, access to resources, and environmental tobacco smoke exposure.