

What Have We Learned and Where Do We Go From Here?

Beti Thompson, William R. Lynn, and Donald R. Shopland

INTRODUCTION The Community Intervention Trial for Smoking Cessation (COMMIT) provided unique opportunities for learning about community interventions. From the beginning of the project, when design issues played an important role in determining the extent to which communities would be involved in decisionmaking, to the final dissemination of trial data, we learned much about understanding communities, mobilizing and working with communities to implement interventions, sustaining key aspects of the intervention after the funding ended, and disseminating final results to the communities. This monograph puts together the lessons learned from the field so that future community studies can benefit from the COMMIT experience.

MAJOR LESSONS LEARNED The individual chapters in this monograph discuss the lessons learned in specific channels and activities, but there are also overarching implications for other community projects that revolve primarily around community mobilization and the utility of the COMMIT approach for other community and social problems. This section focuses on these lessons.

The COMMIT project required communities to be heavily involved in the implementation of the intervention. This requisite led to many other demands. First, a necessary condition for intervention was that communities organize for action. Because the project was primarily a research project, the impetus for organization came from an external source rather than a ground swell within the community. Furthermore, once some community organization had been achieved, community groups had to be convinced that tobacco control was a significant problem in *their* community. Even when groups were convinced of that, mobilizing people to plan and implement interventions was not easy.

Establishing a Partnership With the Community It is clear from the COMMIT experience that identifying and involving community members who represent the community to serve on Boards and task forces is both necessary and possible. The extensive community analysis conducted in all communities led to the involvement of appropriate individuals and organizations, as shown in a questionnaire disseminated at the end of the intervention part of the trial. Each site was asked how well the Board and task forces represented the community, and the respondents confirmed that the composition of the volunteer membership was appropriate. The process of identifying and recruiting community members to become involved in a research partnership, more fully explained in Chapter 5, resulted in structures of Boards and task forces that provided good representation of the communities. Furthermore, the process happened quickly, generally within 7 months of randomization.

We also learned that the membership of Boards and task forces was fluid, with members resigning and new individuals being recruited according to the specific project focus and the interests and availability of individuals.

Promoting the Research Agenda Initially, there were concerns that communities would not think of tobacco control as being a sufficiently important issue or as requiring the amount of volunteer time we were requesting. In the early days of the project, some community members argued that there were other compelling problems in their communities (such as alcohol, other drugs, and violence) and that those problems should be the focus of attention. As a result, there was some natural dropout in volunteer membership as individuals decided not to participate in this research. However, within a short time, all 11 intervention communities, and the individuals, groups, and organizations representing them, became heavily involved in organizing the community to help smokers achieve cessation. Thus, we learned that communities will enthusiastically embrace an externally imposed research agenda, even when that agenda is not seen as including key problems or issues facing the community. One community member stated that there were enough community problems for everyone to get involved in, and if resources were available, she was determined to make a difference where she could.

As Chapters 5 through 13 indicate, community Boards, task forces, and individual volunteers took on most of the activities with enthusiasm, which should not be construed to mean that community representatives were always pleased with the constraints of the protocol. After some practice and experience, many communities wished to rearrange the focus of the protocol, spending less time on organizations (Chapter 11) and more on preventing smoking onset (Chapter 13). Nonetheless, community volunteers regarded the protocol as being important and tried to conduct the activities in a manner congruent with the needs of their communities.

As discussed in Chapter 5, the need to put research aims before community aims was a compromise made among the investigators in the early days of COMMIT. Although every attempt was made to allow for flexibility, the intervention was set up as a “one size fits all” model, which was occasionally frustrating to investigators and community members alike. Future community intervention planners might consider ways to better incorporate the changing interests and agendas of communities into a protocol.

Planning Intervention Activities The initial task of the Boards and task forces was to develop a Smoking Control Plan, the blueprint for the 4 years of intervention activities that were to occur in a community. The plan served many purposes: It introduced the project to the community, provided an overall guide for what would be done and when it would be done, gave the community volunteers their first real opportunity to work together, and forced volunteers to agree on how the tobacco control issue would be approached in their community. Because of the research nature of the project, the timeline for

producing this plan was extremely short. The community Boards and task forces were organized by the end of January 1989. By May 1989, they were expected to produce this comprehensive plan and to prepare its presentation to the community. Familiarizing the volunteers with the project and the protocol required a significant amount of learning; thus, the May deadline for developing the Smoking Control Plan was not ideal. Although staff members experienced considerable anxiety (and worked many extra hours), the volunteers put forth superb efforts, and plans were produced.

Immediately after the overall Smoking Control Plan was developed, volunteers had to begin producing Annual Action Plans, which specified the activities to be accomplished in the first intervention year. Action plan development required that Boards and task forces identify how activities would be implemented, what the activities would build on, who would do them, how much they would cost, and other details. The Boards and task forces accepted this task and devised plans that incorporated creativity in the implementation of activities, added other community groups to the intervention process, and allocated resources wisely. (Indeed, many communities used this as an opportunity to generate in-kind contributions.) Thus, it was clear that community volunteers were eager and able to become involved in planning intervention activities.

Implementing Intervention Activities The final community task was to implement the intervention activities so that research objectives could be achieved. The data in Table 1 indicate that community volunteers and staff members took that task seriously, with 94 percent of process objectives achieved across COMMIT. In planning the trial, investigators outlined the percentage of intermediary groups, such as health care providers, workplaces, and schools, that had to be reached for a minimal intervention to be achieved (see Chapter 2). Community volunteers took pride in feedback that indicated they were making progress in achieving process objectives. Community volunteers participated in diverse activities, ranging from stuffing envelopes, to recruiting worksites to become involved in community promotions, to becoming media and legislative advocates, to being regular speakers at schools, and many activities in between. Some of these activities are described in Chapters 5 through 13.

Utility for Other Community Projects As COMMIT drew to a close, we began asking our community partners for input on the process. One item put forward by all communities was the relevance of the COMMIT use of community organizations to other types of community interventions. Volunteers commented that the COMMIT experience provided them with excellent skills that could be applied subsequently to other community problems. Specifically, they liked the idea of drawing on volunteers from the entire community to organize around a problem. They also liked the structures set up by COMMIT that distributed work among a Board and separate task forces. Volunteers from at least three communities stated that they had used that approach in other projects.

Table 1
Percentage of process objectives achieved trialwide by intervention channel

Intervention Channel (number of activities)	Average for All Intervention Communities Combined (%)
Mobilization of Boards and Task Forces (34)	99
Health Care Providers (30)	96
Worksites (31)	92
Organizations (13)	83
Cessation Resources (24)	92
Public Education: Media (20)	94
Public Education: Youth (15)	90
Total (167)	94

Feedback Issues Research projects often do not have data until late in the trial. In COMMIT, a deliberate decision was made to keep everyone, including investigators, from seeing any outcome data until the project was over. More than one community representative was disturbed that outcome data were not available throughout the trial. Being blinded from outcome data made it impossible to institute midcourse corrections. Similarly, data on the attainment of impact objectives came late in the trial and were not useful for communities in planning how to direct their energies. Providing feedback during the intervention using process and outcome data can be important for motivating communities and tailoring intervention to individual communities.

Durability of Intervention Activities Another lesson was learned late in the trial. As COMMIT ended, many investigators, community representatives, and National Cancer Institute (NCI) personnel expressed an interest in continuing tobacco control activities. The COMMIT Steering Committee developed plans for encouraging the communities to make “transition plans” for the future. Each community expressed an interest in continuing some aspects of tobacco control activities and spent considerable time on this process. Unfortunately, when intervention funding ended, the communities were left on their own to carry out their plans to institutionalize tobacco control activities. We learned that the process of ensuring longevity of intervention activities or structures needed to begin early in the trial, not in the last 18 months. Despite the problems with trying to continue intervention activities, 9 of the 11 intervention communities were still conducting tobacco control activities a year after the project ended and had dedicated staff and resources to do so. Two communities, which had received large State or provincial grants, expanded activities greatly, but the remaining communities were selective in choosing which activities to continue. Nevertheless, we learned that communities will continue tobacco control activities even after external funding ends.

The Role of Resources NCI, which funded COMMIT, perceived that resources would go to the community as “seed resources” that would generate other means to conduct activities. In many communities, the reality differed. For small communities, resources of \$150,000 per year were seen as highly significant, especially because volunteers and staff members did not have to engage in fundraising to acquire those resources. This is counter to the practice in most community projects where a volunteer board is responsible for activities to generate resources. Interestingly, although the funds ended, organized, well-defined groups continued in many communities.

The following list summarizes the overall lessons learned from COMMIT field activities:

- It is possible to establish a partnership with communities so that they will organize around a community problem. The process of forming the partnership requires extensive understanding of the community and substantial input from key informants in the community regarding recruitment of appropriate individuals, organizations, and groups.
- It is possible to promote a research agenda even when that agenda is not necessarily viewed as the primary problem facing a community. The COMMIT experience indicates that external resources for addressing a problem that may not be the community’s primary concern are a strong incentive for participation. Furthermore, the COMMIT communities had some existing groups and organizations that were interested in and committed to dealing with tobacco control, and those groups were able to draw other community members into the project.
- Community volunteers are willing and able to plan intervention activities that are congruent with an intervention protocol. As community volunteers gain more familiarity with projects and see other potential options for solving the problem, they may wish to change the focus of the intervention protocol. This was evident in COMMIT where, by the end of the trial, all the communities expressed a desire to spend more time and resources on prevention as opposed to cessation. Although the COMMIT project maintained the original intervention protocol to achieve its research emphasis, it may be more desirable to allow protocol changes during the intervention, as long as those changes apply to all the communities. In fact, COMMIT did allow such changes in the organizations channel (Chapter 11), and those changes were accepted by the communities.
- Community volunteers are willing to implement intervention activities. However, one cannot assume that volunteers possess all the information and skills needed to implement interventions. For that reason, ongoing training opportunities are required for individuals to learn the skills of advocating positions, presenting tobacco issues to other community sectors, and placing tobacco control on the agenda of diverse community groups and organizations. In addition, the

training programs provided by COMMIT (i.e., training for physicians, dentists, other health care professionals, worksites, organizations, cessation services providers, and educators) were generally well received and left a substantial legacy in the communities.

- The COMMIT model of community organization and a structure of Boards and task forces was well received and has utility for other community problems. Board and task force members also found it a good structure to distribute COMMIT's work activities.
- As noted above under "Feedback Issues," community volunteers would have liked outcome data during the trial so that they could have made midcourse corrections, if necessary. Formative evaluation methodology requires continuous feedback to revise interventions. Availability of process and early outcome data also would have provided opportunities to sell the project to other groups and organizations in the community. Process data on events, contests, and new strategies to recruit heavy smokers also would have allowed for changes to be made the next time those activities were conducted. Community volunteers felt hampered by lack of data.
- Communities were interested in maintaining tobacco control activities. Unfortunately, the COMMIT protocol did not include durability as one of its goals or intervention objectives. Despite this, all 11 communities discussed the issue and developed plans for sustaining at least some project activities. An earlier planning period for transition and assistance in obtaining resources would have been useful for the communities. The plan for durability and transition from a funded research project to a community-supported project should have been an explicit COMMIT goal, and steps to achieve that should have been incorporated from the beginning of intervention activities.
- Resources are important in maintaining tobacco control; however, organized groups can undertake tobacco control. The COMMIT experience suggests that a foundation was laid by the project, considerable enthusiasm and energy were developed, and avenues were found for maintaining many project activities. Although these results differed by community, 9 of the 11 communities continued some form of activity for a year after the project ended, and 2 expanded activity with new funding.

**IMPLICATIONS OF
COMMIT RESULTS
ON LESSONS LEARNED**

Although COMMIT data continue to be assessed, especially in terms of impact objectives, the outcomes of the trial have been published (COMMIT Research Group, 1995a and 1995b). A statistically significant difference in the proportion of light-to-moderate smokers who quit during the 4 years of the intervention was noted in the intervention communities (30.6 percent) compared with control communities (27.5 percent). However, there was no difference in smoking cessation between intervention and control communities among heavy smokers.

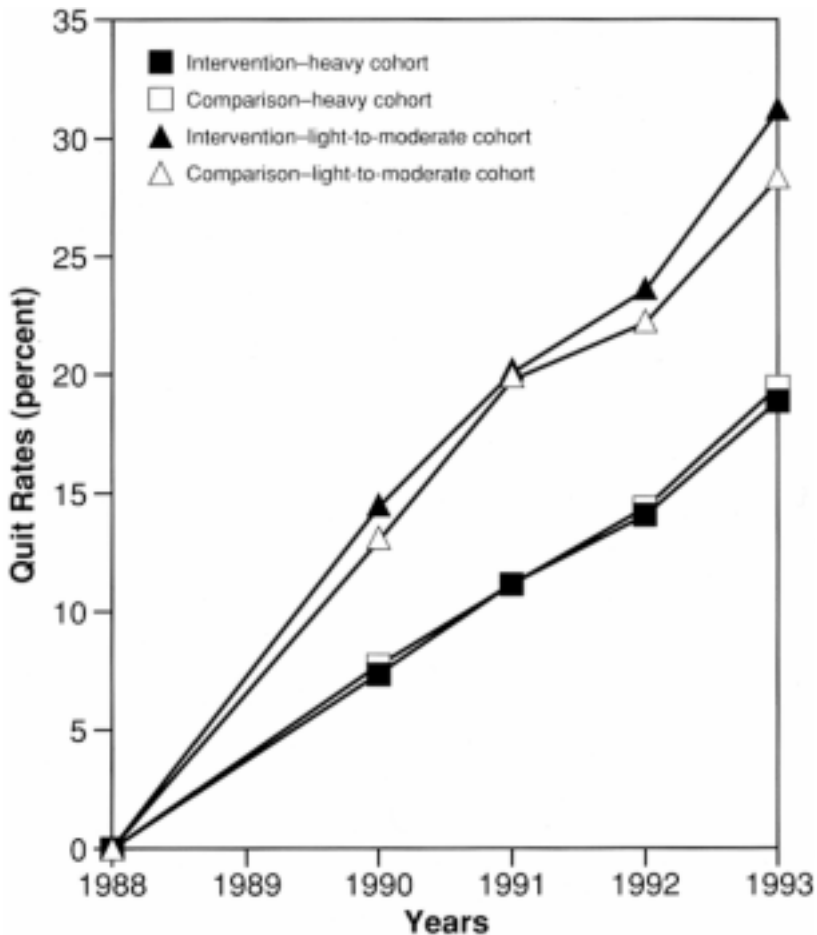
Cessation among light-to-moderate smokers was associated with educational level, with most of the beneficial effect of the intervention seen in the less educated subgroup (no college education). This is contrary to other studies that indicate cessation is more likely to occur among more educated groups (Pierce et al., 1989). It may be that less educated smokers benefit more from a community-based intervention.

Receipt indices were calculated from questions regarding respondents' experiences in the various intervention channels; for example, individuals were asked whether their physician had talked with them about stopping smoking, whether there were any antismoking activities in their worksite, and whether they had participated in any stop-smoking contests. Separate indices were devised for cessation resources, health care, worksites, public education and media, religious organizations, programs and materials, contests and events, and perceived unacceptability of smoking. Summary standardized scores of those indices for heavy smokers were 0.695 for the intervention communities and 0.118 for the control communities ($p = .012$). For light-to-moderate smokers, the summary scores were 0.386 for the intervention communities and -0.178 for the control communities ($p = .004$). These scores indicate that cohort members in the intervention communities were more aware of and had participated in more smoking control activities than their counterparts in the control communities. There also was a significant rank order correlation between community receipt indices and the quit rate for the light-to-moderate cohort (rank order correlation = .75, $p = .01$). In addition, an examination of the observed quit rates over time shows an emerging difference between intervention and control communities for light-to-moderate smokers.

Quitting was measured in 1990, 1991, 1992, and at the end of the trial in 1993. Heavy and light-to-moderate smokers showed an increase in quitting over time in both the intervention and control communities. However, Figure 1 suggests an emerging difference in quit rates for light-to-moderate smokers, one that could perhaps attest to the durability of the community intervention approach if smoking cessation were to be measured again (COMMIT Research Group, 1995a). One of the primary considerations in selecting a community-based approach for the COMMIT intervention was the potential for a sustained intervention effect.

The COMMIT findings regarding heavy smokers and cessation are consistent with other studies (Luepker et al., 1994; Dwyer et al., 1986). The difference detected in light-to-moderate smokers is consistent with those reported earlier in eight community studies in seven different countries. Furthermore, the difference observed in COMMIT is greater than that in the Minnesota Heart Health Program, where a difference was seen only among women (Luepker et al., 1994), and the Pawtucket Heart Health Program, where there was no significant difference in cessation rates (Carleton et al., 1995). Based on their cohort sample, the Stanford Five-City Project observed a greater decline in prevalence in treatment cities compared with controls, and light-to-moderate smokers did better than heavy smokers; however,

Figure 1
Observed quit rates over time for heavy and light-to-moderate smoker cohorts



nearly half the cohort could not be followed (Fortmann et al., 1993). No difference was detected between treatment and controls based on cross-sectional data in the Stanford Five-City Project (Fortmann et al., 1993).

Although process objectives were achieved and the intervention receipt indices were favorable for reaching smokers, they had an influence on the quit rates of only light-to-moderate smokers. These outcomes, although significant in terms of potential public health benefit, are more modest than the investigators had hoped to achieve and should be interpreted in light of the successful implementation of the intervention protocol. Several possible reasons for this limited impact of community organization on smoking behavior exist.

First, the project may not have lasted long enough to realize the link between process objectives and impact objectives or between impact

objectives and outcomes. This has been the case in other studies, such as the North Karelia Project, where significant results were not seen until the 10-year followup (Puska et al., 1983). Conversely, the Stanford Three Community Study saw results in the 2nd and 3rd years of intervention, although that study did not focus on heavy smokers. It may be that heavy smokers take longer to move from awareness and participation to cessation than do light-to-moderate smokers. Second, the group of interventions, although efficacious in specific settings, may not have been the right ones for a community trial. Clearly, the interventions did not reach heavy smokers who are strongly addicted to nicotine, so it is possible that they need more individualized and clinical attention to quit. Third, COMMIT did not emphasize policy and media interventions; there is some evidence that these could be more effective, especially if done in conjunction with the other COMMIT activities (Flora and Cassidy, 1990; Sorensen and Pechacek, 1989).

Other investigators believe that behavioral outcome measures may not be the only appropriate outcome for a community trial. Mittelmark and colleagues (1993) argue that problems of secular trend, sampling, economic patterns that can contribute to migration, difficulty of measuring outcomes, need to follow cohorts, and need to repeatedly survey large cross-sections of the population make it unreasonable to rely on behavioral change outcomes as indicators of success; rather, they argue that assessing participation may be the most important measure of success. Although COMMIT investigators were not willing to give up the behavioral outcome, they did believe it necessary to collect enough process data so that outcomes could be better understood. Only a few of those process data have been published to date. The process objectives indicate that interventions targeting heavy smokers were conducted. The intervention receipt indices described above indicate heavy smokers received the intervention. Other process measures, such as those documenting policy changes in worksites, organizations, and schools, remain to be analyzed. Similarly, we do not know yet whether there was an impact on the intermediary agencies (e.g., health care providers, cessation resources) that serve smokers. Those analyses are being conducted.

FUTURE DIRECTIONS FOR COMMUNITY TOBACCO CONTROL Increasingly, community intervention programs for tobacco control are being funded and implemented. Sponsorship varies from support from public health departments, to grants and contracts from Federal agencies (e.g., NCI's American Stop Smoking Intervention Study for Cancer Prevention [ASSIST] and the Centers for Disease Control and Prevention's Initiatives To Mobilize for the Prevention and Control of Tobacco Use [IMPACT] program), to foundation support (e.g., the Robert Wood Johnson Foundation Program for Smokeless States). However, fiscal resources for these projects vary considerably. In ASSIST, NCI has committed \$20 million annually to support smoking interventions in 17 States, whereas 33 States are due to receive approximately \$5 million annually under the IMPACT program. Staff members who are charged with implementing the programs seek information from COMMIT and other previously implemented community tobacco control projects to determine

how best to address tobacco control. Given the limited resources of an implementation project compared with a research project, important decisions must be made as to project emphasis.

The cornerstone of COMMIT and any other community intervention project is community organization. Community representatives know how their communities operate and how to reach individuals or groups who practice unhealthy behaviors such as smoking. Although community organization may require a considerable amount of work at the beginning of a project, it is effective in mobilizing a community because a variety of volunteers can be recruited to participate in the project and the diversity of representatives will ensure that all community sectors are involved.

Community organization requires a careful and thorough community analysis. All sectors of the community must be analyzed for their potential contribution to reaching project goals within the community. This analysis is the basis for forming community structures to take on tobacco control or other community problems. For some communities, a small coalition may work best; for others, one existing community agency may be prepared to take on the implementation role while involving others in the decisionmaking processes. The importance of community analysis cannot be overemphasized; an incomplete or erroneous analysis can omit the very groups or individuals who are most necessary to reach a target population.

Community tobacco control projects must be clear as to their specific aims. For example, Fisher (1995) has argued that what needs to be tested in community studies is a defined approach to community organization, not a defined intervention. Such an approach would require considerable flexibility for program planning, development, and implementation. Funding agencies may need to accept that greater flexibility and community freedom are necessary for effective community interventions. On the other hand, ASSIST embraces coalitions as a defined organizational structure (Shopland, 1993) but requires an intervention that focuses on policy and media (National Cancer Institute, 1991). The defined intervention has some general components but is not as regulated as COMMIT. Perhaps that approach will be more suitable to coalitions and the groups they represent.

Community groups must consider many factors when deciding on tobacco control activities. Are there particular subgroups that must be reached? How can they best be reached? Is addiction a major issue for the intervention the community groups wish to implement? If so, is a community study the best avenue for dealing with addiction? Is prevention the primary goal? If so, a focus on policy and media is probably most appropriate. Community projects that are not part of research have the advantage of picking their area of emphasis and then using the best knowledge available to tackle that problem. Community projects involved in research have less latitude.

Future tobacco control activities must be seen as part of a comprehensive national agenda. In COMMIT, most communities did not have the

concurrent stimulus from Federal, State, county, and local regulations and ordinances that could form a synergy between local efforts and broader efforts. Although it is well known that the price of cigarettes is a major factor in consumption (Warner, 1986; Sweanor et al., 1993), only recently have substantial increases in tobacco taxation been instituted. Both Canada and California saw significant decreases in smoking prevalence after such tobacco tax increases. Environmental restrictions also have an impact on decreasing prevalence (Borland et al., 1990; Brighan et al., 1994). Taxation, environmental restrictions, and government-funded mass media campaigns are necessary elements for a comprehensive, synergistic approach to tobacco tax control. Communities do not operate independently of the broader political and social systems, and sources of future community projects may be limited without support from those broad sectors.

The tobacco problem is likely to continue for some time. Community projects are ways to organize entire communities to combat this problem, and all the evidence from COMMIT indicates that communities will organize and implement many activities to fight tobacco use. The lessons learned from the field in the COMMIT project can and should be used to help communities develop and implement their own tobacco control activities.

REFERENCES

- Borland, R., Chapman, S., Owen, N., Hill, D. Effects of workplace smoking bans on cigarette consumption. *American Journal of Public Health* 80: 178-180, 1990.
- Brighan, J., Gross, J., Stizer, M.L., Felch, L.J. Effects of a restricted worksite policy on employees who smoke. *American Journal of Public Health* 84: 773-778, 1994.
- Carleton, R.A., Casater, T.M., Assaf, A.R., Feldman, H.A., McKinlay, S., and the Pawtucket Heart Health Program Writing Group. The Pawtucket Heart Health Program: The community changes in cardiovascular risk factors and projected disease risk. *American Journal of Public Health* 85: 777-785, 1995.
- COMMIT Research Group. Community Intervention Trial for Smoking Cessation (COMMIT): I. Cohort results from a four-year community intervention. *American Journal of Public Health* 85: 183-192, 1995a.
- COMMIT Research Group. Community Intervention Trial for Smoking Cessation (COMMIT): II. Changes in adult smoking prevalence. *American Journal of Public Health* 85: 193-200, 1995b.
- Dwyer, T., Pierce, J.P., Hannam, C.D., Burke, N. Evaluation of the Sydney "Quit for Life" anti-smoking campaign: 2. Changes in smoking prevalence. *Medical Journal of Australia* 144: 344-347, 1986.
- Fisher, E.B. Editorial: The results of the COMMIT trial. *American Journal of Public Health* 85: 159-160, 1995.
- Flora, J.A., Cassidy, D. Roles of media in community-based health promotion. In: *Health Promotion at the Community Level*, N.F. Bracht (Editor). Newbury Park, CA: Sage, 1990, pp. 143-157.
- Fortmann, S.P., Taylor, C.B., Flora, J.A., Jatulis, D.E. Changes in adult smoking prevalence after 5 years of community health education: The Stanford Five-City Project. *American Journal of Epidemiology* 137: 82-96, 1993.
- Luepker, R.V., Murray, D.M., Jacobs, D.R., Mittelmark, M.B., Bracht, N., Carlaw, R., Crow, R., Elmer, P., Finnegan, J., Folsom, A.R., Grimm, R., Hannan, P.J., Jeffrey, R., Lando, H., McGovern, P., Mullis, R., Perry, C.L., Pechacek, T., Pirie, P., Sprafka, M., Weisbrod, R., Blackburn, H. Community education for cardiovascular disease prevention: Risk factor changes in the Minnesota Heart Health Program. *American Journal of Public Health* 84(9): 1383-1393, 1994.
- Mittelmark, M.B., Hunt, M.K., Heath, G.W., Schmid, T.L. Realistic outcomes: Lessons from community-based research and demonstration programs for the prevention of cardiovascular diseases. *Journal of Public Health Policy* 14(4): 437-462, 1993.
- National Cancer Institute. "ASSIST Program Guidelines." Internal document prepared for the National Cancer Institute, 1991.
- Pierce, J.P., Fiore, M.C., Novotny, T.E., Hatziandreu, E.J., Davis, R.M. Trends in tobacco smoking in the United States: Educational differences are increasing. *Journal of the American Medical Association* 261: 56-60, 1989.

- Puska, P., Nissinen, A., Salonen, J.T., Toumilehto, J. Ten years of the North Karelia Project: Results with community-based prevention of coronary heart disease. *Scandinavian Journal of Social Medicine* II: 65-68, 1983.
- Shopland, D.R. Smoking control in the 1990's: A National Cancer Institute model for change. *American Journal of Public Health* 83(9): 1208-1210, 1993.
- Sorensen, G., Pechacek, T.F. Implementing nonsmoking policies in the private sector and assessing their effects. *New York State Journal of Medicine* 89: 11-15, 1989.
- Sweanor, D., Martial, L., Dossetor, J. *The Canadian Tobacco Tax Increase: A Case Study*. Ottawa, Ontario, Canada: The Non-Smokers' Rights Association (Canada) and the Smoking and Health Action Foundation (Canada), 1993.
- Warner, K. Smoking and health implications of a change in the federal excise tax. *Journal of the American Medical Association* 255: 1028-1032, 1986.

AUTHORS

Beti Thompson, Ph.D.
Associate Professor
University of Washington School of
Public Health and Community Medicine
Associate Member
Fred Hutchinson Cancer Research Center,
MP-702
1124 Columbia Street
Seattle, WA 98104

William R. Lynn
COMMIT Project Officer
Public Health Applications Research Branch
Cancer Control Science Program
National Cancer Institute
National Institutes of Health
Executive Plaza North, Room 241
6130 Executive Boulevard, MSC-7337
Bethesda, MD 20892-7337

Donald R. Shopland
Coordinator
Smoking and Tobacco Control Program
National Cancer Institute
National Institutes of Health
Executive Plaza North, Room 241
6130 Executive Boulevard, MSC-7337
Bethesda, MD 20892-7337