

1. The Historical Context

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1. The Historical Context

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

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

Needed: A New Approach

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

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

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

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

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

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



ASSIST Logo

The Context for Creating ASSIST

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

The National Cancer Institute Is Ready

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

decade after the founding of NCI in 1937. Reports on studies by Wynder and Graham⁶ and Levin and co-workers⁷ appeared in the *Journal of the American Medical Association*. The results of two other studies also were published.^{8,9} All four studies observed that lung cancer rates were higher for men who were smokers than for men who were non-smokers. These studies were the foundation of the evidence linking tobacco to cancer. They generated media attention and stimulated efforts to substantiate the far-reaching health consequences of tobacco use.

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

Cancer control includes developmental research, i.e., the identification of new methods and techniques and their field

testing and evaluation in limited community settings, and community demonstration and application activities, i.e., the promotion of community-tested cancer control methods and techniques to ensure their appropriate application and use.^{11(p329)}

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

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

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

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

Research Precedes Interventions

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

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

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

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

They explained cancer control to be

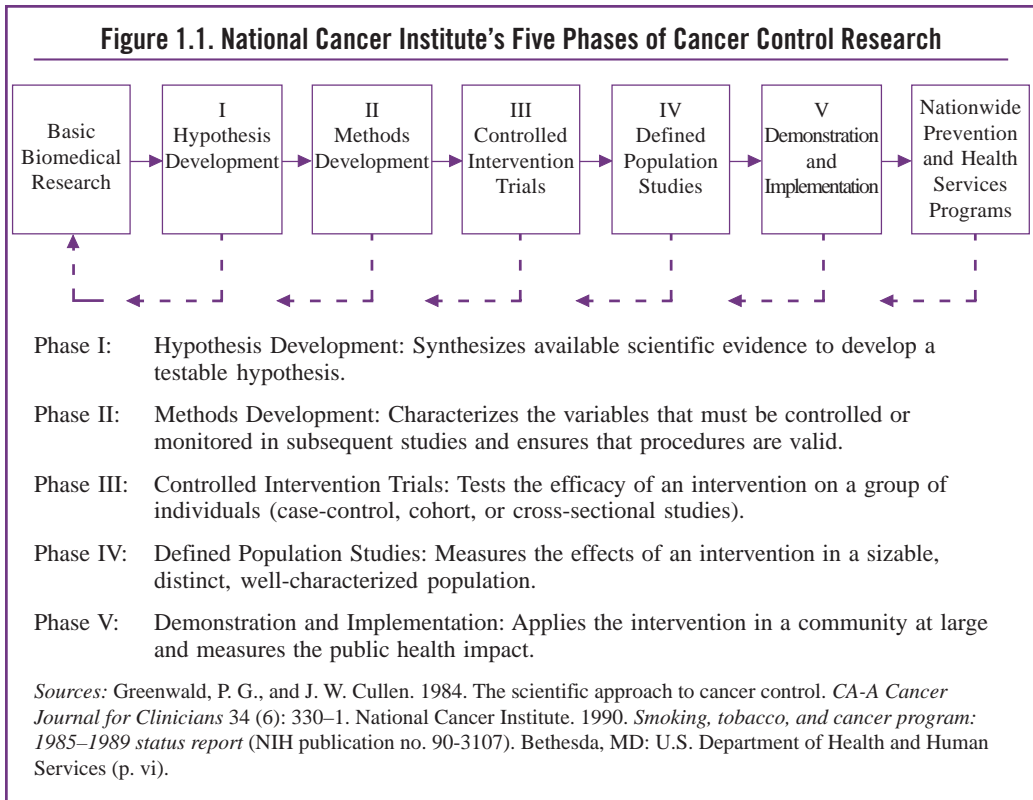
the reduction of cancer incidence, morbidity, and mortality through an orderly sequence from research on interventions and their impact in defined populations to the broad, systematic application of the research results.

“Interventions” is a key word. For example, an epidemiologic study that examines an etiologic factor, but does not involve interceding for the benefit of a specific patient or the general public, would not be considered cancer control.^{12(p329)}

The Five Phases of Cancer Control

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

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



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

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

ing NCI's STCP the largest program of its kind in the world. (See figure 1.2.)

Studies Establish a Scientific Basis for Community-based Interventions

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

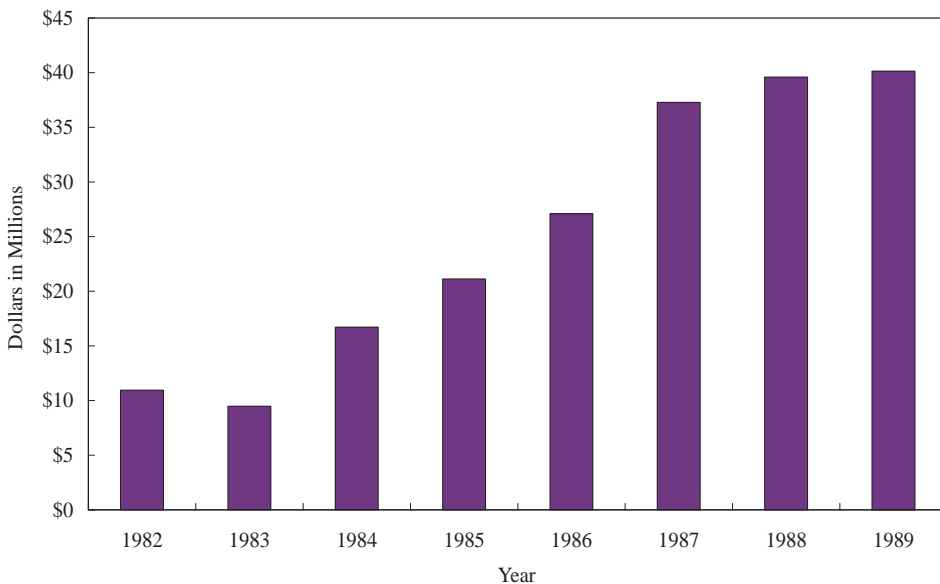
primary emphasis on individual-based interventions to interventions designed to reach large population groups and helped to verify the importance of the community and environmental factors in tobacco prevention and control.^{5,13} The following examples are representative of pre-ASSIST community-based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

- The Stanford Three-Community Study, initiated in 1972, demonstrated the effectiveness of mass media and intensive face-to-face interventions in decreasing the number of cigarettes smoked per day and the risk for cardiovascular disease.¹⁴
- One study component of the Minnesota Heart Health Program was the Class of 1989 Study, which tested the efficacy of a smoking prevention intervention as one part of a larger

program to reduce heart disease in entire communities. After the program ended and at the cohort's completion of high school, the smoking rate for adolescents in the intervention community was 40% lower than in the reference community.¹⁵

- The Midwestern Prevention Project was another longitudinal intervention study that was implemented in 50 middle/junior high schools in Kansas City and Indianapolis. The media-based interventions included schools, media, parent and community organizations, and health policy programs that focused on resistance skills training and environmental support for not using cigarettes or drugs. The smoking rates for students in intervention schools increased

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



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

significantly less than those for students in comparison schools.¹⁶

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

A Major Shift

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

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

moderate smokers were more likely to quit than were heavy smokers as a result of a community education intervention that mobilized personal and community resources to promote a healthful lifestyle. The program was integrated into existing local health and social services, and efforts toward individual action were supplemented by mass media and other community interventions.²¹

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

From COMMIT to ASSIST

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

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

As of 1988, STCP had supported 60 studies. At that time, 20% were complete, but by 1991, when ASSIST was slated to begin, 90% would be complete, adding to the body of knowledge guiding the ASSIST interventions during its 2-year planning stage that preceded the 5-year implementation phase to begin in 1993. All the studies were scheduled to be completed by 1992.²⁵

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

time, this community-based focus was considered to be innovative and was based on an increasing knowledge that

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

The Rationale for a Commitment to the Community Approach

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

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

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

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

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

The American Cancer Society as a Partner

NCI recognized the value of a community-based approach in changing the social and physical environment to

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

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

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

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

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

Approval Is Sought

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

Dr. Joseph W. Cullen, representing STCP, and Dr. Harmon J. Eyre, representing ACS, made the principal presentations to the Board of Scientific Counselors and outlined the history of STCP and NCI and selected intervention trials that had already been funded. Cullen provided the history, context, and

rationale for the project. He also explained the proposed, unprecedented arrangement between ACS and NCI. Although NCI was quite familiar with funding scientific research grants, it had no track record of partnering with voluntary health organizations. To explain and to reassure this board of scientists about this new model for demonstrating tobacco prevention and control programs, he used the metaphor that NCI cannot do tobacco prevention and control without an army and that ACS could provide this army because it had 3,400 units, 57 divisions, and 2,000,000 volunteers. Cullen said that these large numbers would be required as NCI moved from science to public health application.^{25(p231)}

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

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

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

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

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

component at the outset and raised questions about the wisdom of proceeding with ASSIST before all data from the COMMIT trials were analyzed.

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

Concerns and Issues Expressed to the Board of Scientific Counselors

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

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

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

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

A benefit of the contract mechanism rather than the grant mechanism later became apparent once the ASSIST project was underway. In contrast to the

grant mechanism, the contract required that the states agree to specific deliverables. By having these deliverables built into the funding commitment, NCI was able to maintain consistency and the states were able to resist the pressures of individuals who might have been politically motivated.

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

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

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

Readiness to Go Forward

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

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

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

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

The NCI's Smoking and Tobacco Control Program has operated under the philosophy that research, in and of itself, is not capable of producing large-scale national change in smoking prevalence rates. It was recognized from the outset that there must be a concerted effort to systematically and comprehensively apply the knowledge gained from the intervention trials.

Thus, from its inception, the STCP has continually used information from such studies to plan the next steps for implementation of a national strategy to significantly reduce smoking in the 1990's.^{30(px)}

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

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Additional Resource

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