6. Public and Private Policy Interventions

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At the center of the American Stop Smoking Intervention Study (ASSIST) model is the use of policy to alter the environment in which people live and change the social norm from one that tolerates smoking to one that actively discourages the use of tobacco in any form. This chapter presents the ASSIST states' intervention strategies to achieve policies that advance objectives in four tobacco control areas: eliminating exposure to environmental tobacco smoke, increasing the price of tobacco products, restricting tobacco advertising and promotions, and reducing youth access to tobacco products. All 17 ASSIST states made progress in these four areas, but not without overcoming formidable challenges. Through policy advocacy interventions, ASSIST educated policymakers, organizations, businesses, and individuals about the benefits of mandatory and voluntary tobacco control policies. In this chapter, case studies of interventions and insights of staff and coalition members illustrate the process of mobilizing ordinary citizens to effect major policy change despite opposition from a powerful, determined tobacco industry.

Policy as an Intervention

Changes in public and private policies are formal reflections of changes in community norms and as such, predictors of behavioral change. Providing leadership for policy development is a core function of governmental public health agencies.[1,2(pp6–7),3] State and local health departments have a long history of using policy interventions (requiring immunizations and restaurant inspections, etc.) to prevent and control infectious diseases. However, using a policy advocacy approach to prevent chronic disease caused by tobacco use was a major change in the public health approach to tobacco prevention and control at the time ASSIST began.

Shaping community norms about tobacco use and building support for public and private policies through the mass media and social networks are at the heart of the ASSIST model. Policy interventions must convince decision makers that the public perceives a proposed policy to be in the best interest of the community as a whole. Media advocacy helps bring about public and private policy changes, which in turn increase the demand for and use of program services. The three types of intervention—mass media, policy, and program services—can be likened to a three-legged stool: all three support behavioral change and without any one of the legs, the stool will not stand.

As all ASSIST contractors and subcontractors knew, federal money carries a variety of contractual, regulatory, and legislative restrictions. In 1991, at the start of the project, these restrictions were identified, explained, and widely disseminated in the

White Paper entitled *Restrictions on Lobbying and Public Policy Advocacy by Government Contractors: The ASSIST Contract.*[4] It was revised, updated, and redistributed to all ASSIST project directors, project managers, and the ASSIST Coordinating Center by the National Cancer Institute (NCI) ASSIST contracting officer on July 23, 1997.[5] The restrictions were also the subject of numerous trainings.[6] Throughout the ASSIST intervention phase, additional restrictions in regard to lobbying were attached to federal funding, especially through the annual appropriations process. Beginning October 1, 1998, none of the federal funding for ASSIST could be used by any partners for lobbying at any level, including the local level. The provisions of the Federal Acquisition Streamlining Act of 1994[7] applied to the ASSIST contract extensions for the last year of ASSIST, in 1998, because they were considered "new contracts." Encumbrances on the use of federal and foundation funding were one of the important reasons that ASSIST coalitions included different partners. Charitable organizations—called 501(c)(3)s in the Internal Revenue Code—including the American Cancer Society (ACS), are allowed to make substantial expenditures on lobbying.[8,9] Most of the public education that precedes policy and all of the enforcement that follows policy do not constitute lobbying. Partners like ACS and the many volunteers who participated in ASSIST coalitions could lobby and perform other functions that could not be financed with federal funds. (See section on Understanding the Regulations on Lobbying, chapter 8, part 2).

Interventions in Four Policy Areas

Following the ASSIST framework described in chapter 2, the 17 states promoted interventions in four policy areas, expressed as objectives in the "ASSIST Program Guidelines for Tobacco-free Communities":

> Eliminate environmental tobacco smoke in all areas where others may face involuntary exposure and the serious health risks associated with inhalation of other people's tobacco smoke.
>
> Eliminate all tobacco product advertising and promotion, other than point of sale price and objective product information advertising.
>
> Reduce access to and availability of tobacco products, particularly to persons under the legal age of purchase.
>
> Reduce consumption of cigarettes and other tobacco products through price increases using increased taxes and other costs imposed on tobacco products.[10(p12)]

Ordinances Passed during ASSIST Years

Tobacco control efforts by the ASSIST coalitions stimulated the passage of state and local laws and also private policies. Between 1992 and 1999, municipalities enacted local ordinances in the ASSIST states in the four policy areas: clean indoor air (506), excise taxes (7), youth access (688), and advertising (74).

Source: ANR Foundation Local Tobacco Control Ordinance Database(c), 9/18/03.

These objectives guided ASSIST's tobacco control advocates in developing their strategies to reduce tobacco use by influencing social norms through policy. See appendices 6.A–6.C for excerpts from the ASSIST policy guides on youth access to tobacco, clean indoor air, and tobacco advertising and promotion.

Eliminating Exposure to Environmental Tobacco Smoke

The purpose of environmental tobacco smoke (ETS) policies is to protect people from involuntary exposure to other people's tobacco smoke and from the serious health risks associated with inhaling it. For most people, tobacco smoke is the most widespread and harmful indoor pollutant that they will encounter. The harmful effects of ETS or secondhand smoke are well documented and are described in numerous reports:

- Centers for Disease Control and Prevention's 1986 *Health Consequences of Involuntary Smoking: A Report of the Surgeon General*[11]
- U.S. Environmental Protection Agency's (EPA) 1992 *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*[12]
- California EPA's 1997 *Health Effects of Exposure to Environmental Tobacco Smoke: Final Report and Appendices*[13]
- National Toxicology Program's 2000 *Ninth Report on Carcinogens*[14]
- International Agency for Research on Cancer's 2004 monograph, *Tobacco Smoke and Involuntary Smoking*[15]

Terms for Environmental Tobacco Smoke

> "ETS, or 'secondhand smoke,' is the complex mixture formed from the escaping smoke of a burning tobacco product and smoke exhaled by the smoker. The characteristics of ETS change as it ages and combines with other constituents in the ambient air. Exposure to ETS is also frequently referred to as 'passive smoking,' or 'involuntary tobacco smoke' exposure. Although all exposures of the fetus are 'passive' and 'involuntary,' . . . in utero exposure resulting from maternal smoking during pregnancy is not considered to be ETS exposure."[a]

The ASSIST project originally used the term *clean indoor air* to refer to policies but later expanded the concept to include outdoor environments as well and used the term *environmental tobacco smoke*.

[a]National Cancer Institute. 1999. *Health effects of exposure to environmental tobacco smoke: The report of the California Environmental Protection Agency* (Smoking and tobacco control monograph no. 10, NIH publication no. 99-4645). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health (p. ES1).

The U.S. Environmental Protection Agency designated ETS as a Class A (known human) lung carcinogen in 1993.[12(p1)] The National Institutes of Health's National Toxicology Program has determined that ETS is a known human carcinogen. NIH's *Ninth Report on Carcinogens* concluded that ETS exposure is causally related to lung cancer. The report notes that secondhand smoke contains at least 250 chemicals that are known to be toxic or carcinogenic.[14] Each year in the United States, ETS is

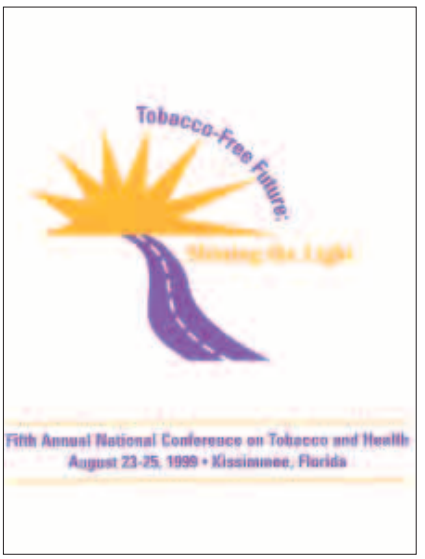
responsible for at least 3,000 deaths from lung cancer and about 47,000 deaths from ischemic heart disease.[16–19] In addition to causing these diseases in adults, ETS has been found to cause a number of health problems in children, including bronchitis, pneumonia, asthma, middle ear infections, and sudden infant death syndrome.[16] The Surgeon General has concluded that, compared with children of nonsmoking parents, children of parents who smoke have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly lower rates of increase in lung function.[11] The evidence that ETS poses serious health risks has become even stronger since the end of ASSIST.

While the primary purpose of smoking restrictions is to protect nonsmokers from the carcinogens and toxins found in ETS, recent evidence points to a second benefit—ETS policies help reduce smoking prevalence:

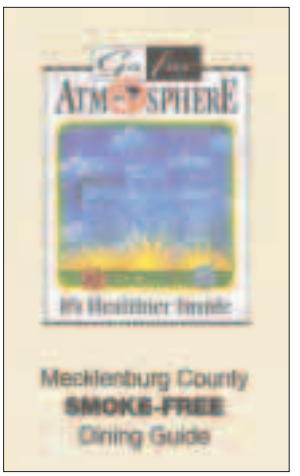
> Research clearly shows that smoke-free public places, especially workplaces, provide a more supportive environment for smokers to quit. Even the tobacco industry's own internal research has shown this. For example, a Philip Morris study that followed some 25,000 smokers over time found that those working in a smoke-free work environment experienced an 84 percent higher quit rate than those facing no or minimal smoking restrictions.[20(piii)]

A 1990 study of nearly 12,000 California residents found that employees in smoke-free workplaces had a lower smoking prevalence and, among continuing smokers, lower cigarette consumption than individuals working where smoking was permitted.[21] A review of 26 studies conducted between 1984 and 1993 on the effects of smoke-free workplaces found that totally smoke-free workplaces were associated with reductions in smoking prevalence of 3.8% and of 3.1 fewer cigarettes smoked per day per continuing smoker.[22]

When the ASSIST project started, a few states or localities had restrictions on public smoking; however, many of these had been enacted for fire prevention or nuisance purposes rather than for health protection purposes. By 1991, the adverse health effects of tobacco use and ETS



1999 ASSIST conference materials



Mecklenburg County (NC) Health Department guide to smoke-free restaurants

exposure were well documented, and a mounting body of scientific evidence supported the effectiveness of certain policies for reducing tobacco use. For example, in 1989, Congress prohibited smoking on all domestic commercial flights up to 6 hours in duration to protect airline workers and passengers from health risks associated with ETS. NCI, through its systematic research approach that led to ASSIST, was ready in 1991 to greatly increase the use of policy interventions to reduce and prevent tobacco use.

The ASSIST program objectives for smoke-free environments sought the following four outcomes:

1. State and municipal regulations creating smoke-free environments
2. Substantial and progressive voluntary action by employers, property owners, commercial enterprises, university and school officials, healthcare providers, municipal and transportation authorities, day care centers, media gatekeepers, parents, and others to support and adopt smoke-free policies
3. Broader and more intense public and policymaker support for implementation of smoke-free policies in worksites, public places, schools, and other locations
4. Increased levels of citizen awareness of the harmful nature of ETS

The primary policy intervention strategy was direct policy advocacy aimed at increasing the public's and policymakers' awareness of the issues. Coalition members informed public regulatory authorities about legislative steps taken in other jurisdictions to create smoke-free environments; encouraged property owners and managers, business owners, employers, and healthcare providers to voluntarily implement smoke-free policies on their premises; and provided media contacts with the evidence and rationale to support a smoke-free position in articles and editorials. (See chapter 5.)

ASSIST state and local coalitions recognized the strategic advantages of focusing efforts for smoke-free policies on a variety of public settings. In many communities, protecting children from ETS exposure was the first and most obvious choice. For some indoor commercial settings (e.g., restaurants, hotels, and theaters) advocates could present clear evidence of financial benefits to the businesses in addition to the health benefits of smoke-free environments. For other settings, such as bars, the evidence became available only in the later ASSIST years.[23,24] After reviewing all 97 studies on the economic impact of smoke-free policies on the hospitality industry, Scollo and colleagues concluded, "All of the best designed studies report no impact or a positive impact of smoke-free restaurant and bar laws on sales or employment."[25(p13)] The tobacco industry circulated anecdotal information that led restaurant and bar proprietors to believe that smoking restrictions would negatively affect their business.[25] However, the tobacco industry's internal documents make clear that its real concern was the economic impact that these policies were having on the industry itself by motivating smokers to quit or reduce their consumption. In the tobacco industry's own words, "Total prohibition of smoking in the workplace strongly affects industry volume. Smokers facing

these restrictions consume 11%–15% less than average and quit at a rate that is 84% higher than average."[26] Table 6.1 contains a breakout of the clean indoor air ordinances enacted as of August 25, 2003. The tables in this chapter include data for all states, to put the ASSIST states in context. For more current data, contact the Americans for Nonsmokers' Rights at www.no-smoke.org.

As the ASSIST states succeeded in securing adoption of clean indoor air policies, they also sought to eliminate exposure in all public settings in which a large number of people could be exposed to environmental tobacco smoke. Outdoor settings for sports and entertainment events were also of particular concern to ASSIST coalitions because children and adolescents tend to be present at these settings.

Promoting Higher Taxes for Tobacco

An increase in the price of cigarettes results in a decrease in cigarette consumption. The substantial evidence for the relationship between price (including increases by taxation) and consumption has been summarized in numerous reports: the 1992 report of the surgeon general, *Smoking and Health in the Americas*;[27] a 1993 summary report of a National Cancer Institute Expert Panel;[28] the 1994 Institute of Medicine report, *Growing Up Tobacco Free*;[1] the 2000 Institute of Medicine report, *State Programs Can Reduce Tobacco Use*;[29] and the 1999 World Bank report, *Curbing the Epidemic*.[30]

Studies show a range of estimates for the price elasticity of demand for cigarettes, but most fall in the range from –0.25 to –0.50. The range indicates that if cigarette prices rise by 10%, overall cigarette smoking will fall by between 2.5% and 5%. The long-term response to a permanent change in cigarette prices will be larger than the initial short-run response.[31] Another finding is that young smokers are up to three times more sensitive to price than are adult smokers.[32] The relationship between price and consumption is also noted in internal tobacco industry documents:

> In the opinion of PM Inc. and Philip Morris International, past increases in excise and similar taxes have had an adverse impact on sales of cigarettes. Any future increases, the extent of which cannot be predicted, could result in volume declines for the cigarette industry, including PM Inc. and Philip Morris International.[33(p165)]

Many major health and medical organizations in the United States and the

Long-standing Benefits of Tobaco Excise Taxes

The benefits of excise taxes have long been recognized. In a report on the economics of tobacco control, the World Bank refers to Adam Smith's reasoning regarding the advantages of tobacco taxes. Because tobacco taxes would lessen the need for other excise taxes, for example, on necessities and other manufactured goods, he promoted excise taxes as benefiting the poor. Smith argued that with tobacco excise taxes, poor people would "live better, work cheaper, and . . . send their goods cheaper to market."

Source: World Bank. 1999. *Curbing the epidemic: Governments and the economics of tobacco control.* Washington, DC: World Bank (p. 37). www1.worldbank.org/tobacco/book/html/chapter4.htm.

Table 6.1. Number of Municipalities per State with Clean Indoor Air Ordinances, as of August 25, 2003
(Shading indicates ASSIST states.)

State	Total	Workplaces	Restaurants	Bars	Public Places
California	332	293	272	22	304
Massachusetts	227	173	211	76	211
Missouri	108	95	39	3	105
New Jersey	91	39	6	0	52
Texas	74	46	61	7	73
Alabama	68	62	18	1	65
Wisconsin	58	47	23	1	54
West Virginia	54	53	53	2	54
New York	52	48	18	4	47
North Carolina	51	43	32	5	50
Kansas	50	44	7	1	47
Colorado	47	42	38	6	46
Georgia	38	33	21	1	35
Louisiana	38	31	6	0	37
Mississippi	34	33	1	1	33
Arizona	30	28	25	2	29
Illinois	30	20	19	0	28
Ohio	23	21	20	2	23
Oregon	21	20	16	3	20
Virginia	20	9	17	0	20
Florida	15	5	0	0	6
South Carolina	15	8	3	0	14
Michigan	14	10	1	0	12
New Mexico	14	11	8	1	13
Maryland	12	10	7	1	11
Minnesota	12	4	4	0	6
Indiana	9	8	3	2	9
Pennsylvania	9	5	5	0	8
Rhode Island	9	1	1	0	1
Tennessee	9	8	3	0	9
Alaska	7	5	6	0	5
Washington	7	4	3	0	5
Hawaii	5	3	5	0	5
Montana	5	5	4	1	5
Nebraska	5	4	0	0	4
North Dakota	5	4	2	0	5
Arkansas	4	3	2	0	4
Maine	4	3	2	0	3
New Hampshire	4	0	3	0	0
Iowa	3	3	0	0	3
Wyoming	3	3	2	0	3
Delaware	2	2	2	0	2
Oklahoma	2	1	0	0	2
Utah	2	1	0	0	1
Kentucky	1	1	1	1	1
District of Columbia	1	1	1	0	1
Vermont	1	1	1	0	1
Connecticut	1	1	0	0	1
South Dakota	1	1	0	0	1
Idaho	0	0	0	0	0
Nevada	0	0	0	0	0

Source: ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003 American Nonsmokers' Rights Foundation. All rights reserved.

Note: Because some municipalities have coverage in more than one category, the numbers are not mutually exclusive.

ASSIST States Increase Tobacco Taxes

During the ASSIST project, 12 of the 17 ASSIST states increased tobacco taxes. Increases ranged from 1–71¢ and averaged 14¢. After the ASSIST project ended, the capacity built by the project helped facilitate a number of states to pass tobacco tax increases.

Sources: American Lung Association. 2001. *State legislated actions on tobacco issues*, ed. E. M. Schilling and C. E. Welch. Washington, DC: American Lung Association; The Tobacco Institute. 1998. *The tax burden on tobacco. Historical compilation*, vol. 33. Washington, DC: The Tobacco Institute.

World Health Organization, in its publication *Guidelines for Controlling and Monitoring the Tobacco Epidemic*,[34] identify increasing tobacco taxes as a key strategy for reducing tobacco use.[35] The most common means available to the public for raising the price is to increase the excise tax on tobacco products.

The public tends to support increases in tobacco taxes in part because they favor funding tobacco prevention programs.[36] Reporting the results of a 1997 telephone poll paid for by the Abell Foundation and the Maryland Teachers Association, the *Baltimore Sun* stated,

> Anti-smoking activists released a poll yesterday showing Maryland voters favor by nearly 2-to-1 a $1.50-a-pack increase in the state's cigarette tax and said teen smoking has become so potent a political issue that it can outweigh party loyalty.[37]

More recently, a 2003 synthesis (by the Campaign for Tobacco-Free Kids) of polls conducted in 28 states in 2002 and 2003 shows that there is broad public and voter support for cigarette-tax increases.[36] In most states, voters favor the proposed cigarette-tax increase by a 2-to-1 margin. They prefer cigarette-tax increases to other tax increases or to budget cuts but also strongly believe that at least some tobacco-tax revenues should be used for programs to prevent and reduce smoking, especially by children and adolescents.[36] A second reason that the public supports tobacco tax increases may be the exposure of the tobacco industry's culpability in deceiving the public and its diminished credibility resulting from the litigation of the 1990s and the internal industry documents that were consequently made public.

The ASSIST objective for the tobacco-pricing policy area was to reduce consumption of cigarettes and other tobacco products through price, and especially tax, increases. The objective can be best achieved by gaining the support of the public and of policymakers; therefore, a public-private partnership, such as that of NCI with ACS, is fundamental to the strategy. To increase the public's and policymakers' awareness of the need for higher taxes on tobacco products, the ASSIST coalitions disseminated data on the effectiveness of substantial tobacco-tax increases in reducing tobacco consumption and on public support for such measures. Coalition members met with community and business leaders and with media contact persons to encourage them to write editorials supporting substantial tax increases. Table 6.2 shows the state tax excise rate increases during the ASSIST years. (See NCI Monograph 17 for a comparative evaluation of

Table 6.2. State Tax Rates for 2000 and Rate Increases, 1991–99 (per pack)

(Shading indicates ASSIST states.)

State	2000 Rate	Rate Change	Date of Change
New York	$1.110	39 to 56¢ 56¢ to $1.11	6/1/93 3/1/00
Alaska	$1.000	29¢ to $1.00	1/29/97
Hawaii	$1.000	60¢ 60 to 80¢ 80¢ to $1.00	7/1/93 9/1/97 7/1/98
California	$0.870	35 to 37¢ 37 to 87¢	1/1/94 1/1/99
Washington	$0.825	43 to 54¢ 54 to 56.5¢ 56.5 to 81.5¢ 81.5 to 82.5¢	7/1/93 7/1/94 7/1/95 7/1/96
New Jersey	$0.800	40 to 80¢	1/1/98
Massachusetts	$0.760	26 to 51¢ 51 to 76¢	1/1/93 10/1/96
Michigan	$0.750	25 to 75¢	5/1/94
Maine	$0.740	31 to 33¢ 33 to 37¢ 37 to 74¢	1/1/91 7/1/91 11/1/97
Rhode Island	$0.710	37 to 44¢ 44 to 56¢ 56 to 61¢ 61 to 71¢	7/1/93 7/1/94 7/1/95 7/1/97
Oregon	$0.680	28 to 33¢ 33 to 38¢ 38 to 68¢	11/1/93 1/1/94 2/1/97
Maryland	$0.660	13 to 16¢ 16 to 36¢ 36 to 66¢	6/1/91 5/1/92 7/99
District of Columbia	$0.650	17 to 30¢ 30 to 50¢ 50 to 65¢	7/1/91 6/1/92 7/1/93
Wisconsin	$0.590	30 to 38¢ 38 to 44¢ 44 to 59¢	5/1/92 9/1/95 11/1/97
Arizona	$0.580	15 to 58¢	1/29/94
Illinois	$0.580	30 to 44¢ 44 to 58¢	7/14/93 12/16/97
New Hampshire	$0.520	25 to 37¢ 37 to 52¢	7/1/97 7/6/99
Utah	$0.515	23 to 26.5¢ 26.5 to 51.5¢	7/1/91 7/1/97
Connecticut	$0.500	40 to 45¢ 45 to 47¢ 47 to 50¢	10/1/91 7/1/93 7/1/94
Minnesota	$0.480	38 to 43¢ 43 to 48¢	6/1/91 7/1/92

Table 6.2. (continued)

State	2000 Rate	Rate Change	Date of Change
North Dakota	$0.440	30 to 39¢	7/1/91
		29 to 44¢	7/1/93
Vermont	$0.440	17 to 18¢	7/1/91
		18 to 19¢	1/1/92
		19 to 20¢	7/1/92
		20 to 44¢	7/1/95
Texas	$0.410	No rate change during this period.	
Iowa	$0.360	31 to 36¢	6/1/91
Nevada	$0.350	No rate change during this period.	
Arkansas	$0.345	21 to 22¢	7/1/91
		22 to 34.5¢	2/1/93
		34.5 to 31.5¢	7/1/93
Nebraska	$0.340	27 to 34¢	7/1/93
South Dakota	$0.340	22 to 33¢	7/1/95
Florida	$0.339	No rate change during this period.	
Pennsylvania	$0.310	18 to 31¢	8/19/91
Idaho	$0.280	18 to 28¢	7/1/94
Delaware	$0.240	19 to 24¢	1/1/91
Kansas	$0.240	No rate change during this period.	
Louisiana	$0.240	No rate change during this period.	
Ohio	$0.240	18 to 24¢	1/1/93
Oklahoma	$0.230	No rate change during this period.	
New Mexico	$0.210	15 to 21¢	7/1/93
Colorado	$0.200	No rate change during this period.	
Mississippi	$0.180	No rate change during this period.	
Montana	$0.180	18 to 19.26¢	8/15/92
		19.26 to 18¢	8/15/93
Missouri	$0.170	13 to 17¢	10/1/93
West Virginia	$0.170	No rate change during this period.	
Alabama	$0.165	No rate change during this period.	
Indiana	$0.155	No rate change during this period.	
Tennessee	$0.130	No rate change during this period.	
Georgia	$0.120	No rate change during this period.	
Wyoming	$0.120	No rate change during this period.	
South Carolina	$0.070	No rate change during this period.	
North Carolina	$0.050	2 to 5¢	8/1/91
Kentucky	$0.030	No rate change during this period.	
Virginia	$0.025	No rate change during this period.	

Sources: American Lung Association. 2001. *State legislated actions on tobacco issues,* ed. E. M. Schilling and C. E. Welch. Washington, DC: American Lung Association; The Tobacco Institute. 1998. *The tax burden on tobacco. Historical compilation,* vol. 33. Washington, DC: The Tobacco Institute.

ASSIST and non-ASSIST states.) Some municipalities also passed local ordinances levying excise taxes on tobacco products. During the ASSIST years (1991–99), cigarette excise taxes levied by municipalities in the ASSIST states ranged from 3 to 36¢ per pack. For cigars, the range was 3 to 4¢ per cigar, and for smokeless tobacco, it was 4 to 36¢ per smokeless tobacco container.[38]

Limiting Tobacco Advertising and Promotions

Cigarette advertising and promotions by the tobacco industry depict and reinforce social norms that support smoking, contribute to the social pressures on young people to start smoking, and weaken the resolve of smokers to quit. Advertising and promotions help create the impression, especially among young people, that smoking is more pervasive than it is and create misleading images of social rewards and healthfulness of smoking. The tobacco industry has systematically marketed its products to youths.[39–42] A study of 1,752 adolescents in California, from 1993 to 1996, found that 34% of teen smoking experimentation was attributable to tobacco advertising and promotional activities.[43] The tobacco industry spends billions of dollars each year on advertisements and promotions. During the ASSIST years and directly thereafter, those expenditures increased from $4.6 billion in 1991 to $8.24 billion in 1999 and $12.5 billion in 2002.[44(p1)]

There is strong evidence that advertising targeted at youth influences youth attitudes and behavior. In an *Advertising Age* survey conducted in April 1992, 325 children (8 to 13 years of age) were asked to name familiar cigarette brands; 90% named Camel.[45] Having a favorite advertisement and having a promotional item are each predictive of cigarette experimentation.[43] As Fischer and colleagues noted, "Approximately 30% of 3-year-old children correctly matched Old Joe with a picture of a cigarette compared with 91.3% of 6-year-old children."[46(p3145)] ("Old Joe" was a cartoon character featured prominently in a Camel cigarette ad campaign.)

Strategies to Limit Tobacco Advertising and Promotions

The states implemented the following types of strategies to counter tobacco advertising and promotions:

- Petition and persuade public authorities with regulatory powers to restrict or ban advertising and promotion within their scope of authority (e.g., on public transportation).
- Persuade property and business owners and managers to voluntarily reject cigarette advertising and tobacco promotion on their premises.
- Persuade civic, sports, arts, and other event sponsors, especially those events appealing to priority population audiences, to reject cigarette advertising and promotional sponsorship of such events.
- Persuade media owners and advertising managers to refuse cigarette advertising and to write editorials in support of advertising and promotion bans.
- Provide the media with evidence about the tobacco industry's advertising and promotion strategies, especially as they appeal to youth; public attitudes and actions supportive of advertising control policies; and financial ties and conflicts of interest of organizations that accept tobacco industry business and support.

Restrictions on advertising and promotions at the state or local level are difficult to achieve because of First Amendment concerns, federal preemption under the 1965 Federal Cigarette Labeling and Advertising Act, and the economic self-interest of the media in preserving advertising revenue. Fear of losing those revenues severely inhibits publishers from printing articles that openly present the hazards of tobacco use.[47] When ASSIST began, it was not entirely clear what policy actions could be implemented within the legal limits of the Constitution to restrict advertising of tobacco products. Case law on cigarette advertising and promotion has evolved over time. For some actions the states could build on precedent, but for others they had to chart new territory. For example, states and communities could bar certain forms of advertising and promotion, such as the distribution of free samples, advertising on state or municipally owned or operated subways and buses, and billboards in municipal stadiums. However, no state can ban cigarette advertising in magazines that are sold through interstate commerce. The authority of states and municipalities to bar intrastate forms of advertising, such as billboards or tobacco-sponsored music or sports events, had not been adequately tested in the courts. See table 6.3 for a listing by state of the number of municipalities that had enacted ordinances restricting tobacco advertising, as of August 25, 2003.

The ASSIST program objectives for restricting tobacco advertising and promotions sought the following four outcomes:

1. Permissible state and municipal restrictions on cigarette advertising and promotion (e.g., bans on advertising on mass transit vehicles and in municipal stadiums, billboard restrictions, bans on free samples, and action to prosecute "unfair or deceptive" cigarette advertising under state laws)
2. Substantial and progressive voluntary action by media owners and advertising managers and by sports, cultural, music, and other event managers to refuse cigarette advertising and promotion
3. Broader and more intense public and policymaker support for restraints on tobacco advertising and promotion
4. Increased levels of citizen awareness of the nature and role of cigarette advertising and promotion[1,10(p2),40]

ASSIST pursued a number of strategies to limit tobacco industry advertising and promotions. The following are some examples of direct advocacy efforts:

- Persuading property owners to prohibit tobacco advertising on billboards in ballparks and on posters at convenience stores near schools
- Persuading sponsors of cultural and sports events to reject tobacco advertising opportunities

With respect to media advocacy, ASSIST staff worked to expose and draw attention to factual omissions and distortions in tobacco advertising and media coverage. Though lacking the resources for an effective paid countermarketing campaign, ASSIST staff did respond opportunistically to tobacco media ads by seeking and gaining media coverage that highlighted the health

Table 6.3. Number of Municipalities per State with Advertising Ordinances, as of August 25, 2003
(Shading indicates ASSIST states.)

State	Total	Location/ Zoning	Public Transit	Retailer Restrictions	Tombstone Exemption
California	48	45	6	36	22
Massachusetts	29	6	25	2	0
New York	20	13	7	14	4
New Jersey	6	5	0	5	1
Oregon	6	0	0	6	0
Florida	4	0	1	2	0
Michigan	4	3	1	0	1
Washington	4	4	2	1	2
Colorado	2	2	0	2	0
Connecticut	2	2	1	2	1
Hawaii	2	2	0	1	0
Maryland	2	2	0	0	1
Minnesota	2	2	0	2	2
Missouri	2	1	1	0	0
Ohio	2	2	1	1	1
West Virginia	2	2	0	0	0
Wisconsin	2	2	0	1	1
Alaska	1	0	1	0	0
Arkansas	1	1	0	1	0
Illinois	1	0	1	0	0
Indiana	1	1	0	0	0
Maine	1	0	0	0	0
Oklahoma	1	1	0	0	0
Pennsylvania	1	1	0	0	1
Rhode Island	1	1	0	0	0
Texas	1	1	0	0	0
Alabama	0	0	0	0	0
Arizona	0	0	0	0	0
Delaware	0	0	0	0	0
District of Columbia	0	0	0	0	0
Georgia	0	0	0	0	0
Idaho	0	0	0	0	0
Iowa	0	0	0	0	0
Kansas	0	0	0	0	0
Kentucky	0	0	0	0	0
Louisiana	0	0	0	0	0
Mississippi	0	0	0	0	0
Montana	0	0	0	0	0
Nebraska	0	0	0	0	0
Nevada	0	0	0	0	0
New Hampshire	0	0	0	0	0
New Mexico	0	0	0	0	0
North Carolina	0	0	0	0	0
North Dakota	0	0	0	0	0
South Carolina	0	0	0	0	0
South Dakota	0	0	0	0	0
Tennessee	0	0	0	0	0
Utah	0	0	0	0	0
Vermont	0	0	0	0	0
Virginia	0	0	0	0	0
Wyoming	0	0	0	0	0

Source: ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003. American Nonsmokers' Rights Foundation. All rights reserved.

Note: Because some municipalities have coverage in more than one category, the numbers are not mutually exclusive.

Access, Availability, and Restriction

The terms *access, availability,* and *restriction* are defined as follows for the purposes of this discussion of policy interventions for tobacco control.

Access refers to the ease or difficulty with which an individual can obtain tobacco products. ASSIST sought to make it more difficult for individuals, especially minors, to purchase tobacco in the community.

Availability refers to where tobacco products can be purchased or acquired in the community and where they are placed with stores. ASSIST sought to limit the locations where tobacco products can be obtained.

A *restriction* is any public or private policy, mandatory or voluntary, that reduces the use, possession, promotion, access, or availability of tobacco products in a given location.

consequences of tobacco use. The literature on the effectiveness of mass media campaigns suggests that this type of countermarketing increases awareness of the health consequences of tobacco use but does not result in behavior change.[48] The goal of ASSIST staff efforts in this context was simply to increase awareness.

Reducing Minors' Access to Tobacco Products

The main purpose of establishing and effectively enforcing restrictions on minors' access to tobacco products is to decrease the number of adolescents who initiate smoking. Almost 90% of all adult smokers started smoking before age 18.[49] As of 1989, more than 3 million American children under the age of 18 consumed an estimated 947 million packs of cigarettes and 26 million containers of smokeless tobacco yearly.[41] Policies that reduce the access of minors to tobacco products, especially the purchase of those products, create barriers to early experimentation and reinforce a social norm that disapproves of smoking by children and adolescents.

When ASSIST began, 49 states and the District of Columbia had laws that made it illegal to sell tobacco products to minors, but few, if any, of these laws were being enforced. A 1990 report of the inspector general of the Department of Health and Human Services found that these laws were ineffective in preventing the sale of tobacco to minors, as confirmed by studies demonstrating the ease with which minors obtained tobacco.[50]

Restrictions on youth access work best when they are introduced as part of a multifaceted, comprehensive strategy that includes interventions designed to address the appeal of tobacco to minors. These include interventions addressing tobacco advertising and promotion, adult modeling of smoking in public places, smoking by adult role models, and other environmental cues and social norms that youths encounter daily in adult society. In one study, the authors considered the very process of intensive community organizing as an important context for the effects of local policies and their enforcement.[51]

The ASSIST program objectives for tobacco access and availability policy sought the following four outcomes:

1. State, municipal, and private action restricting the access and availability of tobacco products, such as eliminating the sale of tobacco in

smoke-free areas (e.g., hospitals, pharmacies) or on municipal property and moving all tobacco products behind the counter
2. Substantial and progressive voluntary action by retailers to observe existing restrictions on the access to and availability of tobacco products
3. Broader and more intense public and policymaker support for restrictions on, enforcement of, and improvement in regulations on the access to and availability of tobacco products
4. Increased levels of citizen awareness of the access to and availability of tobacco products

The ASSIST states implemented a broad array of strategies to reduce minors' access to tobacco. The states promoted strengthening access laws, adopting laws that require tobacco retailers to obtain licenses, and restricting sales—for example, requiring that retailers move tobacco products from self-service displays to vendor-assisted displays, prohibiting the sale of single cigarettes, and prohibiting point-of-purchase displays. (See table 6.4.) The strategies included persuading hospitals, pharmacies, and public places frequented by minors (e.g., schools, sports arenas, movie theaters) to voluntarily limit or eliminate the sale or free distribution of tobacco on their premises. Also, as with all policy interventions, the coalitions provided the media with information supporting the effectiveness of access restrictions.

More important, the coalitions took actions to ensure compliance with these laws. For example, in cooperation with law enforcement and regulatory agencies, minors participated in compliance checks. The coalitions also implemented programs to educate vendors about the restrictions. The ASSIST states were able to intensify their efforts in this policy area because of efforts by two other federal agencies—the Food and Drug Administration and the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration—to reduce youth access to tobacco. (See chapter 9.)

Challenges to Public Policy Interventions

Throughout the process of advocating for tobacco control policies, ASSIST advocates encountered opposing efforts by the tobacco industry, some major and some minor. The strength of that opposition reflected the high stakes at risk for the tobacco industry. As noted by Tina Walls of Philip Morris, "Financial impact of smoking bans will be tremendous. Three to five fewer cigarettes per day per smoker will reduce annual manufacturer profits a billion dollars plus per year."[52(p4)] The chief barriers posed by the tobacco industry to the ASSIST efforts, as identified in monograph 11 of NCI's monograph series on smoking and tobacco control, were discrediting research; enlisting front groups for smokers' rights; and promoting ineffective alternatives, legal challenges, and preemptive legislation.[20] (See chapter 8 of this monograph for a recent analysis of the tobacco industry's documents and a categorization of eight strategies to interfere with the ASSIST project.)

Table 6.4. Number of Municipalities per State with Youth Access Ordinances, as of August 25, 2003

(Shading indicates ASSIST states.)

State	Total	Vending Machine	Sampling	Licensing	Self-Service Displays	Single Cigarette Sales	Use/ Possession/ Purchase
Massachusetts	225	218	180	199	174	174	18
New Jersey	222	196	2	16	87	2	53
California	197	185	47	34	123	48	5
Minnesota	192	172	11	161	127	72	105
Illinois	138	62	59	68	11	11	124
Missouri	61	17	12	7	6	8	28
Colorado	42	20	2	3	13	6	35
Florida	42	26	0	0	40	0	2
Wisconsin	35	14	4	11	1	11	23
Ohio	23	16	5	6	5	5	15
Oregon	22	11	0	8	22	1	0
New York	21	17	5	3	16	1	2
Pennsylvania	18	14	0	1	2	1	3
Michigan	15	11	1	4	1	0	5
Texas	14	10	3	0	3	1	6
Connecticut	13	11	0	1	3	0	0
North Dakota	13	13	0	10	7	0	11
Arizona	11	11	0	1	7	0	1
North Carolina	11	2	0	0	0	0	0
Kansas	9	4	2	1	3	3	5
Maryland	9	9	2	0	7	1	0
Rhode Island	7	2	0	3	1	1	4
Utah	7	6	0	0	7	0	0
Alabama	6	5	0	0	0	0	1
Maine	6	4	1	1	5	0	0
Nebraska	6	2	1	1	2	1	4
Washington	6	6	3	4	1	3	2
New Mexico	4	4	2	0	4	4	3
Georgia	3	1	1	0	0	0	1
West Virginia	3	2	0	0	0	0	2
Hawaii	2	0	2	0	0	0	0
Indiana	2	0	2	2	0	0	0
Iowa	2	0	0	1	0	0	0
Louisiana	2	1	0	0	0	0	0
Mississippi	2	0	0	0	0	0	1
Oklahoma	2	0	1	0	0	1	2
Wyoming	2	1	0	0	0	0	2
Alaska	1	1	0	1	1	1	1
Arkansas	1	1	1	0	0	0	1
District of Columbia	1	1	1	1	0	0	0
Montana	1	1	1	0	0	0	1
Vermont	1	1	1	0	1	0	0
New Hampshire	1	1	0	0	0	0	0
Delaware	1	0	0	0	0	1	0
Idaho	0	0	0	0	0	0	0
Kentucky	0	0	0	0	0	0	0
Nevada	0	0	0	0	0	0	0
South Carolina	0	0	0	0	0	0	0
South Dakota	0	0	0	0	0	0	0
Tennessee	0	0	0	0	0	0	0
Virginia	0	0	0	0	0	0	0

Source: ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003 American Non-smokers' Rights Foundation. All rights reserved.

Note: Because some municipalities have coverage in more than one category, the numbers are not mutually exclusive.

Discrediting the Science

The tobacco industry's efforts to discredit research are evident in its opposition to the U.S. Environmental Protection Agency's (EPA's) report on the respiratory and other health effects of passive smoking.[53] The EPA report presented a meta-analysis of studies on the health effects of environmental tobacco smoke.

The tobacco industry objected to the scientific analysis the EPA conducted[54] and referred to the EPA report as "junk science."[55,56] Tobacco industry documents that became public in the late 1990s during litigation indicate the industry's intent:

> OBJECTIVES
>
> Our overriding objective is to discredit the EPA report and to get the EPA to adopt a standard for risk assessment of all products. Concurrently, it is our objective to prevent states and cities, as well as businesses from passing smoking bans. And finally, where possible we will proactively seek to pass accommodation legislation with preemption.
>
> STRATEGIES
>
> To form local coalitions to help us educate the local media, legislators and the public at large about the dangers of "junk science" and to caution them from taking regulatory steps before fully understanding the costs in both economic and human terms.[57(Bates no. 2021183916)]

—Memo from Ellen Merlo (VP, Philip Morris USA Corporate Affairs) to William Campbell (Chairman, Philip Morris USA)

During the public comment period on the EPA report, 71% of submissions claiming the conclusions to be invalid were from individuals affiliated with the tobacco industry.[58] Immediately, after the report was released by the EPA, six tobacco-related organizations filed a lawsuit against the EPA[59] in the U.S. Court of the Middle District of North Carolina Winston-Salem Division. The tobacco industry groups argued that the EPA had exceeded its authority, had violated administrative law procedure, and that the risk assessment was flawed and not the result of reasoned decision making. The lower court ruled in favor of the industry, but a federal appeals court reversed the decision in December 2002. Nevertheless, ASSIST staff found that the publicity given to the industry's claims about the science behind tobacco use confused the public, making it more difficult to promote clean indoor air legislation.

Ineffective Alternatives

The tobacco industry continues to promote its own alternatives to the public health community's tobacco prevention and control programs. Past tobacco industry alternative programs include "Accommodation" and "Red Light-Green Light," which supported smoking in designated public areas; "Helping Youth Say No" and "Right Decisions, Right Now," designed for parents and schools; and Philip Morris's 1998 youth smoking prevention campaign, "Think. Don't Smoke."

These alternatives stimulated research into their efficacy. A limited, but growing body of evidence suggests that these tobacco industry programs were ineffective. For example, focus group research conducted by Teenage Research

Unlimited,[60] a marketing firm that specializes in the teenage market, concluded that the "Think. Don't Smoke." campaign "does not appear to offer any compelling reason for [at-risk] teens not to smoke. Therefore, campaigns should not be developed with a 'choice' theme as a key foundation."[60,61]

Preemption

Preemption is a mechanism by which a higher level of government asserts exclusive jurisdiction over an area of policy. Preemption clauses remove or limit the authority of lower levels of government to enact or enforce legislation that is stronger than the state law in the policy area preempted. Preemptive legislation is perhaps the strongest challenge to effective public policy intervention and can lead to unanticipated and costly litigation.

In the mid-1980s, faced with an increasing number of effective local tobacco control ordinances, especially in the area of ETS and clean indoor air, the tobacco industry launched a major effort to pass preemptive laws aimed at legislatures at the state level.[62–64] Later, after the 1992 EPA report (*Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*) was released, some boards of health banned smoking in public places, and the industry used preemption to challenge the authority of the boards and other local governing bodies to enact smoking regulations.[65] By 1998, a total of 30 states—12 of which were ASSIST states—had enacted some form of preemptive legislation, including 14 laws preempting local ordinances on clean indoor air, 22 laws preempting local ordinances on youth access to tobacco, and 17 laws preempting some or all types of local restriction on tobacco advertising and promotion.

Internal Tobacco Industry Documents Confirm the Power of Local Measures

"By introducing pre-emptive statewide legislation we can shift the battle away from the community level back to the state legislatures where we are on stronger ground."

—Tina Walls

Source: Walls, T. CAC presentation #4, draft. Philip Morris. July 8, 1994. http://legacy.library.ucsf.edu/tid/vnf77e00. Bates no. 2041183751–3790.

The threat of preemption drew varied responses from different communities. In North Carolina, the threat of preemption in the summer of 1993, when ASSIST was to enter its intervention phase, prompted 89 communities to hold public hearings and fast-track smoking control rules passed mostly by local boards of health over a 3-month period. A legal challenge to the authority of the boards of health to regulate smoking in public places subsequently invalidated the enforcement of 88 of the 89 local rules. The issue was that the ordinances exceeded the authority of the boards of health, which were appointed rather than elected. The only rule that withstood the challenge was in Durham County. In Durham County, not only the board of health but also the Durham City Council and the Durham County Commissioners passed the ordinance during the 3-month interval before the preemption law took effect.[66] The first state to repeal preemp-

tion of tobacco control was Maine (an ASSIST state), which restored local control over tobacco displays, placement, and time of sale provisions in 1996 (the preemptive language was included in a youth access bill passed a year earlier).[67] In 2002, Delaware became the first state to repeal preemption of local clean indoor air ordinances, simultaneously adopting a comprehensive smoke-free state law.

Insights from Policy Advocacy Experiences

The overall experience of the 17 ASSIST states was that policy change—resulting from community education, grassroots mobilization, and media advocacy—is a powerful tool in reducing tobacco use and tobacco-related disease. Stillman et al., in their evaluation of ASSIST, concluded that "investment in building state-level tobacco control capacity and promoting changes in tobacco control policies are effective strategies for reducing tobacco use."[35(p1681)]

The enactment of new policies or changes in existing policies regarding any issue typically result from advocacy processes that involve challenges from those with opposing views. In the case of advancing tobacco control policies, these challenges are almost always strong and well organized. To be successful in bringing about tobacco control policies, advocates must be prepared not only to propose the policies, but also to endure substantial opposition. Furthermore, as described in chapters 3–5, not only the advocates but also the community must be involved and ready to support and defend the policies. Advocates must have a clear concept of the specific policy desired, the ability to present persuasive reasons for supporting the policy, messages and approaches tailored to specific individuals and population groups, and a realistic strategic plan that pulls together community resources.

Presented in this chapter are 14 insights that the authors derived from the experiences of ASSIST staff and coalition members working in the field to promote tobacco control policies. Many of those insights are illustrated with case studies shared over the ASSIST years and from formal presentations at conferences. These insights are told in the words of those who were personally involved and reflect their experience. The case studies illustrate how, through persistence and with creative strategies, the ASSIST staff and coalitions met many of the challenges to their policy intervention efforts. As historical experiences, the case studies reflect the environment at the time, especially the legal environment, which has changed during the past several years. The insights are sequenced from broad principles of policy advocacy, to specific tactics, to implications for the future.

Insight 1: Most Policymakers Want to Do the Right Thing for the Public's Health, but the Right Thing Must Be Explained and Promoted to Them by Their Constituents

> They don't see the light until they feel the heat.
>
> *—A lobbyist's insight*

A Leadership Taxonomy*

It takes more than one leader, or one type of leader, for a community to achieve its goals.

The *Visionary* challenges conventional views of the possible, aims high, takes risks, and rethinks priorities.

The *Strategist* thinks backward from the goals to the means to achieve the goals, sorts out what is realistically attainable, and develops the road map to get there.

The *Statesperson* carries the movement's flag, is the "bigger than life" public figure who embodies authority and respect, lends credibility, and is widely known and respected beyond the movement.

The *Expert* provides a solid foundation of science and makes it known through peer-reviewed writings and authoritative public statements.

The *Inside Advocate* knows the most effective intervention points: how to open doors, to confront decision makers, to feel out the arguments that resonate with them, to press them in ways that cannot be dismissed, and to negotiate the tribute that must be paid.

The *Strategic Communicator* is the public teacher, the master of the sound bite, and translates complex scientific data, public policy, or basic concepts of truth and justice, into powerful metaphorical messages.

The *Movement Builder* successfully resolves conflict, bridges ego and turf, opens up lines of communication, and squashes rumor and innuendo. Movement builders are facilitators; they bring people, especially the "insiders" and "outsiders," together, to explore differences through civil discourse and debate.

The *Outside Sparkplug* is an agitator, an unabashed teller of truth, a leader outside the conventional, political establishments, free of the ties that bind "inside" players, and capable of holding governments and organizations to their own rhetoric of mission and commitment.

Source: Pertschuk, M. 1999. *A leadership taxonomy.* Washington, DC: Advocacy Institute.

*See Insight #5, page 196.

Reversing the social acceptance of tobacco use requires educating the public and policymakers about tobacco's serious health and economic threats not only to the individuals who use tobacco, but also to their families, friends, and communities. That educational process must be ongoing because new generations must also understand the health and economic issues associated with tobacco use.

Educating the public and policymakers about why policies should be enacted to protect the public health was a major undertaking of the ASSIST coalitions. Policymakers, especially at the local level, care about the opinions of their constituents. In numerous communities, ASSIST coalitions presented to their city councils the scientific evidence of the health consequences of smoking. The council members listened, and some passed ordinances restricting environmental tobacco smoke.

One must make some educational efforts in person to be effective with policymakers, but the media can also attract policymakers' attention. Many policymakers regularly rely on the editorial pages to take the pulse of the community. Editorials can make an appealing case

by presenting a solution and by making a practical policy appeal. Other types of media coverage can also attract attention. For example, in 1995, a social studies teacher introduced her fifth-grade class to a fact that she learned from ASSIST. As a class project, the class took out a classified ad in *USA Today* asking, "Each year, what kills more people than AIDS, alcohol abuse, car accidents, murders, suicides, illegal drugs, and fires combined?" The answer—cigarette smoking—drew nationwide media coverage about the hazards of tobacco use and earned attention for the class that conducted this media experiment.

Case study 6.1 shows how knowledgeable teenagers made a direct appeal to policymakers for their own health and won over the county council.

Insight 2: The Process of Laying the Groundwork for Policy Change Can Be as Important as the Policy Itself

Critical to success in passing tobacco control policies, especially at the local level, is laying the groundwork for change through a well-planned process of community education and mobilization. The elements of the process are raising the community's awareness about the issues involved, educating residents about the benefits of the policy, changing community norms, and paving the way for smooth implementation and enforcement of the policy. When community support for a policy is ensured, a campaign for policy change can be launched, and it can be strengthened with media advocacy for the policy. Media coverage of an issue is important when advocating for policies that depend on changes in a population's attitudes and, eventually, in the social norm. Media coverage can build community support for a policy initiative; it can influence the way that individuals think about an issue, which eventually influences social norms.

Laying this groundwork is time consuming and requires patience; however, without the groundwork, the proposed policy is not likely to move forward or be well received even if it is passed. In fact, the groundwork may be even more important than the policy outcome. The very process of debating a proposed policy influences social norms by drawing attention to the issue. Thus, even if the proposed policy is defeated, the effort put into advocating for it will not have been wasted, since community attitudes and norms will have been influenced. In a way, the adoption of the policy is the ratification of an already-occurring change in attitude and possibly norms. Without community support, if a policy is somehow enacted, it may be ignored or resisted as well as difficult to enforce.

A mistake that well-meaning individuals might make is to push prematurely for policy change. For example, a legislative sponsor or individual advocate might independently introduce a policy, anticipating little or no opposition. If opposition arises from the tobacco industry and its allies, the sponsor and other policymakers might quickly back off. Without the visible support of the community and the media, the policymakers are not likely to withstand the opposition. The net result is that not only is the policy initiative defeated, but it also becomes

Case Study 6.1
Kids Make Crucial Appeal to Policymakers in St. Louis County

Situation: In 1995, 75% of the tobacco retailers in St. Louis County, Missouri, were selling tobacco products to children younger than 17 and were not asking for proof of age. The St. Louis ASSIST Coalition wanted to curb teen smoking by taking a stand on youth access to tobacco.

Strategy: The coalition sought to persuade the county council to pass a countywide ordinance covering all 92 municipalities. The only way to avoid a public vote in each municipality was to give the St. Louis County Department of Health and its health inspectors the authority to collect the license fees and enforce the ordinance throughout St. Louis County.

Intervention: The first step toward passing this ordinance involved raising the awareness of the legislators and educating them about how tobacco affects the health of children. In September 1995, six coalition members explained the magnitude of the tobacco problem in St. Louis County to four members of the St. Louis County Council. They reported that the legislators appeared startled by their presentation.

The coalition members proposed a youth access ordinance that would require licensing every retail tobacco vendor in St. Louis County. That week, a council member agreed to be the principal sponsor and began writing an ordinance. The coalition furnished him with sample ordinances from other cities. From that council member, the coalition learned which council members would likely oppose the ordinance. The coalition's allies—the American Cancer Society, American Heart Association, American Lung Association, National Council on Alcoholism and Drug Dependence, and the St. Louis Clergy Coalition—then conducted a letter-writing and telephone campaign in the ZIP-code areas of the resistant council members to urge them to support the youth access ordinance.

Two public hearings were held in January 1996. Anticipating strong opposition to the ordinance from retailers and their tobacco industry associates, the coalition leaders invited people who were knowledgeable about tobacco issues and could maintain a focus on children's health to testify. Most important, the American Cancer Society van picked up students at the various high schools for their "day in court."

Testimonies, discussions, and arguments continued for 2 hours before the first youth advocate took the podium. He was a 13-year-old who had participated in compliance checks and eloquently explained how easy it was for underage youth to purchase cigarettes from gas stations, convenience stores, bowling alleys, and, especially, vending machines. A healthy-looking 17-year-old smoker who wanted to quit smoking was called next. His story of addiction began at age 14 when a friend gave him a cigarette. At that time, he wanted only to look cool, but now he was hooked on cigarettes. A 16-year-old girl explained how the tobacco industry confused younger

children through its advertising on the numerous billboards in residential areas, in grocery stores, and in gas stations. She said that it seemed to her that children were receiving the message "smoking can't be that bad if it is sold legally in stores everywhere."

Only these students spoke, but they were supported by the presence of dozens of other students in the room. When they spoke, the room was silent. Two months of revisions and amendments to the ordinance followed. In the meantime, the nonprofit organizations wrote letters and made phone calls to the most resistant council member.

Results: On April 4, 1996, the St. Louis County Council approved the toughest youth access ordinance in Missouri. The resistant council member made a 180-degree turn and became the cosponsor of the ordinance. That afternoon, the St. Louis county executive signed the ordinance into law, which became effective on July 1, 1996. After the St. Louis County youth access ordinance was passed, many municipalities and school districts strengthened their existing tobacco policies. Tobacco and children's health had finally become a serious issue worthy of discussion at city council meetings throughout the area. Again and again, it was the children who made the policymakers understand what was the right thing to do.

Source: Adapted from P. Lindsey. 1997. Kids are crucial for local ordinances. In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 79–82. Rockville, MD: ASSIST Coordinating Center.

much more difficult to revisit it in the future. Policymakers may be reluctant to get involved again on the same issue later on.

Laying the groundwork by increasing awareness is illustrated in case study 6.2. The purchase of counteradvertising opened the doors of the sports stadiums to a community and closed them to smoking.

Insight 3: Policy Change Is Political; Therefore, Boundaries Must Be Defined and Redefined

> You don't need a weatherman to know which way the wind blows.
>
> —*Bob Dylan*

Policy is made within complex social and political contexts. Policy advocacates must be aware of the agendas and missions of all relevant individuals and organizations. In a state tobacco prevention initiative, it is very important to establish a clear division of tasks among partner organizations and to obtain consensus among the partners on this arrangement. As part of this process, individuals and organizations should be assigned roles that are within their competence and legal capacity, including any real or perceived restrictions that are attached to their sources of funding. One should also take care to avoid inadvertently doing anything to restrict these individuals and organizations' freedom of

Case Study 6.2
Tobacco and Sports Don't Mix in Virginia!

Situation: In its initial tobacco control plan, Virginia's ASSIST staff and coalitions set an objective to change smoking policies in stadiums. The campaigns were to be designed by the state coalition's media committee with a focus on preventing tobacco use by youths. Focusing the message on youths rather than on the total population was an acceptable approach in a tobacco-growing and -manufacturing state.

Strategy: The approach was to identify partners within existing sports programs and organizations through which the coalition could channel tobacco control messages.

Interventions and Results: In 1995, the coalition approached seven minor league baseball stadiums in Virginia to discuss advertising within the stadiums as a mechanism to counter tobacco use messages. None of the stadiums was willing to donate ad space, but all seven accepted paid counteradvertising; two required that the ads focus strictly on prevention of tobacco use by youths. At several stadiums, counteradvertising in event programs and billboards was expanded to include sponsoring a youth tobacco prevention day at the ballpark. The community response was overwhelmingly positive.

In 1996, coalitions leveraged their status as advertisers to work on policy change. They offered to help the management develop no-smoking policies and presented a comprehensive package for implementation. The package included cards and buttons for ushers; messages for scoreboards, message centers, and announcements; signs for seating areas; and a message to be printed on tickets and/or ticket envelopes to promote the new policy.

The managers were receptive to policy change, and by 1997, three stadiums adopted 100% smoke-free seating polices, and the other four adopted smoke-free family sections.

The early successes with minor league stadiums led coalitions to focus on developing similar projects in high school stadiums. They worked with students to develop advertisements that were placed in sports programs for football and basketball games and wrestling matches. Students who had been through advocacy training encouraged their schools to expand smoke-free policies to include athletic stadiums. Several groups had success and held celebrations to inform the community of the change. One such activity, Sack the Pack, occurred as a partnership with a local television sports department.

Over the next several years, coalitions throughout the state expanded their sports initiatives. In one region, a coalition recruited the general manager of a minor league baseball team to become active in the coalition's efforts. His involvement led to a decision to remove a lifesize advertisement of the Marlboro Man from the team's

stadium when the contract expired. In another region, the department of parks and recreation was instrumental in persuading regional and national youth baseball events to be tobacco free.

The state coalition created a partnership with the Hampton Roads Mariners, a semiprofessional soccer franchise. Coalition members worked with the management to ensure that the team's new stadium opened smoke free. The team was pleased with the support that they had received and asked for assistance to promote a tobacco-free message through its Kids' Club packets and autograph day.

Source: Adapted from M. White. 1999. Tobacco and sports don't mix! In *Tobacco free future: Shining the light* (Case studies of the fifth annual national conference on tobacco and health, August 23–25, 1999), 29–32. Rockville, MD: ASSIST Coordinating Center.

action. Partners should not accept funds that restrict their ability to use a wide range of advocacy tools.

Advocates working for policy change are almost invariably called upon to make adjustments or compromises to get their policies adopted. Advocates must determine which concessions are and are not acceptable. Tension may arise on this point between the perspectives of leaders at the state or community level and those of experienced national tobacco control advocates. For example, a community that lacks any smoking regulations might perceive a proposed clean indoor air ordinance that contains numerous exemptions as taking a significant step forward, whereas national advocates might view the measure as setting a bad precedent for other communities.

There is no easy resolution to this issue. However, general principles that should be followed include advocating for the maximum degree of policy change possible, never accepting a measure that actually weakens existing policy, never accepting preemptive legislation, and balancing the lessons learned in other communities against the unique circumstances of the community in question and the perception by community members of what is possible. Veteran advocates should help the local coalition or advocacy group understand the potential implications and pitfalls under consideration so that they can make an informed decision. This is especially true because provisions in fine print that look innocuous on paper can severely undermine a policy in practice. For this reason, legal expertise early in the planning stage is very important. It is important that people at the local level consider input but make the final decision. When sharing policy case studies and model policies, one should take care to highlight the local context and potential risks, pitfalls, and loopholes. Perhaps most important, the coalition or an advocacy organization should discuss and reach consensus from the start about which concessions it is and is not willing to accept—in other words, its nonnegotiable bottom line.

Insight 4: United, We Succeed

> When spider webs unite, they can tie up a lion.
>
> —*Ethiopian proverb*

The combined assets of a public-private partnership and the ability to activate a range of state and local coalitions were strengths of the ASSIST model. The public sector partners (state health departments) have the legitimacy and expertise associated with government programs. Their public policy responsibilities include the presentation of information and statistics about the health problem being addressed, educating the public about evidence-based interventions and how public policies affect the public's health, policy analysis and scientific review of various policy options, and policy development (in some states and in some policy arenas, the authority of policy enforcement). In addition, state agencies have organizational or contractual relationships with local educational agencies.

ASSIST's formal partner from the private, voluntary health sector—the ACS—has a compatible mission to recognize and promote cancer prevention and control. In 1991, ACS had a local volunteer network of approximately 1 volunteer per 1,000 population.[68,69] ACS and all public charities—501(c)(3) organizations—are allowed by the Internal Revenue Code to expend significant portions of their operating budgets on lobbying.[7]

Mobilization of these grassroots networks toward a priority policy goal can be a powerful tool. However, this was not always easy to achieve. In some states, other voluntaries were more committed and better prepared than ACS. Moreover, dissension among the voluntaries and between the voluntaries and the state health departments sometimes inhibited collaboration. Nongovernmental partners became quite frustrated from their dealings with the bureaucratic constraints and restrictions on the use of federal funds.

State and local tobacco control coalitions played a crucial role in the policy successes of the ASSIST states. In fact, community coalitions probably made the single most important contribution to policy change in these states. In addition to successfully spearheading local policy initiatives, they were also instrumental in mobilizing grassroots support for beneficial state legislation (e.g., increases in state cigarette excise taxes, retailer licensing, and allocation of Tobacco Master Settlement Agreement funds to tobacco control) and in opposing harmful state legislation (e.g., bills preempting local authority to enact clean indoor air, youth access, and advertising ordinances). Working in tandem, though not always without tension, these diverse partners drew on their complementary strengths to win a series of significant policy victories at the local and state levels and, in the process, to dramatically influence social norms.

Case study 6.3 shows how bonds of trust among organizations and community members serve all involved when the right issue or moment arrives. Involving the African American clergy of St. Louis in an effort to eliminate tobacco billboard advertising from all neighborhoods especially benefited African Americans,

Case Study 6.3
ASSIST Unites with Faith Leaders to Ban Tobacco Advertising in St. Louis

Situation: A strong bond of trust had been established between ASSIST staff in Missouri and the St. Louis Clergy Coalition, a network of African American ministers and priests who represent 47,000 congregation members from 13 religious denominations in 109 churches in St. Louis. They had worked together successfully on tobacco control initiatives. With that trust in mind, the St. Louis ASSIST coalition invited the clergy coalition to collaborate on a project to eliminate tobacco advertising from all residential areas in St. Louis.

Strategy: The strategy was for the clergy coalition to add its influence to a proposed ordinance to ban tobacco billboard advertising and to draw media attention to the initiative.

Intervention: A press conference kicked off the campaign to ban tobacco billboards. World No Tobacco Day was on a Sunday, so the press conference was held in an inner-city African American church at 3 p.m., after church services and before the 5 p.m. television news deadline. Representatives from the St. Louis Clergy Coalition, the Mound City Medical Forum, the American Cancer Society, the St. Louis Catholic Archdiocese, and ASSIST staff, as well as a teenage boy, spoke at the press conference. The St. Louis ASSIST media consultant assisted in preparing speeches for them, which covered different facts and emphasized how often children are exposed to tobacco advertising in neighborhoods. As in other cities, tobacco billboards were far more common in poor African American neighborhoods than in white neighborhoods.

The media arrived in full force, and the story of the ministers' commitment to getting an ordinance passed became the lead news story on three major television stations at 5 p.m. and 10 p.m. The visuals on the television newscasts were the billboards located on almost every corner on the streets surrounding the church. The next day, the faith leaders' commitment to ban tobacco billboards in St. Louis City made the front page of the *St. Louis Post-Dispatch*, and the day after that, it was the subject of a *Post-Dispatch* column. The story was also covered several times on radio stations KMOX-AM and KTRS-AM.

Without delay, the faith leaders contacted an African American member of the Board of Aldermen and asked her to sponsor the ordinance to ban tobacco billboards. She willingly agreed, and a meeting was set to discuss the language of the ordinance and to plan the strategy for getting the ordinance passed. The proposed ordinance stated that tobacco advertising could remain on interstate highways but would be eliminated from all residential areas. The sponsor said that she would introduce the bill in committee the following week and get the bill passed before the legislative session ended in 5 weeks.

Case Study 6.3 (continued)

On the day that the ordinance was read in the Legislation Committee, members of the local coalition showed up at city hall in large numbers to show community support and to testify. Radio and television reporters covered the hearing. The committee approved the bill 7–0. Following the vote, several other committee members quickly approached the sponsor of the bill and asked to sign on as cosponsors.

Results and Insights: On Friday, July 17, 1998, the bill was debated before the full membership of the Board of Aldermen. On the final day of the legislative session, the 24 aldermen who were present gave their final vote on the tobacco-advertising ordinance. It passed 24–0.

The faith leaders' involvement strengthened the St. Louis coalition. The faith leaders knew that they had powerful influence in their communities, and they were pleased to learn another way they could wield that power. The mutual effort for tobacco control demonstrates what coalition really means—a union for a common purpose.

Much of the success of this project was the result of some excellent advice from a credible political consultant and a skilled attorney, the ability of the ASSIST coalition members to do much of the background for the faith leaders, and good timing.

Source: Adapted from P. Lindsey. 1998. Faith leaders ban tobacco advertising. In *No more lies: Truth and the consequences for tobacco* (Case studies of the fourth annual national conference on tobacco and health, October 26–28, 1998), 77–81. Rockville, MD: ASSIST Coordinating Center.

whose neighborhoods had a disproportionate share of undesired tobacco billboard advertising.

Insight 5: Develop the Necessary Skills among Various Leaders to Advance a Winning Combination of Activism, Advocacy, and Diplomacy

Leadership is not one-dimensional or static in the ASSIST model. The most effective coalitions used a synergistic and well-timed combination of activism, advocacy, and diplomacy. The Advocacy Institute's *A Leadership Taxonomy* (see sidebar, page 188) reflects the types of leaders required by a movement to achieve its goals, and these were present among the tobacco control practitioners working with ASSIST. The organizational affiliations of the individuals who fill these roles may vary, as long as the organizations' restrictions do not prevent these individuals from performing the functions necessary to their roles. The important consideration is whether the right person is in the right role at the right time. An individual's role should match his or her actual skills (not self-perceived skills) and comfort level. Finally, the individuals involved must commit adequate time to fulfill the responsibilities of their roles. Case study 6.4 illustrates how the commitment by the right people in the right roles made it possible to lead the Las Cruces, New Mexico, community

Case Study 6.4
Filling the Roles in Las Cruces, New Mexico

Situation: In 1995, when the first comprehensive clean indoor air ordinance in New Mexico—the Las Cruces Clean Indoor Air Ordinance—was under consideration, the Las Cruces tobacco control coalition was cochaired by two individuals. One, a health educator and member of the regional health department's health promotion team, was a native of Las Cruces who knew the community very well and was respected by community residents. The other, a retired pharmacologist and toxicologist whose research had focused on tobacco and who had recently moved to Las Cruces, brought a different kind of credibility to the table: the credibility that derived from his technical expertise. He conveyed this expertise powerfully in his testimony before the city council at key junctures in the debate about the ordinance.

Strategy: These two individuals complemented each other well. The retired academician was essentially irrefutable in his presentation of the scientific evidence about the health risks posed by environmental tobacco smoke and was not afraid to be confrontational when necessary. The health educator, in contrast, was adept at community outreach and drew on his community organizing skills, knowledge of the community, and acceptance within the community to identify and recruit potential allies.

Intervention: Both these individuals were fully committed to the cause and were able to work full-time on the ordinance campaign for long stretches. The health educator, though not in a categorical tobacco control position, recognized the importance of this opportunity to protect the public's health, while the academician, having retired, had time available to devote to the effort.

Results: The contributions of several other key figures further complemented those of the retired academician and the health educator. The director of a local public-housing-authority youth program recruited, trained, and mobilized a cadre of youth tobacco control advocates who had a major impact on the city council. Several other core coalition leaders, working as a team, set the overall strategy for the efforts to pass, defend, and strengthen the ordinance. The regional ASSIST field director and the New Mexico ASSIST program staff as a whole also played a number of important roles by providing the coalition with staff support and technical assistance that linked the coalition to external resources; coordinating its media advocacy efforts; providing education and testimony about the health risks posed by exposure to secondhand smoke; and overseeing the development, maintenance, and evolution of the coalition (including recruiting new members and facilitating leadership transitions). Without capable, appropriate persons to fill these essential, complementary roles, the ordinance could not have been adopted and sustained.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

in successful efforts to pass a clean air ordinance.

Insight 6: Shining Light on the Tobacco Industry's Tactics Can Help Advocates Achieve Policy Goals

> Sunlight is the best disinfectant.
> —*U.S. Supreme Court Justice Louis Brandeis*

Introducing or changing policies, whether government regulations or private sector guidelines, is a political process, and stakeholders with opposing views are likely to challenge those policies. As detailed in chapter 8, internal tobacco industry documents that came to light during lawsuits in the 1990s reveal a number of political tactics used by the industry, including strong lobbying of key policymakers, campaign contributions, and support of allies to make its case. Shining light on these tactics can help to effectively counter or prevent the industry's opposition.

In countering the tobacco industry's advertising and promotions, the ASSIST states had to navigate the legal issues imposed by the first amendment and by the preemption provision of the Federal Cigarette Labeling and Advertising Act enacted by Congress in 1965 (as amended in 1970): "No requirement or prohibition based on smoking and health shall be imposed under State law with respect to the advertising or promotion of any cigarettes the packages of which are labeled in conformity with the provisions of this chapter. . . ."[70] Although preemption laws prevented a number of ASSIST states from changing public policies on advertising tobacco products, they could, and did, develop strategies to influence private policies in an effort to reduce tobacco advertising in their communities. Many volunteers rallied to oppose advertising that targeted youths and other vulnerable populations, as illustrated in case study 6.5.

Insight 7: Effective Social Movements Engage Many Segments of the Community

> If there is a problem within a community, one must go within that community and solve the problem from the inside out.
> —*Adage*

Social norms reflect the values of a community. Thus, to promote and strengthen the social norm of a tobacco-free society, the ASSIST model relied on community coalitions. The ASSIST coalitions set the priorities for policy interventions in the communities and the strategies for conducting policy advocacy. First, however, the coalitions ensured that their memberships and outreach were comprehensive in involving as many segments of the population as possible. The coalition membership represented health organizations, social service agencies, community groups, and private citizens of diverse ages and socioeconomic and ethnic characteristics. In advocating for policy, there is strength not only in numbers but also in the degree to which the entire community is represented. Case study 6.6 illustrates how 70 organizations worked together to achieve mutual goals.

Case Study 6.5
Shining the Light on Tobacco Advertising and Promotions

- **Reducing Point-of-Purchase Advertising.** Exposure to point-of-purchase advertising influences youths to purchase and experiment with cigarettes. In 1999, a 4-month study of 3,031 retail outlets in 163 communities nationwide found that some form of tobacco point-of-purchase marketing (interior or exterior advertising, self-service pack placement, multipack discounts, tobacco-branded functional objects, or vending machines) was observable in 92% of the stores.[a(p185)]
  - Operation Storefront, developed by the California Tobacco Control Program, was adopted by many ASSIST states as an intervention to reduce the amount of storefront and in-store tobacco advertising in convenience stores, especially in neighborhoods with schools and other vulnerable populations. (See insight 9 for examples.)
- **Exposing Advertising Targeted to Specific Populations.** Advocates in several ASSIST states exposed the tobacco marketing technique of targeting youths by concentrating advertising in convenience stores and on billboards near middle schools and high schools and in African American, Hispanic/Latino, and American Indian communities.[b]
- **Exposing Advertising and Giveaways in Family Settings.** ASSIST volunteers brought attention to the advertising and marketing techniques used in family venues, such as tobacco product giveaways at NASCAR races and at sports and entertainment events. Some states countered the advertising by introducing an alternative, such as entering a tobacco-free car in a NASCAR race, at the event.
  - Tobacco industry giveaways such as Marlboro Miles and Camel Cash were countered by paid and earned media events. For example, a popular event encouraged teens to bring in cigarettes, lighters, or any item with a cigarette logo on it and drop them off in exchange for an item with a health message.
  - A local coordinator in Minnesota organized a tobacco merchandise "buyback" during a lunch hour at a local high school. Teens turned in tobacco merchandise in exchange for antitobacco items.
  - Twenty-six New Jersey middle school students attended a workshop on tobacco advertising. Their antitobacco advertising designs were reproduced on T-shirts and tote bags for fundraising purposes.
  - Youths from a Wisconsin antitobacco group monitored outdoor tobacco advertising throughout one county. In another county, 1,000 youths from 16 schools throughout the county collected and exchanged tobacco industry paraphernalia for prizes.
  - Piggybacking on the national Kick Butts Day, a Virginia high school held a gear exchange in which more than 50 students exchanged tobacco promotion

Case Study 6.5 (continued)

items for health promotion materials. More than 200 students who professed to have never used tobacco signed a pledge to remain tobacco free for life. This event gained local television news coverage.

- Two Indiana middle schools conducted a T-shirt trade-in, where tobacco T-shirts were exchanged for T-shirts with a tobacco-free message.[b]

- **Placing Tobacco Counteradvertising.** New Mexico placed tobacco counterads in programs for boys' and girls' basketball and soccer championships. For the latter event, antitobacco announcements were read over the loudspeaker during 12 games.
  - Indiana produced press releases and counterads for an annual riverfront event that traditionally has some tobacco industry sponsorship, reaching potentially 100,000 participants.
  - New Mexico helped sponsor a "Play It Tobacco Free" state championship tournament. The tournament featured a number of antitobacco advertising and promotion techniques, including statements by high school and university athletes about the importance of remaining tobacco free and a banner displaying photos of people who had died from smoking-related diseases. The event involved 60 students and was covered by the local public television station.[b]
- **Protesting Tobacco Advertising.** A Ticketmaster/Joe Camel ad protest was held by local coalitions in Washington State against the advertising tactics that provided discount tickets with Camel proof of purchase.[b]

[a]Data on reducing point-of-purchase from Terry-McElrath, Y., M. Wakefield, G. Giovino, A. Hyland, D. Barker, F. Chaloupka, S. Slater, P. Clark, M. Schooley, L. Pederson, et al. 2002. Point-of-purchase tobacco environments and variation by store type—United States, 1999. *Morbidity and Mortality Weekly Report* 51 (9): 184–7.

[b]ASSIST state quarterly reports, 1996–99.

Insight 8: Youth Are Effective Change Agents

Youths are the leaders of today!
—Donna Grande, Director, Office of Program Development, American Medical Association

Involving teens in policy interventions in a meaningful way develops their skills in the areas of leadership, public speaking, policy advocacy, and media advocacy; enhances their self-confidence; and puts them on the public record as opposing tobacco use. The more meaningful the role teens are given in planning a policy initiative, the more likely it is that they will assume ownership of the intervention, that they will be highly motivated to implement the intervention, and that they will do an exceptional job. Furthermore, teens are effective advocates. For example, in the

Case Study 6.6
Massachusetts Increases Tobacco Tax to Fund Healthcare for Children

Situation: Chapter 47 of the Acts of 1997, An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth (Health Care Access Act) was under consideration in Massachusetts in 1996. One part of the bill proposed to expand children's eligibility for Medicaid and a special Massachusetts program that offers health insurance for non-Medicaid eligible children. Passing the bill depended partly on a plan to fund the program. Knowing that any significant increase in the price of tobacco is an effective tobacco control measure, the tobacco control advocacy network saw an opportunity to combine forces with children's health advocates toward complementary goals.

Strategy: Tobacco prevention advocates joined forces with supporters of the Health Care Access Act to communicate a simple message to the public about raising the cigarette tax: Fund children's healthcare by taxing tobacco. Linking children's healthcare and cigarette taxes was the way to reach congruent public health goals.

Intervention: Seventy organizations joined the coalition to fight for passage of the Health Care Access Act, to be funded in part by a 25¢ increase in cigarette taxes. Organized by Health Care for All, the coalition included the following five categories of members:

1. The medical community, including physicians and hospitals
2. Tobacco control advocate groups
3. Public health organizations lobbying for children and healthcare reform
4. Associations representing seniors
5. Insurance companies and business leaders

The broad membership of the coalition allowed for both a traditional statewide grassroots campaign and insider, relationship-based lobbying. This combination created a political will that was impossible to stop despite public opposition by the governor and the tobacco industry's 6-month lobbying expenditures of about half a million dollars.[a]

Grassroots lobbying efforts included rallies in communities across the state and lobby days at the state house. The American Cancer Society mobilized 1,000 members of its tobacco control advocacy network to phone, write, and meet with legislators. Coalition organizations called their members and asked them to call their elected officials and express their support.

A poll of registered voters in Massachusetts found that 78% favored and 20% opposed a bill "that would raise the cigarette tax by 25 cents . . . to buy health insurance for children who don't have it and help buy prescription drugs for senior

Case Study 6.6 (continued)

citizens who can't afford them."[b] The coalition took advantage of the popular support by integrating an aggressive statewide media campaign into its efforts, including hard-hitting radio ads addressing Governor William Weld about his opposition, newspaper ads in small local newspapers of swing legislators, and an op-ed column by former Senator Paul Tsongas. Equally critical to passing the bill was support from the chairs of the House and Senate Health Care Committees, Representative John McDonough and Senator Mark Montigny, as sponsors of the bill.

Opposition to the bill came from retailers who claimed that Massachusetts smokers would flock to neighboring states to purchase cigarettes and from the governor, who was running for the U.S. Senate and tried to use this bill to underscore his reputation as a no-tax governor. Governor Weld had opposed all new taxes since he took office in 1991.[c] His opponent in the race, Senator John Kerry, held press events and ran political ads blasting the governor for his position.

Results[d] and Insights: Before the 4th of July holiday, the tobacco bill passed the Senate by a vote of 30 to 2. The governor vetoed the bill shortly afterward. On July 24th, both the House and Senate overrode the governor's veto with more than the two-thirds vote necessary, and the bill became law. Massachusetts disproved the notion that state legislatures will never pass a tax increase opposed by the tobacco lobby. Coalitions that form around expanded access to healthcare are potentially much stronger than the public health coalitions that have fought for tobacco use prevention and control.

Sources: Adapted from K. Adami and L. Fresina. 1997. Funding health care for children through an increase in the tobacco tax—The Massachusetts experience. In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 1–4. Rockville, MD: ASSIST Coordinating Center.

[a]Massachusetts Lobbyist and Employer Statistics database, Division of Public Records, Massachusetts Ethics Commission. http://db.state.ma.us/sec/pre/stat_search.asp.

[b]Knox, R. A. 1996. Health plan for youths, elders eyed cigarette-tax hike included in state bill; Backing uncertain. *Boston Globe*, March 27, 1996, city ed.

[c]Vaillancourt, M., and D. S. Wong. 1996. Weld may try to stall health bill to stop tobacco levy, he risks triggering business payroll tax. *Boston Globe,* July 9, 1996, city ed.

[d]In 2001, Massachusetts increased the tax another 75¢, for a current total tax of $1.51.

case of the St. Louis County youth access ordinance that went into effect on July 1, 1996, several young people who testified at the public hearings made more of an impact on the county council members than dozens of physicians and adult tobacco control experts. Teens who had participated in compliance checks were able to convince the St. Louis County Council that youth access to tobacco and the subsequent increase in teen tobacco use are community health

problems that must be addressed through local legislation. (See insight 1.)

Case study 6.7 about Grand Rapids, Michigan, and case study 6.8 about Silver City, New Mexico, illustrate that, with training and adult supervision, teens can be entrusted with significant responsibility and can have a significant influence on policymakers.

Insight 9: Framing the Issue and Using the Science Help to Put You in Control

> If you don't like the news, go out and make some of your own.
>
> —*Scoop Nisker*

Success or failure in advocating for a policy may well depend on which side does a better job of framing the issue in the media and in public debate. A policy is more likely to be adopted if public health advocates succeed in framing the issue as a public health problem. On the other hand, a policy may well be defeated if opponents succeed in framing the issue in terms of the rights of businesses or smokers, or of economic impact. In other words, present the issue in a way that will appeal to the public at large, and keep that message in the forefront of the debate.

An important skill for media advocates to develop is the ability to translate research findings and national policy debates into terms that are relevant to local residents. This translation can be done by using simple, common-sense-language; citing concrete local examples and anecdotes; and highlighting the key implications for local policy—the bottom line. The new information can be used to reinforce the central message—the key issue at stake in the ongoing policy debate is public health. This skill is especially valuable in media advocacy. Advocates must clearly know how they wish to frame that information before they participate in an interview or some other opportunity to speak about the issue. They must be well prepared so that when challenged they will not lose the framing. (See chapter 5.)

The ability to frame the issue by using the science is powerful in refuting an opponent's claims. For example, public health advocates might rebut opposition claims that a proposed clean indoor air ordinance violates smokers' rights by making the following points.

- The right to breathe clean air takes precedence over the right to smoke.
- Smokers are not barred from patronizing smoke-free restaurants; they just may not smoke there. On the other hand, persons with respiratory conditions cannot patronize restaurants that allow smoking without placing their health in immediate jeopardy.

Similarly, public health advocates may refute opponents' claims that the passage of such an ordinance will result in restaurants losing business. For example, they could respond to such a claim regarding lost business by asserting, "Every independent, scientific study that has been done on this issue using sales tax data has shown that clean indoor air ordinances do not negatively affect restaurant sales." In both cases, the public health advocates should immediately link back to their main point, their frame: "However, the issue here isn't

Case Study 6.7
Youth Advocates Make Michigan Arena Tobacco Free

Situation: The project director of the Smoke-Free Class of 2000: Education, Action, and Celebration of Grand Rapids, Michigan, was gathering ideas for writing advocacy letters as an exercise in the smoke-free curriculum of Grand Rapids middle schools. She investigated whether the nearly completed Van Andel Arena had a smoking policy. This 12,000-seat sports and entertainment facility is the nucleus of the downtown revitalization. A conversation with the deputy city manager, also chair of the Downtown Development Authority (DDA), revealed that the DDA had not even considered smoking an issue. This information became part of a lesson on advocacy.

Strategy: Eighth graders from six Grand Rapids middle schools involved in the Smoke-Free Class of 2000 used their new skills to advocate for a tobacco-free policy for their community's new sports arena. Through a grant, ASSIST supported an integrated curriculum built on the materials of the Smoke-Free Class of 2000.

Policy Intervention: Seventy students wrote letters requesting a tobacco-free policy for the arena to the mayor, to the chair of the DDA, and to the local newspaper (as letters to the editor). Subsequently, a teacher and a dozen students met with the chair of the DDA. Students read their letters regarding a tobacco-free policy for the arena and answered the chair's question: "Why a tobacco-free arena and not a smoke-free arena?" Students explained that the issue covered tobacco sales, advertising, and even smokeless tobacco. The chair explained the DDA's decision-making process: after the necessary committee meetings, a policy is recommended to the full committee for final determination.

Near the end of the school year, a group representing the Smoke-Free Class of 2000 was in the crowd that attended a DDA meeting. During the public comment period, a student addressed the mayor and the DDA, urging them to approve the tobacco-free policy. A classmate distributed Smoke-Free Class of 2000 bumper stickers and gave a logo T-shirt to the deputy city manager in appreciation of his help in their efforts.

Results and Follow-Up: The DDA vote unanimously supported a tobacco-free policy. The advocacy effort was successful.

They celebrated their success. A front-page news story included quotations from members of the Smoke-Free Class of 2000. To draw attention to the new policy and commend the DDA for its decision, an ad was placed in the Grand Rapids Press. These three full-page ads ran prior to the grand opening activities for the sports arena. They read:

> The SMOKE-FREE CLASS OF 2000 Salutes the City of Grand Rapids' Downtown Development Authority for choosing to put the health of West Michigan first by making the Van Andel Arena tobacco free!

May 8, 1996

Dear Planning Commission,

I am a eighth grade student at Creston-Mayfield Christian School, and a member of the "Smoke Free Class of 2000." Our class has been working hard to inform everyone of the dangers of smoking, and how addictive and habit forming it actually is. We have also been telling about how terrible smoking smells, and how it distracts those around someone who smokes. That brings me to why I have written this letter. A decision has not been made as to if the Vandenkl Arena will be smoke-free or not, and I hope my letter, as well as the others, can influence your decision to make this new arena completely smoke free. Many other arenas and stadiums around the country are being built smoke free, or are changing two smoke free facilities. Joe Lewis arena is smoke free, and a good majority of Old Kent Park is smoke free as well. The new ice in Grand Rapids, Michigan National Ice Center is smoke free as well. So please consider the facts, and the lungs of other people who will be enjoying the Griffins this next season. My family has season tickets, so I will be attending many if not all home games, and I would hate to have to leave just to get away from fans who are smoking. Please make the new arena's air be as clean as the arena itself, and make it a smoke free environment. I really am looking forward to this season, and seriously hope that everything will be perfect with the arena, and it would be perfect if it is a no-smoking environment. Thank you for your time.

Examples of students' letters that helped convince the Grand Rapids (MI) Downtown Development Authority to adopt a 100% tobacco-free policy for the new Van Andel Arena. Letters provided courtesy of Krista Schaafsma.

These lines preceded a list of the 400 students in the Smoke-Free Class of 2000 and the individuals, agencies, and groups who supported their advocacy efforts. Framed ads were presented to the DDA, the Van Andel Arena, the Kent County Board of Health, the American Lung Association, and the Grand Rapids Christian High School.

Members of the ninth-grade class arranged a winter social event at the Van Andel Arena during a Harlem Globetrotters basketball game. Students presented the framed ad to the arena general manager and then received a surprise of their own. The front patio of the arena was being paved with engraved bricks, and the Smoke-Free Air for Everyone Coalition purchased a brick honoring the students. Television reporters filmed the event, including an interview that appeared as a feature on the evening news.

Insights:

- **Give the students a choice regarding advocacy topics.** This helps prevent accusations of using youths to address your agenda.
- **Students love the attention.** The media publicity and attention make them feel empowered, and this empowerment also works to help bridge the gap into a very adult world while it imparts important civic lessons.

Case Study 6.7 (continued)

- **Prepare the youths.** The thought of preparing comments for formal events can discourage youth participants, so provide the students with sample statements and invite them to reword them.
- **Include incentives.** Youths appreciate refreshments or food at meetings. In addition, T-shirts, articles about the youths in school newspapers or school newsletters, and certificates for their school portfolio can all be used to encourage and recognize their work.

Source: Adapted from K. V. Schaafsma. 1997. Youth advocacy in action: Absolutely amazing! In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 23–8. Rockville, MD: ASSIST Coordinating Center.

Case Study 6.8
Teens Lead the Way in Silver City, New Mexico

Situation: A local contractor in the community of Silver City, New Mexico, recruited a team of about 20 peer educators and youth advocates from three local high schools. The students were trained in tobacco control, peer education, youth advocacy, media advocacy, and policy advocacy. Adult supervisors on the staff of the three schools coordinated the training and activities.

Strategy: The students decided to form a community tobacco control coalition. Their initial efforts to recruit adults, including representatives from local public health and youth agencies and other community leaders, met resistance. The adults felt that existing local coalitions that dealt with broader public health issues were already adequately addressing tobacco issues. However, the students persisted and ultimately succeeded in recruiting a strong core of committed adult tobacco control activists. Working together, the teens and adults formed a coalition, with teens filling several of the coalition officer positions and playing an important role in setting the coalition's priorities.

Intervention: The coalition set an objective of a strong municipal clean indoor air ordinance and laid the groundwork for this ordinance by educating the community about the health risks posed by ETS. The coalition's teen members made presentations to a variety of community organizations. They wrote a weekly teen column in a local newspaper that discussed the adverse health effects of ETS, the benefits of clean indoor air policies, and other tobacco issues. The coalition also worked with a professor of journalism at a local university and the ACS state chapter to conduct a poll, which found that an overwhelming majority of Silver City residents supported a clean indoor air ordinance. In addition, the coalition conducted a campaign to recognize local restaurants that adopted voluntary smoke-free policies. Finally, the coalition's teen members held a series of meetings with Chamber of Commerce

officials, other business and community leaders, and city councilors to explore their level of support for an ordinance. A survey conducted among Chamber of Commerce members found a majority of them to be open to the idea of an ordinance making restaurants smoke free. The teen coalition members considered restaurants a priority because many teens worked in or patronized restaurants.

Results and Insights: This careful groundwork ultimately led to an ordinance that (1) made Silver City restaurants smoke free, (2) required that bar areas in restaurants be either smoke free or separately enclosed and ventilated, and (3) banned or restricted smoking in a number of other public places. The coalition's teen chairperson played a leading role in presenting city officials with a model ordinance, negotiating the proposed ordinance's provisions with the city council, and addressing councilors' concerns. The council viewed her as an expert on clean indoor air policy issues and repeatedly deferred to her recommendations. Under her leadership, the coalition was successful in mobilizing more than 30 Silver City residents to testify in favor of the ordinance, including the mayor's own teenage daughter. The mayor, who was a smoker, publicly stated that he did not believe that smoking was a right when it affected other people. The city council adopted the ordinance by a unanimous vote.

The Silver City story illustrates that, when properly trained and supervised by adults, teens can have significant influence on policymakers because the latter are unaccustomed to hearing from teens and are often open to their ideas. Many policymakers are becoming aware that teens offer good advice on addressing teen problems, such as teen smoking and teen exposure to ETS. A major argument used effectively by the teen coalition members was that, in addition to protecting restaurant employees and patrons from the health risks posed by ETS, the ordinance would also set a good example for youths by removing the environmental cue of seeing adults smoking in restaurants.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

rights or economics. It's the serious, documented health risks posed by secondhand smoke, and the right of the public and employees to be protected from these risks."[25,71]

Case study 6.9 on the cigarette excise tax in New York demonstrates that scientific studies can be used to support policy decisions. The data showed that a pro-health policy would not have a harmful economic impact on most communities. Case study 6.10 from North Carolina and case study 6.11 on Operation Storefront illustrate how local coalitions gathered their own observational data on cigarette sales to minors and protobacco advertising in storefronts in their communities. Although the information was not collected

Case Study 6.9
New York Counters Tobacco Industry Claims with Data

Situation: The tobacco industry argued that increasing the cigarette excise tax would damage the economy by causing job loss, reduced productivity, and lost profits on the part of those involved in the distribution and sale of cigarettes. To address these arguments, tobacco control advocates needed scientific evidence that increasing cigarette excise taxes would not hurt the economy.

Strategy: In New York, the American Lung Association of New York State commissioned a study (with funding from a Robert Wood Johnson Foundation SmokeLess States grant) to determine whether New York would suffer economically from a $1 increase in the state's cigarette excise tax. The study showed that a $1 increase in the cigarette excise tax would result in economic benefits to New York. The results of this study, "Estimating the Economic Impact of Increased Cigarette Excise Taxes: A Tool for the State Tax Analyst," were used to support a tax increase of $1.[a] The study—coupled with existing data on medical costs, insurance costs, loss of job productivity, and work absenteeism related to tobacco use—provided data needed to convince policymakers and businesses that they have a vested interest in reducing tobacco consumption.

Insights: The tobacco industry has sponsored economic studies by well-known consulting groups, including Chase Econometrics, Price Waterhouse, and Wharton Applied Research Center; these studies calculate the economic impact of reduced cigarette consumption.[b,c,d] However, these studies are critically flawed: they are based on the assumption that the resources devoted to tobacco product production and distribution would disappear if sales were to decline. In fact, the economic activity associated with tobacco sales does not disappear as consumption falls but rather is redistributed to other sectors of the economy as consumers use money previously spent on tobacco to purchase other goods and services. This alternative spending generates economic activity and employment in the same way that spending on cigarettes does.

In 1996, Kenneth E. Warner and his colleagues published a groundbreaking report that concluded that most states and regions of the country would benefit economically from a reduction in tobacco product sales.[e] Warner and his colleagues found that at that time only the tobacco states of the Southeast would suffer economically from reduced cigarette consumption. For states outside the Southeast, Warner's findings contradicted the tobacco industry's long-standing claim that a drop in tobacco sales is detrimental to the economy.

—Russell Sciandra, Director of the Center for a Tobacco Free New York, and Tim Nichols, Director of Governmental Affairs for the American Lung Association of New York State

[a]Nauenberg E., and J. Nie. 1999. Estimating the economic impact of increased cigarette excise taxes: A tool for the state tax analyst. In *State tax notes* (V17#20), 1313–18.

[b]Chase Econometrics. 1985. *The economic impact of the tobacco industry on the United States economy in 1983.* Bala Cynwyd, PA: Chase Econometrics, v–3.

[c]Price Waterhouse. 1992. *The economic impact of the tobacco industry on the United States economy: Update of 1990 study.* New York: Price Waterhouse.

[d]Wharton Applied Research Center and Wharton Econometric Forecasting Associates Inc. 1979. *A study of the tobacco industry's economic contribution to the nation, its fifty states, and the District of Columbia.* Philadelphia: Univ. of Pennsylvania.

[e]Warner, K. E., G. A. Fulton, P. Nicolas, and D. R. Grimes. 1996. Employment implications of declining tobacco products sales for regional economies of the United States. *Journal of the American Medical Association* 275:1241–6.

Case Study 6.10
Collecting Local Numbers in North Carolina

Situation: Since media coverage is mostly local in North Carolina, a clear strategy was to build the capacity of local communities to develop messages that they could take to the news media.

Strategy and Intervention: In North Carolina, ASSIST sought to build support for an enforceable policy to reduce youth access to tobacco. A policy restricting sales of tobacco to minors had been on the books for almost 100 years but was never enforced. Members of the coalition supervised teens who bought Marlboro cigarettes in randomly selected stores in each of the state's media markets. Ten highly successful press conferences were held on the same day in 1994 to provide the relevant communities with data on tobacco purchases that the youths had made in the local stores. Half of the stores had sold to the teens. The teens told their stories at the press conferences, and the coverage was excellent.

Seeing local people present actual numbers on a local issue on the evening news, hearing the issue debated on talk radio, or reading an editorial that supports a policy to address the local issue can help the public and policymakers realize that the problem is real in their community. This intervention opened the doors to a larger public policy debate on youth access to tobacco that resulted in the adoption of an enforceable youth access law and the governor's appointment of the Alcohol Law Enforcement Division to enforce the youth access to tobacco law. Buy rates in North Carolina dropped from 51% in 1994[a] to 20.8% in 2000[b] and to 14.8% by 2004.[c] Media coverage of the easy access that youth had to tobacco in 1994 also opened

Case Study 6.10 (continued)

doors to a broader public discussion of tobacco prevention and control public policies such as clean indoor air and 100% tobacco-free schools.

—C. Ann Houston, former North Carolina ASSIST field director and current Director for Public Education and Communications, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services, and Jim D. Martin, former North Carolina ASSIST field director and current State Advisor on Preventing Teen Tobacco Use, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services

[a]North Carolina Department of Health and Human Services, Project ASSIST. 1994. *Project ASSIST bulletin.* Raleigh, NC: Division of Adult Health Promotion.

[b]North Carolina Department of Health and Human Services, Substance Abuse Services Section. 2000. *Annual Synar Report.* Raleigh, NC: North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

[c]North Carolina Department of Health and Human Services, Substance Abuse Services Section. 2004. *Annual Synar Report.* Raleigh, NC: North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Case Study 6.11
Point of Purchase: Operation Storefront

Operation Storefront was a two-phase campaign. First, participants documented the nature and scope of storefront tobacco advertising. Second, they educated decision makers about the effects of advertising on youths and promoted private and public policy changes. They documented the changes that resulted. This intervention was conducted from 1996 to the end of ASSIST in Maine, Massachusetts, Michigan, Missouri, New Jersey, New York, Rhode Island, Washington State, West Virginia, and Wisconsin. Below are a few excerpts from states' experiences described in their quarterly reports.

- *Maine* developed and distributed a working manual on Operation Storefront. This manual was distributed to participants in a skills-building train-the-trainer workshop. Displays and data from Operation Storefront were released in a media event, which featured the governor declaring May as Tobacco Awareness Month. Local press conferences for local media outlets were conducted throughout the state.
- *Maine* conducted 248 tobacco advertisement assessments statewide with 102 youths and adult volunteers.
- *Massachusetts's* local providers completed phase 1 of Operation Storefront. Phase 1 entailed assessing tobacco advertising visible from the outside of 3,000

tobacco merchandisers in 125 cities and towns (whose combined population was greater than 3.5 million) throughout the state. Tobacco advertisements made up 52% of more than 2,000 advertisements visible to youths on storefronts. Phase 2 involved educating decision makers and advocating for policy change.

- One of *Michigan's* local coalitions trained 200 students via teleconference on the tobacco industry's advertising tactics and on how to advocate for the removal of tobacco advertising and replacement with countertobacco messages. This event was covered by the local media.
- *Missouri* coalitions conducted Operation Storefront activities, including training and press events. One coalition held a press conference to report the results of its assessment. As a result, the city prosecutor considered strengthening a policy regarding signage for smoking and advertising. Missouri developed a database for community groups participating in the Operation Storefront project, for which more than 60 groups signed up.
- One of *Missouri's* local coalitions held a news conference to release the results of Operation Storefront and the billboard assessment. The coalition also kicked off their countertobacco billboard campaign, which entailed posting prohealth messages on 12 billboards in the Kansas City area. This event was covered by two print and two broadcast media outlets and was also picked up by the Associated Press.
- A *New Jersey* local coalition conducted training on tobacco control issues and Operation Storefront for Eagle Scout candidates.
- Twelve *New York* students conducted Operation Storefront throughout one region of the state. They found an average of 128 tobacco ads in the stores that they visited; this average was significantly higher than for the preceding years. The biggest increase was for cigar products. The students presented their findings on a local radio station talk show.
- *New York* sponsored several activities to raise awareness of tobacco advertising. The activities included a conference on women and tobacco for 70 participants, a conference for 1,200 sixth graders, and a news conference and protest rally on *Marlboro Man's* induction to the Advertising Hall of Fame.
- *Rhode Island* local coalitions and youths conducted outdoor and point-of-purchase tobacco advertising assessments. Rhode Island students assessed tobacco billboard advertisements, took photographs, and documented six sites. Youths also approached an advertising firm to donate billboard space for their posting of antitobacco messages.
- In *Washington* State, a county health department—in collaboration with the local coalition, the Korean Women's Association, and the local Girl Scouts—conducted Operation Storefront. They surveyed 177 stores and awarded certificates of compliance to those retailers who had complied with the tobacco outdoor ad limitation, the yellow warning stickers, and the year-of-birth signs.

Case Study 6.11 (continued)

- Nineteen of 39 *Washington* counties completed Operation Storefront activities in which youths visited tobacco retail outlets in their communities to assess the amount and placement of tobacco advertising.
- Local coalition members in *West Virginia* took photos of tobacco advertising displays in storefronts for media advocacy efforts of the state coalition regarding the effects of advertising on youths.
- *Wisconsin* local coalitions worked with ACS to recruit youth for Operation Storefront activities.

Source: ASSIST state quarterly reports, 1996–99.

with a scientific study design, it did document what was happening in the communities and was useful in media advocacy efforts.

Insight 10: Policy Change Requires a Flexible Strategy and the Ability to Respond Rapidly to Opportunity

> Opportunity is missed by most people because it is dressed in overalls and looks like work.
>
> —*Thomas A. Edison*

Strategies and tactics used in ASSIST were defined as planned or opportunistic. Planned strategies were based on the body of scientific evidence supporting tobacco control, and ASSIST guidelines called for focusing on the policies that would have the greatest effect on the population. Planned strategies were described at the outset of each fiscal year and were implemented as a part of an annual action plan. As states entered the intervention phase, staff realized that the action plans had to be flexible to respond to opportunities that were not known when the plans were written, especially when those opportunities were related to a development in the political climate favorable to achieving policy changes.

Opportunistic strategies are quick responses to breaking news, media events, or other unanticipated opportunities for policy advocacy—a member of a local governing body agrees to sponsor a tobacco control ordinance, a political shift occurs in a governing body that suddenly makes possible the adoption of a proposed ordinance that previously had been stymied, or there is a local hook to a breaking national news story. In ASSIST, opportunistic strategies arose from the resourcefulness of staff and coalitions. For example, when billboards advertising tobacco products were brought down in compliance with a provision in the Tobacco Master Settlement Agreement, the coalitions promoted media events around the dismantling to bring attention to the health issues of tobacco use. The Tobacco Master Settlement Agreement of 1998 was an opportunity for states to seek funding for tobacco control programs.

Key informant interviews were used to examine the worth of responding to opportunities because action might require a redirection of resources, time, and energy. Coalitions were challenged to show that these strategies would lead them to their policy goals more rapidly and with fewer negative repercussions than the previously planned activities. For example, as described in case study 6.12, when the South Carolina state house was declared a historic site, the ASSIST coalition seized the opportunity and advocated successfully to pass a policy that prohibited smoking in the building.

Insight 11: Make Gains Where Possible—Small Changes Add Up

> If you can't do A, then do B, C, and D, but never lose track of A because it may come around again.
>
> *—John M. Garcia, former Project Director, ASSIST Coordinating Center*

Changing social norms requires taking incremental steps that over time add up to arriving at a larger, long-term policy goal. Changing tobacco control policies requires an investment of time. For example, increasing state tobacco taxes may take 6 years from the time a well-thought-out strategy is designed. Numerous smaller victories will be needed on the way to the ultimate goal of increasing tobacco taxes, for example, increasing public awareness in the geographical areas of key legislators who have leadership positions. Advocates should never underestimate the significance of these smaller victories and should never lose track of strategies that may not have been effective at a particular time—because an opportunity to apply the strategies may occur later.

A measure that ASSIST program managers often used to help decide if an activity was worth the effort was to ask "What is it going to get us?" If the answer did not reveal that the activity would lay groundwork or build support for evidence-based policy change, the activity was reconsidered. On the other hand, an activity that could help build community support for an evidence-based policy change in one of the four policy areas would be well worth the effort.

Case study 6.13 illustrates how helping North Carolina public schools solve a school-based problem was a step toward building support for an important tobacco control initiative later.

Insight 12: Keep Policy Advocacy Local and Loud

> Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has.
>
> *—Margaret Mead*

> We could never win at the local level. The reason is, all the health advocates . . . they're all local activists who run the little political organizations. They may live next door to the mayor, or the city councilman may be his or her brother-in-law, and they say "Who's this big-time lobbyist coming here to tell us what to do?" When they've got their friends and neighbors out there in the audience who want this bill, we get killed. So the Tobacco Institute and tobacco companies' first priority has always been to preempt the field, preferably to put it all on the federal

Case Study 6.12
An Historic Opportunity: South Carolina Bans Smoking in Its State House

Situation: South Carolina's 1991 Clean Air Act required that government buildings become smoke-free environments, but legislators exempted the state house from the law. During the next 7 years, health advocates attempted three times to make this historic building smoke free. Finally, in 1998, a 3-year, $68 million historical renovation project provided an opportunity to revive the issue.

Strategy: A grassroots advocacy plan that included the media and the distribution of a postcard was quickly developed to bring the following three key messages to the attention of the House-Senate Oversight Committee:

- The historical significance of the State House makes it appropriate to make the building smoke free. Tobacco smoke would harm historical artifacts, furnishings, and carpet.
- Visitors to the State Capitol are exposed to harmful chemicals in secondhand smoke. Specifically, hundreds of South Carolina school students visit the state house daily.
- The taxpayers of South Carolina are spending $68 million on the historical renovation of the State House. If tobacco use continues, taxpayers will incur additional costs for cleaning and maintaining the building.

Intervention: A 40-member coalition of traditional and nontraditional partners, including ASSIST, collaborated on an initiative for a smoke-free state house. Three of the partners—the American Cancer Society, the American Lung Association, and the American Heart Association—had a working relationship with South Carolina state senator Darrell Jackson and sought his support. He agreed to join this effort (for the third time). Also during this time (June–July 1998), a reporter from the state's largest daily newspaper began to follow the oversight committee's agenda. The oversight committee was charged with developing rules and regulations regarding special events and food consumption inside the state house. The reporter, and a representative of the American Cancer Society, contacted Senator Jackson for comments regarding tobacco use and smoking in the state house. The story, which became the official kickoff of the campaign, was published on July 8, 1998, and became a front-page issue. The Associated Press picked up the story, as did television and radio outlets from all parts of the state.

The grassroots movement also distributed 15,000 postcards with the simple message that smoking does not belong in the House or Senate. Within 2 weeks, all 15,000 postcards were distributed and mailed to the clerk of the senate. Editorials and news articles supporting the smoking ban began to appear in newspapers.

Senator Jackson placed the item on the oversight committee's agenda before the August committee meeting. At the meeting, the senator, along with health advocates

and 75 members of the Young People's Division of the African Methodist Episcopal Church, a community-funded partner of ASSIST, presented the case for a smoke-free state house.

Results: After 45 minutes of discussion, with media representatives present from around the state, the committee voted unanimously to make all public areas of the state house smoke free. The same afternoon, the governor and lieutenant governor banned tobacco use in their offices. The total cost of this campaign was less than $300, which covered printing the postcards.

What had been an issue in South Carolina for many years was now legislative policy in just 22 days. This successful effort to ban smoking in the state house was the lead story that night on television stations across the state and was covered extensively in print the next morning.

Source: Adapted from P. Cobb and G. White. 1999. It's a state house, not a smoke house! In *Tobacco free future: Shining the light* (Case studies of the fifth annual national conference on tobacco and health, August 23–25, 1999), 135–8. Rockville, MD: ASSIST Coordinating Center.

Case Study 6.13
Twice North Carolina Makes Gains for a Smoke-free School Environment

In 1994, the U.S. Congress passed the Pro-Children Act, which required that all education, health, and library institutions that receive federal funds become smoke free.[a] Therefore, the school buildings in North Carolina had to become smoke free; however, the schools were not interested in tobacco prevention and control—the curricula were overburdened already, and North Carolina produces tobacco. Tobacco control advocates learned that schools were under pressure to improve their standardized test scores, but scores do not improve if students are repeatedly suspended for smoking. Thus, an alternative-to-suspension program was created jointly to address the related needs. This alternative program provided a win-win approach and a means to recruit support from school leaders for a tobacco and health initiative.

Three years later, concerned by the data on tobacco use by North Carolina school children, North Carolina's governor, James B. Hunt, called a governor's "Summit to Prevent Teen Tobacco Use" and listened to what the teens had to say. They asked the governor to help make schools in North Carolina 100% tobacco free, not just for students, but also for teachers and visitors campus-wide. The governor responded; he understood that to have good schools, teachers and staff had to be good role models, and he asked every school board in the state to adopt such a policy.

Advocacy continued for 100%-tobacco-free schools in 2001–02 with the North Carolina State Board of Education adopting a resolution endorsing 100%-tobacco-free schools.

Case Study 6.13 (continued)

The Tobacco Prevention and Control Branch (staffed with former ASSIST personnel) wrote grants to the American Legacy Foundation and secured a staff person to be dedicated to this policy change. Intensive training events and earned media have resulted in a new surge in school districts adopting 100%-tobacco-free school policies, including districts that have strong historic ties to the tobacco industry.

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

[a]Pro-Children Act. U.S. Code 20 (1994), § 6083. Available at http://www.unf.edu/dept/fie/sdfs/legislation/pca.pdf and at http://thomas.loc.gov.

> level, but if they can't do that, at least on the state level, because the health advocates can't compete with me on a state level.[72]
>
> *—Victor Crawford, former Tobacco Institute lobbyist who shared insights before his death from tobacco-induced cancer*

All 17 ASSIST states found that most effective tobacco control policy change took place or was initiated at the local level. Policymaking is generally more transparent and responsive to citizen input at the local level than at the state or national level. During the ASSIST era, as illustrated in the Victor Crawford quotation, the tobacco industry was far less effective at fighting a series of local efforts than state and national efforts, where their money and resources invariably outweigh the resources of tobacco control advocates. Moreover, the process of advocating for local policies educates the community about the rationales, benefits, and requirements of these policies and thereby reinforces changes in social norms and facilitates policy implementation and enforcement. Tobacco control policies that are effective at the local level can become the experience and evidence that advocates can point to when promoting state-level policies. The tobacco industry's intensive lobbying for state preemption laws—a goal that, for much of the 1990s, was at the forefront of the industry's state-level legislative agenda[57,58]—seems to be an acknowledgment of the effectiveness of local policy change (see case study 6.14). In some states, the lack of local policies was a key factor in unsuccessful fights against preemption.

Insight 13: It's Not Over 'Til It's Over, or Never Give Up, Never Give Up, NEVER GIVE UP!

> If you are building a house and the nail breaks, do you stop building or do you change the nail?
>
> *—Zimbabwean proverb*

Sometimes it takes years for a community or a state to adopt sweeping policy change. Even when strong public support exists for such change, powerful interests may resist it and create an impasse.

Case Study 6.14
Indiana's Battle against Preemption

Situation: The Indiana General Assembly passed a bill that preempted all local jurisdictions on the sale, distribution, and promotion of tobacco products.

Strategy: The Indiana Campaign for Tobacco Free Communities spearheaded a campaign to bring about a veto of the bill by the governor. The campaign was funded by the National Center for Tobacco-Free Kids and received technical assistance from the Center, the American Cancer Society, and Americans for Nonsmokers' Rights.

Intervention: News coverage of the issue in the *Indianapolis Star* was excellent, with almost daily coverage. The *Star*, which had previously shown little editorial support for tobacco control, published two editorials supporting a veto by the governor; one of the editorials ran on the day of the crucial vote. After the General Assembly overrode the governor's veto of the original bill that had been passed by the General Assembly in 1995, the *Star* ran an in-depth article on the tobacco industry's influence in the state house. The article was a culmination of a year of work by coalition members with reporters who had covered a "state house sellout" series published in 1996. The result was a front-page story outlining the tobacco industry's ties with retailers' groups and the subsequent impact on the vote to overturn the governor's veto.

Results: Indiana's governor vetoed the bill in March 1996. As part of his veto message, he pointed to the lack of local tobacco ordinances as a weakness in Indiana's ability to effectively fight preemption. The governor noted:

> Supporters argue this legislation is necessary to preempt local ordinances that, at present, are virtually nonexistent in Indiana; opponents defend the right of localities to enact measures which, to date, they have shown little or no inclination to enact.

Epilogue and Insight: In 1997, the Indiana legislature removed the right of local communities to regulate youth access to tobacco by a single vote, thereby overturning a veto by Governor Evan Bayh. Though the veto failed, key victories were scored in this hard battle. Tobacco advocates were successful in limiting the preemption coverage to the sale, display, and promotion of tobacco products; thus, clean indoor air laws were excluded from the exemption. Also, the battle became a litmus test for commitment to tobacco control and laid the groundwork for future policy battles.

Source: Adapted from K. Sneegas. 1997. Lessons from Indiana: The battle against preemption. In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 159–65. Rockville, MD: ASSIST Coordinating Center.

However, by refusing to become discouraged and by continuing to lay the groundwork for change through ongoing community education and mobilization, advocates can prepare themselves for opportunities that suddenly create an opening for the long-sought change to occur. (See case studies 6.15 and 6.16.)

Insight 14: It's Never Over!: The Importance of Vigilance after a Policy Takes Effect

Often, getting a policy adopted is only the start of the battle. Advocates cannot afford to relax once they have achieved that goal. In many cases, opponents of the policy will not give up once the policy is passed. Instead, they may seek to reverse it through various means. Advocates must publicize the positive impact of policy change through data and testimonials as well as anticipate and prepare to respond to opposition tactics. One helpful approach is for advocates to "put themselves in their opponents' shoes" and then ask what they would do and what options are open to them. (See case study 6.17.)

Educating Local Store Owners about Tobacco Displays and Placement Fees

The smaller the town, the greater the effect. Many operators of stores in smaller towns and cities live in the same area as their stores. These owners are known by the community and feel more responsibility toward their neighbors than the big-city chains with large, absentee corporate owners. Most small-town retailers are not aware of the tobacco industry's true agenda behind contracts for placement of tobacco products and ads. They simply do what the tobacco representatives tell them to do and take the money. The act of simply educating a retailer about how tobacco displays facilitate shoplifting by children and explaining that the community is aware that he takes placement fees to perpetuate the situation can be quite powerful with some individuals. Several concerned citizens making this point to a storeowner in person is an effective approach and might be enough to change the practice within a chain of stores.

—Anne Landman, former Regional Program Coordinator for the American Lung Association of Colorado

The Influence of Policy

Public policy affects everyone and reflects and reinforces social norms and behaviors. Some policies provide guidance; others mandate adherence to regulations. The role of public health policy is to protect the population from unnecessary health risks and dangers, to promote public knowledge about healthful and preventive behaviors, and to provide opportunities and access to health care. As evidence unfolds about beneficial and harmful environmental factors, scientists and the public health community have a responsibility to disseminate that information to the public. When challenges deter dissemination and application, public health policy is an effective recourse, but it is not an easy process. Enacting new policies requires (1) the support of the community for a policymaker who has introduced a policy or (2) advocacy by the community to introduce a policy.

Policy advocacy was the very core of the ASSIST project, and its focus on interventions in four policy areas proven to be effective in promoting health and

Case Study 6.15
Persistence Pays Off in Mesilla, New Mexico

Situation: In 1995, the small, traditional, predominantly Hispanic/Latino community of Mesilla in south central New Mexico considered adopting a comprehensive clean indoor air ordinance covering all workplaces, including restaurants, along the lines of an ordinance passed earlier in neighboring Las Cruces. However, the board of trustees (the town's governing body) lacked the votes to pass a strong ordinance and settled for a weaker ordinance that allowed smoking in up to 40% of the seating in restaurants. The main obstacle to the ordinance was vigorous opposition by two local restaurants that were among the town's largest employers; the owners were concerned about potential loss of revenues, especially from tourists.

In 1998, Mesilla revisited its ordinance but again was unable to muster a majority for an ordinance requiring restaurants to go 100% smoke free. Finally, in 2000, a key member of the board of trustees shifted his stance on the ordinance from opposition to support. This trustee's change of position was influenced by information on health and economic issues provided to him by the Las Cruces tobacco control coalition (which included a number of Mesilla residents), as well as by personal and political factors. This shift made it possible to amend the original ordinance to ban smoking in restaurants and to require bar areas of restaurants to be either smoke free or separately enclosed and ventilated.

Insight: At each of the three stages of this process, and in the interim between them, the Las Cruces coalition consistently educated Mesilla residents and leaders, as well as the members of the board of trustees, and advocated for smoke-free restaurants. However, the coalition was careful to take a low-key approach that avoided burning bridges with opponents and that was respectful of the tight-knit community's norms of civility and consensus decision making. This steady perseverance ultimately paid off, with the two previous "failures" laying the foundation for the final victory.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

in decreasing premature death and disease related to tobacco use: clean indoor air, restricted tobacco advertising and promotion, reduced youth access to tobacco products, and price increases on tobacco products. The ASSIST staff and coalitions met a variety of challenges in promoting policies in those areas. They met the challenge of developing the personal skills necessary to conduct policy advocacy successfully, of mobilizing community support for policy campaigns, and of responding to tobacco industry opposition. Their strategies and tactics were varied and met the particular needs of their communities, but the coalitions

Case Study 6.16
Changing Policy on Public Transportation: Smoke-free Washington State Ferries

Situation: The Washington State Ferry System serves daily commuters and thousands of tourists. Because smoking was allowed on the ferries, virtually all 23 million passengers and 1,500 employees were exposed to secondhand smoke. A member of the Tobacco Free Coalition of Sno-King was embarrassed that her visitor had to walk through tobacco smoke to enjoy the scenic beauty and breathe in the fresh sea air. The visitor asked, "So what are you going to do about it?" With that question, the wheels of change were put in motion.

Strategy: The Sno-King coalition led multiple efforts to achieve a policy banning smoking on the ferries: volume postcard mailings, peaceful protests, public education events, and persistent contact with state authorities.

Intervention: A series of interventions from June 1997 through July 1998 were necessary to achieve results. First, the Sno-King coalition wrote 15 letters to the chief executive officer of the Washington State Ferry System asking for 100%-smoke-free ferries and wrote several letters to the editors of local newspapers.

Response: No policy change.

Next, the Sno-King coalition collaborated with the Tobacco-Free Kitsap County Coalition and conducted a smoke-free rally at the ferry terminal. This hour-long rally received coverage from two local television stations and the daily newspaper, and positive comments from ferry passengers.

Response: No policy change.

September 1997: The Tobacco-Free Washington Coalition became involved. Hundreds of postcards urging the Washington State Transportation Commission to change its smoking policy were sent to the commission.

Response: No policy change.

October 1997: A smoke-free walking tour was coordinated with a regional youth tobacco conference, "Tobacco in 3-D." Participants held "We want smoke-free ferries" signs or handed out flyers about the smoke-free ferry issue. About 30 participants chanting "secondhand smoke makes us choke" walked all over downtown Seattle, through the Washington State ferry terminal, and past the CEO's office. National Public Radio interviewed participants.

Response: No policy change.

December 1997: It was time to get on the agenda of the Washington State Transportation Commission's meeting. The Department of Transportation's ombudsman was a critical element in this process. Letters and postcards, many from youths, were sent

to the State Transportation Commission, and at the commission's meeting, seven volunteers provided public comment on the smoke-free ferry issue.

Response: The commission decided that because a 1988 law prohibited smoking in state facilities, there was a need to reopen discussion regarding the State Ferry System's smoking policy. The Transportation Commission charged the State Ferry System to evaluate its smoking policy.

January 1998: Representatives from the various coalitions attended six regional meetings of the Ferry Advisory Committee.

Results and Insights: On June 21, 1998, the State Ferry System announced a policy change: smoking would be permitted only in designated areas at the back section of the ferries. Although the policy change was not a 100% ban, it was a step in the right direction, and the Transportation Commission has stated that a total ban will occur sometime in the future.

It is important to determine who has the authority to make policy change in a large state system and to anticipate who might pose barriers. For example, there are 13 unions representing 1,500 ferry employees. Smoking breaks were written into the collective bargaining contracts between the ferry system and the ferry system employees.

Source: Adapted from S. Vermeulen. 1998. Campaign to change policy on public transportation: Smoke free Washington State ferries. In *No more lies: Truth and the consequences for tobacco* (Case studies of the fourth annual national conference on tobacco and health, October 26–28, 1998), 113–6. Rockville, MD: ASSIST Coordinating Center.

all used media interventions and media advocacy to bring attention to the health issues inherent in tobacco use and to the proposed policies.

Once in effect, policies have an impact on the daily lives of many people. Policies protecting workers from environmental tobacco smoke impose rules in the workplace but also liberate those workers from exposure to thousands of secondhand smoke chemicals and poisons. Cigarette taxes raise the price of a pack of cigarettes but also decrease the prevalence of smoking and of the resulting diseases and premature deaths. Advertising restrictions limit the placement of billboard ads and other signage but thereby remove unwanted protobacco messages from the view of children. Restrictions on selling to minors increase the responsibility and culpability of retailers but thereby decrease the ease with which children could have access to cigarettes leading to addiction.

In short, tobacco control policies are experienced in some form by everyone in society and reinforce a tobacco-free way of life. As policies take effect, positive outcomes occur—people quit smoking, employers implement smoke-free work environments, and retailers learn how to refuse to sell tobacco products to minors.

Case Study 6.17
Protecting the Gain in Las Cruces, New Mexico

Situation: In 1995, Las Cruces became the first community in New Mexico to enact a comprehensive clean indoor air ordinance. Before the ordinance had even taken effect, opponents launched a referendum drive. If successful, the drive would have forced the Las Cruces City Council to either repeal the ordinance or place it on a ballot for a public vote. Although the Las Cruces tobacco control coalition was confident that the ordinance would have prevailed in a referendum (a poll conducted by the New Mexico State University Journalism Department and the *Las Cruces Sun-News* found that 73% of the residents surveyed supported the ordinance),[a] the campaign would have consumed enormous energy and resources and would have opened the door to further tobacco industry interference. The drive failed when the opposition gathered fewer than half of the signatures required.

However, the referendum drive was succeeded by a series of other opposition tactics, including the following six tactics:

1. Two lawsuits by local restaurants seeking to block enforcement of the ordinance and to have it struck down
2. The formation of a regional restaurant association created in response to the ordinance
3. A media and public relations offensive against the ordinance by a new restaurant that was refusing to comply with the ordinance in coordination with a local radio talk show host
4. Personal attacks in the media on members of the local tobacco control coalition and, in some cases, legal harassment of these advocates
5. An effort to unseat a mayor who had come to support the ordinance by channeling $10,000 in campaign contributions to his opponent in an election
6. An attempt to invalidate the ordinance through the passage of a preemptive law at the state level

Strategy: Through prompt responses, sound strategic thinking, and effective community mobilization and media advocacy, the Las Cruces coalition, working closely with partners at the local, state, and national levels, was able to turn back each of these challenges.

Intervention: The coalition countered the opposition through a series of its own coordinated tactics: numerous letters to the editor and op-ed columns (which included scientific findings, presented in nontechnical language, with explanations of their policy implications), press conferences, sponsorship of community forums and candidate debates, broad community outreach and cultivation of allies (including proprietors of restaurants that had adopted voluntary smoke-free policies), petition

drives in support of the ordinance, delegation visits to newly elected and incumbent city council members, and ongoing consultation with the ordinance sponsor.

Results: The coalition was able to defeat each of the opposition's attempts to roll back the ordinance. In addition, the coalition was able to achieve passage of several amendments progressively strengthening the ordinance. The Las Cruces experience also helped inspire several other communities in the region (including the New Mexico communities of Carlsbad, Mesilla, and Silver City and the nearby Texas city of El Paso) to adopt ordinances similar to that in Las Cruces. In January 2002, Doña Ana County (the county in which Las Cruces sits) adopted an ordinance that was even more comprehensive than the Las Cruces one.

In October 2002, the Las Cruces City Council, at the request of the Las Cruces coalition, rescinded the original ordinance and replaced it with a new one that contained almost no exemptions. Opponents once more launched a petition drive to force a referendum on the new ordinance, and this time succeeded in collecting enough signatures to do so. The opposition, led by the local Chamber of Commerce, conducted a well-funded, well-organized campaign against the ordinance; the coalition once more waged a vigorous campaign in its defense. The vote was held in March 2003, and the new ordinance lost, 56% to 44%. Technically, the vote was on just the new provisions in this ordinance, which extended the ordinance's coverage to free-standing bars, truck stops, private clubs, parks, and areas within 50 feet of the entrances of buildings where smoking is banned. With the defeat of the new ordinance, Las Cruces reverted to the previous ordinance, which still required most enclosed workplaces and public places to be smoke free, including restaurants.

Throughout the series of events that followed the passage of the original ordinance, the coalition was forced to expend effort on defending the ordinance that could have otherwise been devoted to other policy interventions. The coalition had not anticipated the amount of energy that it would have to spend on sustaining its initial policy victory.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

[a]Giles, M. 1997. Poll shows most residents support smoking ban. *Las Cruces Sun-News*, May 7, 1995.

Program services are needed to respond to the increased demand that are created by these outcomes, whether smoking cessation clinics, management training events, or retailer education programs. Chapter 7 describes how ASSIST staff worked with their coalition partners to encourage them to offer the services, congruent with their organizations' missions, that would help individuals and communities embrace a tobacco-free norm in daily life.

Appendix 6.A. Excerpts from *Youth Access to Tobacco: A Guide to Developing Policy*

Youth Access To Tobacco

A Guide To Developing Policy

Number one in a series of four policy guides

ASSIST
The American Stop Smoking Intervention Study

National Cancer Institute
National Institutes of Health
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared by:
Americans for Nonsmokers' Rights
Berkeley, California
with
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Rockville, Maryland

Contents*

*Page numbers in this Table of Contents are from the original document and do not correspond to page numbers in this monograph.

Background

Tobacco use is the leading cause of preventable disease and death in the United States (US DHHS, 1989). Primary smoking claims an estimated 419,000 lives per year (CDC, 1993a), secondary smoking another 53,000 (Glantz and Parmley, 1991). Tobacco addiction typically begins during childhood or adolescence. Approximately 75 percent of cigarette smokers tried their first cigarette before their 18th birthday (CDC, 1991a). Initiation of daily smoking generally occurs during sixth through ninth grade (Johnston et al., 1992).

Surveys conducted throughout the U.S. show increasingly high rates of smokeless tobacco use, concentrated among young males. Estimates of use range from 10 to 39 percent (US DHHS, 1992).

These young tobacco users underestimate the addictive nature of nicotine. According to a 1986 survey, only five percent of high school smokers believed they would be smoking five years later; in fact, an estimated 75 percent continued to smoke seven to nine years later (Johnston et al., 1992).

Tobacco use among youth has failed to show a significant decline over the past ten years. Although the daily smoking rate for high school seniors decreased from 29 percent to 20 percent between 1977 and 1981, the smoking rate decreased only an additional 1.8 percent through 1991 (Johnston et al., 1992). This trend is in sharp contrast to the greater declines observed for other drug use among youth during the same time period.

Despite the fact that almost all states prohibit the sale and distribution of tobacco products to minors, tobacco is easily accessible to youth. Studies indicate that underage youth can purchase tobacco products 70 to 100 percent of the time from merchants and through vending machines (Altman et al., 1989). Youth themselves report that it is easy for them to purchase tobacco; the majority buy their own cigarettes (Cummings et al., 1992).

The tobacco industry, including manufacturers and retailers, profit from these illegal sales. Researchers estimate that 947 million packs of cigarettes are sold annually to underage youth in the United States, representing total sales worth $1.23 billion and a net profit of $221 million (DiFranza and Tye, 1990).

Overview: Policy Options To Reduce Youth Access to Tobacco

Strategies to reduce youth consumption of tobacco products focus on either the demand or the supply side of the problem. Counter-advertising campaigns and school-based tobacco prevention curricula seek to reduce youth *demand* for tobacco products. Policy options regarding the advertising and promotion of tobacco products will be explored in a future paper in this series. Youth access policies are designed to reduce the *supply* of tobacco products available to youth.

Youth access policies are based on the premise that reducing access will lead to a reduction in youth consumption and addiction. The effectiveness of these policies cannot be measured simply in terms of achieved reduction in tobacco sales to minors. The ultimate goals of all of these policies are to reduce youth consumption of tobacco products and reduce childhood addiction, ultimately reducing adult consumption.

Preliminary results from three studies indicate that youth access legislation may reduce youth consumption. Following enactment and enforcement of a youth access ordinance in Woodridge, Illinois, student surveys showed over a 50 percent reduction in rates of cigarette experimentation and regular use of cigarettes (Jason et al., 1991). A youth access ordinance in Everett, Washington, reduced tobacco use among girls from 26.4 percent to 11.5 percent (Hinds, 1992). In Leominster, Massachusetts, active local enforcement of a state sales to minors law was followed by a significant decrease in the number of youth identifying themselves as cigarette smokers (DiFranza et al., 1992).

Policies to reduce youth access to tobacco can be enacted at the Federal, state and local levels. A recent Federal initiative, the Synar Amendment, requires states to adopt and enforce laws prohibiting tobacco sales and distribution to youth less than 18 years of age. States which fail to achieve specified reductions in the rate of youth sales risk losing a percentage of their Federal funding for drug and alcohol prevention and treatment.

The majority of existing state laws focus on establishing a minimum age for purchase of tobacco products; some states have restricted placement of vending machines, banned free distribution of tobacco product samples, or licensed tobacco retailers (US DHHS, 1993b). State legislation has been largely unenforced and ineffective in reducing youth access (US OIG, 1992). Florida and Vermont are the only two states which currently provide for statewide enforcement of their youth access laws (US OIG, 1992). This situation may change, as the Synar Amendment offers significant incentives for states to achieve reduction in rates of tobacco sales to minors.

Although it is not strictly speaking a youth access policy, increasing state tobacco excise taxes does reduce youth access by placing the product out of financial reach of many youth. An increase in the excise tax will lead to a reduction in tobacco consumption among youth (US GAO, 1989). The issue of excise taxes will be explored in greater depth in a future paper in this series.

To date, the greatest successes in reducing youth access have been achieved at the local level (US DHHS, 1993b). Provisions that have been enacted at the local level include:

- Licensing tobacco retailers, providing for suspension/revocation for repeated sales to minors.
- Banning or restricting tobacco vending machines.
- Banning self-service displays of tobacco products.

- Banning distribution of free samples or coupons for free samples of tobacco products.
- Banning sale of single cigarettes.
- Requiring point-of-purchase warning signs.

The provisions listed above are also appropriate for adoption at the state level. Several of the options (vending machines, licensure, point-of-purchase signs) are included in the Model Sale of Tobacco Products to Minors Control Act for States developed by the Department of Health and Human Services (US DHHS, 1990).

Studies consistently show strong public support for stronger laws and better enforcement to reduce youth access (CDC, 1991b; US OIG, 1992; Burns and Pierce, 1992). The only substantial opposition to reducing youth access comes from the tobacco industry and merchants, both of whom profit from sales to minors.

Policy Options

MINIMUM AGE OF PURCHASE FOR TOBACCO PRODUCTS

Forty-nine states have established a minimum age of purchase for tobacco products; the majority set the minimum age at 18 years of age (US DHHS, 1993b; US OIG, 1992). Under the Synar Amendment, states are required to prohibit the sale or distribution of tobacco products to persons under the age of 18 (US DHHS, 1993a).

Legislation should avoid vague language stating that it is a violation to "knowingly sell tobacco products to minors." This provides a loophole for merchants, who can claim they were not aware the customer was underage (US OIG, 1992). Stronger language requires merchants to request photographic identification if a customer appears to be under a specified age, before concluding the sale.

Options

- Prohibit the sale or distribution of tobacco products to persons under 18 years of age.
- Require merchants to request photographic proof of age for customers who appear to be under 21 years of age.

Passing a law which simply prohibits the sale and distribution of tobacco products to minors will not automatically decrease youth access to tobacco. In order to achieve a true reduction in access, policies must also address the locations and manner in which tobacco is sold or otherwise made available (Reynolds and Woodward, 1993). Policies must also include clear enforcement mechanisms and be actively enforced if they are to achieve their potential to reduce youth access. Policy provisions and enforcement

mechanisms to achieve compliance with minimum age requirements are discussed in this paper.

TOBACCO RETAILER LICENSING

Tobacco retailer licensing legislation requires merchants to obtain a license to sell tobacco products *and* provides for the suspension or revocation of the license if the merchant sells tobacco to a minor. This scheme, similar to that used to control alcoholic beverage sales to minors, creates a significant financial incentive for retailers to avoid illegal sales to minors. The profits lost by forfeiting the right to sell tobacco to adults exceed the typical $100 to $500 fine exacted for violations under most youth access legislation. License fees can be earmarked to fund enforcement activities.

Licensing ordinances are a relatively new development, and there is only preliminary research documenting their effects. Researchers report that a licensing ordinance in Woodridge, Illinois, has reduced the rate of illegal sales to minors, from 70 percent at baseline to less than five percent 18 months after initiating enforcement (Jason et al., 1991). King County, Washington, reduced sales to minors to 27 percent following enactment of a licensing ordinance (Spokane County Health District, 1992).

These licensing ordinances include strong enforcement provisions. Both Woodridge and King County have used underage "inspectors" who, under adult supervision, spot check retailer compliance. The license fee is set at a level sufficient to cover the cost of enforcement efforts. The King County ordinance was recently superceded by preemptive state legislation passed to satisfy the Synar Amendment, and the local enforcment activities have been dismantled. (See sections on Preemption and the Synar Amendment.)

Most licensing ordinances contain a graduated schedule of fines and penalties; suspension or revocation of a license is the last resort, after the retailer has shown a consistent pattern of illegal sales to minors. Under some ordinances, the retailer may appeal suspension or revocation of the license at a public hearing. To avoid frivolous appeals, the retailer may be required to bear the costs of the appeal process.

Options

- Require a license for the retail sale of tobacco products. Earmark fees to fund enforcement efforts.
- Establish a graduated penalty system which culminates in suspension or revocation of the tobacco retail license for repeated sales to minors.
- Establish a public appeal process for suspension or revocation of license. The retailer may be required to pay the costs of the appeals process.
- Enforcement: Systematic, unannounced spot checks of all retailers by underage "inspectors."

TOBACCO VENDING MACHINES

A study commissioned by the vending machine industry found that 23 percent of youth that smoke use vending machines "often" or "occasionally" (NAMA, 1989). A recent study found an even higher percentage (37.8 percent) of youth that smoke who reported using vending machines "often" or "sometimes" (Cummings et al., 1992). Younger children rely more heavily on vending machines as a source of cigarettes (US DHHS, 1989). The NAMA study found that 13-year-olds reported using a vending machine "often" 11 times more frequently than did 17-year-olds (NAMA, 1989).

Option One: A Complete Ban on the Sale of Tobacco Products Through Vending Machines

Former Secretary of Health and Human Services Louis Sullivan and former Surgeon General C. Everett Koop both have called for a total ban on cigarette vending machines. Unlike over-the-counter sales, vending machine sales to minors don't respond to merchant education programs (Altman et al., 1989) or to increased penalties and fines for sales to minors (Forster et al., 1992b).

Complete bans are relatively easy to enforce; the simple presence of a tobacco vending machine indicates a violation. A study of two cities with tobacco vending machines bans found complete compliance two years after the bans were enacted (Forster et al., 1992a).

Options

- Ban the sale of tobacco products through vending machines in all locations.
- Enforcement: If a tobacco vending machine is present, the owner is in violation of the law.

Option Two: A Partial Ban on the Sale of Tobacco Products Through Vending Machines, Restricting Their Placement to Adult Locations

A partial ban provides an exemption for tobacco vending machines placed in bars or other "adult-only" locations, such as employee cafeterias or adult social clubs. These policies are less effective than total bans in preventing illegal sales to minors. Researchers from the University of Minnesota have demonstrated that underage youth experience high rates of success (78 percent) in purchasing cigarettes from vending machines placed in establishments characterized as adult locations (Forster et al., 1992b).

The effectiveness of a partial ban may increase if machines are required to be placed at least 25 feet from any entrance. This prevents placement of the machines in unattended lobbies and entrances. Defining adult-only locations should be done carefully.

For instance, exempting the bar area of a restaurant may fail to prevent sales to minors; 47 percent of youth using tobacco vending machines report that the machine was placed in a restaurant (NAMA, 1989).

Options

- Ban the sale of tobacco products through vending machines, providing an exemption for adult-only locations.
- Require that tobacco vending machines be placed at least 25 feet away from any entrance in an exempted location.
- Enforcement: If a tobacco vending machine is present, verify that it is in an exempted location. Verify that the machine is 25 feet from any entrance. Periodic purchase attempts by underage "inspectors."

Option Three: Require Installation of Locking Devices on all Tobacco Vending Machines

This option is often promoted by vending machine trade associations and the tobacco industry as an alternative to full or partial bans. This is the least effective means of curtailing illegal sales to minors through vending machines.

The state of Utah, which required their use until 1988, found that locking devices were rarely installed, and, where installed, seldom operating. In St. Paul, Minnesota, one year after a locking device ordinance was passed, 30 percent of the machines were not equipped with a locking device. Of those machines with a locking device, compliance deteriorated during the first year after the law was passed, from 30 percent sales to minors at three months to 48 percent at one year (Forster et al., 1992a).

Locking device requirements entail a greater enforcement burden than complete bans (Forster et al., 1992a). Even when installed and operating, attendants may continue to sell cigarettes to underage youth. However, in areas where a full or partial tobacco vending machine ban is politically infeasible, some researchers feel that a locking device requirement accompanied by strong enforcement to ensure installation and operation is better than nothing.

Options

- Require installation of a locking device on all tobacco vending machines.
- Enforcement: Site visits to verify locking device installation and operation. Periodic purchase attempts by underage "inspectors."

SELF-SERVICE DISPLAYS

Self-service displays allow customers to acquire tobacco products without the intervention of a store employee. Tobacco companies offer retailers "slotting fees" for favorable placement of their products in the store, including placement of self-service displays.

Banning self-service displays may reduce youth access in two ways: (1) youth may be less likely to attempt purchase when they must request tobacco from a store employee, rather than handing the product to a sales clerk for checkout, and (2) the absence of displays makes it more difficult to steal tobacco products. This is a relatively new policy development; there is no research to date which indicates whether banning self-service displays reduces youth access to tobacco.

Options

- Prohibit open displays of tobacco products which can be reached without the intervention of a store employee.

DISTRIBUTION OF FREE TOBACCO PRODUCT SAMPLES

Distribution of free tobacco samples is a popular form of promotion for both cigarette and chewing tobacco manufacturers. Free tobacco samples frequently are distributed in locations where underage youth are likely to congregate: music festivals, rock concerts, sports events, zoos, and fairs (Davis and Jason, 1988; Chudy et al., 1993).

Most states prohibit the distribution of tobacco samples to underage youth. In addition, the tobacco industry has a voluntary code addressing product sampling which prohibits the distribution of tobacco products to "any person whom they know to be under 21 years of age or who, without reasonable identification to the contrary, appears to be less than 21 years of age" (Tobacco Institute).

Despite these state laws, and the industry's voluntary code, free sampling of tobacco products in public areas and through the mail is a source of tobacco products for underage youth. A survey of underage youth found that 50 percent reported witnessing other people their age receiving free samples (Davis and Jason, 1988). The same study found that 20 percent of high school students and four percent of elementary students surveyed reported that they themselves had received free samples of tobacco products.

Options

- Ban distribution of free tobacco samples or coupons for free samples in publicly and privately owned property accessible to the general public.
- Ban the distribution of free tobacco samples through the mail.

SINGLE CIGARETTE SALES

Although the Federal Cigarette Labeling and Advertising Act prohibits the sale or distribution of cigarettes without the mandated warning label, some stores sell single cigarettes which are taken out of their packages and stored in cups and trays. This practice is illegal, unless the cigarettes are removed from their packages by the customer or in the presence of the customer (Manfreda, 1989). A study of stores in a southern California community found that almost half sold single cigarettes and that youth were able to purchase them almost twice as often as adults (Leary, 1993). This despite the fact that California prohibits all sales of single cigarettes.

Options

- Prohibit the sale or distribution of one or more cigarettes, other than in a sealed package which conforms to the Federal labeling requirements, including the Federal warning label.

POINT-OF-PURCHASE WARNING SIGNS

Requiring warning signs stating that sales to minors are illegal does not lead to a reduction in sales to minors. A merchant education project in New York found that posting signs had no effect on the rate of sales. Although the intervention led to an increase in the number of stores posting warning signs (40 percent), those stores showed no significant reduction in sales to minors when compared to control stores which did not receive the intervention (Skretny et al., 1990). Posting of signs is the major component in the Tobacco Institute's program "It's the Law." Researchers have shown that this program does not reduce merchants' illegal sales to minors (DiFranza and Brown, 1992). Studies conducted in Missouri and Texas also found that the likelihood of success was not significantly different for stores with and without warning signs (CDC, 1993b).

A study of stores in Massachusetts found that stores which posted signs were less likely to sell to minors; however, the majority (32 of 36) of the signs were not visible to the customers (DiFranza et al., 1987). The warning signs may have served as a cue to the clerks, reminding them to avoid selling tobacco products to minors.

Some tobacco control professionals are concerned that posting warning signs where they are visible to minors presents tobacco as a "forbidden fruit" reserved for adults and may encourage teen rebellion against adult rules (Carol, 1992; DuMelle, 1991). A study of youth susceptibility to smoking found that rebellious attitudes were associated with an increased susceptibility to smoking among adolescents (Pierce et al., 1993). This dilemma may be solved by posting a warning sign so as to be visible to the clerk, but not to underage youth.

Options

- Require warning signs to be posted at point-of-purchase in view of the sales clerk.

Appendix 6.B. Excerpts from *Clean Indoor Air: A Guide to Developing Policy*

Clean Indoor Air

A Guide to Developing Policy

Number two in a series of four policy guides

ASSIST
The American Stop Smoking Intervention Study

National Cancer Institute
National Institutes of Health
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared by:
Americans for Nonsmokers' Rights
Berkeley, California
with
Prospect Associates
Rockville, Maryland

June 1994

Contents*

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Background

THE HEALTH EFFECTS OF ENVIRONMENTAL TOBACCO SMOKE

Environmental tobacco smoke (ETS), also called secondhand smoke, is a combination of smoke exhaled by the smoker and sidestream smoke emitted from a burning cigarette. Exposure to ETS is often referred to as involuntary smoking. The adverse health effects of ETS on the nonsmoker are no longer in question. Environmental tobacco smoke is a cause of respiratory disease, including lung cancer, and may also cause heart disease in nonsmokers (US DHHS, 1986; US EPA, 1992; Glantz & Parmley, 1991; Taylor et al., 1992).

The 1986 Surgeon General's Report was devoted to the health effects of involuntary smoking on the nonsmoker. Based on a comprehensive review of the scientific research, the report reached three major conclusions (US DHHS, 1986):

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.
2. Children of parents who smoke, compared with children of nonsmoking parents, have an increased frequency of respiratory infections, increased respiratory symptoms and slightly smaller rates of increase in lung function as the lung matures.
3. Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, exposure of nonsmokers to environmental tobacco smoke.

The findings of the Surgeon General's Report were seconded by the National Academy of Sciences, which also reviewed the scientific evidence regarding secondhand smoke in 1986 (NAS, 1986).

In 1990, the Environmental Protection Agency convened a scientific advisory board to review research on the respiratory effects of ETS on nonsmokers. The final report, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders, was released in 1992 and included the following conclusions (US EPA, 1992):

In adults:

1. ETS is a Group A (known human) carcinogen.

In children, ETS exposure is causally associated with:

1. Increased prevalence of lower respiratory tract infections;
2. Increased prevalence of middle-ear effusion, symptoms of upper respiratory tract irritation, and a small but statistically significant reduction in lung function;
3. Additional episodes and increased severity of symptoms in children with asthma; and,
4. Exposure to ETS is a risk factor for new cases of asthma in children who have not previously displayed symptoms.

The EPA did not issue any findings regarding the link between heart disease and ETS exposure. However, the American Heart Association's Scientific Council has concluded that ETS increases the risk of heart disease (Taylor, et al., 1992). Some research indicated that the public health burden caused by ETS may be greater for heart disease than lung cancer (Steenland, 1992; Taylor, et al., 1992; Glantz & Parmley, 1991). Researchers have estimated that in addition to the cancer deaths attributable to ETS exposure (up to 3,700 to lung cancer and up to 12,000 to other cancers), up to an additional 37,000 nonsmokers die from heart disease caused by ETS exposure (Glantz & Parmley, 1991).

In addition to the EPA's classification of ETS as a Group A carcinogen, the National Institute for Occupational Safety and Health (NIOSH) has determined that ETS meets OSHA's criteria for classifying substances as potential occupational carcinogens (NIOSH, 1991). NIOSH also concludes that exposure to ETS poses an increased risk of heart disease among occupationally exposed workers (NIOSH, 1991).

CONSTITUENTS OF ENVIRONMENTAL TOBACCO SMOKE

Environmental tobacco smoke is a combination of mainstream smoke exhaled by the smoker and sidestream smoke emitted by the burning tip of a cigarette. The major source of ETS is sidestream smoke. Because of a lower burning temperature, sidestream smoke actually contains higher amounts of toxins and carcinogenic agents per gram of tobacco burned than mainstream smoke (US DHHS, 1986).

Nonsmokers' exposure to ETS can be measured by cotinine levels in body fluids. Cotinine, a metabolic by-product of nicotine, is an accurate marker for ETS exposure because of nicotine's specificity to tobacco smoke (US DHHS 1986). Many people who report no exposure to ETS have measurable levels of cotinine in their body fluids (NIOSH, 1991). The tobacco industry has claimed that cotinine levels in nonsmokers are caused by eating vegetables from the solanecae family (e.g., eggplant). However, a nonsmoker would have to eat several pounds daily to produce measurable levels of cotinine (Perez-Stable, et al., 1992; Repace, 1994). Although a metabolized by-product of nicotine is the biological marker of ETS exposure, nonsmokers are exposed to far more than just nicotine when they are exposed to ETS.

Four thousand seven hundred (4,700) chemical compounds have been identified in ETS, including carbon monoxide, nicotine, carcinogenic tars, ammonia, hydrogen cyanide, formaldehyde, benzene, and arsenic (US EPA, 1989). Many of these compounds are treated as hazardous when released into outdoor air by industrial plants (US EPA, 1989). Forty-three chemicals in tobacco smoke are identified carcinogenic compounds (US DHHS, 1989).

EFFECTS ON INDOOR AIR QUALITY

The EPA considers ETS the most widespread and harmful indoor air pollutant and a major contributor to indoor air pollution (US EPA, 1990). A 1980 study found that every indoor environment where smoking was permitted had air pollution levels of respirable suspended particles above the standards for outdoor air, while all smokefree areas met Federal standards for outdoor air (Repace & Lowrey, 1980). Exposure to ETS is high because most people spend approximately 90 pecent of their time indoors (US EPA, 1993).

RECOMMENDATIONS TO ELIMINATE EXPOSURE TO ETS

Both the Environmental Protection Agency and the National Institute for Occupational Safety and Health (NIOSH) recommend that nonsmokers should not be exposed to ETS (US EPA, 1989; NIOSH, 1991). Both agencies recommend two methods by which nonsmokers' ETS exposure can be eliminated (US EPA, 1989; NIOSH, 1991):

1. **Complete elimination of smoking in the building; or**
2. **Establishment of separate, enclosed smoking areas that are separately ventilated and directly exhausted to the outside.**

Overview: Clean Indoor Air Policy Options

Clean indoor air policies to reduce nonsmokers' exposure to environmental tobacco smoke (ETS) have historically treated public places, workplaces, restaurants, and bars as separate entities (Hanauer, et al., 1986; Pertschuk & Shopland, 1989; US DHHS, 1993). At a minimum, these policies set nonsmoking as the norm and restrict smoking to designated areas. A more recent trend is to prohibit smoking altogether (US DHHS, 1993).

Clean indoor air policies have been adopted in both the private and the public sectors. In the private sector, voluntary clean indoor air policies generally have been adopted by private employers, although public venues such as hospitals, hotels/motels, airports, and shopping malls have also adopted voluntary policies.

In the public sector, clean indoor air policies take either the form of legislation passed by elected legislative bodies or regulations adopted by public agencies. State laws are often referred to as clean indoor air laws, while local laws are called smoking ordinances (Pertschuk & Shopland, 1989).

Although the chief purpose of clean indoor air policy is to protect nonsmokers from the hazards of ETS exposure, restrictions on smoking have been shown to reduce both smoking prevalence and, among continuing smokers, cigarette consumption (Woodruff, et al., 1993; Emont, et al., 1992; Borland, et al., 1990; Stillman et al., 1990, Brigham, et al., 1994).

VOLUNTARY CLEAN INDOOR AIR POLICIES

Voluntary smoking policies have generally been the purview of private workplaces. The earliest workplace smoking policies were developed as safety measures to prevent fires, protect machinery, avoid product contamination, and improve workplace safety and were more commonly found among blue-collar (i.e., manufacturing) workplaces (US DHHS, 1986). Not until the 1970s did the nature and scope of voluntary workplace policies begin to change (US DHHS, 1986).

During the 1980s, smoking restrictions began shifting from workplace safety to employee health, and more nonmanufacturing workplaces began adopting policies (US DHHS, 1986). The policies themselves became more stringent, restricting smoking to even smaller designated areas.

Since the late 1980s, a growing trend to eliminate smoking in the workplace has emerged. A 1991 survey by the Bureau of National Affairs found that 34 percent of companies had eliminated smoking in the workplace, compared with 7 percent in 1987 and 2 percent in 1986 (BNA, 1991). In 1992, 52 percent of facilities managers surveyed reported that their facility had a smokefree workplace policy (Ward, 1992).

CLEAN INDOOR AIR LEGISLATION

Clean indoor air legislation has shown a bottom-up trend, with the strongest and most comprehensive policies concentrated at the local level, followed by state legislation, and, lastly policy established at the Federal level.

FEDERAL CLEAN INDOOR AIR POLICY

Federal clean indoor air policy focuses on smoking in Federal facilities and on public transportation (US DHHS, 1989). Both the U.S. Department of Health and Human Services and the U.S. Postal Service have adopted policies eliminating smoking in all of their facilities. Other Federal agencies have implemented policies that prohibit smoking except in designated smoking areas.

Amtrak, a quasi-governmental agency, has adopted a policy that eliminates smoking completely on trains traveling less than 4$^{1}/_{2}$ hours such as the metroliner between Washington and New York. The ban also covers all trains in California and other selected trains. To date, congressional action on clean indoor air has been limited to the airline smoking ban. Smoking is banned on all airline flights within the continental United States and overseas domestic flights of 6 hours or less.

STATE CLEAN INDOOR AIR POLICY

Early state legislation restricting smoking was intended to reduce fire and other safety hazards or treated tobacco use as a moral wrong (US DHHS, 1986). This trend

continued until the 1970s. With the first reports that smoking's ill effects were not limited to the smoker, state legislation began to shift its concern from fire safety to protecting nonsmokers (US DHHS, 1986).

In 1975, Minnesota passed its Clean Indoor Air Act, the first comprehensive state legislation to set nonsmoking as the norm. This landmark legislation restricted smoking except in designated areas in many public places, including restaurants and public and private worksites. In 1993, Vermont passed the most restrictive state clean indoor air legislation. Vermont is the first state to completely ban smoking in public places, restaurants, and all government buildings.

As of 1993, 46 states and the District of Columbia had passed some form of clean indoor air legislation dealing with public places. Forty-two restrict smoking in the public workplace and 22 include restrictions in private workplaces (Nobel, 1994).

LOCAL CLEAN INDOOR AIR POLICY

As with state legislation, the first local clean indoor ordinances were passed in the 1970s (US DHHS, 1993). As of September 1992, 543 local smoking ordinances were on the books (US DHHS, 1993).

Local ordinances are almost always stronger and more comprehensive than their corresponding state laws (US DHHS, 1989). The recent trend to completely eliminate smoking in public places, workplaces, and restaurants began and continues to flourish at the local level. In 1985, Aspen, Colorado was the first municipality to ban smoking in restaurants. Following the release of the draft EPA risk assessment in 1990, an increasing number of local 100 percent smokefree ordinances were enacted. As of May 1994, 87 smokefree ordinances completely eliminate smoking in public places, workplaces, and restaurants; 35 eliminate smoking in public places and restaurants; and 16 eliminate smoking in public places and workplaces (ANR, 1994).

Local ordinances have been adopted at a much faster rate than state legislation. A 1993 status report for the Tobacco Institute tracked a total of 388 local clean indoor air ordinances. Of these, 215 had been adopted, 147 were pending, and only 26 had been defeated (Tobacco Institute, 1993a). In contrast, of the clean indoor air bills introduced in 43 state legislatures in 1993, 20 were defeated (including an attempt to repeal preemption in Iowa) and only 16 were adopted (at least two of which include preemption of local ordinances) (Tobacco Institute, 1993b).

The tobacco industry has been largely unsuccessful in defeating clean indoor air policy at the local level. For this reason, preemption of local ordinances by state legislation has emerged as the tobacco industry's primary strategy to prevent the passage of clean indoor air legislation. (See section on Opposition to Clean Indoor Air Policy for more information on preemption.)

LOCATIONS COVERED BY CLEAN INDOOR AIR LEGISLATION

Locations that are generally covered by clean indoor air policies (legislative or regulatory), at both the local and the state level include:

- Workplaces, both public and private
- Enclosed public places, which include most areas open to the general public or to which the public is invited (e.g., retail stores, banks, theatres, museums, and public transit)
- Restaurants, and in some instances, bars (particularly those attached to restaurants)
- Schools
- Child care centers
- Health care settings
- Public transportation
- Prisons
- Recreation facilities such as sports stadiums, bowling centers, and bingo parlors

PUBLIC SUPPORT FOR CLEAN INDOOR AIR POLICIES

As early as 1964, a majority (52 percent) of adults thought smoking should be allowed in fewer places than it was at the time (US DHHS, 1989). Years before the 1986 Surgeon General's report on involuntary smoking, nonsmokers believed that exposure to secondhand smoke was harmful. A 1978 survey completed for the tobacco industry found that 58 percent of Americans believed that being exposed to other's cigarette smoke was hazardous to their health (The Roper Organization, 1978).

A 1988 Gallup survey found that the percentage favoring a total ban on smoking in public places was 60 percent (75 percent of nonsmokers) (Gallup, 1988). In 1994, that percentage had increased to 67 percent (78 percent of nonsmokers), according to a New York Times/CBS NEWS poll (Janofsky, 1994). The public has also shown a consistent trend in support of restrictions on smoking in the workplace (US DHHS, 1989).

Adoption of smokefree policies may actually lead to an increase in support for smoking bans in certain environments. In 1984, a Field poll in California found that only 38 percent of the state's residents favored a complete ban on smoking in airplanes. In 1993, a few years after the congressional ban of smoking on domestic flights, that number had more than doubled to 81 percent (The Field Poll, 1993).

Policy Options

Given the serious health risks associated with secondhand smoke exposure, it is imperative that nonsmokers be provided with smokefree public places and workplaces to the greatest extent possible. In some instances, it is not judged to be politically possible to immediately enact smokefree legislation; this may be particularly true in jurisdictions that are adopting restrictions on smoking for the first time. To be effective, it

is essential that the legislation be supported by the community. Policy development should always begin with community education, including media advocacy, before any legislation is introduced.

The options listed below contain several provisions that can be incorporated into a piece of clean indoor air legislation. Each list begins with the total elimination of smoking; recommendations for partial restrictions are located at the end of each options list. Although these options specifically focus on enacted legislation, many of the options are appropriate guidelines to develop voluntary policies.

WORKPLACES

Approximately 80 percent of the average nonsmoker's exposure to secondhand smoke occurs at work (Repace & Lowrey, 1985). In addition to reducing secondhand smoke exposure, worksite restrictions and bans help some smokers reduce or quit smoking (Borland, et al., 1990; Stillman, et al., 1990). A recent study estimates that if every California workplace went smokefree, consumption among employees would drop 41 percent below that if there were no workplace smoking policies (Woodruff, et al., 1993). The effect of a workplace policy on smoker behavior is reduced when the workplace is only partially smokefree (Woodruff, et al., 1993).

Many workplaces voluntarily restrict or eliminate smoking. A 1991 survey by the Bureau of National Affairs found that 85 percent of responding firms adopted policies restricting smoking, with 34 percent completely eliminating smoking at work. Although many of these were adopted voluntarily, 36 percent of the respondents reported that their policies were adopted as a result of state or local legislation (BNA, 1991). (See section on Voluntary Worksite Programs for more information.)

Many local jurisdictions and state legislatures first adopt policies that cover only governmental workplaces, restricting or eliminating smoking in all government facilities. These restrictions are often adopted through administrative policies or resolutions, although some are put in place through enacted legislation. The next phase is to extend these restrictions to private workplaces. The majority of state and local laws partially restrict smoking in public and private workplaces, although a growing number of local ordinances completely eliminate smoking in all workplaces.

Smokefree workplace legislation prohibits smoking in all enclosed areas of the workplace. Some legislation has allowed the construction of smoking areas, which are enclosed and separately ventilated from the rest of the building. (See section on Common Exemptions for more information.)

Partial bans on smoking in the workplace generally prohibit smoking in all common areas, particularly restrooms, hallways, common work areas, and meeting rooms. In addition, many allow employees to designate their own immediate work areas as nonsmoking (Pertschuk & Shopland, 1989; US DHHS, 1993). Partial restrictions often include a "nonsmoker's preference" clause, specifying that in the event of a dispute over

a smoking policy, the right of the nonsmoker to a smokefree workplace prevails (US DHHS, 1993). Partial restrictions almost always specify that the proprietor of any regulated area has the right to designate the entire facility smokefree (US DHHS, 1993).

Most workplace legislation, smokefree or partial restrictions, includes a "nonretaliation clause" protecting employees and job applicants who seek their rights under the law (US DHHS, 1993). Many clean indoor air laws also require employers to develop a written policy for the workplace, which conforms with the requirements of the law (US DHHS, 1993).

Options

* Prohibit smoking in all enclosed workplaces.
* Prohibit smoking in all enclosed workplaces, except for a designated smoking area that is enclosed, separately ventilated, and directly exhausted to the outside.
* Include a nonretaliation clause protecting nonsmokers who assert their rights under the law from retaliation by an employer.
* Require the employer to develop a written workplace policy whose provisions comply with requirements established by the law. Copies shall be provided on request.
* If smoking is allowed in designated areas, prohibit smoking in all commonly used areas of the workplace, allow employees to designate their immediate work area as nonsmoking, specify that the nonsmoking employee's rights prevail when disputes arise over smoking in the workplace, and specify that any regulated area may designate the entire facility as smokefree.

ENCLOSED PUBLIC PLACES

Legislation restricting smoking in public places typically prohibits smoking completely rather than mandating separate smoking and nonsmoking areas. "Public places" includes any enclosed area open to the public such as retail stores, businesses open to the public, theatres, museums, and reception areas (Pertschuk & Shopland, 1989; US DHHS, 1993). Some of the newest local ordinances regulate smoking in the common areas of apartment buildings such as lobbies, stairways, common laundry facilities, and hallways between apartments (ANR, 1994).

Most clean indoor air legislation lists various venues covered under the law to clarify the intent and coverage of the law. When such lists are present, it is important to include language stating that the list "includes, but is not limited to" the listed areas.

Options

* Prohibit smoking in all enclosed public places, specifying that all enclosed public places, unless specifically exempt, are included.
* List specific environments (e.g., elevators and restrooms, service lines, retail stores, office areas where the public is allowed, and theatres) that are covered by the ban.

RESTAURANTS AND BARS

Although restaurants and bars serve as both public places and workplaces, they have historically been treated separately in clean indoor air legislation (Pertschuk & Shopland, 1989; US DHHS, 1993; Hanauer, et al., 1986). However, the debate has begun to focus on restaurants and bars as workplaces. This is important, as secondhand smoke levels in both restaurants and bars are higher than those found in most other workplaces.

The level of environmental tobacco smoke in restaurants is about 1.6 to 2 times higher than that found in an office. In bars, exposure to ETS is 3.9 to 6.1 times higher than office exposure. This increased exposure to secondhand smoke results in a 50 percent greater risk of contracting lung cancer for restaurant and bar workers (Siegel, 1993b).

Many clean indoor air laws require restaurants to establish smoking and nonsmoking sections. A move to completely eliminate smoking in restaurants began in the mid-1980s and has accelerated in the 1990s with the release of the Environmental Protection Agency's risk assessment classifying secondhand smoke as a Group A carcinogen (US DHHS, 1993; US EPA, 1992). A report released by an Attorneys General Working Group on Tobacco, recommending that fast food restaurants go smokefree, has provided additional impetus to the restaurant industry to adopt voluntary smokefree policies (Attorneys General, 1993).

Policymakers have been reluctant to restrict smoking in free-standing bars and taverns. A handful of local laws require separate smoking sections in bars, but by early 1994, only 10 local ordinances completely banned smoking in all bars (ANR, 1994). Smoking is more commonly regulated in bars that are attached to restaurants. Thirty-six local ordinances that prohibit smoking in restaurants have also covered smoking in bars attached to restaurants (ANR, 1994). Generally, these laws either prohibit smoking in restaurant cocktail lounges and bars or allow smoking only if the bar area is separately

enclosed and ventilated in a manner that prevents secondhand smoke from recirculating into the rest of the restaurant.

Options

* Eliminate smoking completely in all restaurants and bars.
* Permit smoking in free-standing bars, but eliminate smoking in bars attached to restaurants unless the bar: (1) is in a separate room from the dining room; (2) has a separate ventilation system; (3) is not the sole entrance or waiting area for dining; and (4) prohibits minors from entering.
* If smoking sections are established, set the maximum allowable size of the smoking area at a percentage that is no larger than the percentage of smokers in the community.

SCHOOLS

A growing number of public schools completely prohibit tobacco use on school grounds, by students, faculty, staff, and visitors. Some of these restrictions follow state or local law, others have been adopted by the local school district. By the end of 1992, nine states and the District of Columbia prohibited smoking on school grounds. A survey by the National School Board Association found that in the 1991-92 school year, 40 percent of school districts totally prohibited tobacco use by both students and adults (NSBA, 1992).

Fourteen states ban tobacco use by students on school grounds (O'Connor, 1992). Because these policies still allow smoking by faculty, staff, and visitors, they may fail to adequately protect nonsmokers. Smokefree policies that include faculty and staff receive greater support among students (Phillips & McCoy-Simandle, 1993). A policy that applies to both students and adults promotes "a consistent message — tobacco use is hazardous for adults as well as students and therefore unacceptable in the school setting" (Griffin, et al., 1988).

Options

* Prohibit the use of tobacco products by students, faculty, staff, and visitors within all public school buildings and on school grounds during and after school hours.
* Prohibit tobacco use at all off-campus school functions by students, faculty, staff, and visitors.

CHILD CARE CENTERS

Child care centers have begun prohibiting smoking as a result of their own voluntary policies or state or local laws. These policies are the result of increased awareness of the health risks of secondhand smoke, especially for children.

By the end of 1993, 14 states prohibited smoking in child care centers, while many others restricted smoking (Nobel, 1994; ANR, 1994). Many local ordinances ban smoking in all day care centers, covering facilities serving both children and adults (ANR, 1994).

Options

* Prohibit smoking in all child care centers.
* In child care centers that are operated in private homes, allow smoking only after hours in areas where clients are not permitted.

HEALTH CARE SETTINGS

Smoking restrictions in hospitals are fairly common. A 1987 survey by the American College of Healthcare Executives found that 96 percent of responding hospitals had some type of restrictions on smoking (American Medical News, 1991). As a result of standards established by the Joint Commission on Accreditation of Healthcare Organizations, hospitals, including long-term care and mental health care programs housed within a hospital, must be virtually smokefree. The standards permit smoking only for patients with a physician's prescription that permits smoking based on criteria developed by medical staff. Hospitals that were not already smokefree must at least have a plan for going smokefree by December 31, 1993 (JCAHO, 1991).

Under revisions of the JCAHO standards, hospitals may also designate certain smoking areas for patients who do not have patient-specific permission to smoke, providing that the smoking areas are designed in a way to protect nonsmokers and providing that the areas are only for the use of chronically mentally ill patients, long-term/intermediate care and skilled nursing patients, forensic psychiatry patients, and post-acute head trauma (social rehabilitation) patients (Sachs, 1993).

There is little information about smoking policies in non-hospital health care settings. An area that generates controversy is long-term care facilities. Because patients reside in these types of facilities for long periods of time, staff are reluctant to adopt complete bans on smoking. In some states, only the state can regulate smoking in these facilities. In California, for example, the Department of Health Services, rather than counties or municipalities, has regulatory jurisdiction over skilled nursing facilities and intermediate care facilities (Cal DHS, 1992).

Options

* Prohibit smoking completely in hospitals and other health care facilities, including private homes when used as a health care facility.
* Allow exemptions for chronically mentally ill patients, long-term/intermediate care and skilled nursing patients, forensic psychiatry patients, and post-acute head trauma (social rehabilitation) patients, if they have written, patient-specific permission from their attending physician based on standards established by the medical staff and smoking is allowed only in areas that are enclosed, separately ventilated, and directly exhausted to the outside.

PUBLIC TRANSPORTATION

Today, smoking is rarely permitted on public transportation vehicles. Numerous Federal, state, and local laws eliminate smoking on public transportation vehicles and transit depots (US DHHS, 1993). In 1989, Congress banned smoking on all airline flights within the continental United States. The airline smoking ban also extends to overseas domestic flights of 6 hours or less (e.g., California to Hawaii).

Smoking policies covering local public transportation systems, such as buses or light rail, are typically adopted in one of two ways. The first is through inclusion in a local smoking ordinance. The second is adoption of a smoking policy by the local policymaking body with jurisdiction over the system. A total of 391 local ordinances regulate smoking on public transportation. In addition, 39 state clean indoor air laws ban smoking on public transportation (US DHHS, 1993).

Options

- Prohibit smoking in all vehicles of public transportation, including buses and taxicabs.
- Prohibit smoking in all transit depots such as airports and train platforms.

PRISONS

Although prisoners smoke at rates significantly higher than the general population (Duggan, 1990), an increasing number of prisons and jails are eliminating smoking. The American Jailers Association adopted a resolution in May 1990 urging jails to ban smoking (Skolnick, 1990), and about 10 million prison inmates are currently covered by some sort of smoking restrictions (CDC, 1992a).

Some prison policies prohibit smoking in jail cells but permit it in prison yards, while others prohibit smoking by inmates entirely, and the strongest do so for prison staff as well. Some of these policies are put in place by administrators, while others are the result of state or local legislation and regulation.

A recent court case has increased the incentives for prisons and jails to establish smoking policies. In Helling v. McKinney, the U.S. Supreme Court opened the door to potential lawsuits brought by nonsmoking prison inmates on the theory that exposure to secondhand smoke constitutes cruel and unusual punishment, prohibited by the 8th Amendment to the U.S. Constitution.

Although many jails are adopting smokefree policies, larger prisons are responding more slowly (Skolnick, 1990). Nearly two-thirds of inmates are housed in prisons rather than jails (CDC, 1992a), leaving a substantial number of inmates and prison staff exposed to secondhand smoke.

Options

* Prohibit smoking in enclosed areas of jails and prisons by both inmates and staff.
* Establish a nonsmoking area in prison yards.

RECREATIONAL FACILITIES

Although recreational facilities are considered public places, they are often treated separately in clean indoor air legislation. Recreational facilities, including sports arenas, bingo parlors, bowling alleys, and card rooms often seek exemptions from restrictions covering public places.

SPORTS ARENAS AND STADIUMS

Many sports arenas and stadiums, including open-air stadiums, have voluntarily implemented smokefree policies. By mid-1993, 12 open air stadiums and the two enclosed stadiums for Major League baseball teams eliminated smoking in seating areas, compared with 12 open-air stadiums that permitted smoking. Of the 12 that permitted smoking, 6 had nonsmoking seating sections (SES, 1993).

Options

* Prohibit smoking in all seating sections, concourses, and restrooms. If the facility is open air, permit smoking only in a designated area away from the seating sections and restrooms.
* Prohibit smoking in all concourses and restrooms. Establish nonsmoking and smoking seating sections.

BINGO PARLORS

Many lawmakers are reluctant to confront churches, schools, and other non-profit organizations that operate bingo parlors as fundraisers. As a result, bingo parlors are often exempt from provisions regulating smoking in public places. Exemptions for bingo parlors are particularly troubling because some of the highest levels of indoor air pollution ever measured were in bingo parlors (Repace & Lowrey, 1980; Repace & Lowrey, 1982). More recent clean indoor air legislation is beginning to drop the exemption for bingo parlors. The state of Vermont and numerous local ordinances prohibit smoking at bingo games, while others require the establishment of smoking and nonsmoking sections or rooms (Rau, 1993; ALA, 1993b; ANR, 1994; Sullivan, 1992).

Options

* Prohibit smoking at all bingo games.
* Require separate rooms for nonsmoking and smoking patrons.

BOWLING CENTERS

Although bowling centers market themselves as "family entertainment" and are frequented by children, bowling centers have historically been exempted from clean indoor air legislation. As with bingo parlors, new legislation is beginning to drop this exemption. The state of Vermont and numerous local ordinances now include bowling centers under provisions regulating smoking in public places (Rau, 1993; ANR, 1994; ALA, 1993a).

Many bowling centers have restaurants or bars located on the premises. These restaurants and bars must comply with whatever requirements have been established for these venues under state or local legislation.

Options

* Prohibit smoking in bowling centers.
* Prohibit smoking except for a designated area on the concourse.

ENFORCEMENT ISSUES

Clean indoor air legislation has historically required relatively little enforcement activity. Most laws are "self-enforcing;" enforcement is activated by complaint, rather than through active surveillence.

DESIGNATING AN ENFORCEMENT AGENCY

At the state level, the state health department is the most commonly designated enforcement agency (US DHHS, 1989). Most local ordinances designate either the city manager or local health department as the primary enforcement agency (US DHHS, 1993; Hanauer, et al., 1986). Fewer jurisdictions have designated the police department as the enforcement agency (US DHHS, 1989). As a supplement to enforcement activities by the primary agency, environmental health officers and fire officials may be required to inspect facilities for compliance with clean indoor air legislation during the course of other mandated inspections.

VIOLATIONS AND PENALTIES

Compliance with clean indoor air legislation is required of smokers, employers, and proprietors of public places covered by the legislation. Language should be included specifying that each of these parties must comply with the provisions of the law.

Violations should be civil rather than criminal. Many laws classify violations as an infraction. As has been observed in the youth access to tobacco arena, the criminal justice system is already overburdened, and violations of clean indoor air legislation are not likely to be a high priority with law enforcement officials or the courts.

Most legislation establishes a graduated fine structure that increases with multiple violations.

IMPLEMENTATION

One of the chief means of achieving compliance is the posting of "No Smoking" signs and the removal of ashtrays and other smoking paraphernalia from areas in which smoking is prohibited (Hanauer, et al., 1986). Posting of signs informs the public about the law and provides a mechanism for employers and proprietors to request compliance. A study examining the compliance level of retail stores under a local ordinance found that employees and patrons in stores that posted signs were more likely to comply with the prohibition against smoking (Rigotti, 1993).

Because the majority of clean indoor air legislation is "self enforcing," it is important to inform the general public and the business community about the requirements of the law (Rigotti, 1993). Some legislation includes a public education component, requiring the health department or other enforcing agency to develop a program or mechanism to educate the community.

Enforcing laws protecting nonsmokers does not require vast amounts of resources. In Minnesota, the Department of Health spent about $4,600 per year for the first 3 years in which their statewide Clean Indoor Air Act was in effect (Kahn, 1983). San Luis Obispo, California, spent $3,000 on educational materials to help implement their ordinance (Reiss, 1992). Several local jurisdictions have found that enforcement activities required a decreasing amount of attention over time, with the majority of complaints received during the first few months after enactment (Martin, 1988).

Although enforcement activities largely rely on community education and adequate signage to achieve compliance, resources should be available to follow up on complaints and, if necessary, issue citations.

Options

* Designate an enforcement agency.
* Require proprietors and employers to post "No Smoking" signs and remove all ashtrays and smoking paraphernalia in all areas where smoking is prohibited.
* Define violations by smokers, proprietors, and employers who are out of compliance.
* Create a graduated civil fine structure for violations.
* Require the enforcement agency to engage in a public education program to inform the public and the business community about the law.
* Require Health and Fire Department officials to inspect an establishment for compliance during the course of any other mandated inspections.

Appendix 6.C. Excerpts from *Tobacco Advertising and Promotion: A Guide to Developing Policy*

Tobacco Advertising and Promotion

A Guide to Developing Policy

Number three in a series of four policy guides

ASSIST
The American Stop Smoking Intervention Study

National Cancer Institute
National Institutes of Health
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared by:
Americans for Nonsmokers' Rights
Berkeley, California
with
Prospect Associates
Rockville, Maryland

November 1994

Contents*

*Page numbers in this Table of Contents are from the original document and do not correspond to page numbers in this monograph.

Background

INTRODUCTION

"Advertising, in the hands of manufacturers of tobacco products, has become a powerful tool for the construction of the massive edifice of this industry."

"There is no obstacle to large-scale sales of tobacco products that cannot be surmounted by aggressive selling."

Although these statements from the *United States Tobacco Journal* were made in 1953 and 1955, respectively, they document the tobacco industry's early recognition of the impact and value of advertising and promotion to increase and maintain the consumption of cigarettes and other tobacco products (US DHHS, 1994). The magnitude and scope of tobacco advertising and promotion have increased to such a great extent that many localities, states, and the Federal Government have enacted or are considering policy remedies to curb tobacco advertising and promotion as a complement to other tobacco control activities such as the adoption of smoking ordinances and restrictions on youth access to tobacco products.

ADVERTISING VS. PROMOTION

With approximately 400,000 people dying each year from tobacco-related diseases as well as smokers who die of other causes and 1.5 million Americans who quit smoking, the tobacco industry must attract more than 2 million new smokers each year to maintain its market (Myers & Hollar, 1989).

Two major forms of tobacco marketing exist: advertising and promotion. "Advertising" is the use of advertisements in the paid media, which is comprised of newspapers, magazines, billboards and other outdoor venues, and transit system vehicles. Advertising entails direct targeting of current or prospective consumers of tobacco products to initiate or maintain cigarette consumption. The tobacco industry argues that advertising functions strictly as a means to encourage brand switching or maintain brand loyalty. Other evidence indicates that advertising serves to foster new and expanded consumption.

"Promotion" encompasses efforts to influence consumers beyond advertising. One prominent form of promotion is sponsorship of artistic, athletic, and cultural events. Other promotions include point-of-purchase displays that publicize the location of tobacco products and increase brand recognition. Retail stores are filled with clocks, grocery cart signs, in/out decals on doors, and banners (Cummings, 1991). Other promotions include coupons, retail value-added items (such as free cigarette lighters and T-shirts), and free samples. Another promotional device that has been extremely successful, but expensive, is the distribution of merchandise that displays tobacco logos (US DHHS, 1994; Warner et at, 1992). The names and addresses of those requesting

merchandise, often along with survey data, are entered into databases that are used for additional marketing efforts as well as political organizing efforts.

TOBACCO INDUSTRY EXPENDITURES

In 1992, according to the Federal Trade Commission, tobacco advertising and promotion expenditures had reached $5.23 billion (FTC, 1994). These expenditures have been increasing dramatically, with the industry spending $361 million in 1970 and $1.2 billion in 1980 (US DHHS, 1994).

By the mid-1980's, *advertising* expenditures had decreased relative to *promotional* activities, primarily as a result of decreased reliance on print advertisements in newspapers and magazines (US DHHS, 1994). In addition, the number of newspapers and magazines that have voluntarily instituted policies banning tobacco advertising continues to grow, although many are more narrowly read journals rather than major publications such as *Time* and *People* magazines. Use of outdoor advertising (billboards) and transit posters remains high (US DHHS, 1994).

In 1992, promotional activities such as coupons, merchandise, and sponsored events accounted for approximately 80 percent of overall advertising and promotion expenditures, up from 12 percent in 1970 (Butler, 1993; FTC, 1994). The largest category of promotional spending includes coupons and retail value-added promotions such as free shirts and lighters, totaling $2.17 billion in 1992, or more than 40 percent of all cigarette advertising and promotional expenditures (FTC, 1994). This is a stunning figure, up from $960 million in 1988 (FTC, 1994).

Promotional allowances are another growth area for tobacco promotion. Promotional allowances are designed to provide incentives to wholesalers and retailers to promote a company's products and include free goods or price reductions, slotting allowances, contests, and training programs. Cigarette companies spent $1.5 billion on promotional allowances in 1992, accounting for nearly 29 percent of the total spent on advertising and promotion (FTC, 1994).

THE IMPACT OF ADVERTISING AND PROMOTION ON TOBACCO CONSUMPTION

Research has demonstrated that a connection exists between advertising, promotion, and tobacco consumption. The tie between tobacco marketing and consumption is confirmed by the following findings:

- Advertising and promotion may encourage children or young adults to experiment with tobacco, and regular use may be initiated with repeated exposure to positive images associated with tobacco use (US DHHS, 1989).
- Advertising and promotion may influence former smokers to resume smoking.
- The paid media's dependence on revenue from tobacco advertising decreases coverage of the risks and consequences of tobacco use (Warner & Goldenhar, 1989; Warner, 1992).

- Organizations such as professional sports teams, cultural and charitable organizations, and groups that serve populations targeted by the tobacco industry (e.g., communities of color and women) have become dependent on tobacco company resources. These groups may be less likely to publicize the negative impact of tobacco use and possibly mute opposition to the tobacco industry's political agenda (Robinson et al., 1992).
- Tobacco advertising and promotion encourages the social acceptability of tobacco products, sometimes diminishing the smokers' perception of the danger of tobacco use (US DHHS, 1989; Myers & Hollar, 1989).

THE IMPACT OF ADVERTISING ON CHILDREN

The *Surgeon General's Report on Preventing Tobacco Use Among Young People,* released in February 1994, documents the problem of underage smoking. Although the report acknowledges that many factors contribute to the initiation and maintenance of tobacco use by children and adolescents, considerable attention is given to the strong influence of advertising and promotion (US DHHS, 1994).

Tobacco industry marketing researchers have successfully produced tobacco-related themes and images that appeal to teenagers. Youth of both genders are enticed with images that associate tobacco use with independence, popularity, and relaxation. Boys are influenced by the ties between smoking and masculinity, athleticism, and adventure, but girls are conditioned to associate tobacco use with thinness, romance, and liberation (US DHHS, 1994).

More than 90 percent of all new smokers are under age 20. During the past decade, the smoking rate for adults has steadily declined, but the teenage rate has remained virtually constant (McKenna & Williams, 1993).

Evidence of the association between tobacco advertising, promotion, and underage smoking is found in a number of studies:

- Approximately 86 percent of adolescent smokers prefer either Marlboro, Newport, or Camel, which are the brands that spend the most on advertising (CDC, 1994).
- In an analysis of tobacco advertising, a study showed that as tobacco expenditures targeting women rapidly increased from 1967 to 1974, a corresponding rise in the annual rates of initiation for 11- to 17-year-old girls was found (Pierce et al., 1994).
- One-half of the adolescents in a Gallup survey could associate brand names with cigarette slogans (US DHHS, 1994).

To counter concerns about tobacco advertising's appeal to children, the tobacco industry adopted a voluntary code of advertising ethics (CigaretAdvertising Code, 1964). The industry's code, for example, purports to prohibit tobacco advertisements in publications intended for persons under age 21 and admonishes against the use of models

who are or appear to be under age 25. The existence of the code has resulted in little, if any, reduction in tobacco advertising's impact on children. In some cases, the guidelines are insignificantly weak. In other cases, the guidelines are apparently ignored, as in the case of the rule against young-looking models. Indeed, the most egregious example of advertising that targets children, the Joe Camel campaign, appeared long after the code had been adopted.

The Joe Camel Campaign

In 1988, R.J. Reynolds began one of the most successful advertising campaigns in history with its "Smooth Character" campaign, featuring a cartoon character named Joe Camel. The mischievous Joe Camel appears in numerous daring, adventurous, and of course, cool situations. The campaign was also among the first to offer products with brand logos in exchange for proofs-of-purchase.

Critics charge that this campaign targets children. Not only is the Joe Camel character well recognized by children, but Camel cigarettes have improved Reynolds' market share among underage smokers (Pierce et al., 1991).

Several indicators substantiate the campaign's youth appeal:

- Camel's share of the under age 18 market increased from 0.5 percent in 1988, when Joe Camel was introduced, to 32.8 percent in 1991 (DiFranza et al., 1991).
- Camel was identified as the most advertised brand of cigarettes by 28.5 percent of teenagers. This brand was preferred by 24.5 percent of males age 12 to 17 and 21.7 percent of females in the same age group (Pierce et al., 1991).
- Approximately 30 percent of 3-year-olds could match the Old Joe character with a cigarette, and 6-year-olds could accomplish this task 91 percent of the time. In addition, the 6-year-old children identified Joe Camel as often as the Mickey Mouse ears of the Disney channel (Fischer et al., 1991).

TARGETED ADVERTISING AND PROMOTION BY RACE AND SEX

Particular attention has been paid to advertising and promotion that targets ethnic groups and women (US DHHS, 1989). The tobacco industry has a long history of courting ethnic populations. The most obvious example of this is a history of extensive financial contributions to political, social, and artistic organizations. Examples include the Congressional Black Caucus, the National Women's Political Caucus, the Kool Jazz Festival, and various Cinco de Mayo celebrations.

The introduction of population-specific brands of cigarettes is one of the more recent avenues that the tobacco industry has taken to target its marketing efforts to particular groups. One of the most notorious examples was the "Uptown" cigarette brand, targeted at African Americans. After a community coalition in Philadelphia mobilized opposition to this marketing strategy by R.J. Reynolds, Uptown was *not* introduced as

part of a planned test market (US DHHS, 1994; *Advertising Age,* 1990). In another case, the tobacco industry enraged women's groups with the introduction of the "Dakota" brand, which targeted young "virile" females (Cotton, 1990).

There are numerous examples of tobacco industry targeting, and the best can often be found in one's own backyard. However, some examples follow:

- Targeting of African Americans includes sponsorship of cultural activities such as the Kool Jazz Festival and the Alvin Ailey Dance Theater. Other activities include the Kool Achiever Awards and image advertisements featuring Martin Luther King. African-American newspapers and magazines receive about $6 million per year in tobacco advertising revenues (Williams, 1986).
- Targeting of the Latino/Hispanic community includes sponsorship of cultural events such as Cinco de Mayo celebrations. Philip Morris is the largest advertiser in Latino magazines, and 20 percent of all Latino newspaper advertising revenue comes from alcohol and tobacco companies (Maxwell & Jacobson, 1992).
- There is growing evidence of targeting of Asian/Pacific Islanders. Several California surveys indicate that Asian/Pacific Islander neighborhoods suffer the highest concentrations of tobacco billboards (Le, 1994). One survey indicated that Asian-American neighborhoods have 17 times more cigarette billboards than white neighborhoods (McLaughlin, 1993).
- One notorious example of a promotion targeting women is Philip Morris' Virginia Slims tennis sponsorship. Virginia Slims has sponsored the women's tennis tour since 1971 (Robinson et al., 1992).
- Native Americans, a group with high use of cigarettes and smokeless tobacco in adults and youth, are also targeted by the tobacco industry, although little if any research on tobacco advertising and promotion has been conducted around this population.
- There is growing evidence that the tobacco industry may be targeting lesbians and gays. Philip Morris ran advertisements for Benson and Hedges' Special Kings in the gay fashion magazine *Genre* and other magazines with a high gay readership as well as for Parliament cigarettes in *OUT* magazine, the largest circulation gay magazine in the United States (Lipman, 1992; CLASH, 1994). Recent advertisements for Virginia Slims may target lesbians, and advertisements for American Brand's Montclair cigarettes feature stereotypically effeminate gay men (Goebel, 1994).

The argument that tobacco industry advertising targets people of color has been validated by numerous surveys of billboard placement. Tobacco billboards are predominantly found in neighborhoods where African Americans and other people of color are more highly concentrated. Some survey results, reported by the Center for Science in the Public Interest (1990), include:

- Seventy percent of the 2,015 billboards in Baltimore advertised alcohol and tobacco; three-quarters of billboards were in predominately African-American neighborhoods.
- In low-income neighborhoods in Detroit, 55 to 58 percent of billboards advertised alcohol or tobacco.
- More than one-third of New Orleans' billboards are located within one-half mile of the city's low-income Federal housing projects.
- Sixty-two percent of billboards in black neighborhoods in St. Louis advertised alcohol and tobacco, compared with 36 percent in white neighborhoods; three times as many billboards were found in black neighborhoods as white.

PUBLIC OPINION ON ADVERTISING RESTRICTIONS

Recent public opinion polls suggest that there is growing support for restrictions on tobacco advertising and promotion. A sample of some of the most recent polls include:

- In a Gallup survey conducted in February 1994, 68 percent of Americans believe that cigarette advertisements influence children and teens to smoke; 66 percent believe that some cigarette advertisements are specially designed to appeal to young people; 53 percent want a total ban on tobacco advertising (Colford, 1994).
- In a 1993 Gallup survey, 53 percent favored a complete ban on tobacco advertising, 76 percent of adults favor restrictions on cigarette advertising that appeals to children, 66 percent favor restrictions on advertising that encourages people to smoke, 64 percent favor restrictions on advertisements that make smoking appear glamorous, and a majority of people in the largest tobacco-growing states also favor the restrictions listed above (Coalition on Smoking OR Health, 1993).
- Ten communities participating in NCI's Community Intervention Trial for Smoking Cessation (COMMIT Program) were surveyed, and 60.5 percent agreed that all tobacco advertising should be banned (CDC, 1991).
- A 1990 survey in California found that 54 percent support a ban on billboard tobacco advertisements, 49 percent support a ban on tobacco advertisements in newspapers and magazines, 67 percent supported a ban on the distribution of free tobacco samples or coupons to obtain free samples by mail, and 75 percent support a ban on the distribution of free tobacco samples on public property.

For a detailed discussion of answers to tobacco industry arguments against regulating tobacco advertising, see the ASSIST Key Required Resource *Truth and the Consequences of Cigarette Advertising: An Advocate's Guide to Arguments in Support of Banning Cigarette Advertising and Promotions.*

Overview of Policy Options

Tobacco advertising and promotion constitute one of the greatest obstacles to tobacco control in the United States. Advertising and promotion encourage children and young people to use tobacco, reduce smokers' motivation to quit, and legitimize the tobacco industry (US DHHS, 1989).

Numerous options are available to the public health community to counter tobacco industry advertising and promotion, ranging from a total ban on advertising and promotion to various voluntary approaches.

Before considering how to approach the problem of tobacco advertising and promotion, public health professionals should first understand the role of tobacco advertising in their specific community. The tobacco industry's activities in each community are different, and it is vital to identify those activities of greatest concern in a specific community before crafting a response.

Pro-health interests must also understand the acceptable limits of policy change in a given community. Although some regions may support a complete ban on advertising and promotion, others such as those in tobacco-producing states may be more limited in what the community is prepared to accept.

The following issues should be considered in assessing a particular community:

- How receptive is the community to tobacco control policy? For example, have ordinances that limit smoking or reduce youth access to tobacco products already been adopted? How strong are those policies?
- To what extent does the tobacco industry target particular populations with their advertising and promotion?
- How are tobacco billboards distributed in the community?
- To what extent does the tobacco industry sponsor cultural, artistic, or athletic events?
- Does tobacco advertising appear on public transportation vehicles or transit depots?
- Do tobacco billboards appear in sports facilities such as stadiums?
- What types of point-of-purchase advertising and promotion are found in the community? Promotional displays? Sales or free distribution of logo-branded gear?
- Does the tobacco industry engage in free sampling of tobacco products?

By answering these questions, public health professionals can develop a sense of both the needs of the community and any practical limits on policy change.

After assessing the needs of the community, the next step is considering options. Although many of these policy options may be implemented at the Federal level through either legislative or regulatory mechanisms, this discussion is intended to provide practical information to those working at the local and state levels.

The following are options available to state and local public health professionals and policymakers. It should be noted that the first two categories represent options for policy change, but the latter four categories provide other options for countering the effects of tobacco advertising and promotion and supporting policy change.

Restrictions on Tobacco Advertising

— Banning or limiting tobacco billboards
— Banning or limiting tobacco advertising on public transportation
— Banning or limiting advertising in public facilities
— Banning or limiting advertising in athletic facilities
— Eliminating the tax deductibility of tobacco advertising expenses
— Barring the use of cartoon characters in tobacco advertising

Restrictions on Promotional Activities

— Prohibiting tobacco industry sponsorship of events
— Prohibiting free sampling of tobacco products
— Banning or limiting point-of-purchase displays

Counteradvertising

— Paid counteradvertising
— Mandatory counteradvertising
— Public service announcements (PSA's)

Counterpromotions

— Alternative sponsorship
— Countersponsorship
— Other counterpromotions

Voluntary Approaches

— Community advertising surveys
— Poster contests
— Voluntary advertising restrictions
— Voluntary point-of-purchase advertising bans

Media Advocacy

Policy Options

RESTRICTIONS ON TOBACCO ADVERTISING

The most direct and comprehensive solution to the problem of tobacco advertising is to ban it. In spite of significant legal issues, there are a number of actions that State and local governments and public health professionals can undertake to eliminate or limit tobacco advertising.

Federal law prohibits television and radio advertisement of tobacco products, effective January 1,1972. Under current Federal law, however, billboard, magazine, and newspaper advertising of tobacco products is permitted. Numerous bills have been introduced in Congress to ban or limit tobacco advertisement and promotion, but to date none have passed.

Tobacco Billboards

The Federal Cigarette Labeling and Advertising Act contains a preemption clause that limits the authority of State and local governments to ban tobacco advertising (see Legal Issues). However, the state of Utah banned tobacco billboards in 1929 (Utah Criminal Code). The Utah law bans all types of billboards, public transportation displays, and point-of-purchase advertisements for tobacco products, including in/out signs, clocks, and merchandise racks (Van Dam, 1989).

The tobacco industry has determined that the Utah ban is either legally valid or that a legal challenge would result in undesirable public relations or political consequences. In either case, the Utah approach should be considered an option. Other states have considered adopting laws banning tobacco billboards, including California, Oregon, Massachusetts, Minnesota, and New Jersey.

The potential for local restrictions on tobacco billboards has generated a significant amount of interest. In 1990, Richmond, California considered an ordinance banning tobacco (and alcohol) advertising within 500 feet of any school. Although this approach is not ideal, a large percentage of the billboards in a given community are affected, especially if the distance is increased to 1,000 feet or even 1 mile. This approach may also have a greater chance of surviving a tobacco industry legal challenge than a complete ban because it is so closely tied to protecting children, which is acknowledged as a legitimate function of State and local government (see Legal Issues).

On February 24, 1994, the city of Baltimore adopted a ban on tobacco and alcohol billboards (City of Baltimore, 1993). In June 1994, Cincinnati, Ohio adopted a law prohibiting all tobacco billboards effective June 1, 1996. Signs within 500 feet of schools or other facilities frequented by children are banned immediately. Cincinnati's law also extends to tobacco advertisements on public transportation vehicles. Another city that has considered, but not adopted, tobacco billboard bans is Philadelphia (Bird, 1994).

Options

- Prohibit all tobacco billboards and other outdoor tobacco advertising signs.
- Prohibit all tobacco billboards within 1 mile of schools and other facilities (such as churches or parks), which are frequented by children.

Public Transportation

The most common type of restriction on tobacco advertising affects public transportation. Transportation depots, such as bus shelters and airports, and public transit vehicles, such as buses and subway cars, have traditionally played host to tobacco (and alcohol) advertisements. These advertisements are of special concern because they are observed by children, often in transit to school.

Bans on public transportation tobacco advertisements are also a sound option because they have not been challenged on the Federal preemption issue. They do not appear to be preempted by the Federal Cigarette Labeling Act (see Federal preemption discussion, Legal Issues). Their legal basis is strong because transportation systems are usually public or quasi-public, and their policies are not treated as broad regulations of advertising in the private sector. Indeed, such policies are often adopted as administrative measures or crafted merely as "preferences" for hiring advertising agencies that refuse tobacco advertising.

Transportation systems that have eliminated tobacco advertising include **New York City's** MTA, **San Francisco's** BART and AC Transit bus system, the **Minnesota Valley's** Transit Authority, **Portland's** bus system, **Denver, Boston, Syracuse,** and **Madison** (WI) (Scenic America, 1993). **Utah's** ban on all tobacco billboards extends to public transportation. The **New York** and **New Jersey** Port Authority has banned all tobacco advertising in facilities under its jurisdiction, including LaGuardia, Kennedy, and Newark airports, the World Trade Center bus terminal, and marine terminals (Weigum, 1993).

The primary argument made against transportation-based policies is the potential loss of advertising revenues. None of the systems or facilities that have implemented such bans have reported any net loss of revenues, however, and other advertisers appear to replace the tobacco companies.

Options

- Ban tobacco advertising on all public transit vehicles, shelters, and in transit depots.
- Ban tobacco advertising in airports.
- Ban tobacco advertising in and on public transit shelters such as train stations and bus shelters.

Public Facilities

In addition to eliminating tobacco advertisements on public transportation, some local governments have banned such advertisements in all publicly owned facilities.

In July 1992, King County, Washington adopted the broadest local policy on advertising to date. King County's ordinance covers all county-owned facilities, including the King Dome, Seattle's stadium (King County, 1992).

Option

- Eliminate tobacco advertising in all facilities owned by a given county or city, including sports facilities, fairgrounds, and public transportation vehicles and depots.

Athletic Facilities

Perhaps the single most important local action that can be taken to reduce tobacco advertising is eliminating billboards and other advertisements in stadiums and other athletic facilities. This includes both professional sports facilities and college stadiums. Addressing this advertising is important for two reasons. First, children are present in large numbers at many athletic events. Second, major sporting events are often televised. Tobacco advertisements in stadiums are usually positioned to be picked up on television cameras (Smokefree Educational Services, Inc., 1991).

Tobacco advertising bans in athletic facilities may be adopted by various governing agencies, including a stadium authority, county board of supervisors, or university. In some cases, sports facilities are privately owned and may be approached to voluntarily eliminate tobacco advertisements (see Voluntary Approaches). In some cases, more than one agency will have the jurisdiction to limit tobacco advertisements in an athletic facility. King County, Washington's ordinance banning all tobacco advertisements in county facilities covers athletic facilities (King County Ordinance, 1992).

Many advertisement bans have been adopted voluntarily by stadium management. Sports facilities that prohibit tobacco advertisements include the Minnesota Metrodome, Dodger Stadium (Los Angeles), Wrigley Field (Chicago), Jack Murphy Stadium (San Diego), and the Oakland Coliseum (Hwang, 1992; Smokefree Educational Services, Inc., 1991).

Option

- Prohibit tobacco advertising in all athletic facilities under the jurisdiction of a public agency.

Tobacco Advertising Deductibility

One approach to tobacco advertising that has recently received a great deal of attention relates to the tax deductibility of such advertising. Proposals have been introduced at both the Federal and State levels to remove tobacco advertising from the class of business expenses that are tax deductible (Colford, 1993; Stark, 1986).

Proponents of eliminating the deductibility of tobacco advertisements point out that such deductions amount to a subsidy for cigarette advertisements, a so-called tax subsidy. It should be noted that indirect restrictions on tobacco advertising face the same first amendment challenges as direct bans. In some cases, partial restrictions may be harder to defend legally than a complete on all tobacco advertising (see Legal Issues). Connecticut and California have both considered legislation.

The same arguments in favor of eliminating the tax deductibility of tobacco advertising apply to promotions as well. However, no specific proposal has yet been propounded on the deductibility of tobacco promotional expenses.

Options

- Eliminate the deductibility of tobacco industry advertising expenses under State corporate income tax laws.
- Eliminate the deductibility of tobacco industry promotional expenses under State corporate income tax laws.

Cartoon Characters

Some states have considered prohibiting the use of cartoon figures in tobacco advertising. These proposals represent a reaction not only to Joe Camel but other cartoon figures as well such as the Kool penguin.

The public health impact of the Joe Camel cartoon advertising campaign for Camel cigarettes is well documented (Pierce et al., 1991; DiFranza et al., 1991; Fischer et al., 1991). The campaign clearly targets children and has been extremely successful in attracting them to Camel cigarettes. Therefore, eliminating the use of cartoons in tobacco advertising can be easily justified.

Although the Federal Government would have the authority to prohibit cartoon characters in all tobacco advertisements, states' jurisdiction is probably limited to advertising signs such as billboards. States are not permitted to place significant burdens on interstate commerce, and magazines normally fall into this category. This is also true of newspapers if at any time even a single copy enters interstate commerce.

As in the case of advertising deductibility, selective bans on particular types of tobacco advertising may raise more serious constitutional issues than a complete ban (see Legal Issues).

Although proposals to date have focused on advertising, it would also be possible to eliminate the use of cartoon figures in promotional activities and materials. This could be accomplished by defining advertising broadly in any proposed legislation. The phrase "other display advertising" is an example of such language.

Option

- Prohibit the use of cartoon characters in tobacco billboards and other display advertising.

RESTRICTIONS ON PROMOTIONAL ACTIVITIES

Although tobacco advertising remains the most obvious marketing tool for cigarettes and other tobacco products, other promotional activities are playing an increasingly important role. During the past 25 years, expenditures on promotional activities other than advertising have increased dramatically relative to advertising expenditures themselves (Butler, 1993). Therefore, an effective strategy to counter tobacco marketing must address promotional activities as well as advertising. The most direct approach to tobacco industry promotional activities is to simply prohibit them by law or by voluntary policy.

Tobacco Industry Sponsorship

A number of organizations and governing bodies have adopted bans on tobacco (and alcohol) promotions at community events such as county fairs, college gatherings, Cinco de Mayo celebrations, and rodeos. Much of this activity has occurred in California under Proposition 99, the state's tobacco tax/tobacco education program. Although no State or local government has yet taken this action, it is within their authority to do so.

Options

- Prohibit tobacco industry sponsorship of all athletic, artistic, cultural, or musical events.
- Prohibit tobacco sponsorship of a specific athletic, artistic, cultural, or musical event.

Free Sampling

Distribution of free tobacco product samples is a popular form of promotion of tobacco products (Hobart & Goebel, 1994). Of greatest concern is the fact that free samples are often distributed at events and locations popular with children such as rock concerts, music festivals, sports events, and fairs (Davis & Jason, 1988).

Although most states prohibit the distribution of free tobacco samples to underage youth, free samples are a source of tobacco products for children (Davis & Jason, 1988). Only the elimination of free tobacco sampling will ensure that samples do not end up in the hands of underage youth. The States of Utah, Minnesota, and California ban or significantly restrict the free sampling of tobacco products. These bans may also prohibit free sampling by mail. More than 103 cities and counties prohibit free sampling as well (ANR, 1994).

Options

- Prohibit the distribution of free tobacco samples in all private and publicly owned facilities and grounds accessible to the public.
- Prohibit the distribution of free tobacco samples through the mail.

Point-of-Purchase Displays

In-store advertising is among the most prevalent forms of tobacco promotion. One study of tobacco advertising in stores found that 87 percent of retail stores carry some promotional items advertising tobacco products (Cummings et al., 1991). Two-thirds of stores displayed tobacco posters, and 80 percent of all tobacco displays were for cigarettes.

Point-of-purchase advertising can be especially damaging to public health efforts. This type of advertising encourages impulse shopping and can undermine the resolve of those who are attempting to quit (Weigum, 1993). Such advertising is also perfectly situated to impact children in stores and gives the impression that cigarettes and other tobacco products are merely ordinary consumer goods like candy or food, rather than

deadly and addictive drugs. Additionally, countertop displays make it easier to shoplift cigarettes. Because the tobacco companies provide financial incentives for retailers to use these displays, shoplifting is less of a financial burden.

The past 5 years have seen a flurry of activity addressing various forms of point-of-purchase tobacco promotion (Weigum, 1993; ANSR PA, 1991). Several communities have campaigned successfully against cigarette advertisements on handbaskets in grocery stores, including New York City and North Carolina (ANSR PA, 1991). More recently, an effort was undertaken in Minnesota to promote ordinances that prohibit all point-of-purchase tobacco promotions.

In Minnesota, the city of Preston adopted a law banning point-of-purchase advertising (see Appendix B). Brooklyn Center (MN) adopted an ordinance on first reading that limits in-store advertising to "tombstone" listings of cigarette brands and prices. Tombstone advertisements consist exclusively of black-on-white lettering listing the brands and their prices. The threat of tobacco industry legal challenge, however, held up the final passage of this ordinance on second reading.

Options

- Prohibit all in-store advertising and promotion of tobacco products, including banners and signs, basket or cart advertisements, in/out decals, separator bars, clocks, and logo merchandise.
- Prohibit all point-of-purchase advertising except tombstone advertisements listing the brands and their prices, which may not be disguised advertisements for particular brands.
- Prohibit self-service displays for tobacco products, requiring all tobacco products to be kept behind the counter (thereby eliminating counter displays).

COUNTERADVERTISING

One way to counter tobacco industry advertising is to purchase anti-tobacco advertisements. Three types of counteradvertising exist: paid counteradvertising, mandatory counteradvertising, and public service announcements (PSA's).

Paid Counteradvertising

One strategy for countering the tobacco industry and promoting an anti-tobacco message is the use of paid media campaigns. Although traditional PSA's tend to focus on individual behavior (i.e., "you should quit"), counteradvertisements tend to focus on

social and political issues as well as environmental change (Dorfman & Wallack, 1993).

Until recently, the use of paid media to counter the tobacco industry in the United States has been limited. Since 1989, California has implemented a massive anti-tobacco campaign under Proposition 99, the tobacco tax initiative passed by the voters in 1988. California's campaign is funded by a tobacco excise tax. There is strong evidence that Proposition 99's media campaign has been successful, at last in promoting cessation among smokers (Popham et al., 1993). California's advertisements have ranged from strong messages about the health effects of passive smoking to direct attacks on the tobacco industry. Minnesota and Massachusetts have also undertaken anti-tobacco media campaigns.

Options

- Conduct a sophisticated, well-funded anti-tobacco media campaign, which is funded by a tobacco excise tax increase.
- Conduct limited anti-tobacco media campaigns, focusing on one media market and/or one particular issue.

Mandatory Counteradvertising

Another approach to counteradvertising is requiring broadcasters, billboard companies, and others who carry tobacco advertisements to run a certain number of anti-tobacco advertisements, thereby balancing their pro-tobacco promotions. This strategy was effective on a wide scale in the late 1960's, before the congressional ban on television and radio advertising that took effect in 1972.

During the late 1960's, the Federal Communications Commission (FCC) required broadcasters to run free anti-tobacco advertisements to balance the tobacco advertisements that then appeared on television and radio. The FCC did so by applying the so-called Fairness Doctrine, which has since been abandoned. Many of the most effective television advertisements that ran under the Fairness Doctrine were produced by the acclaimed public interest media consultant, Tony Schwartz (Bird, 1991). The advertisements were so effective that the tobacco industry ultimately embraced the 1972 ban on radio and television advertisements, which eliminated both the tobacco industry's own advertisements *and* the effective counteradvertisements.

More recently, the New York City Council adopted an ordinance in 1992 requiring billboard companies to post one anti-tobacco advertisement for every four tobacco advertisements on city property. The law applies to advertisements on ferries, baseball stadiums, telephone kiosks, taxis, bus shelters, and some billboards (McKinley, 1992). The New York ordinance is currently in litigation.

Options

- Require free counteradvertisements to balance tobacco advertising on public property, including public transportation, sports facilities, and taxis.
- Require free counteradvertisements on billboards.
- Advertisements should be produced by pro-health organizations rather than the tobacco industry.

Public Service Announcements

Traditional PSA's are another option for countering tobacco advertising and promotion. PSA's, however, have several disadvantages relative to paid or mandatory counteradvertisements. PSA's are most often carried for free, and television and radio stations rarely show or play them during the most popular times. PSA's may also not be placed on the air enough to have a major impact. In addition, PSA's tend to be general in scope rather than targeted to specific groups. Some researchers have even suggested that some PSA's may actually cause harm by focusing the media's attention on individual behavior and away from "more effective socially based health promotion strategies" (Dorfman & Wallack, 1993).

PSA's may have more promise when they are associated with a paid media campaign. Under California's Proposition 99, the state negotiated with media outlets for additional free placement of advertisements beyond the substantial paid media buy. Also, these hard-hitting television and radio advertisements will be made available as PSA's after their use as paid advertisements.

Options

- Extend the impact of paid counteradvertising campaigns by negotiating for free additional time for PSA's.
- Fund high quality production of PSA's, equivalent to tobacco industry efforts.
- Focus PSA's on social, political, and environmental change rather than personal behavior.

COUNTERPROMOTIONS

As the tobacco industry invests more of its resources in sophisticated promotional activities rather than advertising, it is important for the public health community to counter such activities. Although the most effective policy alternative is the elimination

of tobacco promotional activities, there are other strategies available for countering such promotions.

Alternative Sponsorship

Perhaps the most insidious form of tobacco promotion is the sponsorship of athletic, cultural, and artistic events. The identification of alternative sponsors for events, which are currently sponsored by tobacco firms, is a relatively new strategy that shows great promise.

In one early example of alternative sponsorship, Doctors Ought to Care (DOC) arranged an alternative sponsor for the "U.S. Boomerang Team." The team was heading for the Boomerang championships in Australia, with sponsorship and funding from Philip Morris. As part of the deal, the team was required to wear Marlboro shirts and hats and promote Marlboro cigarettes in media interviews. After being contacted by a member of the team, DOC contributed funds, solicited additional funds from the anti-tobacco community, and the team rejected Philip Morris' sponsorship in favor of DOC's (Raeburn, 1988; Wolinsky, 1988).

In Victoria, Australia, the government instituted a broad alternative sponsorship program (Powles & Gifford, 1993; Scollo, 1991). In 1987, the Victorian parliament passed legislation that, among other things, raised the tobacco excise tax by 5 percent and allocated the proceeds to a new Victorian Health Promotion Foundation. The Foundation's mission includes buying out tobacco sponsorship and initiating public health sponsorship of artistic, sports, and community organizations. During 1990-91, the Foundation sponsored 128 athletic and 134 cultural organizations (Powles & Gifford, 1993).

Under California's Proposition 99 anti-tobacco program, a program was funded to investigate and promote alternative sponsorship (Alternative Sponsorship Project, 1993). The project provided assistance to groups seeking alternatives to tobacco and alcohol sponsorship for events, with a focus on ethnic events such as Cinco de Mayo. The project also sought to educate those in the business community such as banks about the advantages of marketing to particular ethnic groups with growing economic resources (a lesson that the tobacco industry learned long ago). The project also brought together event organizers and public health professionals to share their perspectives on tobacco industry sponsorship.

Options

- Encourage organizations receiving tobacco funding to reject that funding and seek alternative donors.
- Provide alternative funding to organizations that conduct athletic, cultural, and artistic events.
- Educate event organizers about the availability of alternatives to tobacco sponsorship. Educate them on marketing the benefits of event sponsorship to alternative sponsors.
- Educate potential nontobacco providers of funds about the benefits of sponsoring sports, cultural, and artistic events.

Countersponsorship

A number of activities are available to counter tobacco industry sponsorship of events and organizations. For many years, DOC, the national health advocacy group for medical care practitioners, has pioneered this endeavor. DOC's activities range from protests of tobacco- and alcohol-funded events such as Virginia Slims tournaments to sponsorship of their own events (e.g., "Emphysema Slims") (*Providence Journal-Bulletin,* 1990). At a minimum, these activities appear to decrease the promotional value of tobacco industry sponsorships.

California's Proposition 99 has funded several pro-health athletic programs or events. Among these are a Tobacco Free Challenge racing car and a ski racing program for children. Such activities often draw attention because they place pro-health messages in events traditionally dominated by the tobacco and alcohol industries.

Option

- Fund and organize artistic, cultural, and athletic events with a pro-health message.

Other Counterpromotions

Other examples of counterpromotions include a T-shirt exchange organized by the National Association of African Americans for Positive Imagery (NAAAPI). The project encouraged smokers (and others) to turn in tobacco- and alcohol-branded items in exchange for a T-shirt or cap bearing a pro-health message. In another example, youth in New Jersey surrounded a tobacco van that was giving away promotional items. The youth-led protest cut short the van's promotional mission.

Options

- Organize a tobacco-branded merchandise exchange project.
- Implement a protest, preferably organized by and for young people, against a specific tobacco industry promotional event.

VOLUNTARY APPROACHES TO TOBACCO ADVERTISING AND PROMOTION

A number of voluntary approaches can be developed to counter tobacco advertising and promotion. In some cases, advertising and promotion can be limited by the voluntary action of businesses such as billboard companies.

Community Advertising Surveys

One strategy that effectively combines youth education with efforts to counter tobacco advertising is tobacco advertising surveys. In a community advertising survey, a group of school-age youth would organize to survey the type and location of tobacco advertisements in a given community. Such a survey has several positive outcomes:

- Young people learn about tobacco industry targeting and other advertising-related issues by studying them directly.
- Public health professionals gain knowledge of the quantity and placement of tobacco advertisements in their own community.
- The information gained in the survey can assist young people and activists in achieving limits on tobacco advertising in the community.

Of course, tobacco advertising surveys may also be conducted by adults. In some cases, such surveys have also been conducted by college students or public health graduate students as part of their course work.

Options

- Organize a project to survey the quantity, type, and location of tobacco advertisements in the community. Involve young people in your survey project.
- Publicize the results of your tobacco advertising survey to increase public knowledge of the impact of tobacco advertising in the community.
- Use the results of your advertising survey to urge businesses such as billboard companies to voluntarily ban or limit tobacco advertisements.

Poster Contests

Another common community response to tobacco advertising is a poster contest for children. In these contests, young participants create their own anti-tobacco posters. Often, the most powerful of these posters satirize the tobacco industry's own advertisements.

Many such contests have been conducted around the country, but the most well known has been organized in New York City by Smoke-Free Educational Services (Bird, 1991). The winners of the contest receive substantial prizes, their posters appear in a nationally distributed book and are prominently displayed in 6,000 New York subway cars (Coalition for a Smoke-Free City, 1993; Tobias, 1991).

Option

- Conduct an anti-tobacco poster contest among children in your community. Provide significant awards for participants and winners. Encourage business owners to donate awards. Display winning posters prominently in the community.

Voluntary Tobacco Advertising Restrictions

One successful approach to limiting advertising involves encouraging business to voluntarily limit tobacco advertising. This strategy has been particularly successful in the case of newspaper and billboard companies (Guy, 1993; Horovitz, 1991).

Unlike many magazines, newspapers typically receive a very small percentage of their advertising revenues from tobacco advertising. At least 12 U.S. daily newspapers have eliminated tobacco advertisements, including the *Seattle Times* (Bischoff, 1993; Guy, 1993).

Billboard companies are concerned about the negative publicity associated with tobacco advertising, especially the accusation that tobacco billboards target poor neighborhoods and communities of color. Community activists, in many cases local clergy, have succeeded in limiting tobacco billboards in some communities (Horovitz, 1991).

Recently, pressure has been increased on magazine publishers to remove tobacco advertising. Many magazines receive a large percentage of their advertising revenue from tobacco and represent a particularly insidious form of targeted advertising. Of greatest concern are magazines with a large audience of young people such as *Spin* and *Rolling Stone*. More responsible publications such as *Sassy* have never accepted tobacco advertising. Groups ranging from the Women and Girls Against Tobacco (WAGAT) project and the Interfaith Center on Corporate Responsibility have called on magazines to drop tobacco advertisements (Teinowitz & Kelly, 1994).

Options

- Call on local billboard companies to voluntarily eliminate or limit tobacco advertisements.
- Encourage local, privately owned athletic facilities to eliminate tobacco advertising.
- Organize a meeting with your local newspaper to encourage them to drop tobacco advertising.
- Urge magazine publishers to stop accepting tobacco advertising. This is especially important for those publications such as Vogue, which have a large audience of young people.

Voluntary Point-of-Purchase Advertising Bans

Although legislation that prohibits point-of-purchase advertising is one response to this form of promotion, another is to encourage businesses to eliminate such promotions voluntarily. Because point-of-purchase advertising is so lucrative, voluntary actions by businesses may not be practical unless there is a groundswell of opposition from the community.

Options

- Encourage businesses to stop all in-store advertising and promotion of tobacco products, including banners and signs, basket or cart advertisements, in/out decals, separator bars, clocks, and logo merchandise.
- Encourage businesses to stop particular types of point-of-purchase promotions such as grocery cart advertisements.

MEDIA ADVOCACY

Anti-tobacco activists have successfully countered tobacco industry promotional activities through the strategic use of the media, known as *media advocacy*. Media advocacy not only can support the other categories of advertising and promotion policy but also can serve as a freestanding educational strategy.

One successful example of media advocacy in tobacco control was a campaign initiated by DOC to counter a national Philip Morris Bill of Rights tour that began in 1990. The national tour marked the 200th anniversary of the Bill of Rights and featured Virginia's original copy of the Bill of Rights as well as an elaborate museum-like presentation.

Anti-tobacco activists feared that Philip Morris' association with the Bill of Rights would foster a positive image of tobacco manufacturers and thus promote smoking. In addition, Philip Morris clearly sought to promote the false notion that tobacco advertising is a protected form of speech under the first amendment. In response, the Washington State chapter of DOC constructed a 15-foot replica of the Statue of Liberty called "Nicotina," featuring a cigarette in place of the torch of freedom and a chain representing addiction.

The protest against Philip Morris was spectacularly successful. As the tour moved from state to state, activists set up Nicotina and protested with such slogans as "Bill of Rights—YES; Philip Morris—NO." Rather than the positive publicity they had anticipated, Philip Morris was dogged by negative coverage, with headlines such as "Bill of Rights Display Opens to Protests," and "Tobacco Firm Blasted on Bill of Rights Link" (Pool, 1991; Krebs, 1990). Ultimately, the tour was shortened and Philip Morris ceased publicizing it altogether.

Other examples of media advocacy to counter tobacco promotion include use of the media to end tobacco sponsorship of a specific event. A good example of this occurred in 1993 in San Luis Obispo County, California. The huge California Mid-State Fair, held in the county each year, had planned to include a major Marlboro Adventure Team promotion in exchange for sponsorship funding. The county tobacco control coalition pressured the fair organizers to drop Philip Morris as a sponsor. After the issue was widely covered in the media, the fair's board prohibited Marlboro's promotional activities, and Philip Morris pulled out as a sponsor (San Luis Obispo County Telegram-Tribune, 1993).

Another example of media advocacy is Los Angeles' "death clock," an electronic billboard that continuously updates the number of smoking-related deaths in the United States. Built by billboard owner William E. Bloomfield, the death clock has received extensive media coverage both nationally and internationally. In the process, millions have been impacted by a pro-health, anti-tobacco message.

Options

- Contact the media to express concerns about specific tobacco industry-sponsored events.
- Conduct protests or counter events to draw attention to the negative public health consequences of tobacco sponsorship and promotion.

References

1. Lynch, B. S., and R. J. Bonnie. 1994. *Growing up tobacco free.* Washington, DC: National Academies Press.
2. National Cancer Policy Board, Institute of Medicine, and National Research Council. 1994. *State programs can reduce tobacco use.* Washington, DC: National Academy Press. www.nap.edu/books/NI000240/html.
3. Institute of Medicine, Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion. 2002. *The future of the public's health in the 21st century.* Washington, DC: National Academies Press. www.nap.edu/books/030908704X/html.
4. ASSIST Coordinating Center. 1993. Restrictions on lobbying and public policy advocacy by government contractors: The ASSIST contract. Draft. March 8. ASSIST training manuals, Vol. VI. Media advocacy: A strategic tool for change, 57–69. Internal document, ASSIST Coordinating Center, Rockville, MD.
5. Shroff, T. H. 1997. Memorandum dated July 23, White paper on policy (rev. July 18, 1997) to all ASSIST project directors, ASSIST project managers, and ASSIST Coordinating Center from ASSIST contracting officers. Bethesda, MD: National Institutes of Health, National Cancer Institute.
6. ASSIST Coordinating Center. 1994. Policy advocacy trainer's manual. Internal document, ASSIST Coordinating Center, Rockville, MD.
7. *Federal Acquisition Streamlining Act of 1994,* Public Law 103-355. 103rd Cong., 2nd sess. (October 13, 1994)
8. Berry, J. M. The lobbying law is more charitable than they think. *Washington Post,* November 30, 2003.
9. Berry, J. M., and D. F. Arons. 2003. *A voice for nonprofits.* Washington, DC: Brookings Institution Press.
10. ASSIST Coordinating Center. 1991. ASSIST program guidelines for tobacco-free communities. Internal document, ASSIST Coordinating Center, Rockville, MD.
11. U.S. Department of Health and Human Services. 1986. *The health consequences of involuntary smoking. A report of the surgeon general.* Atlanta: U.S. Department of Health and Human Services, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_1986.
12. U.S. Environmental Protection Agency. 1992. *Respiratory health effects of passive smoking: Lung cancer and other disorders* (Publication no. EPA/600/6-90/006F). Washington, DC: Office of Health and Environmental Assessment, Office of Research and Development. http://cfpub.epa.gov/ncea/cfm/recordisplay.cfm?deid+2835.
13. California Environmental Protection Agency. 1997. *Health effects of exposure to environmental tobacco smoke—Final report and appendices.* Sacramento, CA: Office of Environmental Health Hazard Assessment.
14. National Toxicology Program. 2000. *Ninth report on carcinogens.* Research Triangle Park, NC: U.S. Department of Health and Human Services, National Institute of Environmental Health Sciences. www.knovel.com/knovel2/Toc.jsp?BookID=554.

15. World Health Organization, International Agency for Research on Cancer. 2004. *Tobacco smoke and involuntary smoking.* Vol. 83. www-cie.iarc.fr/htdocs/indexes/vol83index.html.

16. National Cancer Institute. 1999. *Health effects of exposure to environmental tobacco smoke: The report of the California Environmental Protection Agency* (Smoking and tobacco control monograph no. 10, NIH publication no. 99-4645). Bethesda, MD: National Cancer Institute. www.cancercontrol.cancer.gov/tcrb/monographs/10.

17. Centers for Disease Control and Prevention. 2002. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. *Morbidity and Mortality Weekly Report* 51 (14): 300–303. www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm.

18. Wells, A. J. 1999. Commentary: Deaths in the United States from passive smoking; Ten year update. *Environment International* 25 (4): 515–19.

19. Glantz, S. A., and W. W. Parmley. 1991. Passive smoking and heart disease: Epidemiology, physiology, and biochemistry. *Circulation* 83:1–12.

20. National Cancer Institute. 2000. *State and local legislative action to reduce tobacco use* (Smoking and tobacco control monograph no. 11, NIH publication no. 00-4804). Bethesda, MD: National Cancer Institute.

21. Woodruff, T. J., B. Rosbrook, J. Pierce, and S. A. Glantz. 1993. Lower levels of cigarette consumption found in smoke-free workplaces in California. *Archives of Internal Medicine* 153 (12): 1485–93.

22. Fichtenberg, C. M., and S. A. Glantz. 2002. Effect of smoke-free workplaces on smoking behaviour: Systematic review. *British Medical Journal* 325:188–91.

23. Office of Communications. 2003. *Employment up in city bars and restaurants since implementation of the Smoke-Free Air Act.* Press release. New York City Department of Health and Mental Hygiene. www.nyc.gov/html/doh/html/public/press03/pr081-0723.html.

24. Glantz, S. A., and L. R. Smith. 1997. The effect of ordinances requiring smoke-free restaurants and bars on revenues: A follow-up. *American Journal of Public Health* 87:1687–93.

25. Scollo, M., A. Lal, A. Hyland, and S. Glantz. 2003. Review of the quality of studies on the economic effects of smoke-free policies on the hospitality industry. *Tobacco Control* 12:13–20. www.tobaccoscam.ucsf.edu/pdf/scollotc.pdf.

26. Heironimus, J. 1992. Impact of work-place restrictions on consumption and incidence. [Interoffice correspondence to Louis Suwarna]. Philip Morris U.S.A. January 21. http://legacy.library.ucsf.edu/tid/qhs55e00. Bates no. 2044762531. Also, http://legacy.library.ucsf.edu/tid/rvv24e00. Bates no. 2023914280.

27. U.S. Department of Health and Human Services. 1992. *Smoking and health in the Americas: A report of the surgeon general* (CDC publication no. 92-8419). Atlanta: U.S. Department of Health and Human Services, Office on Smoking and Health.

28. National Cancer Institute, Cancer Control Science Program, Division of Cancer Prevention and Control. 1993. *The impact of cigarette excise taxes on smoking among children and adults: Summary report of a national cancer institute expert panel.* Rockville, MD: National Cancer Institute.

29. National Cancer Policy Board, Institute of Medicine, and National Research Council. 2000. *State programs can reduce tobacco use.* Washington, DC: National Academies Press.

30. World Bank. 1999. Measures to reduce the demand for tobacco. In *Curbing the epidemic: Governments and the economics of tobacco control.* Washington, DC: World Bank. www.worldbank.org/tobacco/book/html/chapter4.htm.

31. Chaloupka, F. J., K. M. Cummings, C. P. Morley, and J. K. Horan. 2002. Tax, price and cigarette smoking: Evidence from the tobacco documents and implications for tobacco company marketing strategies. *Tobacco Control* 11 Suppl. 1: i62–i72.

32. Warner, K. E. 1986. Smoking and health implications of a change in the federal cigarette excise tax. *Journal of the American Medical Association* 255 (8): 1028–32.

33. Philip Morris Companies Inc. Annual report for 12/31/98. 10-K filing. www.secinfo.com. Quoted in Sweanor, D., D. M. Burns, J. M. Major, and C. M. Anderson. 2000. Effect of cost on cessation. In *Population based smoking cessation* (Smoking and tobacco control monograph no.12). Bethesda, MD: National Institutes of Health, National Cancer Institute.

34. World Health Organization. 1998. *Guidelines for controlling and monitoring the tobacco epidemic.* New York: World Health Organization.

35. Stillman, F. A., A. M. Hartman, B. I. Graubard, E. A. Gilpin, D. M. Murray, and J. T. Gibson. 2003. Evaluation of the American Stop Smoking Intervention Study (ASSIST): A report of outcomes. *Journal of the National Cancer Institute* 95 (22): 1681–91.

36. National Center for Campaign for Tobacco-Free Kids. 2003. *Voters across the country support significant increases in state cigarette taxes.* Washington, DC: National Center for Tobacco-Free Kids.

37. Shane, S. 1997. Across party lines, voters favor raising cigarette tax by $1.50. *Baltimore Sun*, October 23, 1997. www.baltimoresun.com.

38. ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003 American Nonsmokers' Rights Foundation. All rights reserved.

39. O'Keefe, A. M., and R. W. Pollay. 1996. Deadly targeting of women in promoting cigarettes. *Journal of the American Medical Women's Association* 51 (1–2): 67–9.

40. DiFranza, J. R., J. W. Richards Jr., P. M. Paulman, N. Wolf-Gillespie, C. Fletcher, R. D. Jaffe, and D. Murray. 1991. RJR Nabisco's cartoon camel promotes Camel cigarettes to children. *Journal of the American Medical Association* 266 (22): 3149–53.

41. DiFranza, J. R., and J. B. Tye. 1990. Who profits from tobacco sales to children? *Journal of the American Medical Association* 263 (20): 2784–7.

42. Arnett, J. J., and G. Terhanian. 1998. Adolescents' responses to cigarette advertisements: Links between exposure, liking, and the appeal of smoking. *Tobacco Control* 7:129–33.

43. Pierce, J. P., W. S. Choi, E. A. Gilpin, A. J. Farkas, and C. C. Berry. 1998. Tobacco industry promotion of cigarettes and adolescent smoking. *Journal of the American Medical Association* 279 (7): 511–5.

44. Federal Trade Commission. 2004. *Cigarette report for 2002.* Washington,

DC: Federal Trade Commission. www.ftc.gov.

45. Levin, G. Poll shows Camel ads are effective with kids. *Advertising Age* 27 Apr. 1992: 1–2.
46. Fischer, P. M., M. P. Schwartz, J. W. Richards, A. O. Goldstein, and T. H. Rojas. 1991. Brand logo recognition by children aged 3 to 6 years: Mickey Mouse and Old Joe the Camel. *Journal of the American Medical Association* 266 (22): 3145–8.
47. Warner, K. E., L. M. Goldenhar, and C. G. McLaughlin. 1992. Cigarette advertising and magazine coverage of the hazards of smoking: A statistical analysis. *New England Journal of Medicine* 326 (5): 305–9.
48. Farrelly, M. C., J. Niederdeppe, and J. Yarsevich. 2003. Youth tobacco prevention mass media campaigns: Past, present and future directions. *Tobacco Control* 12 Suppl. I: i35–i47.
49. U.S. Department of Health and Human Services. 1994. *Preventing tobacco use among young people: A report of the surgeon general.* Atlanta: U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_1994.
50. Office of the Inspector General. 1990. *Youth access to cigarettes* (OEI-0290-02310). Washington, DC: U.S. Department of Health and Human Services.
51. Forster, J. L., D. M. Murray, M. Wolfson, T. M. Blaine, A. C. Wagenaar, and D. J. Hennrikus. 1998. The effects of community policies to reduce youth access to tobacco. *American Journal of Public Health* 88 (8): 1193–8.
52. Walls, T. 1993. A smokers' alliance [draft]. July 1, 1993. http://legacy.library.ucsf.edu/tid/pfo14e00. Bates no. 2025771934–1995.
53. Environmental Protection Agency. 1994. *Setting the record straight: Secondhand smoke is a preventable health risk* (Document no. 402-F-94-005). www.epa.gov/smokefree/pubs/strsfs.html.
54. Muggli, M. E., J. L. Forster, R. D. Hurt, and J. L. Repace. 2001. The smoke you don't see: Uncovering tobacco industry scientific strategies aimed against environmental tobacco smoke policies. *American Journal of Public Health* 91 (9): 1419–23.
55. Ong, E. K., and S. A. Glantz. 2001. Constructing "sound science" and "good epidemiology": Tobacco, lawyers, and public relations firms. *American Journal of Public Health* 91 (11): 1749–57.
56. Muggli, M. E., R. D. Hurt, and J. Repace. 2004. The tobacco industry's political efforts to derail the EPA report on ETS. *American Journal of Preventive Medicine* 26 (2): 167–77.
57. Merlo, E. 1993. [Memo to W. Campbell]. Philip Morris. February 17. http://legacy.library.ucsf.edu/tid/qdf02a00. Bates no. 2021183916–3930.
58. Bero, L. A., and S. A. Glantz. 1993. Tobacco industry response to a risk assessment of environmental tobacco smoke. *Tobacco Control* 2:103–13.
59. *Flue-cured Tobacco Cooperative Stabilization Corp. et al. v. U.S. Environmental Protection Agency, and Carol Browner.* 1998. The Osteen decision. www.tobacco.org/Documents/980717osteen.html.
60. Teenage Research Unlimited. 1999. *Youth focus groups to assess tobacco-use-prevention ads.* Northbrook, IL: Teenage Research Unlimited.
61. Farrelly, M. C., C. G. Healton, K. C. Davis, P. Messeri, J. C. Hersey, and M.

L. Haviland. 2002. Getting to the truth: Evaluating national tobacco countermarketing campaigns. *American Journal of Public Health* 92:901–7.

62. National Cancer Institute. 1993. *Major local tobacco control ordinances in the United States* (Smoking and tobacco control monograph no. 3, NIH publication no. 93-3532). Bethesda, MD: National Cancer Institute.
63. Hobart, R. 2002. *Preemption: Taking the local out of tobacco control.* Chicago: American Medical Association.
64. Siegel, M., J. Carol, J. Jordan, R. Hobart, S. Schoenmarklin, F. DuMelle, and P. Fisher. 1997. Preemption in tobacco control. Review of an emerging public health problem. *Journal of the American Medical Association* 278 (10): 858–63.
65. Dearlove, J. V., and S. A. Glantz. 2002. Boards of health as venues for clean indoor air policy making. *American Journal of Public Health* 92 (2): 257–65.
66. Fellers, T. 1993. Durham public smoking ordinance to force puffing in private. *Herald-Sun*. October 10, 1993.
67. Centers for Disease Control and Prevention. 1999. Preemptive state tobacco-control laws—United States, 1982–1998. *Morbidity and Mortality Weekly Report* 47 (51): 1112–4.
68. National Cancer Institute, American Cancer Society. 1990. Memo of understanding between the National Cancer Institute and the American Cancer Society. Internal document, National Cancer Institute, Bethesda, MD.
69. United States Bureau of the Census. 1993. *Selected historical decennial census population and housing counts: Table 2. Population, housing units, area measurements, and density: 1790 to 1990.* www.census.gov/population/censusdata/table-2.pdf.
70. *Preemption Cigarette Act. U.S. Code 15*, 1970. § 1334b. www4.law.cornell.edu/uscode/15/1334.html.
71. Glantz, S. A. 2002. *Tobacco Scam: How big tobacco uses and abuses the restaurant industry.* www.tobaccoscam.ucsf.edu.
72. Skolnick, A. 1995. Cancer converts tobacco lobbyist: Victor L. Crawford goes on the record. *Journal of the American Medical Association* 274 (3): 199–202.

Additional Resources

1. Kelder, G., and P. Davidson. 1999. *The Multistate Master Settlement Agreement and the future of state and local tobacco control: An analysis of selected topics and provisions of the Multistate Master Settlement Agreement of November 23, 1998.* www.tobacco.neu.edu/tobacco_control/resources/msa.
2. Web site for the Tobacco Control Resource Center, Inc. & The Tobacco Products Liability Project: www.tobacco.neu.edu.