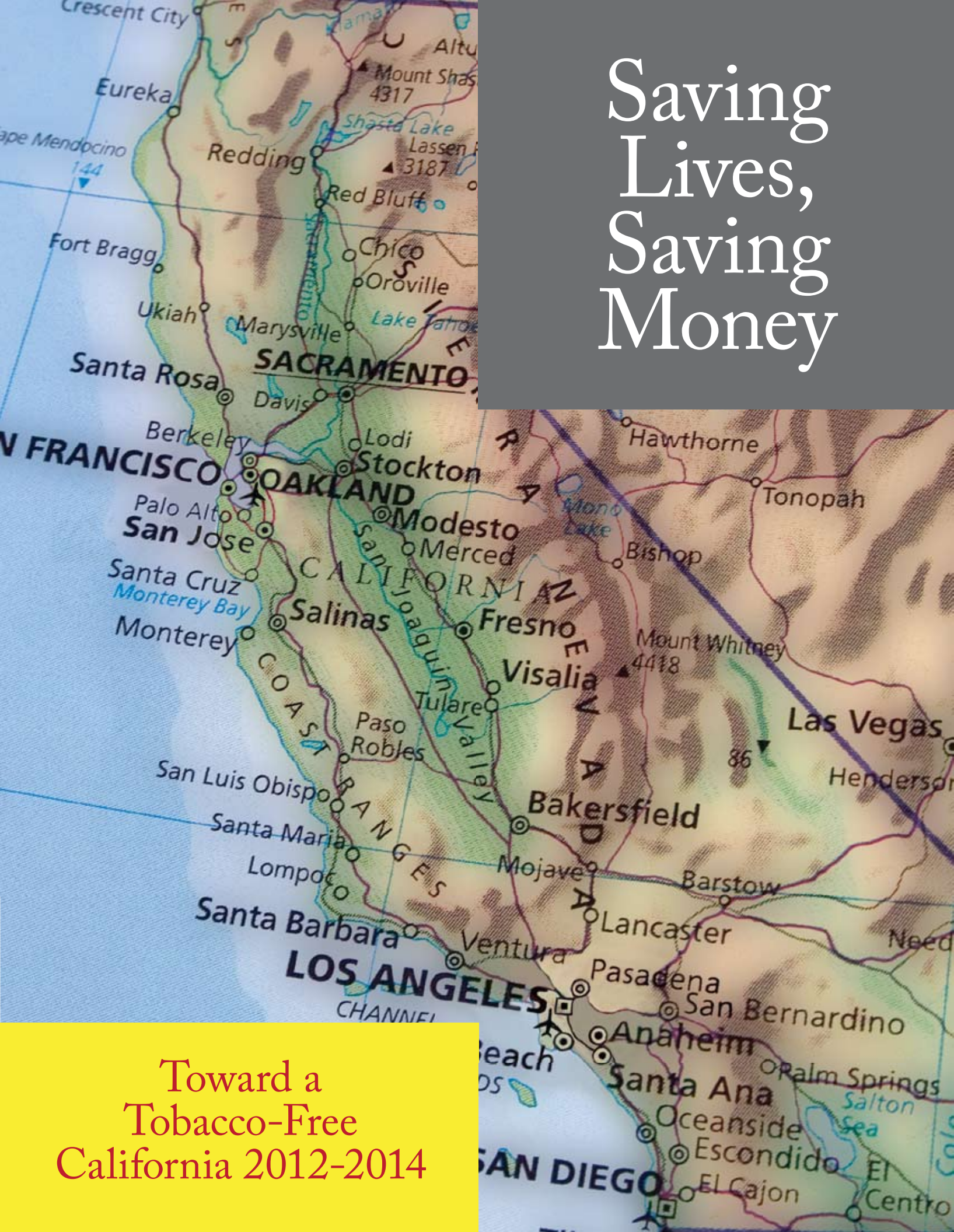

Saving Lives, Saving Money

Toward a Tobacco-Free California 2012-2014

Toward a Tobacco-Free California 2012-2014

Saving Lives, Saving Money

Master Plan of the
Tobacco Education and Research Oversight Committee

January 2012

Available on the Internet at:
http://www.cdph.ca.gov/services/boards/teroc/Pages/default.aspx

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Forward

California has achieved phenomenal success in tobacco control. California's cigarette smoking prevalence rate of less than 12 percent has only been achieved by one other state. Over the past 22 years, the reductions in tobacco use have saved $86 billion dollars and over a million lives in California: over a 50 to one return on investment.

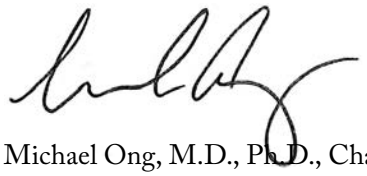
Unfortunately, we have reached a crossroads for tobacco control in California. Researchers from the University of California have projected that California's cigarette smoking prevalence will no longer decline, and will start increasing again, due to the current and future funding projections for California tobacco control. California's tobacco control efforts have been funded by a portion of a $0.25 tax on each cigarette pack sold in California. The past successes in California have also paradoxically reduced the funding available for tobacco control. In addition, what $0.25 bought in 1988 does not buy the same amount in 2012.

In other words, we as Californians have gotten tobacco use in our state as low as possible without making additional investments.

In these difficult economic times, it is hard to ask Californians to make any additional investments. However, further investments in tobacco control will save lives and save money. Getting more people to quit using tobacco and preventing people from starting to use tobacco saves lives and saves money. We would save more lives by preventing tobacco-related illnesses, which also saves money by preventing costly hospitalizations and other health care use among remaining tobacco users and those affected by secondhand smoke. We all share these costs through our public and private health insurance programs. Tobacco use also generates other costs shared by all from environmental clean-up costs, whether in public places or in private buildings.

The members of the Tobacco Education Research Oversight Committee in this 2012-2014 Master Plan have developed principles to guide tobacco control in California regardless of the level of investment that Californians consider appropriate for tobacco control. These principles infuse the seven objectives we describe that are needed to achieve the short-term goal of reducing smoking prevalence among adults below 10 percent, and among youth below eight percent, by 2014. These principles and achieving these objectives will ultimately help us reach our vision of a tobacco-free California that can be enjoyed by all of our diverse populations. Skeptics should be reminded of how social norms on smoking have dramatically changed in the past 25 years.

We have achieved so much in California, but we can be even better. We urge the Legislature and all Californians to make additional investments in tobacco control.



Michael Ong, M.D., Ph.D., Chair
January 2012


LIBERTY
1988
LIBERTY
1988
LIBERTY
1988

Proposition 99

In November 1988, California voters passed a ballot initiative known as Proposition 99 (the Health Promotion and Protection Act of 1988) which added a $0.25 excise tax per cigarette package and a proportional tax increase on other tobacco products beginning January 1, 1989. The tax was earmarked for public health programs to:

- prevent and reduce tobacco use,
- provide healthcare services,
- support tobacco-related research, and
- protect environmental resources.

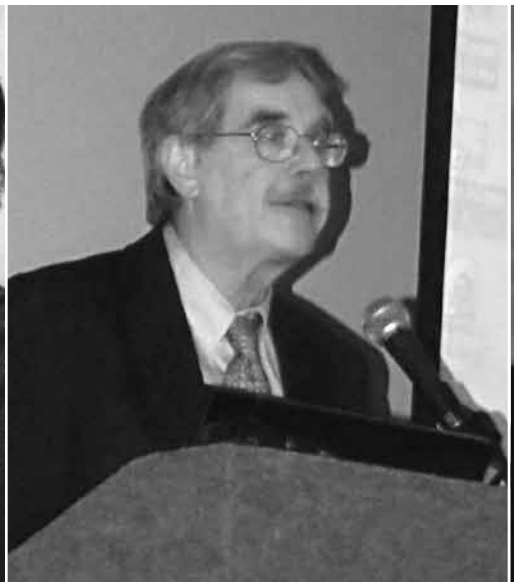
The California Tobacco Control Program (CTCP) was established in 1989. Twenty years later, the history of its development and its many accomplishments were celebrated in a special supplement of the journal *Tobacco Control*, entitled *The Quarter that Changed the World*.

About the Tobacco Education and Research Oversight Committee

The Tobacco Education and Research Oversight Committee (TEROC) was established by the enabling legislation for Proposition 99 (California Health and Safety Code, Sections 104365-104370) which mandates TEROC to:

- Prepare a comprehensive Master Plan to guide California tobacco control efforts, tobacco use prevention education, and tobacco-related disease research;
- Advise the California Department of Public Health, the California Department of Education, and the University of California regarding the administration of Proposition 99 funded programs;
- Monitor the use of Proposition 99 tobacco tax revenues for tobacco control programs, prevention education, and tobacco-related research; and
- Provide programmatic and budgetary reports on Proposition 99 tobacco control efforts to the California Legislature with recommendations for any necessary policy changes or improvements.

Pursuant to the Bagley-Keene Open Meeting Act, all TEROC meetings are open to the public. More information about TEROC, including meeting announcements, meeting minutes, press releases, and previous Master Plans can be accessed online at http://www.cdph.ca.gov/services/boards/teroc/.


Members of the Tobacco Education and Research Oversight Committee

TEROC is made up of 13 members. Pursuant to California Health and Safety Code Section 104365, the Governor appoints eight members, the Speaker of the Assembly appoints two, the Senate Rules Committee appoints two, and the Superintendent of Public Instruction appoints one member. Current TEROC members are:

Lourdes Baézconde-Garbanati, Ph.D., M.P.H., M.A.
Associate Professor in
Preventive Medicine and Sociology
Institute for Health Promotion and Disease Prevention Research
Keck School of Medicine
University of Southern California, Alhambra

Wendel Brunner, Ph.D., M.D., M.P.H.
Director of Public Health
Contra Costa Health Services, Martinez

Patricia Etem, M.P.H.
Executive Consultant
CIVIC Communications, Long Beach

Lawrence W. Green, Dr.P.H., Sc.D. (Hon.)
Professor, Department of
Epidemiology and Biostatistics,
School of Medicine,
Helen Diller Family Comprehensive Cancer Center & Center for Tobacco Control Research & Education
University of California, San Francisco

Alan Henderson, Dr.P.H., C.H.E.S.
Professor Emeritus,
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College of Health and Human Services
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Naphtali Offen
Tobacco Documents Researcher
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School of Nursing
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Division of General Internal Medicine and Health Services
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Dorothy Rice, Sc.D. (Hon.)
Professor Emeritus, Institute for Health and Aging
School of Nursing
University of California, San Francisco

Peggy M. Uyeda
Tobacco-Use Prevention Education Coordinator (Ret.)

Kathleen Velazquez, M.P.H., M.A.
Chief, Office of Leadership and Workforce Development
California Department of Public Health

Valerie B. Yerger, N.D., M.A., L.M.
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Department of Social and Behavioral Sciences,
School of Nursing Center for Tobacco Control Research and Education
University of California, San Francisco

Shu-Hong Zhu, Ph.D., M.S.
Professor, Department of Family and Preventive Medicine School of Medicine
University of California, San Diego


LIGHTS
ACTION!
RESPONSIBLE
Smokin
Rated 'R'
Whats More
Important
Smoking on
your Life
A Better
Life
FREE

Mission, Vision, and Goal of Tobacco Control in California

Mission: To eliminate tobacco-related illness, death, and economic burden
Vision: A tobacco-free California
Goal: To achieve smoking prevalence rates in California of 10 percent for adults and eight percent for high-school age youth by December 2014

Administration of California's Proposition 99 Tobacco Control Efforts
California's Proposition 99 tobacco control efforts are administered by three state entities that work together toward achieving the mission, vision, and goal defined by TEROC for this Master Plan period.

The California Tobacco Control Program of the California Department of Public Health (CDPH/CTCP) administers the public health aspects of the program, including current Proposition 99-funded tobacco control activities of 61 local health departments, 37 community non-profit organizations, eight statewide training and technical assistance or cessation service projects, the statewide media campaign, and an evaluation of the effectiveness of the public health and school-based components. http://www.cdph.ca.gov/programs/Tobacco

The Coordinated School Health and Safety Office of the California Department of Education (CDE/CSHSO) is responsible for administering the Tobacco-Use Prevention Education (TUPE) program in over 961 school districts, 58 county offices of education, and more than 600 direct-funded charter schools. http://www.cde.ca.gov/ls/he/at/tupe.asp

The Tobacco-Related Disease Research Program (TRDRP), administered by the University of California, Office of the President, funds research that enhances the understanding of: tobacco use, prevention, and cessation; the social, economic, and policy-related aspects of tobacco use; and tobacco-related diseases. http://www.trdrp.org


NO DUMPING
¡NO CONTAMINE!
DRAINS TO TRUCKEE RIVER


YUBA RIVER
CLEAN-UP 2010
CIGARETTE LITTER
FACTS

Acknowledgments

TEROC thanks the many individuals and groups that are committed to tobacco control in California and that contributed to this Master Plan. Special appreciation is extended to the following:

- Local health departments, tobacco control community programs, and schools throughout California, without which a comprehensive tobacco control program would not exist.

- Participants in California tobacco control efforts that provided input into the development of the 2012-2014 Master Plan objectives and supporting strategies.

- The African American Tobacco Control Leadership Council (AATCLC).

- Members of the academic community whose research findings are contributing to a greater understanding of tobacco control.

- Colleen Stevens, April Roeseler, David Cowling, Glen Baird, Majel Arnold, Deana Lidgett, Linda Lee, Gretta Foss-Holland, Laine' Clark, Tonia Hagaman, Francisco Michel, other staff of the California Tobacco Control Program, and Donald Lyman, Chief, Chronic Disease and Injury Control Division, California Department of Public Health.

- Tom Herman, Greg Wolfe, John Lagomarsino, and other staff of the California Department of Education, Coordinated School Health and Safety Office, and Greg Austin, WestEd.

- Bart Aoki, Phillip Gardiner, and other staff from the Tobacco-Related Disease Research Program; and Mary Croughan, Executive Director of the Research Grants Program Office, University of California, Office of the President.

- Carol D'Onofrio and Todd Rogers, who facilitated the development and writing of this Master Plan.


NO
SMOKING
ALLOWED


Smoke-Free
Campus
Smoking and tobacco are not
permitted on any Sierra College
campus. Thank you.

Executive Summary

Benefits of Tobacco Control. Over the past 22 years, Proposition 99 funds for tobacco control have saved lives and saved money, providing a large return on investment for the people of California.

- Deaths from lung cancer, heart disease, and other tobacco-related diseases have declined more in California than in other states, saving over one million lives and incalculable human suffering.
- Cumulative savings in healthcare costs over the first 15 years of the program totaled $86 billion, representing a 50 fold return on a $1.8 billion investment.
- In 2010, the state's adult smoking prevalence dropped to a record low of 11.9 percent, making California one of only two states in the United States to reach the federal Healthy People 2020 target of 12 percent.

Challenges. Despite these and other impressive accomplishments, California still has 3.6 million smokers, and smoking remains the state's number one preventable cause of disease and death. Sustaining and advancing progress in tobacco control depends on effectively responding to three major challenges:

- The need to reverse the decline in tobacco control resources resulting from reductions in tobacco consumption and related tax revenues, decreased purchasing power due to inflation, and staffing shortages in California's tobacco control agencies related to state budget problems.
- The need for intensified efforts and new approaches to reduce tobacco-related disparities and to promote cessation among those whose tobacco use still endangers their health, that of others, and the environment.
- The need to expose and counter the tobacco industry's massive marketing expenditures, campaign contributions, affiliations, legal maneuvers, and other tactics that undermine California's advances in tobacco control.

Importance of Renewed Commitment. Saving lives and saving money during the next three years and into the future depends on renewed commitment to tobacco control by the people of California. Leadership is needed at all levels. The status quo is not good enough. In this context, TEROC presents the 2012-2014 Master Plan for tobacco control in accord with California Health and Safety Code Sections 104365-104370.

Principles for Tobacco Control in California

Regardless of whether funding for tobacco control increases or decreases, decision-making by tobacco control agencies, other organizations, local communities, and people throughout the state should be based on principles that have guided tobacco control efforts in California since Proposition 99 was passed in 1988.

- Ensure implementation of comprehensive tobacco control efforts throughout California.
- Continue and expand social norm change and population-based approaches to tobacco control.
- Address health disparities in populations disproportionately affected by tobacco-related diseases and death to help achieve health equity.
- Use evidence to guide decisions about tobacco control programs, education, and research.
- Set performance goals for tobacco control programs, education, and research that achieve positive outcomes for Californians and serve as models for other states and nations.
- Develop, maintain, and enhance training and mentoring to prepare and support health professionals, educators, academics, and advocates from all segments of California's diverse populations for present and future leadership across the tobacco control continuum.

2012-2014 Master Plan Objectives and Strategies

Seven key objectives and related strategies are identified for tobacco control in California over the next three years.

- **Objective 1. Raise the Tobacco Tax**. Raising the tobacco excise tax by at least $1.00 per cigarette pack with an equivalent tax on other tobacco products and designating at least $0.20 for tobacco control is critical to achieving the Master Plan's other six objectives. The tax increase should be indexed incrementally to inflation, and untaxed or low-taxed sources of tobacco should be eliminated. California is one of only three states without a tobacco tax increase since 1999.

- **Objective 2. Strengthen the Tobacco Control Infrastructure**. Strengthening the statewide tobacco control infrastructure is essential to sustain and extend the health and economic benefits already achieved and to address new challenges effectively. Critical strategies include increasing communication, collaboration, and resource leveraging among traditional and new tobacco control partners; building the capacity of state and local agencies and health systems to contribute to tobacco control efforts; and adequately funding California's three tobacco control agencies to ensure stability, continuity, and momentum.

- **Objective 3. Achieve Equity in all Aspects of Tobacco Control Among California's Diverse Populations**. Raising the tobacco exise tax will reduce socioeconomic disparities in the prevalence of tobacco use and subsequently in tobacco-related diseases and deaths. Policies should be adopted and enforced at state and local levels to curtail tobacco industry targeting of priority populations. Equity and cultural competency standards should be incorporated in all tobacco control agencies, programs, processes, practices, and infrastructures. The involvement and competencies of priority populations in tobacco control should be increased to reduce tobacco-related disparities.

- **Objective 4. Minimize the Impact of Tobacco Use on People and of Tobacco Waste on the Environment**. Based on its 2006 finding that secondhand smoke is a toxic air contaminant, the California Air Resources Board should act to eliminate all smoking in public places and to declare tobacco smoke a public nuisance. Exemptions and loopholes in California's smoke-free workplace laws must be removed to protect workers, reduce disparities, and earn California recognition as a smoke-free state. Additional tobacco-free laws and policies should be adopted and enforced to minimize secondhand smoke exposure. Research should address emerging health, social, and economic concerns about new tobacco products, third-hand smoke, and the effects of tobacco waste on the environment.

- **Objective 5. Prevent Initiation of Tobacco Use**. Coordination and resource leveraging should be enhanced among California's tobacco control agencies and between community tobacco control programs, schools, and youth organizations throughout the state to accelerate the decline in youth tobacco use prevalence. Critical strategies include developing collaborative community-school tobacco prevention programs, increasing the number of tobacco-free schools, providing training and technical assistance to increase the capacity and competency of schools and community organizations in tobacco use prevention. The priority should be on limiting tobacco industry activities targeted towards youth and young adults, and conducting research and evaluation to strengthen these preventive efforts.

- **Objective 6. Increase the Number of Californians who Quit Using Tobacco**. This objective and key strategies for achieving it have been influenced by the population-based Tobacco Quit Plan for California developed in 2009, increases in the proportions of light and non-daily smokers, and an increasing likelihood that tobacco users are members of priority populations. Priority approaches should boost the number and frequency of tobacco quit attempts across populations, expand the availability and utilization of cessation aids and services, engage healthcare providers in helping patients quit, promote tobacco use cessation through additional channels, and conduct studies that strengthen cessation programs and services.

- **Objective 7. Minimize Tobacco Industry Influence and Activities**. To save lives and save money, Californians must work together to achieve strong regulation of the tobacco industry at every level of its operation. Closely monitoring and exposing tobacco industry spending and activities through rapid-response surveillance systems, the use of social media, and other methods of communication is critical to inform specific actions. Laws that regulate the sale, distribution, and marketing of tobacco products should continue to be adopted and enforced at state and local levels. Statewide legislation that preempts stronger local ordinances should be opposed. Californians should support additional regulation of tobacco by the United States Food and Drug Administration and work within the state to increase refusals of tobacco industry funding, sponsorships, and partnerships.

Saving Lives, Saving Money: Toward a Tobacco-Free California 2012-2014

The Tobacco Education and Research Oversight Committee (TEROC) presents this 2012-2014 Master Plan for tobacco control in accord with California Health and Safety Code Sections 104350-104480. This document provides programmatic recommendations to the State's three tobacco control agencies: the California Department of Public Health, the California Department of Education, and the University of California.

Beyond this, the Master Plan informs elected officials, agencies, organizations, groups, educators, researchers, advocates, community leaders, and other concerned citizens about the status of tobacco control in California and critical actions needed to achieve a tobacco-free California. Much has been accomplished, but much remains to be done. Continued progress toward a tobacco-free California will require a renewed commitment from the people of the state.

Seize the Moment

Tobacco prevention and control efforts need to be commensurate with the harm caused by tobacco use. Otherwise, tobacco use will remain the largest cause of preventable illness and death in our nation for decades to come. When we help Americans quit tobacco use and prevent our youth from ever starting, we all benefit. Now is the time for comprehensive public health and regulatory approaches to tobacco control. We have the knowledge and tools to largely eliminate tobacco caused disease. If we seize this moment, we will make a difference in all of our communities and in the lives of generations to come.[1]

Kathleen Sebelius
Secretary of Health and Human Services


Linking Tobacco Control Research & Practice for a Healthier California
Hyatt Regency Sacramento, April 10-12,
CTCP's New Retail
Advocacy Ca
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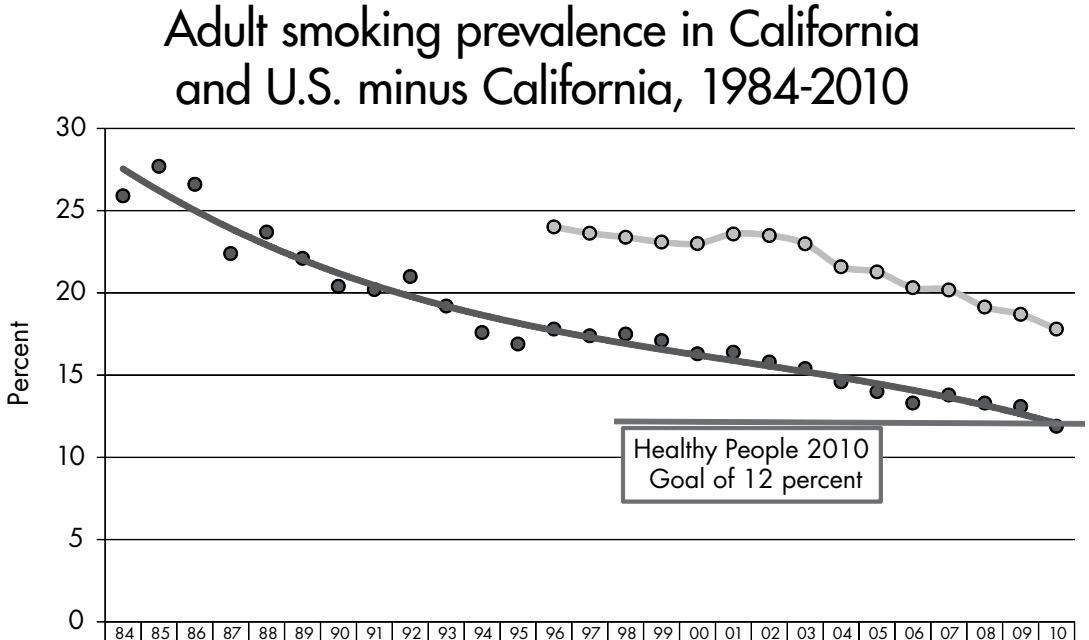
Tobacco Control P

Key Considerations in Plan Development

Return on Investment. Over the past 22 years, Proposition 99 funds for tobacco control have saved lives and saved money, providing a large return on investment for California and its residents. Deaths from lung cancer, heart disease, and other tobacco-related diseases have declined more in California relative to the rest of the nation, saving more than an estimated one million lives and incalculable human suffering.[2] Cumulative savings in healthcare costs over the first 15 years of the program totaled $86 billion, representing a 50-fold return on a $1.8 billion investment.[3]

In 2010, the state's adult smoking prevalence dropped to a record low of 11.9 percent (see Figure 1), making California one of only two states in the United States to reach the federal Healthy People 2020 target of 12 percent.[4] Adult per capita consumption of cigarettes (see Figure 2) and 30-day smoking prevalence among youth (see Figure 3) also have declined at greater rates in California than the rest of the United States.[5] These trends promise to save more lives and more money far into the future.

Figure 1

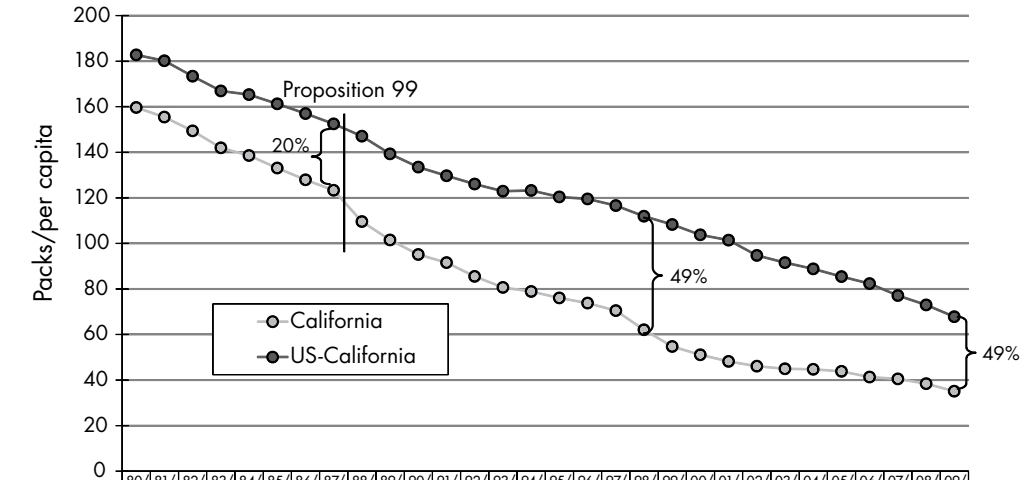


	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10
CA	25.9	27.7	26.6	22.4	23.7	22.1	20.4	20.2	21.0	19.2	17.6	16.9	17.8	17.4	17.5	17.1	16.3	16.4	15.8	15.4	14.6	14.0	13.3	13.8	13.3	13.1	11.9
US-CA													24.0	23.6	23.4	23.1	23.0	23.6	23.5	23.0	21.6	21.3	20.3	20.2	19.1	18.7	17.8

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data are combined for 1993-2010. The data are weighted to the 2000 California population. State BRFSS data are weighted to 2000 national population based on each states population. Note an adjustment was made to address the change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program, April 2011.

Figure 2

Adult per capita cigarette pack consumption for California and the U.S. minus California, 1980 to 2010

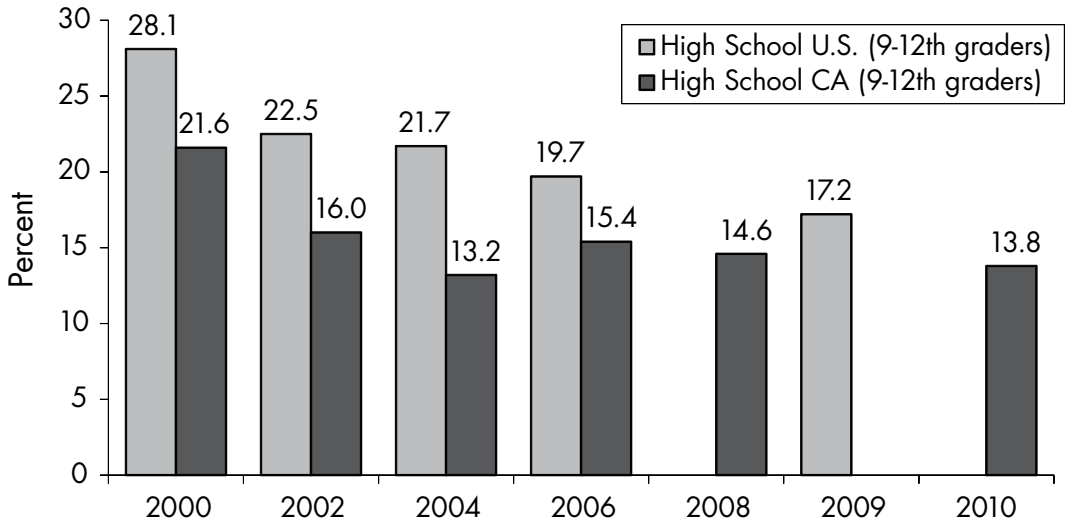


	80/81	81/82	82/83	83/84	84/85	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
California	160	156	149	142	139	133	128	123	110	102	95	92	86	81	79	76	74	71	62	55	51	48	46	45	45	44	41	41	38	35
US-California	183	180	173	167	165	161	157	153	147	139	134	130	126	123	123	120	120	117	112	108	104	101	95	92	89	85	82	77	73	68

Source: Tax Burden on Tobacco, 2010, California State Board of Equalization (packs sold), Department of Treasury for 2010 US and US Census (population). Prepared by: California Department of Public Health, California Tobacco Control Program, April 2011.

Figure 3

30-day student smoking prevalence (9th-12th grade) for California and the United States, 2000-2010



Source: The 2000 California data is from the National Youth Tobacco Survey (NYTS) collected by the American Legacy Foundation, which used passive parental consent. The 2002, 2004, 2006, 2008, and 2010 data are from the California Student Tobacco Survey. The 2002 and 2004 data collection used active parental consent while the 2006, 2008, and 2010 used a mixed parental consent procedure. The United States data are from the NYTS collected by the American Legacy Foundation and the Centers for Disease Control and Prevention. Note that the NYTS was conducted in 2009 thus s 2008 and 2010 United States data are unavailable.
Prepared by: California Department of Public Health, California Tobacco Control Program, April 2011.

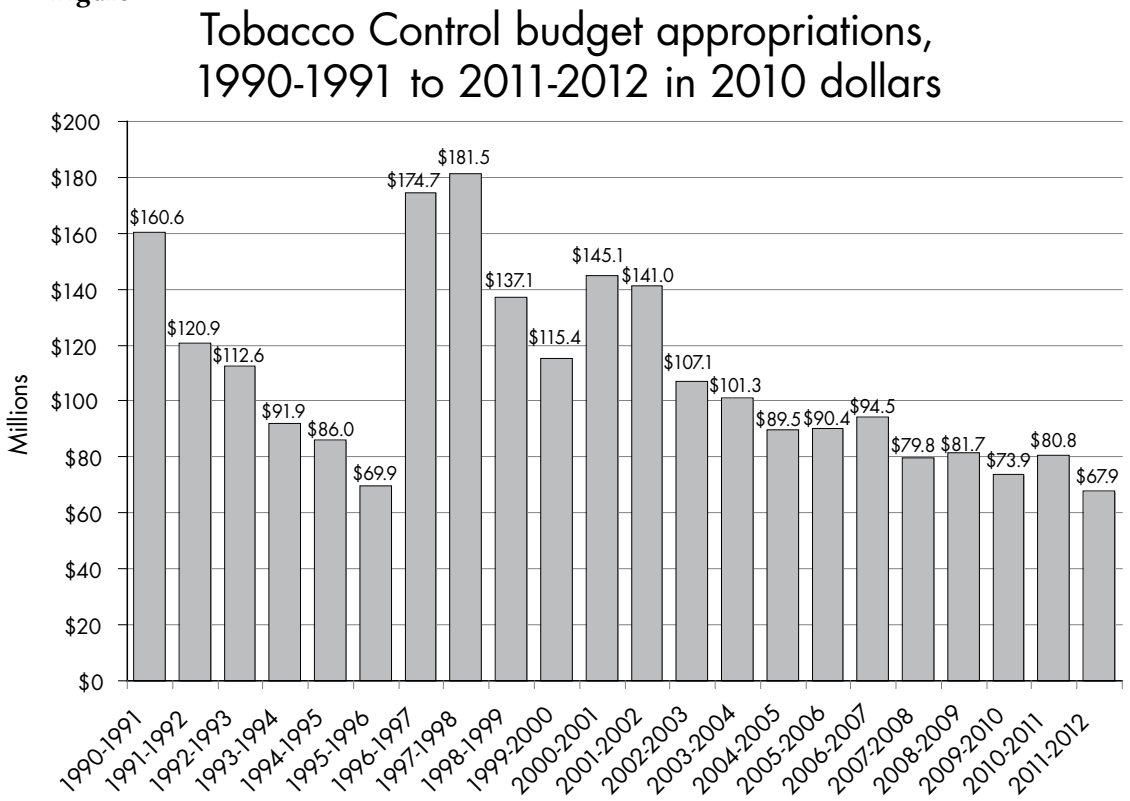
California's comprehensive approach to tobacco control has clearly been effective. The program has saved lives and saved money by changing social norms around tobacco use, conducting research and evaluation to inform tobacco control efforts, and developed policy and programmatic approaches that have become models to help other states and countries address the world-wide tobacco epidemic. However, despite an impressive track record of accomplishments, tobacco control in California faces many challenges.

Challenges. Smoking remains the number one preventable cause of death and disease in California and the United States. Despite declines in smoking prevalence since the establishment of the statewide tobacco control program, California still has 3.6 million smokers; that number is greater than the total populations for 23 States and the District of Columbia.[6] Further progress in tobacco control depends on effectively responding to three major challenges.

- **Decreased tobacco control resources**. Resources for tobacco control in California have dwindled dramatically in the last decade (see Figure 4). In part, these declines reflect victories in reducing tobacco consumption and resulting decreases in tobacco tax revenues. Inflation has also diminished purchasing power over time in all areas, including personnel, media production and airtime, and research. Moreover, California's tobacco control agencies have experienced declines in workplace capacity as a result of furloughs, the elimination of positions, or leaving vacant positions unfilled due to the overall state budget deficit and hiring freezes. These shortfalls make it difficult to sustain the progress already made and to develop the public health initiatives needed to address new challenges.

- **The need to address continuing and emerging problems**. As tobacco use rates decline, intensified efforts and new approaches are

Figure 4



needed to reduce tobacco-related health disparities and reach those whose tobacco use still endangers their health, that of others, and the environment. Addressing these persistent issues, and emerging concerns such as the effects of toxic tobacco waste on the environment is essential to protect the health of Californians and yield further long-term cost savings.

In 2008, tobacco industry expenditures just on marketing in California were over eight times more than the state's spending on tobacco control.

Increased tobacco industry spending. In 2008, tobacco industry expenditures on marketing in California were over eight times more than the State's spending on all of tobacco control.[7] The tobacco industry relentlessly works to undermine gains in California tobacco control. Examples include sophisticated marketing of its products, new product innovations, sponsorship of events, dissemination of ineffective and counterproductive tobacco prevention materials, legal challenges to effective tobacco control policies, campaign contributions to elected officials, and affiliations with influential civic, community, and social organizations and leaders.

California Tobacco Control at a Crossroads. Considering both the return on investment in tobacco control and the challenges described above, TEROC has concluded that tobacco control in California is at a crossroads. The decline in tobacco control funding must be reversed in order to sustain the progress already made in saving lives and saving money, to vigorously address new and emerging issues, and to protect California's highly successful investment in tobacco control.

Without this recommitment to tobacco control, the state will experience increases in the prevalence of cigarette smoking and other tobacco use, exposure to secondhand smoke, tobacco-related diseases and deaths, related social and health care costs, and environmental damage. California's comprehensive tobacco control program infrastructure will deteriorate and the state's return on its investment in tobacco control will decline. Thus, the status quo is not good enough.

An increase in the tobacco excise tax is the only realistic source of additional tobacco control funding in California. Raising the tobacco tax and dedicating a significant portion to tobacco control—the first Master Plan objective— is therefore critical to achieving all objectives.

Progress toward a tobacco-free California therefore depends on the will of the people of the state and their ability to see through the tobacco industry's deceit and obfuscation. The people of California—voters and those who influence voters—will determine whether our state moves closer to becoming clean, green, and tobacco-free, or whether our air becomes more contaminated by smoke, our outdoor spaces and waterways become more contaminated with tobacco litter, our families continue to suffer from tobacco-related diseases and deaths, and our struggling economy continues to suffer from rising health care costs caused by tobacco use. Leadership in advocating for tobacco control is needed at all levels.

TEROC presents the 2012-2014 Master Plan for tobacco control in this context.

Overview of the 2012-2014 Master Plan. TEROC cannot predict the path that tobacco control funding will follow in the next few years. Therefore, this Master Plan begins by identifying principles to guide decision-making by tobacco control agencies regardless of whether their funding increases or decreases. TEROC views these principles as the foundation for the objectives of the 2012-2014 Master Plan and for achieving the overall goal of a tobacco-free California.

Use this Master Plan to inform and educate....

- Yourself
- Your family, friends, and neighbors
- Elected officials
- Business, professional, youth and other organizations, and leaders
- The media


wir
doors and
through vents,
can enter your home
Secondhand smoke
Even if you don't smoke, your family can still be exposed to secondhand s
Talk to your landlord about making your building 100% smoke-free.
Millions
are exposed
to secondhand smoke
and some can't do
anything
about it.
Even if you don't smoke, you can still be exposed to secondhand smoke in your home through vents, doors and
Talk to your landlord about making your building entirely smoke-free.
©2011 California Department of Public Health
TobaccoFre

Principles for Tobacco Control in California

Decision-making about goals, priorities, and strategies for tobacco control in California is difficult in these times of rapid change and uncertain resources. If funding continues to decline, hard choices will need to be made about which current programs to cut and which new initiatives to place on hold. If a new tobacco tax is passed, if grant funds are obtained, and/or if new resource-sharing partnerships can be developed, judgments about which programs to restore and which new directions to pursue also will require careful thought.

To maintain and advance progress in tobacco control, the following principles must guide decision-making by tobacco control agencies, other organizations, local communities, and people throughout the state. These principles have guided tobacco control efforts in California since Proposition 99 was passed in 1988:

Ensure implementation of comprehensive tobacco control efforts throughout California. A comprehensive statewide tobacco control program is a coordinated effort to:

- establish tobacco-free policies and social norms,
- promote and assist cessation of tobacco use,
- prevent tobacco use initiation, and
- counter the marketing practices and political influence of the tobacco industry.

Continue and expand social norm change and population-based approaches to tobacco control. In the social norm approach to tobacco control, agencies and communities throughout the state undertake a range of integrated policy, programmatic, educational, and research initiatives. The common aim of these public health initiatives is to change the political, social, economic, legal, and media environments that influence the tobacco-related knowledge, attitudes, and behaviors of Californians. As tobacco use becomes less desirable, less acceptable, and less accessible, enduring social change is created incrementally at a grassroots level across communities.

Address health disparities in populations disproportionately affected by tobacco-related diseases and death to help achieve health equity. Health disparities are systematic, plausibly avoidable health differences that adversely affect socially disadvantaged groups. The health differences may reflect social disadvantage, but causality need not be established. This definition, grounded in ethical and human rights principles, focuses on the subset of health differences that reflect social injustice, distinguishing health disparities from other health differences also warranting concerted attention.[8]

Tobacco control priority populations are those that, when compared to the general population, suffer from disparities related to disproportionately high rates of smoking prevalence, tobacco consumption, secondhand smoke exposure at work and at home, targeting by the tobacco industry, tobacco-related diseases and deaths, and related economic hardships. In California, these populations include, but are not limited to:

- African Americans, other people of African descent, American Indian and Alaska Natives, some Asian Americans, and Hispanics/ Latinos;
- people of low socioeconomic status, including the homeless;
- people with limited education, including high school drop-outs;
- lesbian, gay, bisexual, and transgender (LGBT) people;

- rural residents;
- members of the military and individuals employed in jobs not protected by smoke-free workplace laws;
- people addicted to alcohol and other drugs;
- the mentally ill;
- people with disabilities; and
- formerly incarcerated individuals.

In addition to the many social factors contributing to disparities, the tobacco industry directly targets specific communities and cultures with sophisticated marketing to exploit their vulnerabilities. Reducing disparities among these populations would contribute to achieving health equity among California's diverse populations.

Use evidence to guide decisions about tobacco control programs, education, and research. Evidence from California and other states demonstrates that comprehensive, sustained, and accountable statewide tobacco control programs reduce tobacco use and tobacco-related diseases and deaths. Data demonstrating the effectiveness of specific approaches should inform the selection of interventions to tackle the same or similar issues.

When data suggest improvements or indicate that adjustments are needed, the costs, outcomes, risks, and benefits of resulting modifications should be carefully evaluated. Research should be conducted to illuminate promising ways to control intractable and emerging tobacco control problems.

Set performance goals for tobacco control programs, education, and research that achieve positive outcomes for Californians and serve as models for other states and nations. Clearly defining goals and objectives for tobacco control with short-term, intermediate, and long-term indicators to measure achievement requires assessing needs and opportunities, strategic planning, and priority setting.

Selected goals and objectives identify targets, drive action, and provide the basis for forming partnerships, gathering resources, mustering support, and coordinating efforts. They supply the framework for collecting baseline, process, and outcome data to measure progress, develop strategies for the future, and foster continuous quality improvement.

Develop, maintain, and enhance training and mentoring to prepare and support health professionals, educators, academics, and advocates from all segments of California's diverse populations for present and future leadership across the tobacco control continuum. Developing and sustaining comprehensive tobacco control in California depends on constantly strengthening and renewing the capacities of the staff, advocates, and volunteers who collectively have the knowledge, skills, and experience needed to achieve success.

In addition to academic, technical, programmatic, and administrative resources, effective tobacco control requires abilities to generate and develop fresh ideas, think critically, build relationships, and work collaboratively within and across various disciplines and cultures.

2012-2014 Master Plan Objectives

1. Raise the tobacco tax
2. Strengthen the tobacco control infrastructure
3. Achieve equity in all aspects of tobacco control among California's diverse populations
4. Minimize the impact of tobacco use on people and of tobacco waste on the environment
5. Prevent initiation of tobacco use
6. Increase the number of Californians who quit using tobacco
7. Minimize tobacco industry influence and activities

Objectives and Strategies for 2012-2014

OBJECTIVE 1: Raise the Tobacco Tax

- Increase the tobacco excise tax by at least $1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least $0.20 of the increase for tobacco control, indexed incrementally to inflation.
- Eliminate untaxed or low-taxed sources of tobacco.
- Evaluate the effects of tobacco tax increases and disseminate findings.

To reduce tobacco use; to prevent tobacco-related diseases, disabilities, and deaths; and to lower healthcare costs, California must enact a new tobacco excise tax with the provisions identified in Objective 1. This is a cost-effective policy intervention.[9, 10, 11]

The Tobacco Education and Research Oversight Committee (TEROC) views an increase in the tobacco excise tax as the cornerstone for achieving the other six 2012-2014 tobacco control objectives and for progressing toward achieving the overarching goals of a 10 percent adult smoking prevalence rate, an eight percent youth smoking prevalence rate, and ultimately a tobacco-free California.

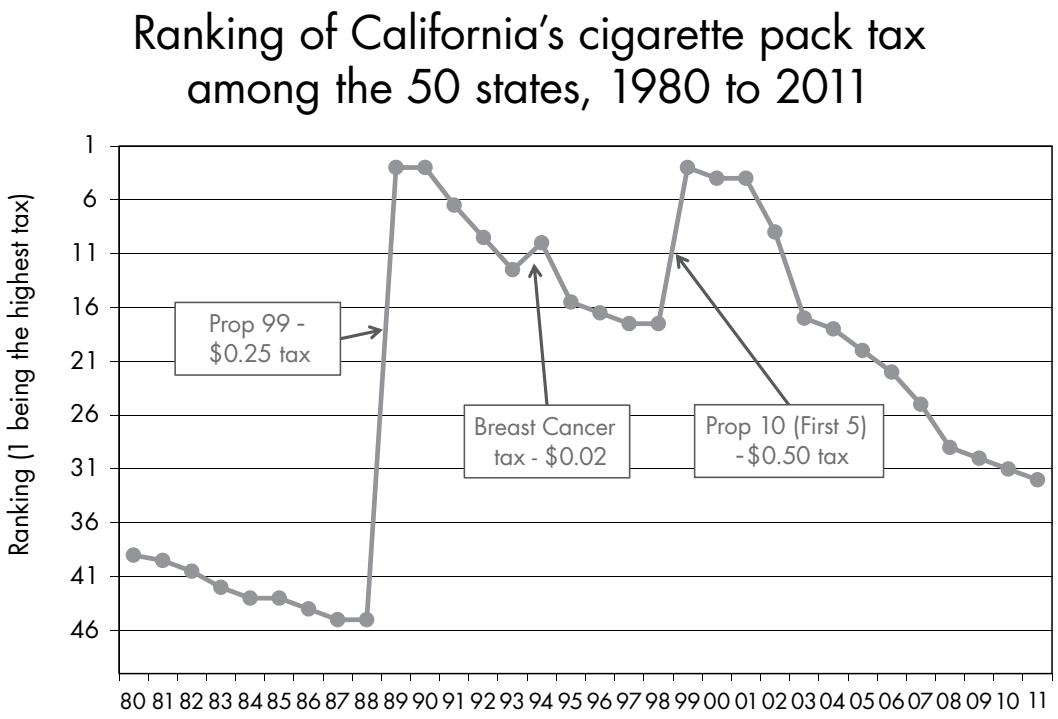
TEROC calls for an increase in the tobacco excise tax of at least $1.00 per pack of cigarettes, with an equivalent tax on other tobacco products, and to specifically designate at least $0.20 of the increase for tobacco control, indexed incrementally to inflation. The evidence clearly shows that the cost of tobacco products matters. As the price of tobacco goes up, consumption goes down. More smokers quit and fewer young people begin using tobacco. Designating or earmarking a portion of the tax increase for comprehensive tobacco control is critical to achieving decreases in consumption, increases in cessation, and the prevention of youth uptake, all of which lead to saving more lives and more money.[12, 13]

In June 2012, Californians narrowly decided not to increase the tobacco excise tax. While TEROC supported Proposition 29, the California Cancer Research Act, TEROC differed from the Proposition in that they strongly recommended that a portion of the increased tax revenue designated for research be allocated to the Tobacco-Related Disease Research Program (TRDRP). TRDRP has supported studies to reduce the harmful effects of tobacco use since the passage of Proposition 99 over two decades ago.

Increasing the excise tax on tobacco is the quickest, simplest, and most effective strategy to increase the price of tobacco. Unfortunately, California has failed to increase its tobacco tax in 13 years and now is one of only three states without an increase since 1999. Because of this neglect, California's tobacco tax, at $0.87 per pack, now ranks 32nd among the 50 states (see Figure 5).[14, 15]

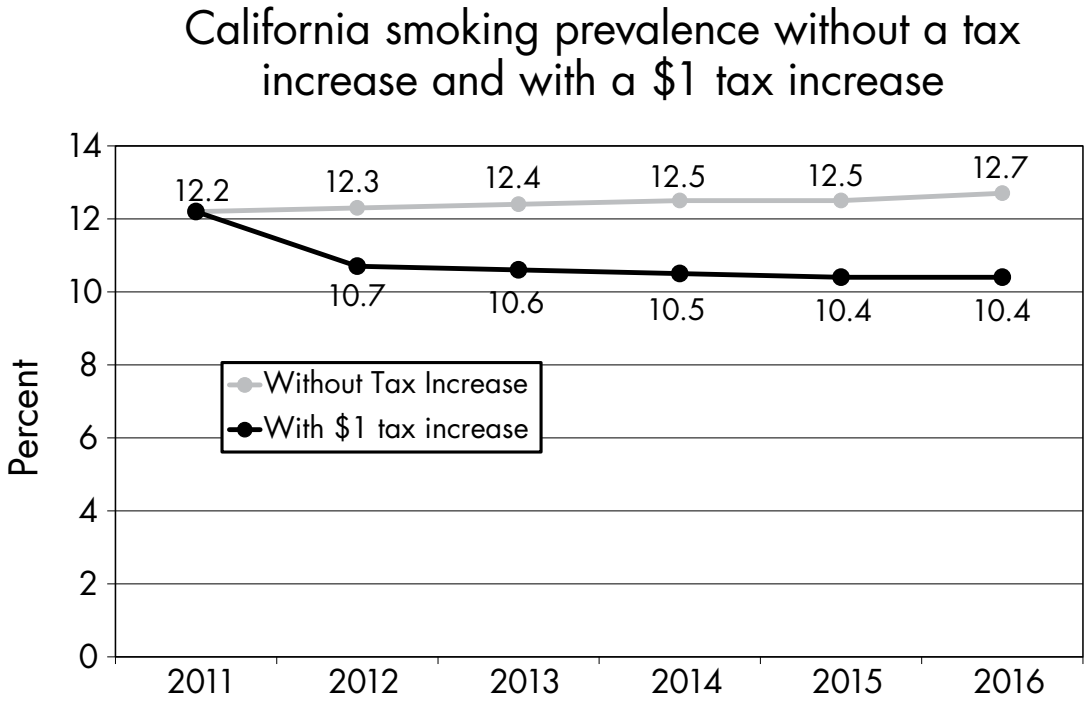
To make matters worse, inflation, combined with price manipulation by the tobacco industry, has reduced the real price of cigarettes in California by approximately $0.63 per pack since 2003. This has diminished the impact of past tax increases on smoking prevalence and cigarette consumption.

Figure 5



Source: The Tax Burden on Tobacco, 2010 and the Campaign for Tobacco-free Kids for 2011.

Figure 6



Source: Max W., Sung H-Y., Lightwood J. 2012.

Benefits of a tax increase. Recent research indicates that increasing the excise tax on tobacco would produce significant benefits:

- Reduced Tobacco Use. If funding for tobacco control is increased to $0.25 per pack ($0.05 from Proposition 99 plus $0.20 from an increase in the tobacco tax), overall smoking prevalence is projected to decline to 10.4 percent by 2016. On the other hand, if tobacco control funding remains at only $0.05 per pack, smoking prevalence is projected to increase to 12.7 percent by 2016 (see Figure 6).[16]

- Lives saved. The long-term health outcome of increasing the tobacco tax by $1.00 would prevent an estimated 35,000 current adult smokers and over 56,000 youth from a smoking-related death[17]. Without a tax increase, smoking-attributable deaths in the states are projected to rise.

- Reduction in lung cancer deaths. California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death.[18] Converting this possibility to reality will require increasing California's tobacco tax and adequately funding tobacco control efforts.

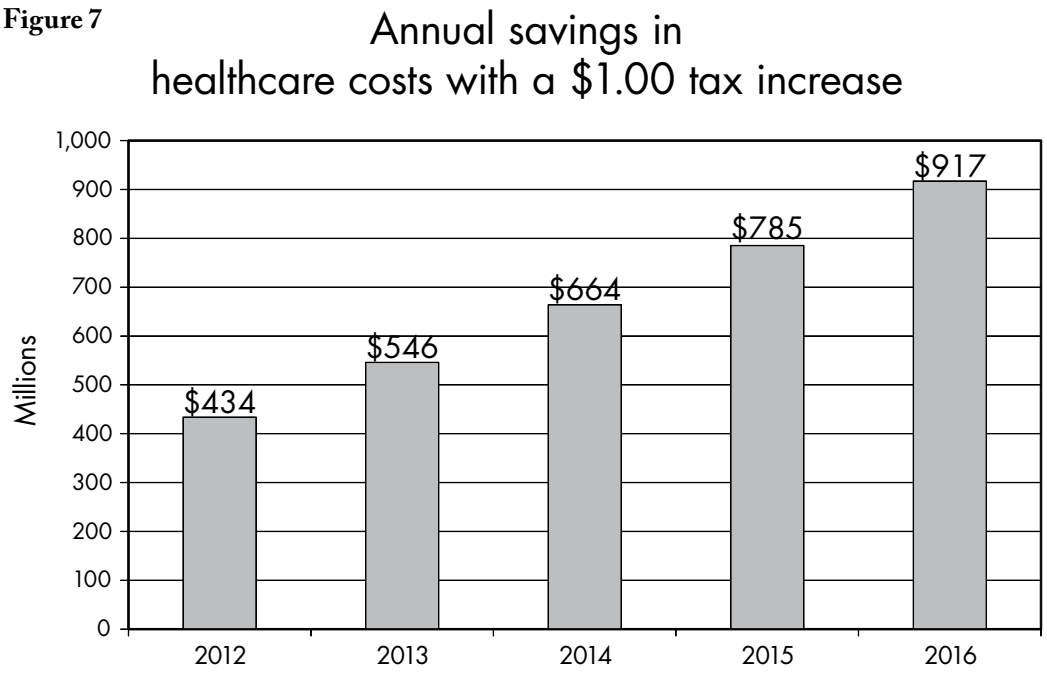
- Savings in healthcare costs. Increasing the tobacco tax by $1.00, with 20 cents earmarked for tobacco control, in 2012 would realize immediate health care savings in California. The lower range estimate is $3.3 billion to be accumulated by 2016 (see Figure 7).[20]

Smoking and Lung Cancer in California

Californians used to smoke more than the rest of the nation, but cigarette consumption began to decline in 1971, with an ever widening gap over time. Lung cancer mortality followed a similar pattern, after a lag of 16 years.

Creation of the California Tobacco Control Program in 1989 doubled the rate of decline in cigarette consumption. However, in 2008, for the first time, both cigarette price and tobacco control expenditures were lower in California than the rest of the nation, suggesting that the gap in smoking behavior will start to narrow. California will have faster declines in lung cancer than the rest of the nation for the next two decades, but possibly not beyond.[19]

Figure 7



Source: Max and Sung, 2011. Note that amounts are in 2009 dollars and the projected cumulative savings from 2012 to 2016 is $3.345 billion.

The California Cancer Research Act

The California Cancer Research Act (CCRA), a statewide ballot initiative, would have increased the excise tax on cigarettes by $1.00 per pack, with $0.20 of the increase specifically designated for tobacco control. Remaining revenues would have supported research to find new ways to detect, treat, prevent, and cure cancer and other tobacco-related diseases. On June 5th 2012, the measure was narrowly defeated by 29,565 votes.

The CCRA was supported by a coalition, "Californians for a Cure," and a steering committee with representatives from the American Cancer Society, the American Lung Association in California, the American Heart Association, the American Stroke Association, the Lance Armstrong Foundation, the Campaign for Tobacco Free Kids, Stand Up To Cancer, and several surgeons and directors of California cancer research institutions.

Ballotpedia, an online encyclopedia states: The "Californians Against Out-of-Control Taxes & Spending" campaign committee was funded by Philip Morris USA and UST LLC, with a Coalition of Taxpayers, small businesses, law enforcement and labor. This committee outspent the "Californians for a Cure" coalition $46.8 million to $12.3 million.

For further information, visit http://www.ballotpedia.org/wiki/index.php/California_Proposition_29,_Tobacco_Tax_for_Cancer_Research_Act.

The tobacco industry commonly argues that raising the excise tax on tobacco is regressive because it would place an unfair burden on the poor. However, because tobacco consumption among the poor is disproportionately high, increasing the excise tax on tobacco will produce the greatest declines in tobacco use among the low income population. This tax is not regressive because individuals are not required to smoke or to use other tobacco products. Increasing the tobacco tax will promote quitting among current tobacco users, prevent relapse, discourage the initiation of tobacco use, and reduce consumption among those who continue to use tobacco. As a result, the health and financial situation of individuals will be improved and there will be a reduction in the exposure of others to secondhand smoke, and a reduction in the amount of tobacco waste added to California's environment.

On a population basis, these changes will result in California saving money on health care costs related to treating tobacco-related diseases among the uninsured and insured as well as mitigating the environmental damage caused by tobacco waste, from fires and water pollution resulting from discarded cigarette butts. For this reason, taxes on tobacco are known as a Pigovian tax—one levied on products or production processes that create excess social costs or pollute the environment. A tobacco excise tax then is an effective and efficient way to offset the societal costs caused by the production and use of tobacco products.

The poor disproportionately consume tobacco.

- The tobacco industry aggressively targets the poor through the pricing, distribution, and advertising of tobacco products.
- Low income smokers make up the greatest proportion of smokers in California.
- The smoking rate among those with a household income lower than $20,000 per year is 19.8 percent compared to 7.8 percent among those with a households over $150,000 year.[21]

Eliminate untaxed or low-taxed sources of tobacco. Increasing the tobacco tax may influence smokers and other users of tobacco products to purchase tobacco from lower or non-taxed sources such as military commissaries, internet stores, other states, and American Indian reservations. Such tax evasion thwarts tobacco control objectives, results in disparities, and may cost the state substantial tax revenues.

Efforts to close such tax loopholes are needed. These may involve supporting or partnering with authorities who have the power to regulate particular venues and to collect taxes. Other approaches to regulate sales of untaxed or low-taxed tobacco can be effective, as demonstrated by the success of the 2005 state and federal agreements with credit card companies and major private shippers to ban payment transactions and shipments for all internet cigarette sales.[22]

Evaluate the effects of tobacco tax increases and disseminate findings. The effects of an increase in the tobacco tax on smoking prevalence, cigarette consumption, and other tobacco use should be evaluated. Related effects on health status, morbidity, mortality, and cost savings should also be studied. Furthermore, research should assess changes in smuggling and the effectiveness of California's Alternative Cigarette Tax Stamp, which has encrypted information and other features to deter contraband cigarette trafficking.[23] Research findings should be widely disseminated to stakeholders throughout California and beyond.

OBJECTIVE 2: Strengthen the Tobacco Control Infrastructure

- Increase communication, collaboration, and resource leveraging among traditional and new tobacco control partners.
- Build leadership and capacity of state and local agencies and health systems to develop, sustain, and contribute to comprehensive tobacco control efforts.
- Increase spending for tobacco control.
- Conduct research and evaluation and disseminate findings to inform tobacco control practice.
- Maintain California's leadership role in ending the global tobacco epidemic.
- Evaluate lives and money saved by tobacco control.

A robust statewide infrastructure for comprehensive tobacco control is essential to sustain and extend the health and economic benefits already achieved and to address new challenges effectively. Strengthening the current infrastructure requires leadership, leveraging public/private partnerships, and adequate financial resources.

Increase communication, collaboration, and resource leveraging among traditional and new tobacco control partners. Frequent and open communication among California's three tobacco control agencies is important for sharing information about progress made toward achieving tobacco control objectives, as well as about programmatic gaps, obstacles encountered, and new opportunities. These exchanges provide the basis for creative problem-solving, collaborative partnerships, resource-sharing, and funding opportunities from federal and philanthropic agencies.

Increased communication is also essential among tobacco control partners—and potential partners—at the state, regional, and local levels. These interactions lay the groundwork for innovative collaborations involving youth and adults, schools and communities, and traditional and new tobacco control partners, including the faith community and social service agencies. Civic engagement is critical to sustaining changes in social norms that make tobacco less desirable, less acceptable, and less accessible.

Build leadership and capacity of state and local agencies and health systems to develop, sustain, and contribute to comprehensive tobacco control efforts. Developing present and future leaders in all aspects and at all levels of tobacco control is fundamental to strengthening and sustaining the infrastructure necessary to realize the vision of a tobacco-free California. Needs identified include:

- Development of tobacco control leadership within racial/ethnic groups and other priority populations that have high rates of tobacco use, exposure to secondhand smoke, and tobacco-related morbidity and mortality.

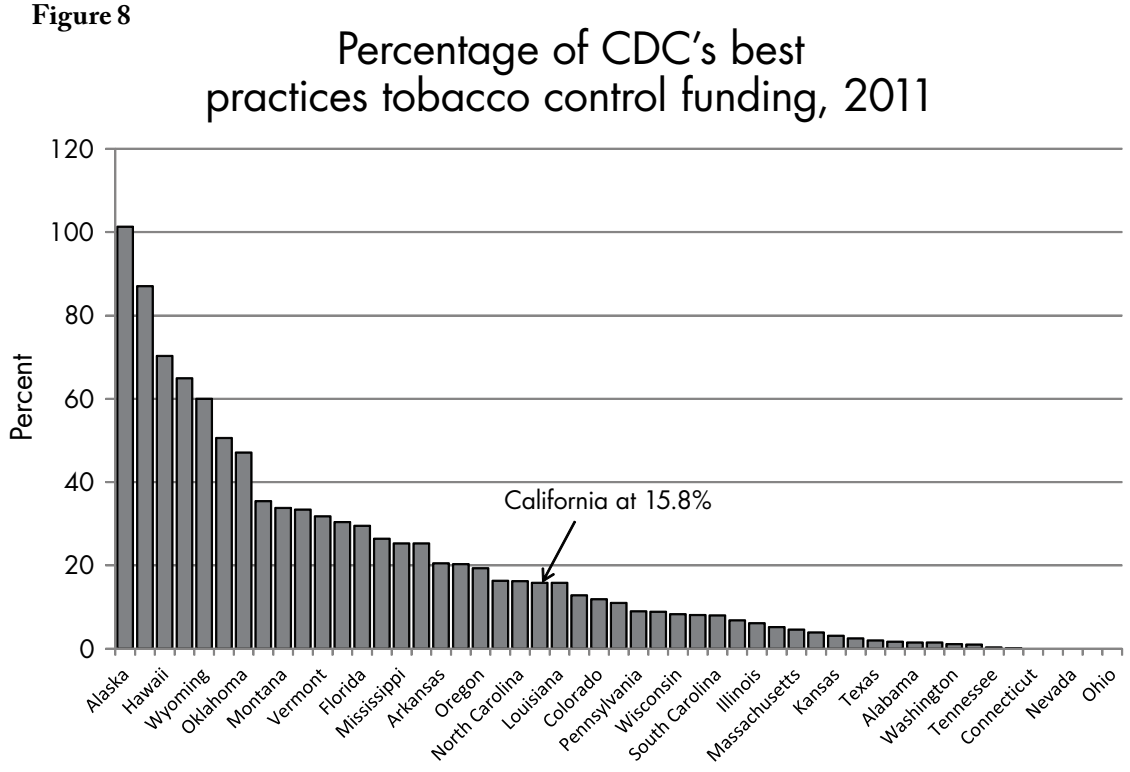
- Involvement of youth from priority populations in tobacco control using developmental strategies, including hands-on experiential participation in anti-tobacco use advocacy.

- Assistance to economically distressed towns, inner city neighborhoods, and rural areas to develop their capacity for tobacco control in the face of scarce resources.

- Identifying ways to effectively engage behavioral health professionals and their clients in tobacco control interventions.

Increase spending for tobacco control. Adequate funding is essential to ensure infrastructure stability, continuity, and momentum. Increased funding would accelerate a decline in smoking prevalence and realize additional health and financial benefits.[24] At present, however, spending on tobacco control in California falls far below the Centers for Disease Control and Prevention (CDC) recommendations of $441.9 million annually (see Figure 8).[25] California earned an "F" on the American Lung Association's 2010 Report Card on its spending for tobacco prevention and control.[26]

Figure 8



Source: Campaign for Tobacco-Free Kids, 2011.

Conduct research and evaluation and disseminate findings to inform tobacco control practice. Research is needed on effective and culturally appropriate tobacco control strategies for priority populations with high rates of tobacco use and exposure to secondhand smoke. Evaluation of approaches employed should identify promising practices and critical factors that need to be considered in intervention design and delivery. In addition, lessons learned about the development, adoption, reach, effectiveness, and enforcement of tobacco control policies in diverse communities should be disseminated.

Maintain California's leadership role in ending the global tobacco epidemic. California can continue to provide national and worldwide leadership in tobacco control by developing policies and programs that serve as models for others, by evaluating the effectiveness of state and local tobacco control efforts, and by conducting cutting-edge research to inform practice and increase understanding of new and complex problems related to tobacco use and secondhand smoke exposure.

In addition, the State of California and organizations within it can support ratification and implementation of the World Health Organization's Framework Convention on Tobacco Control (FCTC),[27] implement articles within it,[28] and link tobacco control initiatives to global health efforts, particularly by using United Nations' treaties that establish human rights to be free of harm to health and welfare.

TEROC Supports Concurrent Resolution 129

Concurrent Resolution 129, adopted by the California Legislature in 2010, requests the California Attorney General to help prepare accurate reports to be filed with the appropriate monitoring bodies to fulfill reporting obligations under the FCTC treaties.

TEROC endorses the preparation, filing and dissemination of these reports, most notably:

- The *International Convention on the Elimination of All Forms of Racial Discrimination* which recognizes the human right of equal treatment under the law without distinction for race, color, national, or ethnic origin. Violations of this treaty include:
    - The development of mentholated tobacco products and their targeted marketing to youth and racial/ethnic minorities in the United States.
    - The exemption of menthol cigarettes from the federal *Family Smoking Prevention and Tobacco Control Act*.
- The *International Covenant on Civil and Political Rights*, which recognizes the human right to life. Violations of this treaty by tobacco companies include:
    - Targeting tobacco products to particular populations through pricing, marketing and distribution practices.
    - Interference in tobacco control policymaking through financial donations to elected officials, sponsorship of organizational events, and other activities.

OBJECTIVE 3: Achieve Equity in All Aspects of Tobacco Control among California's Diverse Populations

Adopt and enforce tobacco control policies to create health equity.

- Incorporate equity and cultural competency standards in all tobacco control agencies, programs, processes, practices, and infrastructures.
- Increase the involvement and competencies of priority populations in tobacco control.
- Strengthen the capacity of agency personnel to reduce tobacco-related disparities.
- Conduct evaluation and research to reduce tobacco-related health disparities and to measure progress toward achieving health equity and social justice.

As stated in the Principles for Tobacco Control, some priority populations in California include:

- African Americans, other people of African descent, American Indian and Alaska Natives, some Asian Americans, and Hispanics/ Latinos;
- people of low socioeconomic status, including the homeless;
- people with limited education, including high school drop-outs;
- lesbian, gay, bisexual, and transgender (LGBT) people;
- rural residents;
- members of the military and individuals employed in jobs or occupations not covered by smoke-free workplace laws;
- people addicted to alcohol and other drugs;
- the mentally ill;
- people with disabilities; and
- formerly incarcerated individuals.

Priority populations are groups that have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are more targeted by the tobacco industry, and have higher rates of tobacco-related disease compared to the general population.

Achieving equity in tobacco control will require societal, organizational, and individual leadership that embraces the powerful integration of science, practice, and policy to create lasting change.[29] Contributions in all of these realms are needed from California's elected leaders; tobacco control agencies; priority population groups; state, local, and tribal governments; community organizations; health, education, and social service providers; business; labor; academia; and grassroots movements.

Raising the tobacco tax—Objective 1—is a pivotal intervention because price increases reduce smoking more among lower-income smokers than among those with higher-incomes.[30] Increasing the tobacco tax thus will reduce socioeconomic disparities in the prevalence of tobacco use and then in tobacco-related diseases and deaths.[31] Other objectives in this Master Plan also have important roles in achieving equity and social justice in

tobacco control and in reducing disparities. For example, increasing the tobacco tax will provide funding for interventions aimed at achieving all of the Master Plan objectives.

Adopt and enforce tobacco control policies to create health equity. The tobacco industry targets its products, pricing strategies, and marketing practices to priority populations in very sophisticated ways. A number of studies have found links between the density of tobacco retail outlets and socio-economically disadvantaged communities, African American communities, and youth tobacco use.[32]

The number of tobacco retailers and proximity to schools in California urban areas has been associated with experimental smoking among high school students.[33]

Contrary to claims of the tobacco industry that the promotion of its products is not based on race/ethnicity, another study found that targeted advertising in California high school neighborhoods exposes Blacks to more promotions and lower prices for the leading brand of menthol cigarettes.[34]

Therefore, adopting and enforcing policies that restrict such practices is critical. Policies that contribute to creating health equity include tobacco retail licensing, conditional use permits, and the prohibition of free or low-cost coupons, rebates, gift cards, and gift certificates for tobacco products.

Incorporate equity and cultural competency standards in all tobacco control agencies, programs, processes, practices and infrastructures. Instituting meaningful equity and cultural competency standards requires understanding cultures as multilevel, multidimensional, dynamic systems involving particular populations. Because the responses of these systems to geographic, social, and political circumstances vary, cultures and sub-cultures evolve differently.[35] One important equity and cultural competency standard is that tobacco control interventions must be designed and evaluated in partnership with the communities of focus to ensure that policies, programs, and services are feasible within the social and cultural determinants of their lifestyle.

Increase the involvement and competencies of priority populations in tobacco control. Priority populations should be represented at all personnel levels in California tobacco control agencies. In addition, CDPH/CTCP, CDE/CSHSO and TRDRP each should develop program-specific plans to reduce tobacco-related health disparities.

Local health departments and local education agencies are expected to engage leaders from priority populations in helping to assess equity gaps in tobacco control and to identify interventions and collaborations needed to facilitate the reduction of local or regional disparities. Members of priority populations active in tobacco control should be encouraged to support strategies that are culturally responsive to the needs of the populations they represent.

Involving priority populations in developing, implementing, and evaluating innovative community, school, and media initiatives is critical. Involvement should include training, mentoring, funding and empowering priority population participants to increase their knowledge, skills, and confidence to provide increased leadership in tobacco control over time. In addition, TRDRP should train and support community and school teams involving priority populations to address tobacco-related health disparities through collaborative research and evaluation projects.

Knowledgeable members of priority populations should be included as equal and valuable partners in local, state, and national conferences, workgroups,

committees, and other interactions concerned with tobacco control advocacy, education, media, policy, programs, services, grant application reviews, and research.

Strengthen the capacity of agency personnel to reduce tobacco-related disparities. Capacity to contribute to reducing tobacco-related disparities should be increased among the personnel of agencies and institutions that work or could work with priority populations. These include public health departments, healthcare systems, local education agencies, social service providers, housing agencies, offices for Veterans' Affairs, voluntary agencies, colleges, universities, and other research institutions.

> Focusing efforts on the identification and elimination of tobacco-related disparities may close the gaps in prevalence of tobacco use and access to effective treatment, thus alleviating the disproportionate health and economic burden experienced by some sectors of the population.[36]

Personnel in these agencies and institutions should be informed about tobacco-related disparities, initiatives to reduce them, progress being made, and opportunities for their involvement. Methods for disseminating this information include conferences and workshops; networking; broadcast, print, and social media; and one-on-one or small group interactions. Showcasing contributions to tobacco control projects by members of priority populations will help to model collaborative relationships and foster new ones.

Additional strategies should include training agency personnel to incorporate culturally competent approaches to reducing disparities in their daily work, as well as quality improvement initiatives and new programs, services, and research.

Conduct evaluation and research to reduce tobacco-related health disparities and to measure progress toward achieving health equity and social justice. Health departments, local education agencies, and recipients of CTCP, CDE, and TRDRP grants should be required to describe and report the involvement of priority populations in their tobacco control efforts.

The effectiveness of interventions to reduce tobacco-related disparities in various priority populations should also be assessed, including the adequacy and cultural appropriateness of the resources used in project implementation. Metrics to measure progress in reducing disparities and achieving equity should be developed and applied, while lessons learned and suggestions for improvement should be identified and disseminated.

For example, can an intervention program that is highly effective in reducing the prevalence of an unhealthy behavior in the general population also reduce disparities among its subgroups? Analysis of the effects of three components of the CTCP (media, worksite policy, and price) on smoking prevalence in groups with the lowest and highest education show that the answer depends on the measure of disparity used.

The rate of decline in smoking prevalence from 1996 to 2005 was as great for the low education group as for the high education group. However, basing analysis of disparity on *relative* difference could result in erroneous conclusions. Such analysis might conclude that an intervention like the California Tobacco Control Program needs to change from its current whole-population approach

to one that focuses on targeting subgroups because it has not reduced relative disparity. This analysis concluded that research should focus more on increasing the *rate of change* among less advantaged groups and less on the relative disparity of one group compared to another.[37]

TRDRP should encourage and support research to assess and reduce tobacco-related disparities and to develop research expertise in priority populations. Multi-disciplinary projects that integrate the perspectives of social epidemiology and community-engaged interventions should be undertaken and tested to determine their potential for improving health equity.[38] Other areas of research with strong potential to reduce tobacco-related disparities include:

- Studies to expose, prevent, and reduce activities of the tobacco industry that target priority populations.
- Identification of factors related to the initiation, maintenance, and cessation of tobacco use in priority populations.
- Highlighting relationships between health insurance coverage, access to resources and aids for tobacco cessation, access to health care, and disparities in morbidity and mortality from tobacco-related diseases.
- Examining the perspectives of priority populations on tobacco-related problems and tobacco-control efforts.
- Assessing the involvement of priority populations in tobacco control.

An example of this research concerns menthol cigarettes, which represents 20 percent of the market share.[39] Menthol smokers tend to be female, younger, members of ethnic minorities, have only a high school education, and buy packs rather than cartons.[40]

Close to 30 percent of all menthol smokers are African American.[41] Since the 1970s, brand names like Kool, Newport, and Salem have been marketed to the African American community in campaigns falsely suggesting that smoking menthol flavored cigarettes is cool, hip, fresh, fun, and less risky than smoking regular cigarettes.[42]

In combined 2004 to 2008 data, 82.6 percent of African American, 53.2 percent of Native Hawaiian/ Pacific Islander, 32.3 percent of Hispanic/Latino, 31.2 percent of Asian, 24.8 percent of American Indian/Alaska Native, and 23.8 percent of White smokers aged 12 years and older reported using menthol cigarettes in the past month.[43]

A 2010 survey found that only 59 percent of Americans were aware of racial and ethnic disparities that disproportionately affect African Americans and Hispanics/Latinos--a very modest increase over the 55 percent awareness recorded in a 1999 survey. The survey also revealed low levels of awareness among racial and ethnic minority groups about disparities that disproportionately affect their own communities.[44]

Data on tobacco-related inequities and progress in eliminating them should be widely disseminated throughout California to raise awareness and stimulate involvement in reducing disparities.

OBJECTIVE 4: Minimize the Impact of Tobacco Use on People and of Tobacco Waste on the Environment

- Regulate secondhand smoke as a toxic air contaminant.
- Remove exemptions and close loopholes in California's smoke-free workplace laws.
- Enforce existing tobacco-free laws and policies.
- Adopt and enforce additional policies to minimize secondhand smoke exposure and the impact of tobacco waste on the environment.
- Conduct research and disseminate findings to advance knowledge about the harms of tobacco use.

Tobacco control efforts initially focused on reducing the negative health consequences of tobacco on users. The field then expanded to include the negative health effects of secondhand smoke exposure on nonsmokers. Interest remains in further minimizing these impacts as well as addressing new and emerging issues, such as the harmful effects of tobacco litter on the environment and the use of, and exposure to, new tobacco products.

The negative health and economic effects of smoking, other tobacco use, and exposure to secondhand smoke are well-documented.[45] Researchers are still investigating the toxic effects of tobacco waste on the health of people, domestic animals, wildlife, and the environment. However, the blight caused by cigarette butts, tobacco wrappings, and smokeless tobacco product waste scattered on sidewalks and in streets, parks and other outdoor places is widely recognized. Clean-up costs for state, regional, and local governments are staggering. Non-biodegradable cigarette filters carried as runoff to drains, rivers, and ultimately the ocean are the single most collected item in international beach cleanups each year.[46] California can protect the environment and save taxpayers money by reducing tobacco litter.

Regulate secondhand smoke as a toxic air contaminant. Minimizing exposure to secondhand smoke will protect health, save lives, and produce major savings in healthcare costs. Each year, exposure to smoke from other people's cigarettes causes over 4,000 non-smokers in California to die from cancer, heart and lung disease, and other diseases.[47]

Children exposed to secondhand smoke in their homes, cars, and elsewhere are at high risk for Sudden Infant Death Syndrome (SIDS), ear infections and chronic middle ear disease, severe asthma attacks, upper and lower respiratory infections, impaired lung function growth, cognitive impairment, and other developmental impacts. Direct medical costs from exposure to secondhand smoke among United States children exceeds $700 million per year.[48]

In 2006, the United States Surgeon General reported that there is no risk-free level of exposure to tobacco smoke.[50] That same year, the California

Air Resources Board classified secondhand smoke as a Toxic Air Contaminant—the same classification as diesel exhaust.[51] However, the Board has not issued regulations to control this toxin.

California citizens should encourage the California Air Resources Board to issue strong regulations without further delay. Based on its 2006 findings, the California Air Resources Board should act to eliminate all smoking in public places and to declare tobacco smoke a public nuisance.

No Risk-Free Level of Exposure to Tobacco Smoke

The harmful effects of smoking do not end with the smoker. Every year, thousands of nonsmokers die from heart disease and lung cancer, and hundreds of thousands of children suffer from respiratory infections because of exposure to secondhand smoke. There is no risk-free level of exposure to tobacco smoke.[49]

Remove exemptions and close loopholes in California's smoke-free workplace laws. In 1994, California passed the nation's first comprehensive smoke-free workplace law (Labor Code Section 6404.5), but exemptions and loopholes in this and other related state laws[52] leave some employees unprotected from secondhand smoke. These include workers in the service industry and small businesses. Labor Code 6404.5 established more than a dozen exemptions which identify where smoking in the workplace is still permitted. As a result, low income, Hispanics/Latinos, and young adults have much higher rates of exposure to secondhand smoke in the workplace than others.[53] Additionally, California is not recognized by the Centers for Disease Control and Prevention as one of the current 25 smoke-free states. This problem can and should be remedied by the California Legislature.

Another example of a workplace where workers and the public are not protected from secondhand smoke exposure is American Indian casinos. The lack of uniform protection from secondhand smoke exposure for workers employed in the American Indian gaming industry and in other places creates health inequities based on employment. Such inequities can be resolved by adopting smoke-free workplace policies at all worksites.

California tobacco control agencies, advocates, and citizens need to join forces to promote 100 percent smoke-free workplace legislation. Such policies are crucial to reducing tobacco-related disparities among priority populations, including low-income Hispanic, African American, and American Indian workers.

Enforce existing tobacco-free laws and policies. Despite the loopholes in California's smoke-free workplace laws, the state and many local jurisdictions have passed laws or adopted voluntary policies to restrict tobacco use in indoor and outdoor public places, including restaurants, schools, vehicles with children in them, parks, beaches, and even multi-unit housing complexes.

To advance toward a tobacco-free California, mechanisms are needed to ensure enforcement and to prevent pre-emption of these laws and policies. These approaches should be complemented by media messages and other efforts to increase voluntary compliance with both tobacco-free laws and voluntary policies.

Adopt and enforce additional policies to minimize secondhand smoke exposure and the impact of tobacco waste on the environment. California government bodies at all levels

Local Smoke-Free Policies in California

As of October 2010:

- 37 California cities and counties had passed comprehensive ordinances to prohibit or restrict smoking outdoors, including in entryways, service areas, sidewalks, worksites, outdoor dining areas, recreation areas, and at public events.

As of January 1, 2011:

- 85 California municipalities had passed ordinances to restrict smoking in at least some outdoor dining areas.
- 273 California municipalities had adopted policies to restrict smoking in at least some recreation areas beyond the requirements set by state law.

As of November 2011:

- 45 California cities and counties had passed an ordinance prohibiting smoking in part or all outdoor common areas of multi-unit housing complexes, such as outdoor eating areas, play areas, courtyards, and swimming pools.

For further information and updates, go to http://www.center4tobaccopolicy.org.

should be encouraged to adopt and enforce additional policies to protect the public from secondhand smoke. One approach would be to encourage more local jurisdictions to implement tobacco-free areas. Businesses, unions, civic and philanthropic organizations, resident associations, and other groups should also be encouraged to adopt voluntary policies that limit tobacco use. Community members who have not yet voluntarily adopted tobacco-free policies for their homes should be persuaded to join the growing number of Californians who have done so.

Statewide legislation can comprehensively protect all Californians from secondhand smoke exposure. Closing the exemptions and loopholes in California's smoke-free workplace law is a first step, but other policy areas which can provide substantial benefit include multi-unit housing and outdoor smoke-free policies. Statewide legislation is needed to eliminate smoking in state parks not only to protect the public but also to reduce environmental damage, including forest fires.

Conduct research and disseminate findings to advance knowledge about the harms of tobacco use. TRDRP should encourage and support research on questions about the harmful effects of tobacco use on people and the environment, and on changing social norms for a tobacco-free California. One priority is studying the effects of environmental tobacco smoke on priority populations such as residents of low-income multi-unit housing. Scientific studies also are needed to assess the health, environmental, social, and economic harms of new and alternative tobacco products, including flavored little cigars and cigarillos, hookah, and e-cigarettes. Studies are also needed on emerging additional risks from use of dissolvable tobacco products.

Additionally, investigations are needed on the health, environmental, and economic effects of tobacco product litter. Based on an assessment conducted in San Francisco, direct abatement costs are estimated to range from $0.5 million to $6 million per year without considering the

Secondhand Smoke Exposure and Breast Cancer Risk

The classification of secondhand smoke as a Toxic Air Contaminant by the California Air Resources Board was based on part A of a report it prepared for the California Environmental Protection Agency (Cal/EPA). Part B, prepared by Cal/EPA's Office of Environmental Health Hazard Assessment, concerned the health effects of exposure to environmental tobacco smoke. This section included pooled risk estimates of association between exposure to secondhand smoke and breast cancer, concluding that these could represent a significant number of breast cancer cases. The full report was approved by a Scientific Panel on Toxic Air Contaminants in June 2005.[54]

Recent analysis of data from the California Teachers Study suggest that cumulative exposures to high levels of side stream smoke may increase breast cancer risk among postmenopausal women who themselves have never smoked tobacco products.[55]

A Canadian Expert Panel recently concluded that the association between secondhand smoke exposure and breast cancer among younger, primarily premenopausal women who have never smoked suggests a cause and effect relationship.[56]

economic effects of tobacco waste on tourism and environmental pollution.[57] Studying policy options for covering the costs of dealing with litter is important, especially since the passage of Proposition 26 makes it more difficult for local jurisdictions to levy fees for this purpose.[58, 59]

Research is also needed on third-hand smoke, the cocktail of toxins that clings to skin, hair, clothing, upholstery, carpets, and other surfaces long after cigarettes or cigars are extinguished and secondhand smoke dissipates.

Existing evidence provides strong support for pursuing research to close gaps in the current understanding of the chemistry, exposure, toxicology, and health effects of third-hand smoke, as well as related behavioral, economic, and socio-cultural consequences.[60] Effects on children are a particular concern because they frequently touch and put their mouths on contaminated surfaces, breathe at a faster rate, have smaller lung capacity, and thus ingest about twice as much dust as adults.

Analysis of citations in 1,877 articles on secondhand smoke published between 1965 and 2005 revealed a gap in the continuum between the discovery of risk factors and the delivery of interventions to reduce them. The quality and speed with which scientific discoveries are translated into practice needs to be improved. Research summaries, such as Surgeon General's reports, were cited frequently and appear to bridge the discovery-delivery gap.[61]

To hasten the translation of research into practice, findings from investigations on these and other topics related to the harms of tobacco use and exposure should be disseminated as soon as possible through the media and other channels to policy-makers, advocates, health and school personnel, scientists, and the general public.

OBJECTIVE 5: Prevent the Initiation of Tobacco Use

- Encourage collaborative community-school programs to prevent tobacco use.
- Increase the number of tobacco-free schools.
- Engage youth and young adults in tobacco control.
- Build capacity for preventing tobacco use.
- Counter tobacco industry actions.
- Support research and evaluation to strengthen tobacco use prevention.

During the past 23 years, California's comprehensive tobacco control program has led to a decline in the prevalence of youth smoking and an increase in the average age of initiation. This important trend can be accelerated through enhanced coordination of CTCP, CDE, and TRDRP efforts; increased collaboration among community tobacco control programs, schools, and youth organizations throughout the state; and resource leveraging at all levels.

Promising strategies for preventing the onset of tobacco use are identified below. These approaches are supported by the principles identified in this Master Plan and complemented by its other objectives.

- Increasing the tobacco tax would make it more difficult for price-sensitive young adults to purchase tobacco and for children and adolescents to ask that others buy it for them.[62]
- Increasing the involvement of priority populations in tobacco control would provide at-risk youth with both opportunities to contribute to these efforts and positive role models.
- Expanding the adoption and enforcement of tobacco-free laws and policies would accustom more children and youth to tobacco-free environments and decrease role-modeling of tobacco use.[63]
- Reducing the influence and activities of the tobacco industry would disrupt its concerted efforts to recruit new generations of addicts.

Encourage collaborative community-school programs to prevent tobacco use. The knowledge, attitudes, and behaviors of young people are influenced by what they learn and observe in their homes, schools, and communities. Accordingly, collaborative community-school programs should be undertaken to prevent tobacco use, particularly in poor and underserved areas with high numbers of young people from priority populations.

Public and private schools of all types are candidates for involvement in preventing tobacco use. CDE's, Local Education Agencies (LEAs), which include County Offices of Education (COEs), K-12 public schools, and direct-funded charter schools, should be encouraged to develop school-community collaborations. Other possibilities include partnerships that involve K-12 private schools, youth drug and alcohol prevention programs, continuation schools, technical and vocational schools, military schools, colleges, and

universities. Community-based participants in these partnerships could include not only tobacco control programs and coalitions, but also youth organizations, sports and recreation departments, agencies serving young adults, those working with school drop-outs, and specialized training programs.

To develop these collaborations, opportunities should be created for schools and community organizations to share observations, insights, ideas, resources, and concerns related to tobacco control. A prime focus of discussion should be how groups can support, reinforce, and complement each other's efforts. Training and technical assistance should be provided to help interested parties develop, sustain, grow, and learn from school-community partnerships. Youth and their families, friends, and neighbors should be involved in meaningful tobacco control activities.

As recommended by the Guide to Community Preventive Services,[64] community mobilization should be combined with additional interventions to reduce tobacco use among youth. These additional interventions could include community-wide education, policies that restrict retail sales of tobacco products, and enforcement of policies against youth purchase, possession, or use of tobacco. Experiences and outcomes of collaborative programs should be shared at local, regional, and state levels.

Increase the number of tobacco-free schools. Achieving tobacco-free certification for 100 percent of LEAs and increasing the number of other schools that adopt and enforce a tobacco-free policy should be priorities for prevention during 2012-2014. *All* schools should be tobacco-free to protect students, provide peer and adult role models who do not use tobacco, limit youth access to tobacco, and

A Community-School Partnership in Stanislaus County

PHAST—pronounced "fast"—is a youth coalition dedicated to Protecting Health And Slamming Tobacco through peer education and advocacy projects in schools and communities throughout Stanislaus County. Coalition goals are to:

- build skills in peer tobacco education through participation in training events such as the annual PHAST Tobacco Slam, Youth Quest, and local community advocacy trainings.
- conduct peer education activities on campus through classroom presentations and events such as the Great American Smokeout, Lose the Chew Day, and Kick Butts Days.
- conduct community education and advocacy activities such as making off-campus presentations to middle and elementary school students; hosting educational booths at Farmers Markets, parades, and other community events; participating in health promotion programs such as Turlock Family Fun Day and Relay for Life; and educating civic organizations, community leaders, and elected officials about the importance of supporting tobacco prevention efforts in the community.

discourage the formation of groups brought together by tobacco use on school grounds and at school events. Therefore, communities should collaborate with LEAs not certified as tobacco-free —as well as private schools, technical and vocational schools, military schools, and colleges and universities —to adopt and enforce policies prohibiting tobacco use in school buildings, on school grounds, and in school vehicles.

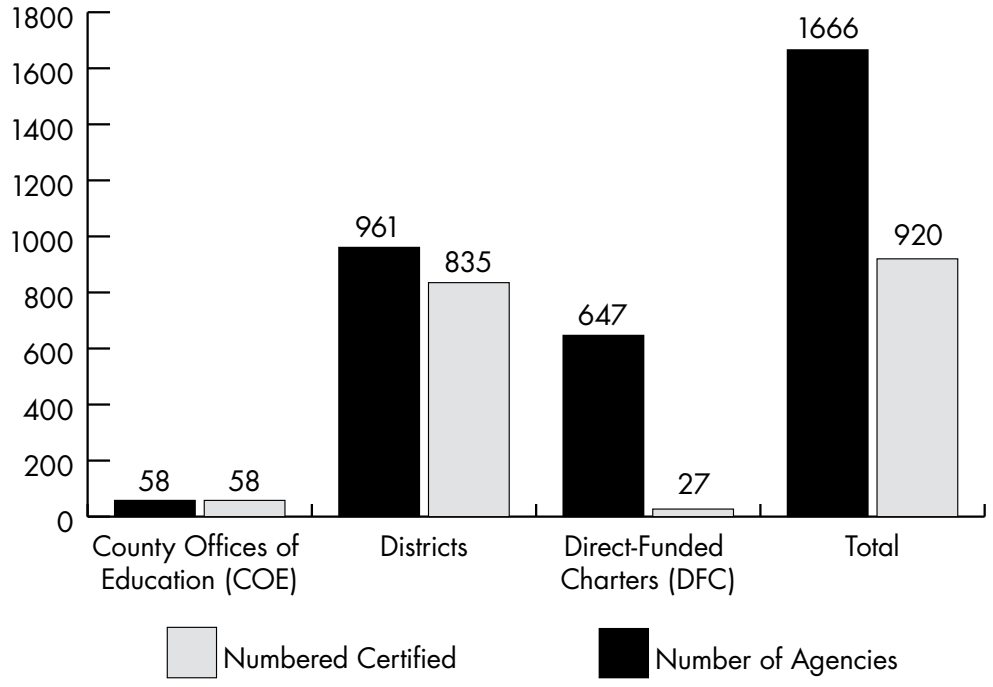
Research has shown that consistently enforced tobacco-free school policies are associated with decreased smoking prevalence among adolescents.[65] Nevertheless, at present, California legislation requires only LEAs that receive Proposition 99 funding for tobacco use prevention education (TUPE) to have and enforce comprehensive tobacco-free school policies. Cuts in CDE funding have reduced the number of schools that must meet this requirement.

The Coordinated School Health and Safety Office (CSHSO) of the CDE has guidelines on its Web site to support LEAs in developing, adopting, enforcing, and monitoring tobacco-free school policies. The CSHSO also has developed a process for certifying schools as being in compliance with tobacco-free requirements. As of 2011, approximately 55 percent of LEAs in California have adopted a tobacco-free policy and the LEAs that enforce this policy serve 92 percent of the K-12 student population in California public schools. In addition, all County Offices of Education, 87 percent of school districts, and four percent of direct-funded charter schools currently are certified as tobacco-free (see Figure 9).

The CSHSO guidelines can be used by schools, parents, and community coalitions to help educational institutions outside the CDE become tobacco-free. For more information visit: http://www.cde.ca.gov/ls/he/at/tupe.asp.

Engage youth and young adults in tobacco control. Encourage schools, communities, youth organizations, and advocates to involve youth and young adults in tobacco control activities appropriate for their age, interests, and skills. This

Figure 9



Close Loopholes in Tobacco-Free School Legislation

Health and Safety Code Section 104220(n)(1)&(2)requires only County Offices of Education, School districts, and direct-funded charter schools that receive Proposition 99 funding for tobacco use prevention education to adopt and enforce a tobacco-free campus policy. These legislative loopholes create health inequities in California's public schools and schools not eligible for Proposition 99 funding, such as private schools.

is important to develop California's next generation of tobacco-free advocates who will support future tobacco control efforts.

Youth development strategies[66] should be used to involve middle- and high-school students in advocacy for tobacco-free policies, peer education about the deceptive practices of the tobacco industry and the harms of tobacco use, school and community tobacco control surveys, and other activities such as Stop Tobacco Access to Kids Enforcement (STAKE) Act enforcement.

To ensure that recipients of Tobacco Use Prevention Education (TUPE) grants engage and involve significant numbers of youth from priority populations in tobacco control efforts, CDE should require them to annually report the number of youth, disaggregated by priority population, that have participated in tobacco-related youth development programs.

Youth who are not in school are at higher risk for tobacco use, so special efforts are needed to engage them in prevention programs.

Because the age of tobacco use onset has increased and the prevalence of young adult smoking is high, developing effective ways to involve this age group in tobacco use prevention programs and tobacco control activities is another priority.[67]

California Youth Advocacy Network

The California Youth Advocacy Network (CYAN), an organization founded to provide meaningful opportunities for youth leadership and involvement in California's revolutionary tobacco control program, engages youth and young adults, whether in or out of school, in tobacco control activities. Current initiatives include:

- uniting youth against the tobacco industry.
- promoting tobacco-free colleges and universities in California.
- building a collaborative bridge between military and civilian tobacco control.
- leading the Tobacco and Hollywood Campaign to eliminate smoking from movies rated G, PG, and PG-13.

Build capacity for preventing tobacco use. CDE is encouraged to provide training and technical assistance to increase the capacity and cultural competence of personnel in schools and community-based organizations to prevent tobacco use among youth and young adults. Assistance should be provided to schools to focus prevention efforts on youth whose school performance is at or below average, who are rebellious, who are "sensation seeking," and who are otherwise at high risk for using tobacco. More importantly, prevention efforts should be targeted to youth who begin smoking cigarettes at or before seventh grade. Early onset cigarette smoking among youth has become a marker for other risk behaviors and problems.[68]

An analysis of 2003-2005 data from the California Healthy Kids Survey (CHKS) involving over 560,000 students across California indicates that current smokers are significantly more likely than nonsmokers to engage in alcohol and other drug (AOD) use, be involved in violence and gang membership, and experience school-related problems and disengagement.[69] To a lesser extent, current smokers are also more likely than nonsmokers to be victims of violence and harassment, feel unsafe at school, and experience incapacitating sadness and loneliness.[70]

These results suggest that efforts to reduce student smoking will be more successful if embedded in approaches that address a broad range of risk behaviors and problems. Cigarette smoking is a marker for other problem behaviors especially among seventh graders, suggesting that early onset smokers are particularly in need of a broad range of prevention services.

Counter tobacco industry actions. All organizations involved in tobacco control should urge the United States Food and Drug Administration (FDA) to ban menthol cigarettes and all other flavored tobacco products. Menthol flavoring is considered the tobacco industry's "starter" ingredient[71] because its anesthetizing effect masks the harshness of tobacco smoke, making it "smooth" and easier to inhale.[72] A wide variety of little cigars, smokeless tobacco, and other tobacco products also are available in menthol.

California's social norm change approach to tobacco control includes challenging the film industry's portrayal of tobacco use in movies, especially those popular among young viewers. Important progress has been made in reducing the depiction of smoking in top-grossing youth rated films, but in 2010, youth-rated movies still accounted for more than 40 percent of the smoking impressions delivered to U.S. theater audiences.[73] These data indicate that the State of California must stop paying subsidies to film producers in the state who show tobacco use in movies and television productions.

TUPE grantees should be prohibited from using smoking prevention materials produced, sponsored, or distributed by the tobacco industry, and their use by all other LEAs, schools, and community organizations should be strongly discouraged.[74] All institutions and agencies that involve or serve youth and young adults should reject funding from the tobacco industry. Helping organizations to develop alternative sources of funding may be an effective intervention.

Support research and evaluation to strengthen tobacco use prevention. Increasing the number of LEAs that conduct the California Healthy Kids Survey, will assist with evaluating the outcomes of tobacco use prevention interventions and identifying the program components, processes, other variables that contribute to or compromise effectiveness. A key goal is to develop and implement a plan to disseminate the results of tobacco-related youth prevalence measures throughout California.

Evaluate the outcomes of tobacco use prevention interventions and identify the program

components, processes, other variables that contribute to or compromise effectiveness. It is important to implement programs to discourage initiation of tobacco use by youth from priority populations, and to evaluate the effectiveness of these programs when used by diverse populations in many different environments.

Since the release of the first Healthy People report,[75] many school and community-based interventions have been developed to prevent the onset of tobacco use. Evaluations over more than two decades have identified important directions to pursue, as well as strategies to be avoided.[76, 77, 78, 79, 80] Although the fidelity with which these prevention programs are implemented is still a concern,[81] more emphasis is needed on translation and dissemination. Evaluations should examine how programs are adapted for youth and environment with different characteristics, and the resulting outcomes. Success stories and model programs should be widely publicized.

Research should be conducted to identify factors that contribute to the resilience of youth and young adults against tobacco use, especially when their environments put them at high-risk of experimentation and development of addiction. Another area for investigation is the relationships between the onset of tobacco use and the initiation of other risky behaviors, including alcohol and marijuana use.

Developing Novel Strategies for School Based-Tobacco Prevention

With funding from TRDRP, Bonnie Halpern-Felsher, Ph.D, is leading the development of a Consortium committed to tobacco control education and to the development of novel, developmentally appropriate, and comprehensive school-based prevention strategies. Partners include:

- elementary, middle and high schools,
- youth and parents,
- county tobacco control coordinators and health educators,
- representatives from CDE, TEROC, and CTCP,
- investigators at the University of California, San Francisco.

The Consortium will analyze and synthesize results of focus groups held with teachers, middle and high school students, parents of K-12 students, and school officials. During this process, novel tobacco education messages and delivery strategies will be identified, and the best forum for applying these findings will be identified. Stakeholders will ensure that new programs developed will meet school guidelines and are developmentally appropriate, feasible within the school setting, and acceptable to funding agencies.

OBJECTIVE 6: Increase the Number of Californians Who Quit Using Tobacco

- Boost the number and frequency of quit attempts across populations.
- Expand the availability and utilization of cessation aids and services.
- Engage health care providers in helping patients quit.
- Promote tobacco cessation through multiple channels.
- Conduct research and evaluation to strengthen cessation interventions.

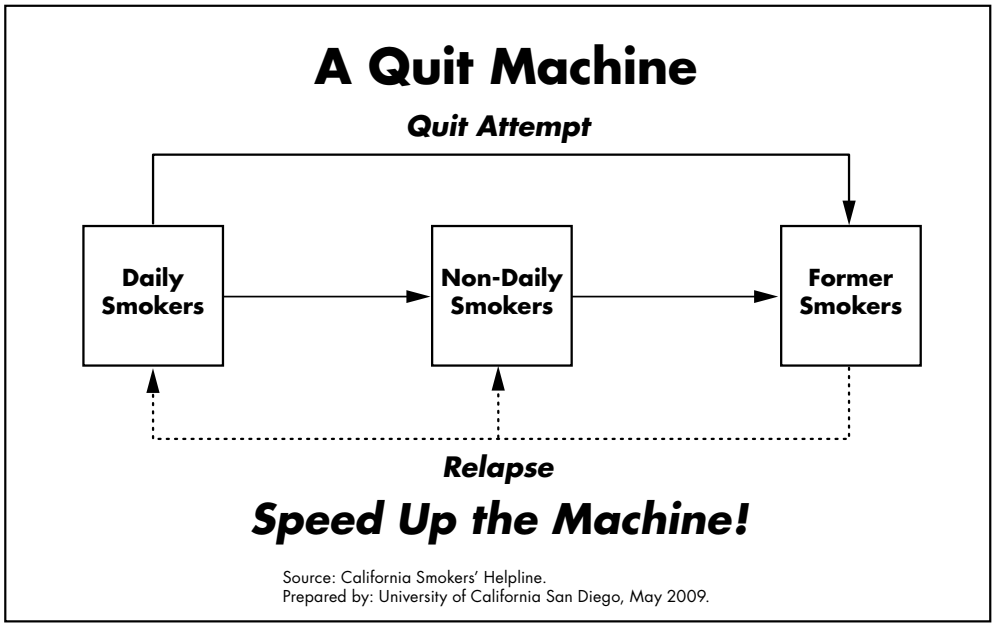
The population-based *Tobacco Quit Plan for California*,[82] developed during a landmark cessation summit convened by the CTCP in May 2009, has been an important influence on the formulation of this objective and key strategies to achieve it. A central theme of the summit was the need to increase both aided and unaided quit attempts, since it is the frequency—not efficacy -- of quit attempts which is the primary determinant of cessation on the population level. Strategies recommended in the *Tobacco Quit Plan* are designed to have a ripple effect throughout the state and create "positive turbulence" for tobacco cessation.[83]

Substantial reductions in the prevalence of tobacco use in California, an increase in the proportions of light and non-daily smokers, and demographic data indicating that tobacco users are increasingly likely to be members of racial/ethnic minority communities also have influenced the shaping of this objective.

In addition, developments at the federal level were considered. The new Prevention and Public Health Fund, created by the Patient Protection and Affordable Care Act of 2010, may continue to augment state investments in cessation. The FDA plans to require that cigarette packs display large graphic warnings and the national 1-800-QUIT-NOW telephone number which routes calls to state quitlines, including the California Smokers' Helpline. The Centers for Medicare and Medicaid Services (CMS) has given state Medicaid programs authority to claim up to 50 percent of state quitline administrative costs associated with providing cessation services to Medicaid insurees. As part of the Medicaid Incentives for Prevention of Chronic Diseases program, CMS has awarded California $10 million to incentivize quit attempts among Medi-Cal beneficiaries.

Boost the number and frequency of tobacco quit attempts across populations. On a population level, increasing the number and frequency of quit attempts is the most effective strategy for achieving tobacco cessation. The process by which tobacco users cycle through cessation and relapse has been characterized as a "Quit machine" (See Figure 10).[84] Daily smokers either quit altogether and become former smokers or reduce their smoking and become low rate or non-daily smokers. The latter often go on to quit altogether. Among recent smokers, relapse is common. They may relapse to non-daily smoking or go back to daily smoking. But their desire to quit usually remains, leading them to cycle through the process repeatedly till they become former smokers long enough to be less vulnerable to relapse. It takes 12-14 quit attempts, on average, before tobacco users quit for good.[85]

Figure 10



The overarching goals of this objective are to get all tobacco users into the "Quit Machine" and to help them cycle through it as expeditiously as possible, till they have successfully quit. Anything that can speed up the machine, motivating relapsed smokers to make fresh quit attempts, will result in increased cessation rates. Intervention activities should be designed to increase the desirability of quitting, to increase the sense of urgency about quitting earlier in life, and to reach all groups of tobacco users.

Other objectives and strategies in this Master Plan can stimulate quit attempts. For example, when the price of tobacco products increases or when new restrictions are placed on tobacco use, cessation increases. Policies that have the effect of de-normalizing tobacco use may be the most important underlying motivators for quit attempts. And as the percentage of Californians who do not use tobacco increases, those who still use tobacco have all the more reason to quit, in order to fit in.

In 2010, 56.8 percent of California smokers reported a quit attempt in the previous 12 months.[86] While policies should be adopted to increase the availability and utilization of cessation aids and services, quitting without such assistance is by far the most common route to success, despite its low efficacy rate.[87] "Cold turkey" quitting is still a critical element of population based tobacco cessation.[88]

Expand the availability and utilization of cessation aids and services. According to the Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, clinicians should "strongly recommend the use of effective tobacco dependence counseling and medication treatments to their patients who use tobacco, and recommends that health care systems, insurers, and purchasers assist clinicians in making such effective treatments available."[89] Treatments to be recommended to patients are individual, group, and telephone counseling, and various first-line medications including nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, bupropion SR (Zyban), and varenicline (Chantix).

The availability and utilization of FDA-approved quitting aids should be increased, especially among uninsured smokers. Individual and group cessation counseling should be widely available. Awareness and use of the California Smokers' Helpline should be

increased. Culturally and linguistically appropriate educational materials should be widely disseminated.

Health insurers and health systems should be urged to realize their critical roles in tobacco cessation by providing comprehensive coverage of effective treatments, supporting their delivery, motivating repeated quit attempts, and otherwise helping patients be successful in quitting. Health care reform creates opportunities to heighten awareness of the importance of cessation. Relevant themes from the reform movement include an emphasis on prevention and wellness rather than simply on treating disease, the importance of cost efficiency in treatment selection, the benefits of coordinated chronic disease management, the need to address disparities in access to treatment, the promise of cost savings from improved care, and keeping pace with the competition.

New health plans should be informed that pursuant to the Affordable Care Act, they are required to cover preventive health care without co-payment. Alerting existing plans that they will be required to provide coverage by 2018 may convince some to offer it sooner.

Training and technical assistance should be provided to help hospitals, clinics, Federally Qualified Health Centers, mental health facilities, and substance abuse treatment centers adopt smoke-free campus policies, implement systematic approaches to cessation, and ensure that tobacco cessation is well supported by electronic medical records. *The Tobacco Quit Plan for California* provides a useful summary of recommended strategies for health care system change, engaging health care providers and engaging other systems to promote cessation.[92]

The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is a not-for-profit organization that accredits over 19,000 health care organizations and programs in the United States, including 82 percent of hospitals. Hospitals should be advised that the Joint Commission has adopted guidelines that require hospitals selecting tobacco cessation as one of their quality measures to screen all adult inpatients for tobacco use, provide cessation medications and counseling, and follow up with them after discharge.

A Model Example

Kaiser Permanente Northern California (KPNC) has identified tobacco cessation as a quality goal. The organization's comprehensive systems approach includes:

- smoke-free medical campuses
- clinical practice guideline development
- practice tools and staff training
- FDA-approved pharmacotherapies
- behavioral support through group classes, individual counseling, and an online program
- performance measurement, physician feedback, and incentives for good performance

Results have been remarkable. The adult smoking prevalence among KPNC members decreased by one-quarter in just a few years, from 12.2 percent in 2002 to 9.2 percent in 2007.[90, 91]

New Tobacco Cessation Measures for Hospital Accreditation

Because tobacco use is the leading preventable cause of death in America, The Joint Commission developed and pilot-tested a new measure set to improve performance in this area. The new measures do not target a specific diagnosis and are broadly applicable to all hospitalized inpatients 18 years of age and older: It includes:

- **Assessment** – all adult patients will be assessed for tobacco use.
- **Treatment** – tobacco users will be offered evidence-based counseling to help them quit and FDA-approved quitting aids during their hospital stay, unless contraindicated.
- **Treatment at discharge** – current tobacco users will be referred to evidence-based outpatient counseling and offered a prescription for quitting aids upon discharge.
- **Treatment follow-up** – current tobacco users will receive a follow-up call within two weeks after hospital discharge to ascertain their tobacco use status.

Engage health care providers in helping patients quit. Physician advice to quit smoking increases the likelihood that patients will quit and remain tobacco-free a year later.[93] The consult can be as simple as *Asking* patients if they use tobacco. *Advising* those who do to quit, and *Referring* them to the California Smokers' Helpline or other evidence-based treatment (see Figure 11).

Efforts should be made to expand the number and diversity of health professionals who routinely assist their patients in quitting tobacco, by helping nurses, physician assistants, dentists, dental hygienists, respiratory therapists, pharmacists, optometrists, and others to see this as part of their mission. All schools for health professionals should include training on tobacco cessation in their curricula and provide this training to practitioners through continuing education.

Promote tobacco cessation through multiple channels. California's three tobacco control agencies should work collaboratively with each other and with state, regional, and local partners to develop and disseminate culturally appropriate tobacco cessation messages and services, especially to priority populations.

Figure 11

Tobacco users who have mental illness or a substance abuse disorder consume 44 percent of all cigarettes and account for 200,000 of the 443,000 tobacco-related deaths in the United States each year.[94] They should be considered a priority population for the California Tobacco Control Program. Although provider and patient perspectives are changing, smoking historically has been an accepted part of mental health treatment settings. Quitting tobacco should become a new norm in mental health and substance use disorder systems.

Place-based campaigns should be used to reach concentrated populations of low socioeconomic status. Other funding agencies such as First 5 California should be encouraged to increase financial support of programs and mass media that address cessation and secondhand smoke exposure in its target populations.

Social service organizations, employers, labor groups, the military, schools, and colleges, should be encouraged to promote cessation and to make referrals to the California Smokers' Helpline or local cessation services. Cessation activities by these groups should be publicized and others should be encouraged to emulate them.

Media and public relations should be used to show that not using tobacco has become the norm in California and to generate social support for cessation. Smokers and other tobacco users should be made to feel hopeful about their chances of quitting successfully. Friends and family members who do not use tobacco should be provided with tips to effectively support quit attempts by those who do. Encouraging quit attempts through social media is another promising strategy to support each other in quit attempts. Efforts should be made to increase quit attempts among younger smokers, as quitting before the age of 30 avoids most of the long term health effects of tobacco use.[95]

Conduct research and evaluation to strengthen cessation interventions. Research should be conducted to analyze the effectiveness of various approaches for promoting and supporting cessation with priority populations. The rate at which health care providers help patients quit should be tracked, and various approaches to increasing provider interventions should be evaluated. Access, awareness, and utilization of cessation treatments should likewise be tracked. Messages and methods for increasing quit attempts and tobacco cessation among youth and young adults should be tested.[96]

Investigators should explore the extent to which media campaigns and other tobacco control strategies prompt aided and unaided quit attempts and normalize social support for cessation among nonsmoking friends, family members, and health and social service providers. Research should evaluate whether tobacco control efforts in California succeed at creating self-reinforcing quitting norms among tobacco users. The impact on California of federal programs, such as the FDA-mandated warning labels on cigarette packs, should be carefully evaluated (See Figure 12).

Efforts should be made to ensure that future revisions of the *Tobacco Quit Plan for California* reflect up-to-date realities about tobacco use and cessation in the state and keep California on the leading edge of research and practice in this area.

Figure 12

OBJECTIVE 7: Minimize Tobacco Industry Influence and Activities

- Monitor and expose tobacco industry spending and activities.
- Increase adoption and enforcement of laws that regulate the sale, distribution, and marketing of tobacco products.
- Support and enhance tobacco regulation by the FDA.
- Increase refusals of tobacco industry funding, sponsorships, and partnerships.
- Make all tobacco use and the tobacco industry socially unacceptable.

The tobacco industry relentlessly fights tobacco control efforts at the local, state, and federal levels. It continually develops new products and promotes them through crafty marketing targeted to young people, priority populations, and others at-risk for tobacco use or already addicted. The tobacco industry spent over eight times more on marketing in California than the state spent on tobacco control in 2008.[97]

However, the tobacco industry's attempts to undermine tobacco control goes far beyond marketing their deadly products. It fights proposed increases in the tobacco tax and challenges proposed legislation to weaken it or derail it altogether. Over the past decade, Big Tobacco—led by Philip Morris—spent nearly $100 million lobbying legislators and contributing to campaigns in California. A large portion of that--$62 million—went into defeating Proposition 86 in 2006. That statewide ballot initiative would have imposed a $2.60 tax on each pack of cigarettes, and lost by just 289,331 votes.[98, 99]

More recently, the industry increased lobbying expenditures to oppose a $1.75 per pack tobacco tax increase intended to fund healthcare reform (ABX1-1). During a six months period, from October 1, 2007 to March 31, 2008, Philip Morris USA Inc. alone spent $887,286 to lobby against this tax increase and two other bills.[100] As the Legislature considered a cigarette tax during 2009 budget talks, the tobacco industry spent $750,000 in lobbying expenses in the three-months period from April through June.[101] After San Francisco instituted a mitigation fee to cover the costs of cleaning up tobacco waste, Philip Morris contributed $1.75 million to support Proposition 26, a successful 2010 ballot initiative that prevents other cities from imposing such fees.[102]

TEROC supports strong regulation of the tobacco industry at every level of its operation. In order to save lives and save money, Californians must work together to increase the tax on tobacco, to support strong tobacco control, and to limit the products, activities, and influences of the tobacco industry. The following recommended strategies are critical to countering Big Tobacco's influence.

Monitor and expose tobacco industry spending and activities. The Tobacco industry continues to outspend the state's Tobacco Control Program eight-to-one on their marketing efforts and because of this their influence is all around us.[103] Tobacco industry marketing strategies are designed to

be integrated with lifestyle activities so that the industry's influence on norms around tobacco use may go unnoticed.

These lifestyle marketing activities continue today. For example, smoking in movies is a powerful pro-tobacco influence on young people. Kids also encounter promotion of tobacco products in retail environments. Adolescents who are exposed to cigarette advertising and tobacco product displays in the retail store environment were more than twice as likely to initiate smoking than those not exposed.[104, 105] Another venue for tobacco marketing is in sporting and outdoor events. In 2008, 45 percent of California youth in grades 9-12 reported seeing advertisements for cigarettes or chewing tobacco when they attend sports events, fairs, or community events.[106]

The tobacco industry's aggressive marketing is constantly evolving and for this reason it is critical to track their spending and activities to identify new trends. In addition, the tobacco industry, its front groups and allies continue to work to undermine tobacco control policies. Implementing innovative rapid-response surveillance systems to assess changes in tobacco industry spending on marketing and political activities will help advocates fight this influence. These surveillance systems may also provide information about the industry's aggressive targeting of priority populations and other specific communities.

The tobacco industry targets priority populations and specific communities through new product development, marketing and advertising, promotions, price manipulation, and the density of tobacco retailers. They also have a history of targeting priority populations with their sponsorship and sampling practices. For example, Skoal's sampling tents at the National Association for Stock Car Racing demonstrate the tobacco industry's interest in rural and low socioeconomic status populations.

Monitoring and exposing the tobacco industry's spending and activities will increase awareness of the industry's current tactics. In addition to surveillance, innovative approaches to counter tobacco industry marketing and political strategies are needed.

Increase adoption and enforcement of laws to regulate the sale, distribution, and marketing of tobacco products. TEROC supports strong regulation of the tobacco industry in order to limit the availability of tobacco products, and to decrease

On-line Information about the Tobacco Industry

Many Web sites have information about the tobacco industry's

- front groups and allies
- strategies, tactics, and deceptive practices
- sponsorships and contributions

Two resources with links to many additional sources of on-line information are:

- Tobacco's Dirty Tricks, Get the Facts. Americans for Nonsmokers' Rights - www.no-smoke.org/getthefacts.php.
- Watching and Regulating the Industry, Tobacco Free Initiative (TFI) World Health Organization - www.who.int/entity/tobacco/en/.

the negative health effects of tobacco use. Statewide legislation that preempts stronger local tobacco control ordinances should be opposed because it weakens local efforts to regulate the sale, distribution, and marketing of tobacco products. In addition, tobacco control advocates should work with the California Attorney General to promote increasing enforcement of all state and local tobacco control laws which will increase the likelihood of success.

Three out of four adult smokers started using tobacco before the age of 18.[107] Therefore, it is reasonable to make efforts to limit tobacco sales to minors. These efforts may include retailer policies that prevent illegal sales of tobacco to minors or conditional use permits and zoning laws to address tobacco retailer density in California communities. Strong policies must include appropriate fees to adequately fund their enforcement.

Increasing the cost of tobacco is one of the most powerful public health interventions available to decrease cigarette consumption and smoking prevalence.[108] Tobacco Industry price manipulation strategies, retail price promotions, free or low-cost coupons, rebates, gift cards, and gift certificates are used to recruit and retain smokers by artificially lowering the price of cigarettes. These strategies target populations that are sensitive to price, such as youth or low socioeconomic populations. Policies are needed to prohibit these price manipulation strategies to help reduce the number of cigarettes consumed by current tobacco users and discourage uptake of tobacco by new users.

Studies show that the density of tobacco retail outlets in communities has an impact on the prevalence of smoking. Significantly higher smoking rates have been found in lower socioeconomic communities with higher density of tobacco retailers.[109] Also, students are more likely to experiment with smoking when there is a higher density of stores that sell tobacco near high schools in urban areas.[110] Eliminating tobacco retailers near schools and reducing the density in areas with priority populations will decrease exposure and access to tobacco products.

"Harm reduction" refers to use of cigarette alternatives that may be promoted as being less harmful or as having reduced risk of certain tobacco-related diseases. Recently, there has been an increase in the variety of alternative tobacco products available on the market, newer smokeless tobacco products like "snus," dissolvable tobacco products, and electronic cigarettes. These products are promoted as a way to circumvent smoking bans and provide an alternative to cigarettes that is less obtrusive and/or lower in price. New alternative tobacco products may undermine tobacco control strategies by prolonging the quitting process or even preventing quit attempts.[111] TEROC recommends prohibiting the promotion and sale of tobacco products for "harm reduction" as either substitutes or as cessation aids.

Health care institutions should not support tobacco use in any way. Any entity that provides health education, health services, dispenses medications and/or is involved in the Affordable Care Act should be prohibited from the sale or promotion of tobacco products. All institutions and public officials should be encouraged to adopt policies that establish

Partnership with the California Attorney General's Office

Between 2000 and 2009, enforcement of state laws and the Master Settlement Agreements by the California Attorney General's Office resulted in more than $24 million in payments, penalties, and fees paid by tobacco companies. Nearly $1.9 million of this total was earmarked for tobacco control.[112]

tobacco-free campuses if they receive, or disburse health, welfare, education, or community development funding from national, state, local, or regional authorities. In addition, public institutions and officials should be prohibited from selling or promoting tobacco products and not allowed to collaborate with, or accept funds from, any tobacco company, its representatives, subsidiaries or front groups.

Support and enhance tobacco regulation by the FDA. The Family Smoking Prevention and Tobacco Control Act was passed in 2009 to provide the FDA with the authority to regulate tobacco products. Based on recommendations, the FDA banned 13 specific flavorings in cigarettes, but menthol was exempt from the ban. Menthol is popular among youth and beginner smokers due to the feeling of coolness provided by menthol that masks the harshness of tobacco.[113] Menthol cigarettes represent 20 percent of the market share.[114] Mentholated cigarettes were originally developed and promoted to women.[115] Since then, the tobacco industry has used a unique combination of advertising, packaging, pricing, and distribution channels to target particular groups, such as youth and young adults, women, African Americans, and other priority or ethnic populations.

The FDA has the ability to prohibit menthol as an ingredient in cigarettes and other tobacco products. Therefore, TEROC recommends encouraging the FDA to ban menthol cigarettes and all other flavored tobacco products, including smokeless tobacco and cigars.

The tobacco industry provides incentives to retailers to display "power walls" – extensive rows of cigarette packages in quantities that far exceed what is needed to meet short term purchase levels. These displays are commonly visible as a backdrop to the cash register as cigarette advertising.[116] Studies have shown that individuals exposed to tobacco product displays are more likely to smoke and to smoke more.[117] The FDA should be encouraged to extend the current requirements for tombstone cigarette advertising, limiting the number and size of tobacco advertisements at retail outlets, and eliminating "power walls." Local and state action to monitor, restrict, and regulate the time, place and manner of tobacco advertising should also be encouraged.

Ban Menthol in Cigarettes and Other Tobacco Products

Menthol smokers tend to be female, younger, members of ethnic minorities, have only a high school education, and buy packs rather than cartons.[118]

Today, menthol cigarettes are the overwhelming favorite tobacco product among African Americans. More than 80 percent of African Americans prefer to smoke menthol cigarettes compared to only about 20 percent of White smokers. The rate is even higher among young African American adults ages 26-34 years, 90 percent of whom smoke menthols.[119]

Tobacco sampling is the giving away of free product to expose potential new consumers to tobacco products and retain customer support and loyalty. The FDA completely bans free samples of cigarettes, but permits the sampling of smokeless tobacco at adult only facilities. Sampling of cigars, cigarillos, hookah tobacco, and dissolvable tobacco products remains legal. TEROC recommends expanding the definition of sampling to include coupons, rebate offers, gift certificates, or any other method of reducing the price of tobacco to a nominal cost. It is also recommended that the FDA ban on cigarette sampling be extended to all tobacco products.

Increase refusals of tobacco industry funding, sponsorships, and partnerships. The Tobacco Industry spends millions of dollars on trying to influence California policymakers through campaign contributions and lobbying expenditures. Tobacco interests spent $9.3 million on campaign contributions and lobbying during the 2009-2010 election cycle.[120] The tobacco industry uses its spending power to influence policymakers as well as to oppose bills and ballot initiatives that would reduce tobacco use. TEROC recommends encouraging public officials to sign a pledge that they will not accept funds from the tobacco industry or its front groups. Contributions from these sources should be monitored and the names of public officials who accept them should be publicized.

The number of universities and public schools that adopt tobacco-free policies should be increased, including refusal of funds from the tobacco industry. All organizations should be encouraged to refuse tobacco industry advertisements, donations, event sponsorships, funded research and the use or distribution of tobacco industry curriculum or materials.

TEROC recommends that partnerships between tobacco control programs and tobacco companies be prohibited. Tobacco companies are trying to position themselves as part of the solution by partnering with tobacco control efforts. In particular, tobacco companies are seeking involvement in partnerships on the science of harm reduction. It is critical to point out that partnering with the tobacco industry does not further the health, welfare, or the economy of California.

Obtain Pledges to Refuse Funds from the Tobacco Industry

In 2004, the San-Francisco Coalition of Lavender-Americans on Smoking and Health (CLASH), the nation's first Lesbian, Gay, Bisexual, and Transgender (LGBT) tobacco control organization, initiated a campaign to persuade California LGBT elected officials and community organizations to sign a statement that they would not accept contributions from the tobacco industry or its affiliates.

By 2011, such a statement had been signed by 41 elected officials and 39 organizations. CLASH co-founder Naphtali Offen said, "Getting leadership on the record helps inoculate them against tobacco industry influence."

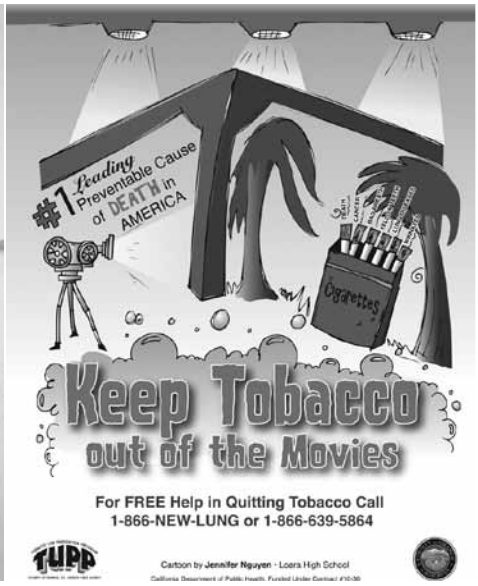
CLASH promotes a tobacco-free norm by publicizing its ongoing efforts to isolate the industry and hopes that others will urge their leaders to take a similar stand against the industry.

For more information visit:
http://www.lgbttobacco.org/files/PledgefromCalifornia.pdf.

Make all tobacco use and the tobacco industry socially unacceptable. As discussed earlier, the tobacco industry maintains a pervasive influence in our communities and is all around us - including in movies, retail stores, sports, fairs, and other community events. The tobacco industry strives to make tobacco a part of everyday life in order to normalize tobacco use. The social norm change model used in California tobacco control efforts seeks to make tobacco less desirable, less acceptable, and less accessible.[121] We must continue to support efforts to denormalize tobacco use, and to counter pro-tobacco influences, including efforts to renormalize tobacco use through the promotion of novel or alternative tobacco products. Our efforts should focus on community and youth development, and integrate more new media activities such as social media, popular music, and other participatory communication modes.

We must continue to support the scientific efforts needed to decrease the social acceptability of tobacco use and the tobacco industry. Research should be conducted to help guide the efforts of the FDA as it regulates tobacco products. For example, compliance with new regulations, tobacco industry adaptations to them, and impacts on tobacco use should be evaluated. Another area for research is studying the impact of California's new high-tech tax stamp in reducing tax evasion, counterfeiting, and smuggling.[122] Other research should be funded to monitor and expose the constantly changing maneuvers of the tobacco industry and its persistent efforts to counter tobacco control.


Don't
Be
A
Butt-Head.


#1 Leading Preventable Cause of DEATH in AMERICA
Cigarettes
Keep Tobacco out of the Movies
For FREE Help in Quitting Tobacco Call
1-866-NEW-LUNG or 1-866-639-5864
TUPP
Cartoon by Jennifer Nguyen - Loara High School


Don't let the movie magic trick you
Make-ups done!
Title:
Production:
Director:
Date
Scene
Take
For FREE Help in Quitting Tobacco Call
1-866-NEW-LUNG or 1-866-639-5864
TUPP
Cartoon by Ashley Sakahara - La Vista High School

Appendices

Significant Tobacco Control Legislation, 2009-2011

California Legislation

Legislation* Assembly Bill (AB), Senate Bill (SB), or Ballot Proposition (Prop) and Author	Description	Effective Date
AB 33010- Blakeslee	Authorizes the Director of the Department of Mental Health to prohibit smoking by patients and staff at any of the five state mental hospitals upon request of the hospital's director.	January 1, 2009
SB 53- DeSaulnier	Authorizes the Attorney General to negotiate amendments to the Master Settlement Agreement.	August 5, 2009
SB 882 – Corbett	Makes sales of electronic cigarettes to minors illegal.	September 25, 2010
Prop 26	With a number of exceptions, city, county, or state charges formerly considered regulatory fees requiring a majority vote now are considered taxes; passage of a "special tax" by local governments requires two-thirds vote; passage of a new state tax requires a two-thirds vote by each house.	November 2, 2010
SB 2496 – Nava	Reduces evasion of Master Settlement Agreement and cigarette tax payments.	January 1, 2011
AB 2733– Ruskin	Changes tobacco retailer licensing laws.	January 1, 2011
AB 795– Block	Strengthens enforcement of tobacco policies at state colleges and universities.	January 1, 2012
SB 332– Padilla	Authorizes landlords to prohibit smoking in rental units.	January 1, 2012
SB 796 – Blakeslee	Create penalties for delivering prohibited items in state hospitals.	January 1, 2012

* AB: Assembly Bill
SB: Senate Bill
PROP: Proposition on state-wide ballot

Federal Legislation

Act	Description	Effective Date
The Children's Health Insurance Program Reauthorization Act	Raises Federal cigarette tax from $0.39 to $1.01 a pack, an increase of $0.62.	April 1, 2009
The Prevent All Cigarette Trafficking (PACT) Act	Regulates sale of tobacco products over the internet and mail; enforces tax laws on vendors.	June 29, 2010
Family Smoking Prevention and Tobacco Control Act ("Tobacco Control Act")	Gives the Food and Drug Administration (FDA) Regulatory authority over tobacco products	June 22, 2009
	• Bans all flavored cigarettes except menthol and the use of misleading descriptors such as light, low, and mild for cigarettes and smokeless tobacco.	June 22, 2009
	• Imposes sponsorship, advertising and sampling restrictions.	
	• Requires FDA approval of new and imported tobacco products.	
	• Requires tobacco companies to disclose all cigarette ingredients.	December 19, 2009
	• Requires product warning labels on 50 percent of front and back of cigarette packaging and 20 percent of advertisements.	
	• Establishes the FDA Center for Tobacco Products and the FDA Tobacco Products Scientific Advisory Committee.	March 22, 2010
	• Allows States to restrict or regulate the time, place, and manner (but not the content) of cigarette advertising and promotion.	September 2012
The Patient Protection and Affordable Care Act (Affordable Care Act)	Creates a new Prevention and Public Health Fund that will expand and sustain prevention, wellness, and public health programs.	March 23, 2010
	Expands smoking cessation coverage for pregnant Medicaid beneficiaries and enhances prevention initiatives by offering financial incentives to States to provide optional services that encourage healthy behaviors by Medicaid beneficiaries.	October 1, 2010

Achievements

Master Plan 2009-2011

The TEROC Master Plan goals for 2009-2011 were established to achieve smoking prevalence rates of 10 percent for adults and eight percent for high-school age youth by the end of 2011. The three-year plan established the following five objectives as guidance for the California Department of Public Health, CTCP; CDE, Safe and Healthy Kids Program Office; and the University of California, TRDRP to comprehensively implement tobacco control in California. Achievements by agency are summarized below, with highlights of major accomplishments and trends.

Objective 1: Strengthen the California Tobacco Control Program.
California has fallen behind the rest of the nation in tobacco excise tax rates. Declining Proposition 99 revenues limit the ability of California's tobacco control agencies to comprehensively address tobacco control issues in all communities. Measures have been taken to address declines in funding, to identify research priorities, and to build organizational capacity.

- CTCP successfully obtained more than $13.2 million in federal funding for the period of March 2009 to March 2014, through the Centers for Disease Control and Prevention procurements: *Collaborative Chronic Disease, Health Promotion, and Surveillance; Communities Putting Prevention to Work; Affordable Care Act, and Conference Support*. With these funds, CTCP is addressing new areas, including policy efforts to decrease barriers in accessing cessation services, particularly among populations with high rates of smoking; including Medi-Cal beneficiaries, people with mental illness, young adults, and military personnel.

- CTCP collaborated with the Department of Health Care Services (DHCS) to successfully obtain federal funding from the Centers for Medicare and Medicaid Services to expand cessation service utilization through the California Smokers' Helpline. Incentives are now provided to Medi-Cal beneficiaries to call the Helpline and enroll in cessation counseling services.

- TRDRP funded and disseminated public policy research to understand the need to increase the state's cigarette surtax. The research conducted by three University of California scientific teams demonstrated that an increase to the state's cigarette tax of $1 per pack with $0.20 allocated to tobacco control would result in billions of dollars of savings in health care expenditures and thousands of lives saved.[123, 124] These key findings provide the foundational evidence in support of the 2012-2014 Master Plan's objective to raise the cigarette surtax. TRDRP sponsored a legislative briefing at the State Capitol on May 12, 2011 to disseminate these findings to policy makers. In addition, local tobacco control advocates throughout the state have been actively disseminating these findings at the community level.

- In September 2011, TRDRP identified and announced new research priorities, reflecting an evolving scientific and regulatory context as well as the need to target the program's limited resources. The new research priorities

resulted from an extensive input and consensus process involving a broad range of program stakeholders as well as tobacco-related disease and tobacco control investigators. Effective 2012, TRDRP's five research priorities are in the areas of: Environmental Exposure, Early Diagnosis, Regulatory Science, Disparities and Equity, and Industry Influence.

- In 2010, the Sacramento Area Human Resource Association and the Sacramento Bee awarded CTCP the *Sacramento Workplace Excellence Leader Award* for a small government organization.

- The National Public Health Information Coalition (NPHIC) recognized eight anti-tobacco communication efforts created by CTCP and funded local and statewide agencies with top honors in 2009, and three in 2010, in their Awards for Excellence in Public Health Communication.

Objective 2: Eliminate Disparities and Achieve Parity in all Aspects of Tobacco Control.
California's tobacco control agencies continue to strengthen tobacco control efforts with priority populations through research, education, building agency capacity and funding.

- CDE started an initiative with TUPE grantees to adopt a mission to develop California's next generation of tobacco-free advocates. All TUPE grantees are now required to adopt youth development strategies that included youth in anti-tobacco efforts as leaders with active roles and experiential participation in tobacco prevention. Grantees are also encouraged to specifically target youth from priority populations for participation in youth development strategies. School Districts, such as San Mateo-Foster City, Westminster, and Chico are working specifically with African Americans, Hispanics, Vietnamese, and LGBT youth in anti-tobacco advocacy projects.

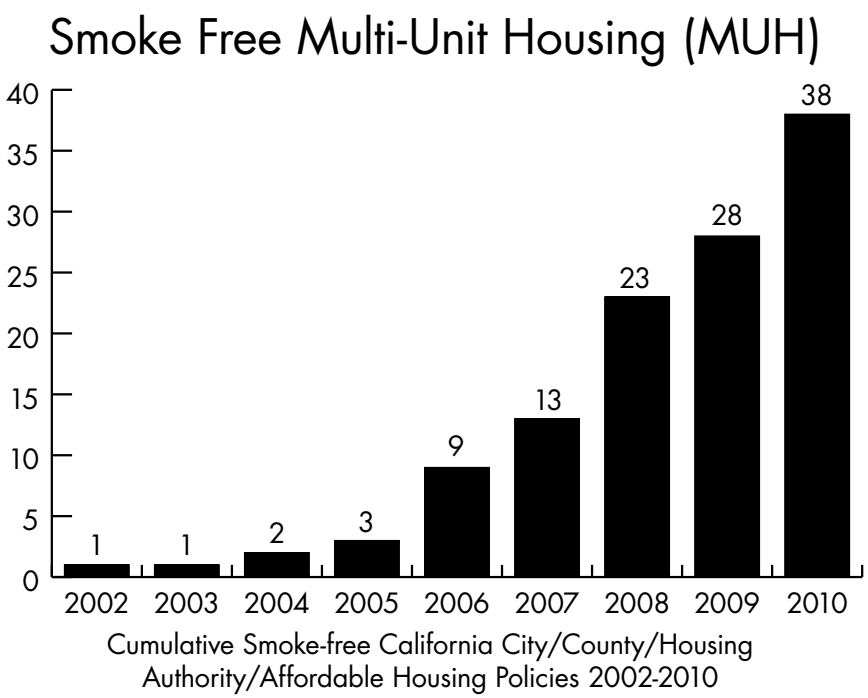
- CTCP produced 62 new television, radio, and print ads that aired in all major general and ethnic media markets in California; many were trans-adapted and aired in other languages. Ads were developed through population-specific, in-person testing and supported local intervention efforts by addressing secondhand smoke exposure in multi-unit housing, worksites, and outdoor environments; cessation; and countering pro-tobacco influences.

- CTCP was awarded the grand prize in the 2009 Association of National Advertising Awards of Excellence for the Asian advertising campaigns: *Your Child* and *Deadliest*. Additionally, *Trapped*, a Hispanic print ad, was awarded Commercial Image of the Year in *American Photo Magazine's* 2009 Images of the Year Competition.

- CTCP awarded $16.2 million (FY 2010-13) in competitive grant funding for 37 projects seeking to reduce tobacco-related disparities among these priority populations and communities: African American; American Indian/Alaska Native; Asian; Hispanic; labor; Lesbian, Gay, Bisexual, and Transgender; low socioeconomic status; people with mental health and substance abuse issues; and rural residents.

Objective 3: Decrease Secondhand Smoke Exposure.
Decreasing exposure to secondhand smoke where Californians live, work and play continues to be an area of considerable progress in California. Since 2008, there has been an increase in the number of local smoke-free policies, as well as in research that supports the elimination of secondhand smoke as a strategy to improve the health and wellness of the public.

Figure 13



- There has been an increase in the number of local community policies protecting against secondhand smoke exposure in multi-unit housing. In 2010, 38 city, county, housing authority, and affordable housing policies were enacted or strengthened (See Figure 13).

- In 2010, 85 municipalities passed ordinances to restrict smoking in at least some outdoor dining areas; and 273 municipalities had passed ordinances stronger than state law to restrict smoking in recreation areas.

- In 2011, approximately 87 percent of school districts and 100 percent of County Offices of Education have been certified as tobacco-free. More importantly, the LEAs that enforce the tobacco-free policy are serving 92 percent of California's student population.

- CDE created a new web page at http://www.cde.ca.gov/ls/he/at/tobaccofreecert.asp that supports LEA efforts to enforce and monitor tobacco-free school policies. The web page includes a list of LEAs that are certified as tobacco-free.

- TRDRP funded a statewide consortium of California researchers to conduct scientific research on third-hand smoke (THS) and its effects on public health. The first of its kind in this relatively nascent area, the research holds high relevance and potential to inform a new generation of tobacco control efforts. The funded consortium brings together investigators in a broad range of disciplines from across California institutions (University of California, San Francisco; Lawrence Berkeley National Laboratory; University of California, Riverside, and San Diego State University) with strong research backgrounds in the characterization, exposure and health effects of tobacco smoke and its potential economic and policy implications.

Objective 4: Increase the Availability and Utilization of Cessation Services.

California tobacco control agencies continue to create innovative ways to increase the availability and utilization of smoking cessation services in California.

- CTCP convened a Cessation Summit in May 2009 to identify program and policy strategies that could be implemented in California to promote quit attempts and increase tobacco cessation at the population level. *Creating Positive Turbulence: A Tobacco Quit Plan for California* outlines strategies designed to achieve the goals of tobacco cessation in California. The plan is available at: http://www.cdph.ca.gov/programs/tobacco/Pages/Ca_Tobacco_Quit_Plan_.aspx.

- A campaign, including print and digital media and health care provider outreach, encouraging health care providers to ask all of their patients about tobacco use, advise them to quit, and refer them to the Helpline for free telephone counseling was successful in increasing the proportion of callers referred to the Helpline through health care providers from 44.2 percent in 2009 to 51.2 percent by the end of 2010.

- CTCP produced the TV ad *Don't Stop Fighting*, in collaboration with the California Smokers' Helpline, based on a new strategy; encouraging repeated quit attempts vs. directly driving calls to the Helpline.

- CTCP and the DHCS partnered to improve cessation benefits for Medi-Cal beneficiaries. The duration of coverage for nicotine replacement therapy was increased from 10 weeks to 14 weeks, and a requirement for prior authorization for nicotine replacement therapy products was eliminated.

- The California Healthy Kids Resource Center (CHKRC) is administered by the CDE to provide high-quality TUPE) instructional materials, and technical assistance to California LEAs, and teacher preparation institutions. The CHKRC also promotes the use of *Research-Validated* instructional programs and research-based strategies such as youth development. A number of curricula have been designated as *Research-Validated*, indicating they have empirically demonstrated reductions in tobacco-use behaviors at least six months after the completion of the program. In addition, the curricular materials must be complete, available, and ready to be implemented at school sites in California. The *Research-Validated* programs list is available at http://www.californiahealthykids.org/rvalidated.

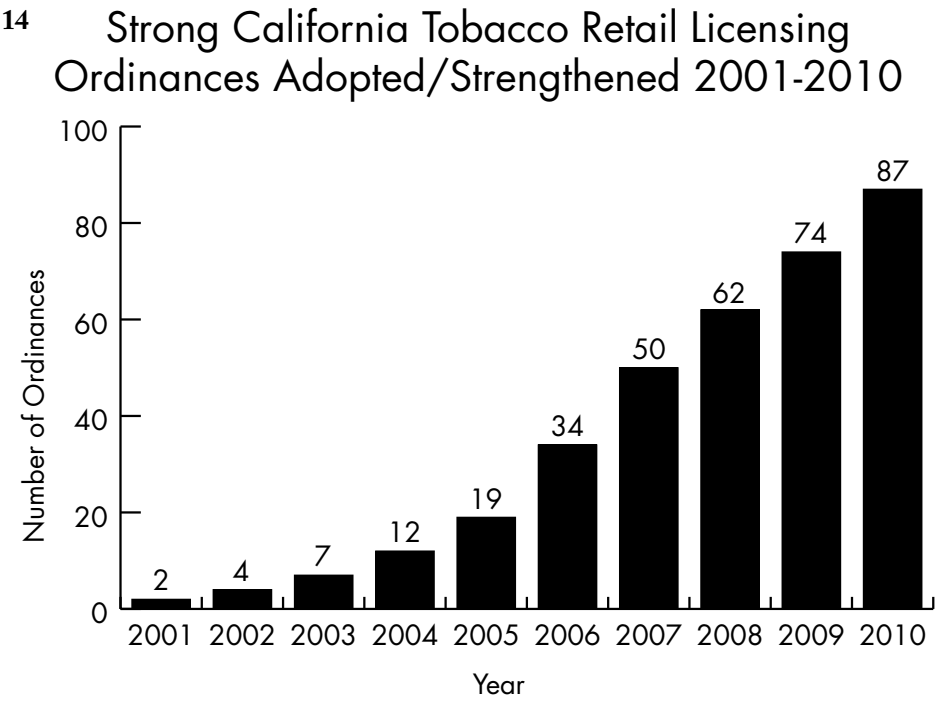
Objective 5: Limit and Regulate Tobacco Industry Products, Activities, and Influence. In California, the tobacco industry's marketing outspends the California Tobacco Control Program 8 to 1. Additionally, in the 2009-2010 election cycle, tobacco interests spent $9.3 million on campaign contributions and lobbying in California to promote and maintain pro-tobacco use interests.[125] Limiting and regulating the tobacco industry, their strategies, funding and influence remains a significant challenge in California.

- CTCP published and disseminated the *Tobacco Retail Price Manipulation and Policy Strategy Summit* proceedings in April, 2009. The proceedings contain policy recommendations to counter tobacco industry price manipulation and have provided a foundation for developing policy efforts to raise the price of tobacco products and have contributed to renewed national interest in minimum price laws. This document is available at: http://1.usa.gov/lW434Z.

- The statewide rate of illegal tobacco sales to minors declined from 17.1 percent in 2002 to 5.6 percent in 2011.

- Since the launch of the Strategic Tobacco Retail Effort (STORE) Campaign in 2002, California has seen a significant increase in

Figure 14

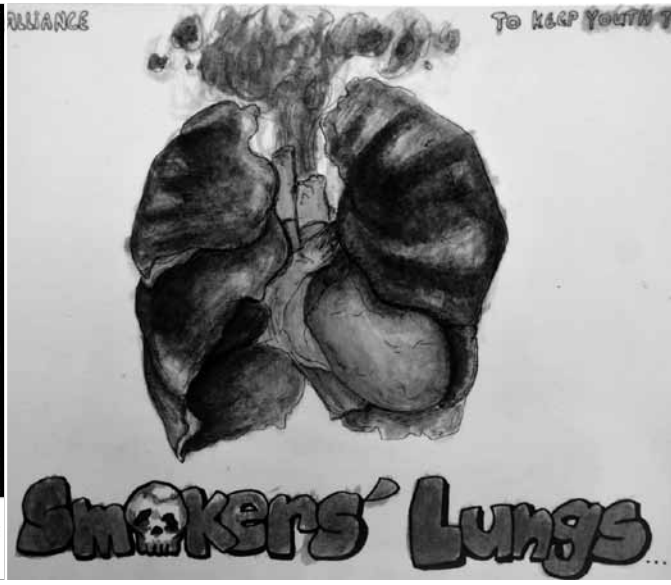


the number of local Tobacco Retail Licensing (TRL) laws (See Figure 14). Local jurisdictions are using TRL polices to regulate the types of stores that may sell tobacco, where stores may be located, the density of retailers, and the types of tobacco products that may be sold.

- **Innovative Use of Tobacco Retail Licensing Policies at the Local Level**. In 2008, San Francisco passed the first law in the United States that bans tobacco sales by pharmacies. In response to a state appeals court ruling, the law was expanded in 2010 to apply more broadly to include grocery and other stores with pharmacies. The City of Richmond passed a comparable ordinance in 2009.

In 2010, Santa Clara County enacted a tobacco retail licensing ordinance which prohibits issuing a license to any retailer where pharmacy services are provided, within 1,000 feet of a school, and within 500 feet of another tobacco retailer; however, existing retailers are exempted. The ordinance additionally prohibits the sale of all flavored tobacco products other than those containing menthol.

Designed By: Haley Miles
12th Grade Center High School MCA Student



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THE FIGHT

AGAINST BIG TOBACCO

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cdph.ca.gov/programs/tobacco

Tobacco companies get into our communities and take our health, our money, and our loved ones. California has been the leader in the fight against tobacco – but we haven't finished the fight. It's time to finish the fight against tobacco.

Table of Contents

Forward

California has achieved phenomenal success in tobacco control. California's cigarette smoking prevalence rate of less than 12 percent has only been achieved by one other state. Over the past 22 years, the reductions in tobacco use have saved $86 billion dollars and over a million lives in California: over a 50 to one return on investment.

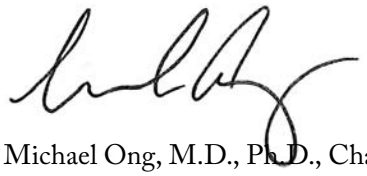
Unfortunately, we have reached a crossroads for tobacco control in California. Researchers from the University of California have projected that California's cigarette smoking prevalence will no longer decline, and will start increasing again, due to the current and future funding projections for California tobacco control. California's tobacco control efforts have been funded by a portion of a $0.25 tax on each cigarette pack sold in California. The past successes in California have also paradoxically reduced the funding available for tobacco control. In addition, what $0.25 bought in 1988 does not buy the same amount in 2012.

In other words, we as Californians have gotten tobacco use in our state as low as possible without making additional investments.

In these difficult economic times, it is hard to ask Californians to make any additional investments. However, further investments in tobacco control will save lives and save money. Getting more people to quit using tobacco and preventing people from starting to use tobacco saves lives and saves money. We would save more lives by preventing tobacco-related illnesses, which also saves money by preventing costly hospitalizations and other health care use among remaining tobacco users and those affected by secondhand smoke. We all share these costs through our public and private health insurance programs. Tobacco use also generates other costs shared by all from environmental clean-up costs, whether in public places or in private buildings.

The members of the Tobacco Education Research Oversight Committee in this 2012-2014 Master Plan have developed principles to guide tobacco control in California regardless of the level of investment that Californians consider appropriate for tobacco control. These principles infuse the seven objectives we describe that are needed to achieve the short-term goal of reducing smoking prevalence among adults below 10 percent, and among youth below eight percent, by 2014. These principles and achieving these objectives will ultimately help us reach our vision of a tobacco-free California that can be enjoyed by all of our diverse populations. Skeptics should be reminded of how social norms on smoking have dramatically changed in the past 25 years.

We have achieved so much in California, but we can be even better. We urge the Legislature and all Californians to make additional investments in tobacco control.



Michael Ong, M.D., Ph.D., Chair
January 2012


LIBERTY
1988
LIBERTY
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LIBERTY
1988

Proposition 99

In November 1988, California voters passed a ballot initiative known as Proposition 99 (the Health Promotion and Protection Act of 1988) which added a $0.25 excise tax per cigarette package and a proportional tax increase on other tobacco products beginning January 1, 1989. The tax was earmarked for public health programs to:

- prevent and reduce tobacco use,
- provide healthcare services,
- support tobacco-related research, and
- protect environmental resources.

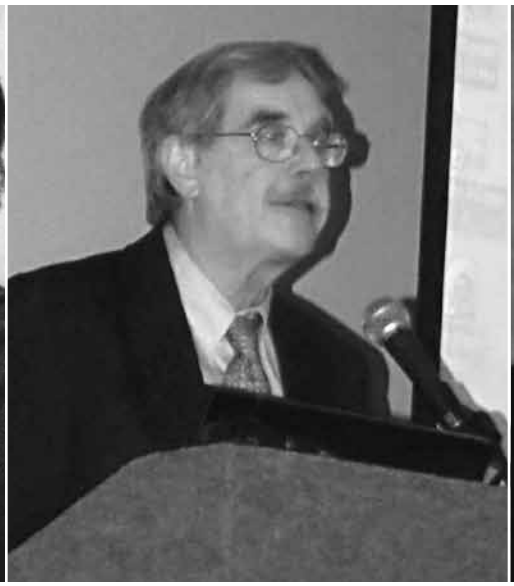
The California Tobacco Control Program (CTCP) was established in 1989. Twenty years later, the history of its development and its many accomplishments were celebrated in a special supplement of the journal *Tobacco Control*, entitled *The Quarter that Changed the World*.

About the Tobacco Education and Research Oversight Committee

The Tobacco Education and Research Oversight Committee (TEROC) was established by the enabling legislation for Proposition 99 (California Health and Safety Code, Sections 104365-104370) which mandates TEROC to:

- Prepare a comprehensive Master Plan to guide California tobacco control efforts, tobacco use prevention education, and tobacco-related disease research;
- Advise the California Department of Public Health, the California Department of Education, and the University of California regarding the administration of Proposition 99 funded programs;
- Monitor the use of Proposition 99 tobacco tax revenues for tobacco control programs, prevention education, and tobacco-related research; and
- Provide programmatic and budgetary reports on Proposition 99 tobacco control efforts to the California Legislature with recommendations for any necessary policy changes or improvements.

Pursuant to the Bagley-Keene Open Meeting Act, all TEROC meetings are open to the public. More information about TEROC, including meeting announcements, meeting minutes, press releases, and previous Master Plans can be accessed online at http://www.cdph.ca.gov/services/boards/teroc/.


Members of the Tobacco Education and Research Oversight Committee

TEROC is made up of 13 members. Pursuant to California Health and Safety Code Section 104365, the Governor appoints eight members, the Speaker of the Assembly appoints two, the Senate Rules Committee appoints two, and the Superintendent of Public Instruction appoints one member. Current TEROC members are:

Lourdes Baézconde-Garbanati, Ph.D., M.P.H., M.A.
Associate Professor in
Preventive Medicine and Sociology
Institute for Health Promotion and Disease Prevention Research
Keck School of Medicine
University of Southern California, Alhambra

Wendel Brunner, Ph.D., M.D., M.P.H.
Director of Public Health
Contra Costa Health Services, Martinez

Patricia Etem, M.P.H.
Executive Consultant
CIVIC Communications, Long Beach

Lawrence W. Green, Dr.P.H., Sc.D. (Hon.)
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Epidemiology and Biostatistics,
School of Medicine,
Helen Diller Family Comprehensive Cancer Center & Center for Tobacco Control Research & Education
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Dorothy Rice, Sc.D. (Hon.)
Professor Emeritus, Institute for Health and Aging
School of Nursing
University of California, San Francisco

Peggy M. Uyeda
Tobacco-Use Prevention Education Coordinator (Ret.)

Kathleen Velazquez, M.P.H., M.A.
Chief, Office of Leadership and Workforce Development
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Professor, Department of Family and Preventive Medicine School of Medicine
University of California, San Diego


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ACTION!
RESPONSIBLE
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Whats More
Important
Smoking on
your Life
A Better
Life
FREE

Mission, Vision, and Goal of Tobacco Control in California

Mission: To eliminate tobacco-related illness, death, and economic burden
Vision: A tobacco-free California
Goal: To achieve smoking prevalence rates in California of 10 percent for adults and eight percent for high-school age youth by December 2014

Administration of California's Proposition 99 Tobacco Control Efforts
California's Proposition 99 tobacco control efforts are administered by three state entities that work together toward achieving the mission, vision, and goal defined by TEROC for this Master Plan period.

The California Tobacco Control Program of the California Department of Public Health (CDPH/CTCP) administers the public health aspects of the program, including current Proposition 99-funded tobacco control activities of 61 local health departments, 37 community non-profit organizations, eight statewide training and technical assistance or cessation service projects, the statewide media campaign, and an evaluation of the effectiveness of the public health and school-based components. http://www.cdph.ca.gov/programs/Tobacco

The Coordinated School Health and Safety Office of the California Department of Education (CDE/CSHSO) is responsible for administering the Tobacco-Use Prevention Education (TUPE) program in over 961 school districts, 58 county offices of education, and more than 600 direct-funded charter schools. http://www.cde.ca.gov/ls/he/at/tupe.asp

The Tobacco-Related Disease Research Program (TRDRP), administered by the University of California, Office of the President, funds research that enhances the understanding of: tobacco use, prevention, and cessation; the social, economic, and policy-related aspects of tobacco use; and tobacco-related diseases. http://www.trdrp.org


NO DUMPING
¡NO CONTAMINE!
DRAINS TO TRUCKEE RIVER


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CLEAN-UP 2010
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FACTS

Acknowledgments

TEROC thanks the many individuals and groups that are committed to tobacco control in California and that contributed to this Master Plan. Special appreciation is extended to the following:

- Local health departments, tobacco control community programs, and schools throughout California, without which a comprehensive tobacco control program would not exist.

- Participants in California tobacco control efforts that provided input into the development of the 2012-2014 Master Plan objectives and supporting strategies.

- The African American Tobacco Control Leadership Council (AATCLC).

- Members of the academic community whose research findings are contributing to a greater understanding of tobacco control.

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- Tom Herman, Greg Wolfe, John Lagomarsino, and other staff of the California Department of Education, Coordinated School Health and Safety Office, and Greg Austin, WestEd.

- Bart Aoki, Phillip Gardiner, and other staff from the Tobacco-Related Disease Research Program; and Mary Croughan, Executive Director of the Research Grants Program Office, University of California, Office of the President.

- Carol D'Onofrio and Todd Rogers, who facilitated the development and writing of this Master Plan.


NO
SMOKING
ALLOWED


Smoke-Free
Campus
Smoking and tobacco are not
permitted on any Sierra College
campus. Thank you.

Executive Summary

Benefits of Tobacco Control. Over the past 22 years, Proposition 99 funds for tobacco control have saved lives and saved money, providing a large return on investment for the people of California.

- Deaths from lung cancer, heart disease, and other tobacco-related diseases have declined more in California than in other states, saving over one million lives and incalculable human suffering.
- Cumulative savings in healthcare costs over the first 15 years of the program totaled $86 billion, representing a 50 fold return on a $1.8 billion investment.
- In 2010, the state's adult smoking prevalence dropped to a record low of 11.9 percent, making California one of only two states in the United States to reach the federal Healthy People 2020 target of 12 percent.

Challenges. Despite these and other impressive accomplishments, California still has 3.6 million smokers, and smoking remains the state's number one preventable cause of disease and death. Sustaining and advancing progress in tobacco control depends on effectively responding to three major challenges:

- The need to reverse the decline in tobacco control resources resulting from reductions in tobacco consumption and related tax revenues, decreased purchasing power due to inflation, and staffing shortages in California's tobacco control agencies related to state budget problems.
- The need for intensified efforts and new approaches to reduce tobacco-related disparities and to promote cessation among those whose tobacco use still endangers their health, that of others, and the environment.
- The need to expose and counter the tobacco industry's massive marketing expenditures, campaign contributions, affiliations, legal maneuvers, and other tactics that undermine California's advances in tobacco control.

Importance of Renewed Commitment. Saving lives and saving money during the next three years and into the future depends on renewed commitment to tobacco control by the people of California. Leadership is needed at all levels. The status quo is not good enough. In this context, TEROC presents the 2012-2014 Master Plan for tobacco control in accord with California Health and Safety Code Sections 104365-104370.

Principles for Tobacco Control in California

Regardless of whether funding for tobacco control increases or decreases, decision-making by tobacco control agencies, other organizations, local communities, and people throughout the state should be based on principles that have guided tobacco control efforts in California since Proposition 99 was passed in 1988.

- Ensure implementation of comprehensive tobacco control efforts throughout California.
- Continue and expand social norm change and population-based approaches to tobacco control.
- Address health disparities in populations disproportionately affected by tobacco-related diseases and death to help achieve health equity.
- Use evidence to guide decisions about tobacco control programs, education, and research.
- Set performance goals for tobacco control programs, education, and research that achieve positive outcomes for Californians and serve as models for other states and nations.
- Develop, maintain, and enhance training and mentoring to prepare and support health professionals, educators, academics, and advocates from all segments of California's diverse populations for present and future leadership across the tobacco control continuum.

2012-2014 Master Plan Objectives and Strategies

Seven key objectives and related strategies are identified for tobacco control in California over the next three years.

- **Objective 1. Raise the Tobacco Tax**. Raising the tobacco excise tax by at least $1.00 per cigarette pack with an equivalent tax on other tobacco products and designating at least $0.20 for tobacco control is critical to achieving the Master Plan's other six objectives. The tax increase should be indexed incrementally to inflation, and untaxed or low-taxed sources of tobacco should be eliminated. California is one of only three states without a tobacco tax increase since 1999.

- **Objective 2. Strengthen the Tobacco Control Infrastructure**. Strengthening the statewide tobacco control infrastructure is essential to sustain and extend the health and economic benefits already achieved and to address new challenges effectively. Critical strategies include increasing communication, collaboration, and resource leveraging among traditional and new tobacco control partners; building the capacity of state and local agencies and health systems to contribute to tobacco control efforts; and adequately funding California's three tobacco control agencies to ensure stability, continuity, and momentum.

- **Objective 3. Achieve Equity in all Aspects of Tobacco Control Among California's Diverse Populations**. Raising the tobacco exise tax will reduce socioeconomic disparities in the prevalence of tobacco use and subsequently in tobacco-related diseases and deaths. Policies should be adopted and enforced at state and local levels to curtail tobacco industry targeting of priority populations. Equity and cultural competency standards should be incorporated in all tobacco control agencies, programs, processes, practices, and infrastructures. The involvement and competencies of priority populations in tobacco control should be increased to reduce tobacco-related disparities.

- **Objective 4. Minimize the Impact of Tobacco Use on People and of Tobacco Waste on the Environment**. Based on its 2006 finding that secondhand smoke is a toxic air contaminant, the California Air Resources Board should act to eliminate all smoking in public places and to declare tobacco smoke a public nuisance. Exemptions and loopholes in California's smoke-free workplace laws must be removed to protect workers, reduce disparities, and earn California recognition as a smoke-free state. Additional tobacco-free laws and policies should be adopted and enforced to minimize secondhand smoke exposure. Research should address emerging health, social, and economic concerns about new tobacco products, third-hand smoke, and the effects of tobacco waste on the environment.

- **Objective 5. Prevent Initiation of Tobacco Use**. Coordination and resource leveraging should be enhanced among California's tobacco control agencies and between community tobacco control programs, schools, and youth organizations throughout the state to accelerate the decline in youth tobacco use prevalence. Critical strategies include developing collaborative community-school tobacco prevention programs, increasing the number of tobacco-free schools, providing training and technical assistance to increase the capacity and competency of schools and community organizations in tobacco use prevention. The priority should be on limiting tobacco industry activities targeted towards youth and young adults, and conducting research and evaluation to strengthen these preventive efforts.

- **Objective 6. Increase the Number of Californians who Quit Using Tobacco**. This objective and key strategies for achieving it have been influenced by the population-based Tobacco Quit Plan for California developed in 2009, increases in the proportions of light and non-daily smokers, and an increasing likelihood that tobacco users are members of priority populations. Priority approaches should boost the number and frequency of tobacco quit attempts across populations, expand the availability and utilization of cessation aids and services, engage healthcare providers in helping patients quit, promote tobacco use cessation through additional channels, and conduct studies that strengthen cessation programs and services.

- **Objective 7. Minimize Tobacco Industry Influence and Activities**. To save lives and save money, Californians must work together to achieve strong regulation of the tobacco industry at every level of its operation. Closely monitoring and exposing tobacco industry spending and activities through rapid-response surveillance systems, the use of social media, and other methods of communication is critical to inform specific actions. Laws that regulate the sale, distribution, and marketing of tobacco products should continue to be adopted and enforced at state and local levels. Statewide legislation that preempts stronger local ordinances should be opposed. Californians should support additional regulation of tobacco by the United States Food and Drug Administration and work within the state to increase refusals of tobacco industry funding, sponsorships, and partnerships.

Saving Lives, Saving Money: Toward a Tobacco-Free California 2012-2014

The Tobacco Education and Research Oversight Committee (TEROC) presents this 2012-2014 Master Plan for tobacco control in accord with California Health and Safety Code Sections 104350-104480. This document provides programmatic recommendations to the State's three tobacco control agencies: the California Department of Public Health, the California Department of Education, and the University of California.

Beyond this, the Master Plan informs elected officials, agencies, organizations, groups, educators, researchers, advocates, community leaders, and other concerned citizens about the status of tobacco control in California and critical actions needed to achieve a tobacco-free California. Much has been accomplished, but much remains to be done. Continued progress toward a tobacco-free California will require a renewed commitment from the people of the state.

Seize the Moment

Tobacco prevention and control efforts need to be commensurate with the harm caused by tobacco use. Otherwise, tobacco use will remain the largest cause of preventable illness and death in our nation for decades to come. When we help Americans quit tobacco use and prevent our youth from ever starting, we all benefit. Now is the time for comprehensive public health and regulatory approaches to tobacco control. We have the knowledge and tools to largely eliminate tobacco caused disease. If we seize this moment, we will make a difference in all of our communities and in the lives of generations to come.[1]

Kathleen Sebelius
Secretary of Health and Human Services

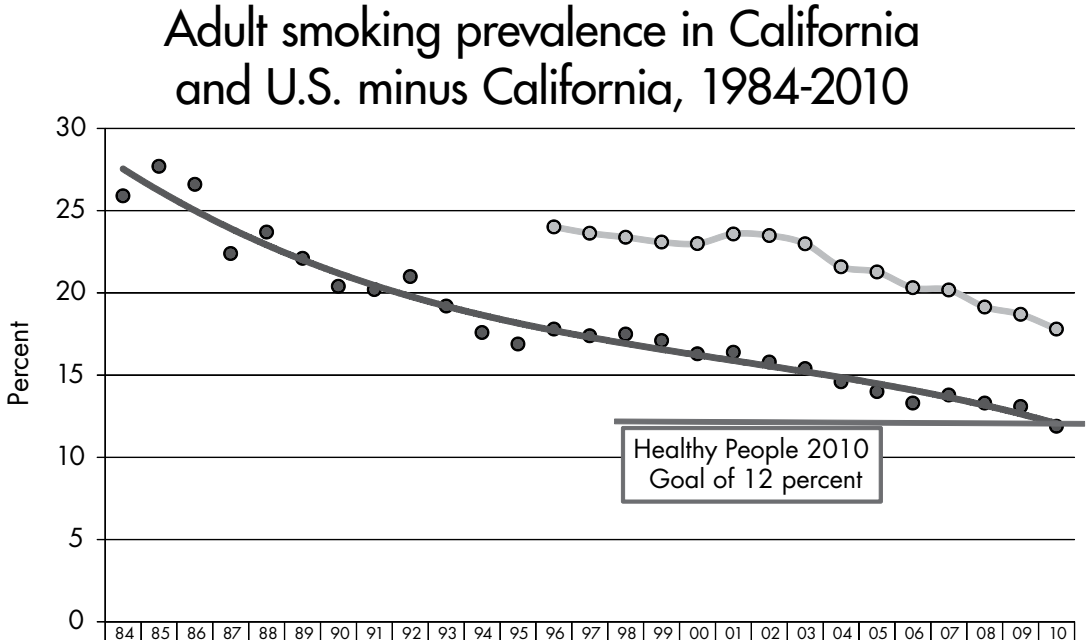

Linking Tobacco Control Research & Practice for a Healthier California
Hyatt Regency Sacramento, April 10-12,
CTCP's New Retail
Advocacy Ca
Califor
CTC
Tobacco Control P

Key Considerations in Plan Development

Return on Investment. Over the past 22 years, Proposition 99 funds for tobacco control have saved lives and saved money, providing a large return on investment for California and its residents. Deaths from lung cancer, heart disease, and other tobacco-related diseases have declined more in California relative to the rest of the nation, saving more than an estimated one million lives and incalculable human suffering.[2] Cumulative savings in healthcare costs over the first 15 years of the program totaled $86 billion, representing a 50-fold return on a $1.8 billion investment.[3]

In 2010, the state's adult smoking prevalence dropped to a record low of 11.9 percent (see Figure 1), making California one of only two states in the United States to reach the federal Healthy People 2020 target of 12 percent.[4] Adult per capita consumption of cigarettes (see Figure 2) and 30-day smoking prevalence among youth (see Figure 3) also have declined at greater rates in California than the rest of the United States.[5] These trends promise to save more lives and more money far into the future.

Figure 1

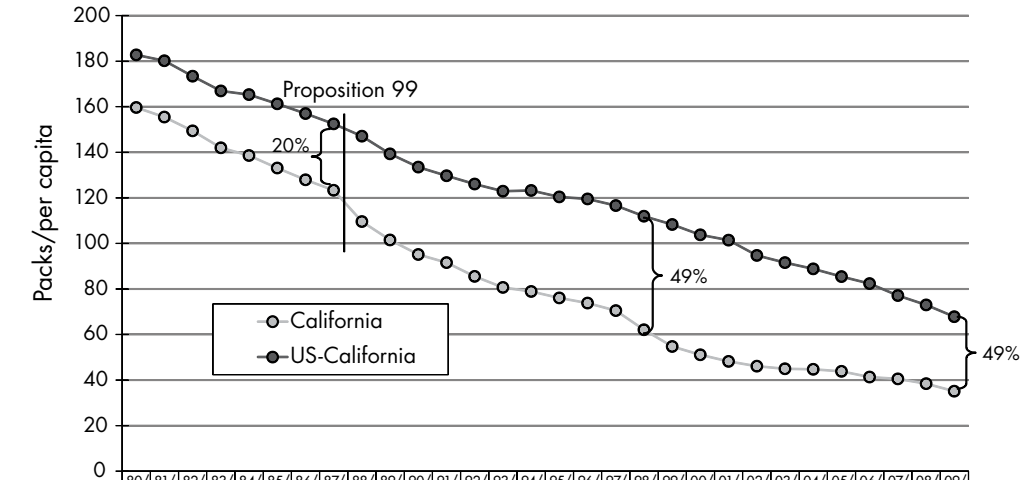


	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10
CA	25.9	27.7	26.6	22.4	23.7	22.1	20.4	20.2	21.0	19.2	17.6	16.9	17.8	17.4	17.5	17.1	16.3	16.4	15.8	15.4	14.6	14.0	13.3	13.8	13.3	13.1	11.9
US-CA													24.0	23.6	23.4	23.1	23.0	23.6	23.5	23.0	21.6	21.3	20.3	20.2	19.1	18.7	17.8

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-1992, BRFSS and California Adult Tobacco Survey data are combined for 1993-2010. The data are weighted to the 2000 California population. State BRFSS data are weighted to 2000 national population based on each states population. Note an adjustment was made to address the change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program, April 2011.

Figure 2

Adult per capita cigarette pack consumption for California and the U.S. minus California, 1980 to 2010

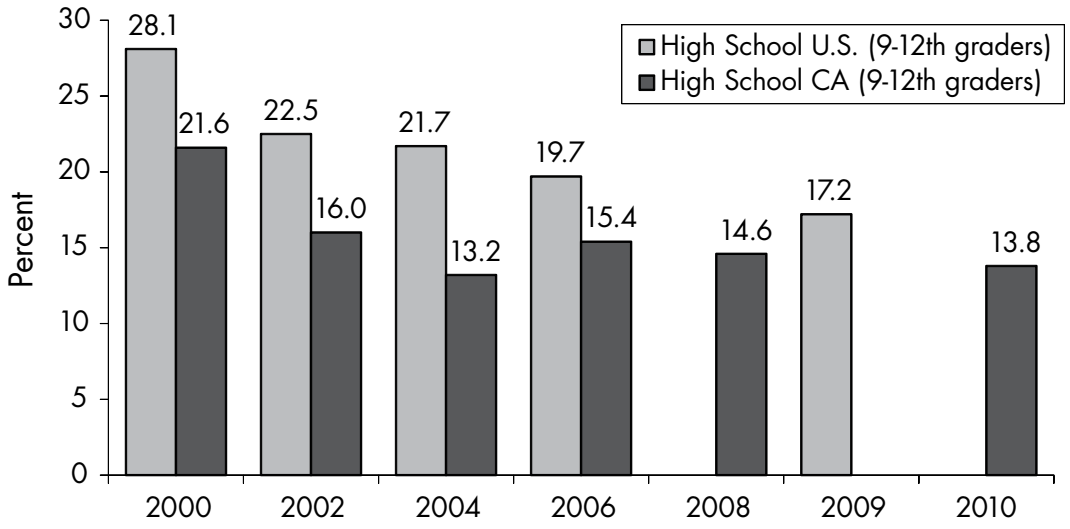


	80/81	81/82	82/83	83/84	84/85	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10
California	160	156	149	142	139	133	128	123	110	102	95	92	86	81	79	76	74	71	62	55	51	48	46	45	45	44	41	41	38	35
US-California	183	180	173	167	165	161	157	153	147	139	134	130	126	123	123	120	120	117	112	108	104	101	95	92	89	85	82	77	73	68

Source: Tax Burden on Tobacco, 2010, California State Board of Equalization (packs sold), Department of Treasury for 2010 US and US Census (population). Prepared by: California Department of Public Health, California Tobacco Control Program, April 2011.

Figure 3

30-day student smoking prevalence (9th-12th grade) for California and the United States, 2000-2010



Source: The 2000 California data is from the National Youth Tobacco Survey (NYTS) collected by the American Legacy Foundation, which used passive parental consent. The 2002, 2004, 2006, 2008, and 2010 data are from the California Student Tobacco Survey. The 2002 and 2004 data collection used active parental consent while the 2006, 2008, and 2010 used a mixed parental consent procedure. The United States data are from the NYTS collected by the American Legacy Foundation and the Centers for Disease Control and Prevention. Note that the NYTS was conducted in 2009 thus s 2008 and 2010 United States data are unavailable.
Prepared by: California Department of Public Health, California Tobacco Control Program, April 2011.

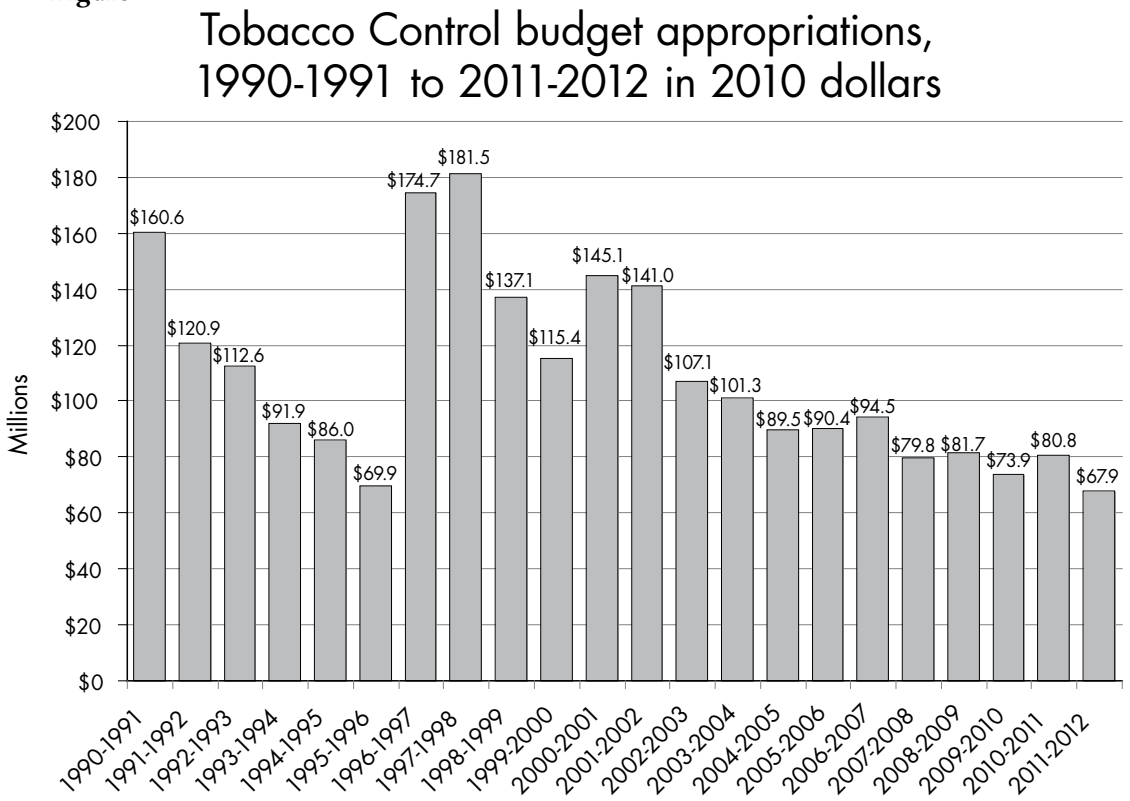
California's comprehensive approach to tobacco control has clearly been effective. The program has saved lives and saved money by changing social norms around tobacco use, conducting research and evaluation to inform tobacco control efforts, and developed policy and programmatic approaches that have become models to help other states and countries address the world-wide tobacco epidemic. However, despite an impressive track record of accomplishments, tobacco control in California faces many challenges.

Challenges. Smoking remains the number one preventable cause of death and disease in California and the United States. Despite declines in smoking prevalence since the establishment of the statewide tobacco control program, California still has 3.6 million smokers; that number is greater than the total populations for 23 States and the District of Columbia.[6] Further progress in tobacco control depends on effectively responding to three major challenges.

- **Decreased tobacco control resources**. Resources for tobacco control in California have dwindled dramatically in the last decade (see Figure 4). In part, these declines reflect victories in reducing tobacco consumption and resulting decreases in tobacco tax revenues. Inflation has also diminished purchasing power over time in all areas, including personnel, media production and airtime, and research. Moreover, California's tobacco control agencies have experienced declines in workplace capacity as a result of furloughs, the elimination of positions, or leaving vacant positions unfilled due to the overall state budget deficit and hiring freezes. These shortfalls make it difficult to sustain the progress already made and to develop the public health initiatives needed to address new challenges.

- **The need to address continuing and emerging problems**. As tobacco use rates decline, intensified efforts and new approaches are

Figure 4



needed to reduce tobacco-related health disparities and reach those whose tobacco use still endangers their health, that of others, and the environment. Addressing these persistent issues, and emerging concerns such as the effects of toxic tobacco waste on the environment is essential to protect the health of Californians and yield further long-term cost savings.

In 2008, tobacco industry expenditures just on marketing in California were over eight times more than the state's spending on tobacco control.

Increased tobacco industry spending. In 2008, tobacco industry expenditures on marketing in California were over eight times more than the State's spending on all of tobacco control.[7] The tobacco industry relentlessly works to undermine gains in California tobacco control. Examples include sophisticated marketing of its products, new product innovations, sponsorship of events, dissemination of ineffective and counterproductive tobacco prevention materials, legal challenges to effective tobacco control policies, campaign contributions to elected officials, and affiliations with influential civic, community, and social organizations and leaders.

California Tobacco Control at a Crossroads. Considering both the return on investment in tobacco control and the challenges described above, TEROC has concluded that tobacco control in California is at a crossroads. The decline in tobacco control funding must be reversed in order to sustain the progress already made in saving lives and saving money, to vigorously address new and emerging issues, and to protect California's highly successful investment in tobacco control.

Without this recommitment to tobacco control, the state will experience increases in the prevalence of cigarette smoking and other tobacco use, exposure to secondhand smoke, tobacco-related diseases and deaths, related social and health care costs, and environmental damage. California's comprehensive tobacco control program infrastructure will deteriorate and the state's return on its investment in tobacco control will decline. Thus, the status quo is not good enough.

An increase in the tobacco excise tax is the only realistic source of additional tobacco control funding in California. Raising the tobacco tax and dedicating a significant portion to tobacco control—the first Master Plan objective— is therefore critical to achieving all objectives.

Progress toward a tobacco-free California therefore depends on the will of the people of the state and their ability to see through the tobacco industry's deceit and obfuscation. The people of California—voters and those who influence voters—will determine whether our state moves closer to becoming clean, green, and tobacco-free, or whether our air becomes more contaminated by smoke, our outdoor spaces and waterways become more contaminated with tobacco litter, our families continue to suffer from tobacco-related diseases and deaths, and our struggling economy continues to suffer from rising health care costs caused by tobacco use. Leadership in advocating for tobacco control is needed at all levels.

TEROC presents the 2012-2014 Master Plan for tobacco control in this context.

Overview of the 2012-2014 Master Plan. TEROC cannot predict the path that tobacco control funding will follow in the next few years. Therefore, this Master Plan begins by identifying principles to guide decision-making by tobacco control agencies regardless of whether their funding increases or decreases. TEROC views these principles as the foundation for the objectives of the 2012-2014 Master Plan and for achieving the overall goal of a tobacco-free California.

Use this Master Plan to inform and educate....

- Yourself
- Your family, friends, and neighbors
- Elected officials
- Business, professional, youth and other organizations, and leaders
- The media


wir
doors and
through vents,
can enter your home
Secondhand smoke
Even if you don't smoke, your family can still be exposed to secondhand s
Talk to your landlord about making your building 100% smoke-free.
Millions
are exposed
to secondhand smoke
and some can't do
anything
about it.
Even if you don't smoke, you can still be exposed to secondhand smoke in your home through vents, doors and
Talk to your landlord about making your building entirely smoke-free.
©2011 California Department of Public Health
TobaccoFre

Principles for Tobacco Control in California

Decision-making about goals, priorities, and strategies for tobacco control in California is difficult in these times of rapid change and uncertain resources. If funding continues to decline, hard choices will need to be made about which current programs to cut and which new initiatives to place on hold. If a new tobacco tax is passed, if grant funds are obtained, and/or if new resource-sharing partnerships can be developed, judgments about which programs to restore and which new directions to pursue also will require careful thought.

To maintain and advance progress in tobacco control, the following principles must guide decision-making by tobacco control agencies, other organizations, local communities, and people throughout the state. These principles have guided tobacco control efforts in California since Proposition 99 was passed in 1988:

Ensure implementation of comprehensive tobacco control efforts throughout California. A comprehensive statewide tobacco control program is a coordinated effort to:

- establish tobacco-free policies and social norms,
- promote and assist cessation of tobacco use,
- prevent tobacco use initiation, and
- counter the marketing practices and political influence of the tobacco industry.

Continue and expand social norm change and population-based approaches to tobacco control. In the social norm approach to tobacco control, agencies and communities throughout the state undertake a range of integrated policy, programmatic, educational, and research initiatives. The common aim of these public health initiatives is to change the political, social, economic, legal, and media environments that influence the tobacco-related knowledge, attitudes, and behaviors of Californians. As tobacco use becomes less desirable, less acceptable, and less accessible, enduring social change is created incrementally at a grassroots level across communities.

Address health disparities in populations disproportionately affected by tobacco-related diseases and death to help achieve health equity. Health disparities are systematic, plausibly avoidable health differences that adversely affect socially disadvantaged groups. The health differences may reflect social disadvantage, but causality need not be established. This definition, grounded in ethical and human rights principles, focuses on the subset of health differences that reflect social injustice, distinguishing health disparities from other health differences also warranting concerted attention.[8]

Tobacco control priority populations are those that, when compared to the general population, suffer from disparities related to disproportionately high rates of smoking prevalence, tobacco consumption, secondhand smoke exposure at work and at home, targeting by the tobacco industry, tobacco-related diseases and deaths, and related economic hardships. In California, these populations include, but are not limited to:

- African Americans, other people of African descent, American Indian and Alaska Natives, some Asian Americans, and Hispanics/ Latinos;
- people of low socioeconomic status, including the homeless;
- people with limited education, including high school drop-outs;
- lesbian, gay, bisexual, and transgender (LGBT) people;

- rural residents;
- members of the military and individuals employed in jobs not protected by smoke-free workplace laws;
- people addicted to alcohol and other drugs;
- the mentally ill;
- people with disabilities; and
- formerly incarcerated individuals.

In addition to the many social factors contributing to disparities, the tobacco industry directly targets specific communities and cultures with sophisticated marketing to exploit their vulnerabilities. Reducing disparities among these populations would contribute to achieving health equity among California's diverse populations.

Use evidence to guide decisions about tobacco control programs, education, and research. Evidence from California and other states demonstrates that comprehensive, sustained, and accountable statewide tobacco control programs reduce tobacco use and tobacco-related diseases and deaths. Data demonstrating the effectiveness of specific approaches should inform the selection of interventions to tackle the same or similar issues.

When data suggest improvements or indicate that adjustments are needed, the costs, outcomes, risks, and benefits of resulting modifications should be carefully evaluated. Research should be conducted to illuminate promising ways to control intractable and emerging tobacco control problems.

Set performance goals for tobacco control programs, education, and research that achieve positive outcomes for Californians and serve as models for other states and nations. Clearly defining goals and objectives for tobacco control with short-term, intermediate, and long-term indicators to measure achievement requires assessing needs and opportunities, strategic planning, and priority setting.

Selected goals and objectives identify targets, drive action, and provide the basis for forming partnerships, gathering resources, mustering support, and coordinating efforts. They supply the framework for collecting baseline, process, and outcome data to measure progress, develop strategies for the future, and foster continuous quality improvement.

Develop, maintain, and enhance training and mentoring to prepare and support health professionals, educators, academics, and advocates from all segments of California's diverse populations for present and future leadership across the tobacco control continuum. Developing and sustaining comprehensive tobacco control in California depends on constantly strengthening and renewing the capacities of the staff, advocates, and volunteers who collectively have the knowledge, skills, and experience needed to achieve success.

In addition to academic, technical, programmatic, and administrative resources, effective tobacco control requires abilities to generate and develop fresh ideas, think critically, build relationships, and work collaboratively within and across various disciplines and cultures.

2012-2014 Master Plan Objectives

1. Raise the tobacco tax
2. Strengthen the tobacco control infrastructure
3. Achieve equity in all aspects of tobacco control among California's diverse populations
4. Minimize the impact of tobacco use on people and of tobacco waste on the environment
5. Prevent initiation of tobacco use
6. Increase the number of Californians who quit using tobacco
7. Minimize tobacco industry influence and activities

Objectives and Strategies for 2012-2014

OBJECTIVE 1: Raise the Tobacco Tax

- Increase the tobacco excise tax by at least $1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least $0.20 of the increase for tobacco control, indexed incrementally to inflation.
- Eliminate untaxed or low-taxed sources of tobacco.
- Evaluate the effects of tobacco tax increases and disseminate findings.

To reduce tobacco use; to prevent tobacco-related diseases, disabilities, and deaths; and to lower healthcare costs, California must enact a new tobacco excise tax with the provisions identified in Objective 1. This is a cost-effective policy intervention.[9, 10, 11]

The Tobacco Education and Research Oversight Committee (TEROC) views an increase in the tobacco excise tax as the cornerstone for achieving the other six 2012-2014 tobacco control objectives and for progressing toward achieving the overarching goals of a 10 percent adult smoking prevalence rate, an eight percent youth smoking prevalence rate, and ultimately a tobacco-free California.

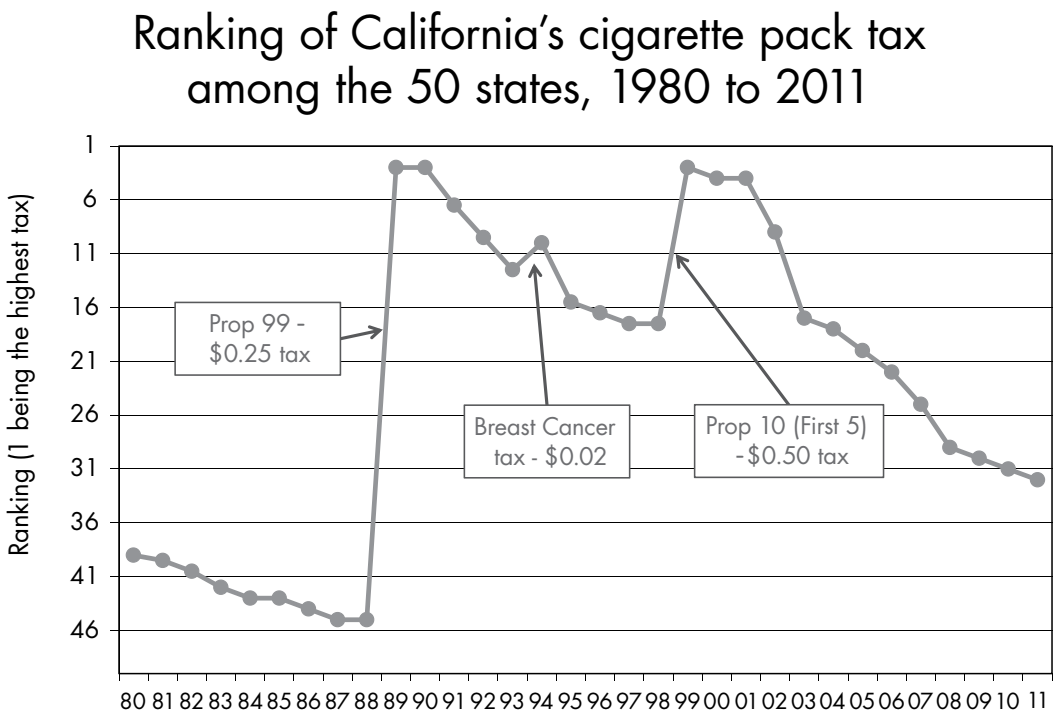
TEROC calls for an increase in the tobacco excise tax of at least $1.00 per pack of cigarettes, with an equivalent tax on other tobacco products, and to specifically designate at least $0.20 of the increase for tobacco control, indexed incrementally to inflation. The evidence clearly shows that the cost of tobacco products matters. As the price of tobacco goes up, consumption goes down. More smokers quit and fewer young people begin using tobacco. Designating or earmarking a portion of the tax increase for comprehensive tobacco control is critical to achieving decreases in consumption, increases in cessation, and the prevention of youth uptake, all of which lead to saving more lives and more money.[12, 13]

In June 2012, Californians narrowly decided not to increase the tobacco excise tax. While TEROC supported Proposition 29, the California Cancer Research Act, TEROC differed from the Proposition in that they strongly recommended that a portion of the increased tax revenue designated for research be allocated to the Tobacco-Related Disease Research Program (TRDRP). TRDRP has supported studies to reduce the harmful effects of tobacco use since the passage of Proposition 99 over two decades ago.

Increasing the excise tax on tobacco is the quickest, simplest, and most effective strategy to increase the price of tobacco. Unfortunately, California has failed to increase its tobacco tax in 13 years and now is one of only three states without an increase since 1999. Because of this neglect, California's tobacco tax, at $0.87 per pack, now ranks 32nd among the 50 states (see Figure 5).[14, 15]

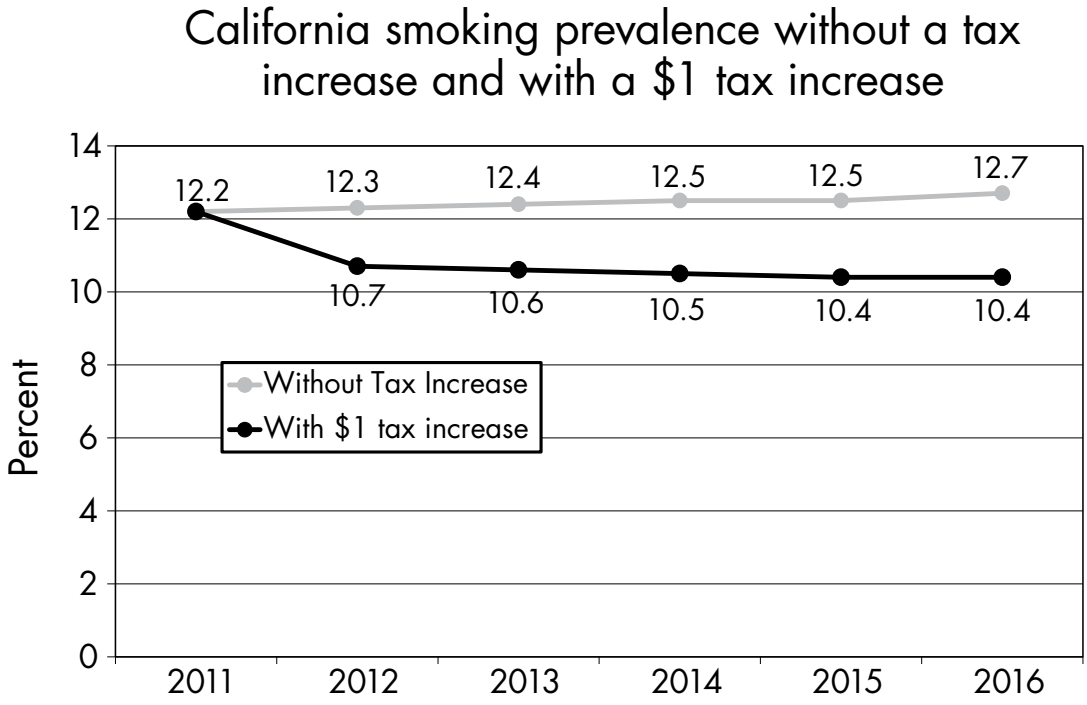
To make matters worse, inflation, combined with price manipulation by the tobacco industry, has reduced the real price of cigarettes in California by approximately $0.63 per pack since 2003. This has diminished the impact of past tax increases on smoking prevalence and cigarette consumption.

Figure 5



Source: The Tax Burden on Tobacco, 2010 and the Campaign for Tobacco-free Kids for 2011.

Figure 6



Source: Max W., Sung H-Y., Lightwood J. 2012.

Benefits of a tax increase. Recent research indicates that increasing the excise tax on tobacco would produce significant benefits:

- Reduced Tobacco Use. If funding for tobacco control is increased to $0.25 per pack ($0.05 from Proposition 99 plus $0.20 from an increase in the tobacco tax), overall smoking prevalence is projected to decline to 10.4 percent by 2016. On the other hand, if tobacco control funding remains at only $0.05 per pack, smoking prevalence is projected to increase to 12.7 percent by 2016 (see Figure 6).[16]

- Lives saved. The long-term health outcome of increasing the tobacco tax by $1.00 would prevent an estimated 35,000 current adult smokers and over 56,000 youth from a smoking-related death[17]. Without a tax increase, smoking-attributable deaths in the states are projected to rise.

- Reduction in lung cancer deaths. California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death.[18] Converting this possibility to reality will require increasing California's tobacco tax and adequately funding tobacco control efforts.

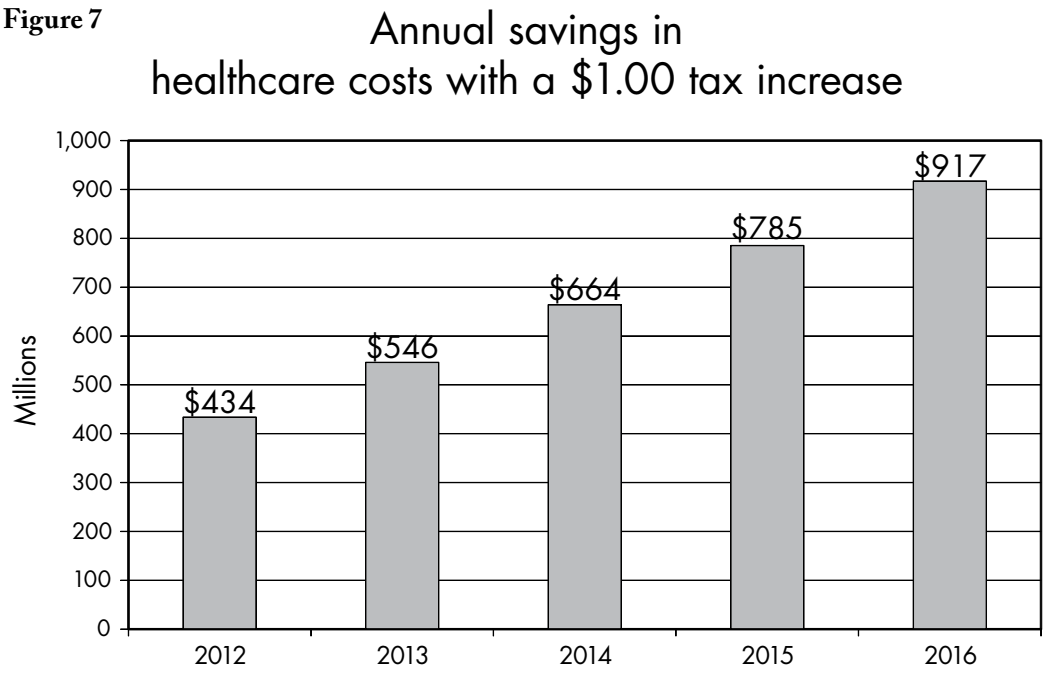
- Savings in healthcare costs. Increasing the tobacco tax by $1.00, with 20 cents earmarked for tobacco control, in 2012 would realize immediate health care savings in California. The lower range estimate is $3.3 billion to be accumulated by 2016 (see Figure 7).[20]

Smoking and Lung Cancer in California

Californians used to smoke more than the rest of the nation, but cigarette consumption began to decline in 1971, with an ever widening gap over time. Lung cancer mortality followed a similar pattern, after a lag of 16 years.

Creation of the California Tobacco Control Program in 1989 doubled the rate of decline in cigarette consumption. However, in 2008, for the first time, both cigarette price and tobacco control expenditures were lower in California than the rest of the nation, suggesting that the gap in smoking behavior will start to narrow. California will have faster declines in lung cancer than the rest of the nation for the next two decades, but possibly not beyond.[19]

Figure 7



Source: Max and Sung, 2011. Note that amounts are in 2009 dollars and the projected cumulative savings from 2012 to 2016 is $3.345 billion.

The California Cancer Research Act

The California Cancer Research Act (CCRA), a statewide ballot initiative, would have increased the excise tax on cigarettes by $1.00 per pack, with $0.20 of the increase specifically designated for tobacco control. Remaining revenues would have supported research to find new ways to detect, treat, prevent, and cure cancer and other tobacco-related diseases. On June 5th 2012, the measure was narrowly defeated by 29,565 votes.

The CCRA was supported by a coalition, "Californians for a Cure," and a steering committee with representatives from the American Cancer Society, the American Lung Association in California, the American Heart Association, the American Stroke Association, the Lance Armstrong Foundation, the Campaign for Tobacco Free Kids, Stand Up To Cancer, and several surgeons and directors of California cancer research institutions.

Ballotpedia, an online encyclopedia states: The "Californians Against Out-of-Control Taxes & Spending" campaign committee was funded by Philip Morris USA and UST LLC, with a Coalition of Taxpayers, small businesses, law enforcement and labor. This committee outspent the "Californians for a Cure" coalition $46.8 million to $12.3 million.

For further information, visit http://www.ballotpedia.org/wiki/index.php/California_Proposition_29,_Tobacco_Tax_for_Cancer_Research_Act.

The tobacco industry commonly argues that raising the excise tax on tobacco is regressive because it would place an unfair burden on the poor. However, because tobacco consumption among the poor is disproportionately high, increasing the excise tax on tobacco will produce the greatest declines in tobacco use among the low income population. This tax is not regressive because individuals are not required to smoke or to use other tobacco products. Increasing the tobacco tax will promote quitting among current tobacco users, prevent relapse, discourage the initiation of tobacco use, and reduce consumption among those who continue to use tobacco. As a result, the health and financial situation of individuals will be improved and there will be a reduction in the exposure of others to secondhand smoke, and a reduction in the amount of tobacco waste added to California's environment.

On a population basis, these changes will result in California saving money on health care costs related to treating tobacco-related diseases among the uninsured and insured as well as mitigating the environmental damage caused by tobacco waste, from fires and water pollution resulting from discarded cigarette butts. For this reason, taxes on tobacco are known as a Pigovian tax—one levied on products or production processes that create excess social costs or pollute the environment. A tobacco excise tax then is an effective and efficient way to offset the societal costs caused by the production and use of tobacco products.

The poor disproportionately consume tobacco.

- The tobacco industry aggressively targets the poor through the pricing, distribution, and advertising of tobacco products.
- Low income smokers make up the greatest proportion of smokers in California.
- The smoking rate among those with a household income lower than $20,000 per year is 19.8 percent compared to 7.8 percent among those with a households over $150,000 year.[21]

Eliminate untaxed or low-taxed sources of tobacco. Increasing the tobacco tax may influence smokers and other users of tobacco products to purchase tobacco from lower or non-taxed sources such as military commissaries, internet stores, other states, and American Indian reservations. Such tax evasion thwarts tobacco control objectives, results in disparities, and may cost the state substantial tax revenues.

Efforts to close such tax loopholes are needed. These may involve supporting or partnering with authorities who have the power to regulate particular venues and to collect taxes. Other approaches to regulate sales of untaxed or low-taxed tobacco can be effective, as demonstrated by the success of the 2005 state and federal agreements with credit card companies and major private shippers to ban payment transactions and shipments for all internet cigarette sales.[22]

Evaluate the effects of tobacco tax increases and disseminate findings. The effects of an increase in the tobacco tax on smoking prevalence, cigarette consumption, and other tobacco use should be evaluated. Related effects on health status, morbidity, mortality, and cost savings should also be studied. Furthermore, research should assess changes in smuggling and the effectiveness of California's Alternative Cigarette Tax Stamp, which has encrypted information and other features to deter contraband cigarette trafficking.[23] Research findings should be widely disseminated to stakeholders throughout California and beyond.

OBJECTIVE 2: Strengthen the Tobacco Control Infrastructure

- Increase communication, collaboration, and resource leveraging among traditional and new tobacco control partners.
- Build leadership and capacity of state and local agencies and health systems to develop, sustain, and contribute to comprehensive tobacco control efforts.
- Increase spending for tobacco control.
- Conduct research and evaluation and disseminate findings to inform tobacco control practice.
- Maintain California's leadership role in ending the global tobacco epidemic.
- Evaluate lives and money saved by tobacco control.

A robust statewide infrastructure for comprehensive tobacco control is essential to sustain and extend the health and economic benefits already achieved and to address new challenges effectively. Strengthening the current infrastructure requires leadership, leveraging public/private partnerships, and adequate financial resources.

Increase communication, collaboration, and resource leveraging among traditional and new tobacco control partners. Frequent and open communication among California's three tobacco control agencies is important for sharing information about progress made toward achieving tobacco control objectives, as well as about programmatic gaps, obstacles encountered, and new opportunities. These exchanges provide the basis for creative problem-solving, collaborative partnerships, resource-sharing, and funding opportunities from federal and philanthropic agencies.

Increased communication is also essential among tobacco control partners—and potential partners—at the state, regional, and local levels. These interactions lay the groundwork for innovative collaborations involving youth and adults, schools and communities, and traditional and new tobacco control partners, including the faith community and social service agencies. Civic engagement is critical to sustaining changes in social norms that make tobacco less desirable, less acceptable, and less accessible.

Build leadership and capacity of state and local agencies and health systems to develop, sustain, and contribute to comprehensive tobacco control efforts. Developing present and future leaders in all aspects and at all levels of tobacco control is fundamental to strengthening and sustaining the infrastructure necessary to realize the vision of a tobacco-free California. Needs identified include:

- Development of tobacco control leadership within racial/ethnic groups and other priority populations that have high rates of tobacco use, exposure to secondhand smoke, and tobacco-related morbidity and mortality.

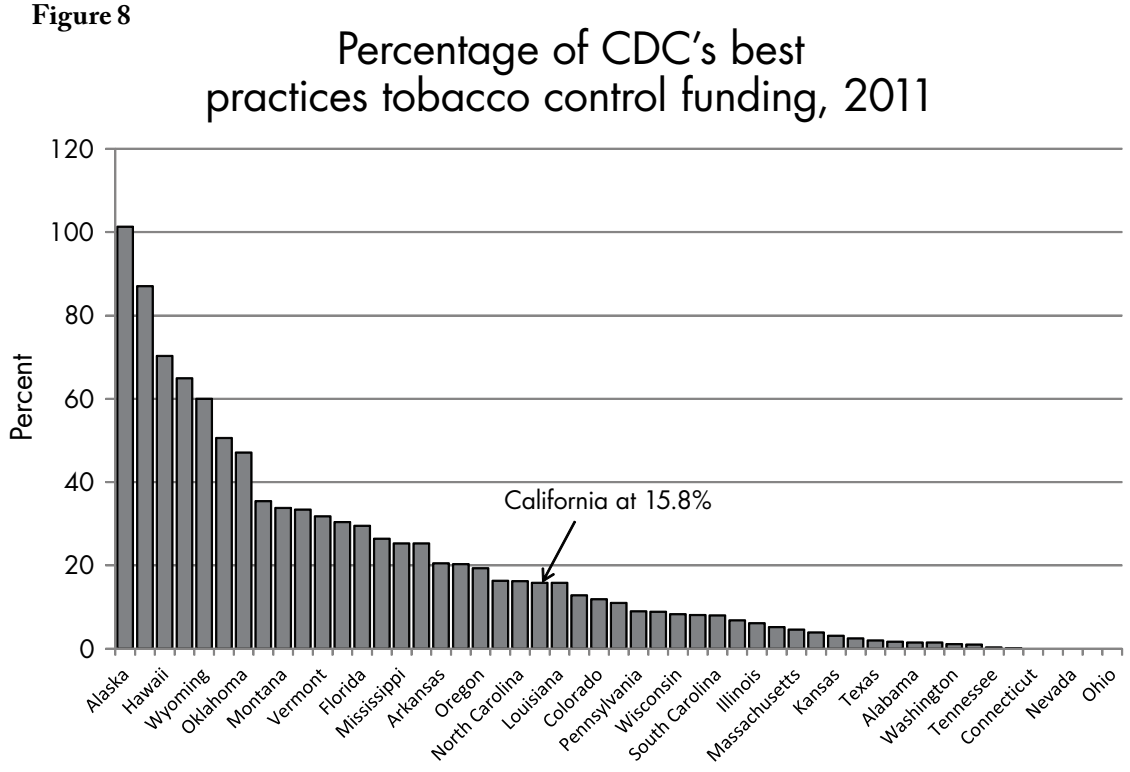
- Involvement of youth from priority populations in tobacco control using developmental strategies, including hands-on experiential participation in anti-tobacco use advocacy.

- Assistance to economically distressed towns, inner city neighborhoods, and rural areas to develop their capacity for tobacco control in the face of scarce resources.

- Identifying ways to effectively engage behavioral health professionals and their clients in tobacco control interventions.

Increase spending for tobacco control. Adequate funding is essential to ensure infrastructure stability, continuity, and momentum. Increased funding would accelerate a decline in smoking prevalence and realize additional health and financial benefits.[24] At present, however, spending on tobacco control in California falls far below the Centers for Disease Control and Prevention (CDC) recommendations of $441.9 million annually (see Figure 8).[25] California earned an "F" on the American Lung Association's 2010 Report Card on its spending for tobacco prevention and control.[26]

Figure 8



Source: Campaign for Tobacco-Free Kids, 2011.

Conduct research and evaluation and disseminate findings to inform tobacco control practice. Research is needed on effective and culturally appropriate tobacco control strategies for priority populations with high rates of tobacco use and exposure to secondhand smoke. Evaluation of approaches employed should identify promising practices and critical factors that need to be considered in intervention design and delivery. In addition, lessons learned about the development, adoption, reach, effectiveness, and enforcement of tobacco control policies in diverse communities should be disseminated.

Maintain California's leadership role in ending the global tobacco epidemic. California can continue to provide national and worldwide leadership in tobacco control by developing policies and programs that serve as models for others, by evaluating the effectiveness of state and local tobacco control efforts, and by conducting cutting-edge research to inform practice and increase understanding of new and complex problems related to tobacco use and secondhand smoke exposure.

In addition, the State of California and organizations within it can support ratification and implementation of the World Health Organization's Framework Convention on Tobacco Control (FCTC),[27] implement articles within it,[28] and link tobacco control initiatives to global health efforts, particularly by using United Nations' treaties that establish human rights to be free of harm to health and welfare.

TEROC Supports Concurrent Resolution 129

Concurrent Resolution 129, adopted by the California Legislature in 2010, requests the California Attorney General to help prepare accurate reports to be filed with the appropriate monitoring bodies to fulfill reporting obligations under the FCTC treaties.

TEROC endorses the preparation, filing and dissemination of these reports, most notably:

- The *International Convention on the Elimination of All Forms of Racial Discrimination* which recognizes the human right of equal treatment under the law without distinction for race, color, national, or ethnic origin. Violations of this treaty include:
    - The development of mentholated tobacco products and their targeted marketing to youth and racial/ethnic minorities in the United States.
    - The exemption of menthol cigarettes from the federal *Family Smoking Prevention and Tobacco Control Act*.
- The *International Covenant on Civil and Political Rights*, which recognizes the human right to life. Violations of this treaty by tobacco companies include:
    - Targeting tobacco products to particular populations through pricing, marketing and distribution practices.
    - Interference in tobacco control policymaking through financial donations to elected officials, sponsorship of organizational events, and other activities.

OBJECTIVE 3: Achieve Equity in All Aspects of Tobacco Control among California's Diverse Populations

Adopt and enforce tobacco control policies to create health equity.

- Incorporate equity and cultural competency standards in all tobacco control agencies, programs, processes, practices, and infrastructures.
- Increase the involvement and competencies of priority populations in tobacco control.
- Strengthen the capacity of agency personnel to reduce tobacco-related disparities.
- Conduct evaluation and research to reduce tobacco-related health disparities and to measure progress toward achieving health equity and social justice.

As stated in the Principles for Tobacco Control, some priority populations in California include:

- African Americans, other people of African descent, American Indian and Alaska Natives, some Asian Americans, and Hispanics/ Latinos;
- people of low socioeconomic status, including the homeless;
- people with limited education, including high school drop-outs;
- lesbian, gay, bisexual, and transgender (LGBT) people;
- rural residents;
- members of the military and individuals employed in jobs or occupations not covered by smoke-free workplace laws;
- people addicted to alcohol and other drugs;
- the mentally ill;
- people with disabilities; and
- formerly incarcerated individuals.

Priority populations are groups that have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are more targeted by the tobacco industry, and have higher rates of tobacco-related disease compared to the general population.

Achieving equity in tobacco control will require societal, organizational, and individual leadership that embraces the powerful integration of science, practice, and policy to create lasting change.[29] Contributions in all of these realms are needed from California's elected leaders; tobacco control agencies; priority population groups; state, local, and tribal governments; community organizations; health, education, and social service providers; business; labor; academia; and grassroots movements.

Raising the tobacco tax—Objective 1—is a pivotal intervention because price increases reduce smoking more among lower-income smokers than among those with higher-incomes.[30] Increasing the tobacco tax thus will reduce socioeconomic disparities in the prevalence of tobacco use and then in tobacco-related diseases and deaths.[31] Other objectives in this Master Plan also have important roles in achieving equity and social justice in

tobacco control and in reducing disparities. For example, increasing the tobacco tax will provide funding for interventions aimed at achieving all of the Master Plan objectives.

Adopt and enforce tobacco control policies to create health equity. The tobacco industry targets its products, pricing strategies, and marketing practices to priority populations in very sophisticated ways. A number of studies have found links between the density of tobacco retail outlets and socio-economically disadvantaged communities, African American communities, and youth tobacco use.[32]

The number of tobacco retailers and proximity to schools in California urban areas has been associated with experimental smoking among high school students.[33]

Contrary to claims of the tobacco industry that the promotion of its products is not based on race/ethnicity, another study found that targeted advertising in California high school neighborhoods exposes Blacks to more promotions and lower prices for the leading brand of menthol cigarettes.[34]

Therefore, adopting and enforcing policies that restrict such practices is critical. Policies that contribute to creating health equity include tobacco retail licensing, conditional use permits, and the prohibition of free or low-cost coupons, rebates, gift cards, and gift certificates for tobacco products.

Incorporate equity and cultural competency standards in all tobacco control agencies, programs, processes, practices and infrastructures. Instituting meaningful equity and cultural competency standards requires understanding cultures as multilevel, multidimensional, dynamic systems involving particular populations. Because the responses of these systems to geographic, social, and political circumstances vary, cultures and sub-cultures evolve differently.[35] One important equity and cultural competency standard is that tobacco control interventions must be designed and evaluated in partnership with the communities of focus to ensure that policies, programs, and services are feasible within the social and cultural determinants of their lifestyle.

Increase the involvement and competencies of priority populations in tobacco control. Priority populations should be represented at all personnel levels in California tobacco control agencies. In addition, CDPH/CTCP, CDE/CSHSO and TRDRP each should develop program-specific plans to reduce tobacco-related health disparities.

Local health departments and local education agencies are expected to engage leaders from priority populations in helping to assess equity gaps in tobacco control and to identify interventions and collaborations needed to facilitate the reduction of local or regional disparities. Members of priority populations active in tobacco control should be encouraged to support strategies that are culturally responsive to the needs of the populations they represent.

Involving priority populations in developing, implementing, and evaluating innovative community, school, and media initiatives is critical. Involvement should include training, mentoring, funding and empowering priority population participants to increase their knowledge, skills, and confidence to provide increased leadership in tobacco control over time. In addition, TRDRP should train and support community and school teams involving priority populations to address tobacco-related health disparities through collaborative research and evaluation projects.

Knowledgeable members of priority populations should be included as equal and valuable partners in local, state, and national conferences, workgroups,

committees, and other interactions concerned with tobacco control advocacy, education, media, policy, programs, services, grant application reviews, and research.

Strengthen the capacity of agency personnel to reduce tobacco-related disparities. Capacity to contribute to reducing tobacco-related disparities should be increased among the personnel of agencies and institutions that work or could work with priority populations. These include public health departments, healthcare systems, local education agencies, social service providers, housing agencies, offices for Veterans' Affairs, voluntary agencies, colleges, universities, and other research institutions.

> Focusing efforts on the identification and elimination of tobacco-related disparities may close the gaps in prevalence of tobacco use and access to effective treatment, thus alleviating the disproportionate health and economic burden experienced by some sectors of the population.[36]

Personnel in these agencies and institutions should be informed about tobacco-related disparities, initiatives to reduce them, progress being made, and opportunities for their involvement. Methods for disseminating this information include conferences and workshops; networking; broadcast, print, and social media; and one-on-one or small group interactions. Showcasing contributions to tobacco control projects by members of priority populations will help to model collaborative relationships and foster new ones.

Additional strategies should include training agency personnel to incorporate culturally competent approaches to reducing disparities in their daily work, as well as quality improvement initiatives and new programs, services, and research.

Conduct evaluation and research to reduce tobacco-related health disparities and to measure progress toward achieving health equity and social justice. Health departments, local education agencies, and recipients of CTCP, CDE, and TRDRP grants should be required to describe and report the involvement of priority populations in their tobacco control efforts.

The effectiveness of interventions to reduce tobacco-related disparities in various priority populations should also be assessed, including the adequacy and cultural appropriateness of the resources used in project implementation. Metrics to measure progress in reducing disparities and achieving equity should be developed and applied, while lessons learned and suggestions for improvement should be identified and disseminated.

For example, can an intervention program that is highly effective in reducing the prevalence of an unhealthy behavior in the general population also reduce disparities among its subgroups? Analysis of the effects of three components of the CTCP (media, worksite policy, and price) on smoking prevalence in groups with the lowest and highest education show that the answer depends on the measure of disparity used.

The rate of decline in smoking prevalence from 1996 to 2005 was as great for the low education group as for the high education group. However, basing analysis of disparity on *relative* difference could result in erroneous conclusions. Such analysis might conclude that an intervention like the California Tobacco Control Program needs to change from its current whole-population approach

to one that focuses on targeting subgroups because it has not reduced relative disparity. This analysis concluded that research should focus more on increasing the *rate of change* among less advantaged groups and less on the relative disparity of one group compared to another.[37]

TRDRP should encourage and support research to assess and reduce tobacco-related disparities and to develop research expertise in priority populations. Multi-disciplinary projects that integrate the perspectives of social epidemiology and community-engaged interventions should be undertaken and tested to determine their potential for improving health equity.[38] Other areas of research with strong potential to reduce tobacco-related disparities include:

- Studies to expose, prevent, and reduce activities of the tobacco industry that target priority populations.
- Identification of factors related to the initiation, maintenance, and cessation of tobacco use in priority populations.
- Highlighting relationships between health insurance coverage, access to resources and aids for tobacco cessation, access to health care, and disparities in morbidity and mortality from tobacco-related diseases.
- Examining the perspectives of priority populations on tobacco-related problems and tobacco-control efforts.
- Assessing the involvement of priority populations in tobacco control.

An example of this research concerns menthol cigarettes, which represents 20 percent of the market share.[39] Menthol smokers tend to be female, younger, members of ethnic minorities, have only a high school education, and buy packs rather than cartons.[40]

Close to 30 percent of all menthol smokers are African American.[41] Since the 1970s, brand names like Kool, Newport, and Salem have been marketed to the African American community in campaigns falsely suggesting that smoking menthol flavored cigarettes is cool, hip, fresh, fun, and less risky than smoking regular cigarettes.[42]

In combined 2004 to 2008 data, 82.6 percent of African American, 53.2 percent of Native Hawaiian/ Pacific Islander, 32.3 percent of Hispanic/Latino, 31.2 percent of Asian, 24.8 percent of American Indian/Alaska Native, and 23.8 percent of White smokers aged 12 years and older reported using menthol cigarettes in the past month.[43]

A 2010 survey found that only 59 percent of Americans were aware of racial and ethnic disparities that disproportionately affect African Americans and Hispanics/Latinos--a very modest increase over the 55 percent awareness recorded in a 1999 survey. The survey also revealed low levels of awareness among racial and ethnic minority groups about disparities that disproportionately affect their own communities.[44]

Data on tobacco-related inequities and progress in eliminating them should be widely disseminated throughout California to raise awareness and stimulate involvement in reducing disparities.

OBJECTIVE 4: Minimize the Impact of Tobacco Use on People and of Tobacco Waste on the Environment

- Regulate secondhand smoke as a toxic air contaminant.
- Remove exemptions and close loopholes in California's smoke-free workplace laws.
- Enforce existing tobacco-free laws and policies.
- Adopt and enforce additional policies to minimize secondhand smoke exposure and the impact of tobacco waste on the environment.
- Conduct research and disseminate findings to advance knowledge about the harms of tobacco use.

Tobacco control efforts initially focused on reducing the negative health consequences of tobacco on users. The field then expanded to include the negative health effects of secondhand smoke exposure on nonsmokers. Interest remains in further minimizing these impacts as well as addressing new and emerging issues, such as the harmful effects of tobacco litter on the environment and the use of, and exposure to, new tobacco products.

The negative health and economic effects of smoking, other tobacco use, and exposure to secondhand smoke are well-documented.[45] Researchers are still investigating the toxic effects of tobacco waste on the health of people, domestic animals, wildlife, and the environment. However, the blight caused by cigarette butts, tobacco wrappings, and smokeless tobacco product waste scattered on sidewalks and in streets, parks and other outdoor places is widely recognized. Clean-up costs for state, regional, and local governments are staggering. Non-biodegradable cigarette filters carried as runoff to drains, rivers, and ultimately the ocean are the single most collected item in international beach cleanups each year.[46] California can protect the environment and save taxpayers money by reducing tobacco litter.

Regulate secondhand smoke as a toxic air contaminant. Minimizing exposure to secondhand smoke will protect health, save lives, and produce major savings in healthcare costs. Each year, exposure to smoke from other people's cigarettes causes over 4,000 non-smokers in California to die from cancer, heart and lung disease, and other diseases.[47]

Children exposed to secondhand smoke in their homes, cars, and elsewhere are at high risk for Sudden Infant Death Syndrome (SIDS), ear infections and chronic middle ear disease, severe asthma attacks, upper and lower respiratory infections, impaired lung function growth, cognitive impairment, and other developmental impacts. Direct medical costs from exposure to secondhand smoke among United States children exceeds $700 million per year.[48]

In 2006, the United States Surgeon General reported that there is no risk-free level of exposure to tobacco smoke.[50] That same year, the California

Air Resources Board classified secondhand smoke as a Toxic Air Contaminant—the same classification as diesel exhaust.[51] However, the Board has not issued regulations to control this toxin.

California citizens should encourage the California Air Resources Board to issue strong regulations without further delay. Based on its 2006 findings, the California Air Resources Board should act to eliminate all smoking in public places and to declare tobacco smoke a public nuisance.

No Risk-Free Level of Exposure to Tobacco Smoke

The harmful effects of smoking do not end with the smoker. Every year, thousands of nonsmokers die from heart disease and lung cancer, and hundreds of thousands of children suffer from respiratory infections because of exposure to secondhand smoke. There is no risk-free level of exposure to tobacco smoke.[49]

Remove exemptions and close loopholes in California's smoke-free workplace laws. In 1994, California passed the nation's first comprehensive smoke-free workplace law (Labor Code Section 6404.5), but exemptions and loopholes in this and other related state laws[52] leave some employees unprotected from secondhand smoke. These include workers in the service industry and small businesses. Labor Code 6404.5 established more than a dozen exemptions which identify where smoking in the workplace is still permitted. As a result, low income, Hispanics/Latinos, and young adults have much higher rates of exposure to secondhand smoke in the workplace than others.[53] Additionally, California is not recognized by the Centers for Disease Control and Prevention as one of the current 25 smoke-free states. This problem can and should be remedied by the California Legislature.

Another example of a workplace where workers and the public are not protected from secondhand smoke exposure is American Indian casinos. The lack of uniform protection from secondhand smoke exposure for workers employed in the American Indian gaming industry and in other places creates health inequities based on employment. Such inequities can be resolved by adopting smoke-free workplace policies at all worksites.

California tobacco control agencies, advocates, and citizens need to join forces to promote 100 percent smoke-free workplace legislation. Such policies are crucial to reducing tobacco-related disparities among priority populations, including low-income Hispanic, African American, and American Indian workers.

Enforce existing tobacco-free laws and policies. Despite the loopholes in California's smoke-free workplace laws, the state and many local jurisdictions have passed laws or adopted voluntary policies to restrict tobacco use in indoor and outdoor public places, including restaurants, schools, vehicles with children in them, parks, beaches, and even multi-unit housing complexes.

To advance toward a tobacco-free California, mechanisms are needed to ensure enforcement and to prevent pre-emption of these laws and policies. These approaches should be complemented by media messages and other efforts to increase voluntary compliance with both tobacco-free laws and voluntary policies.

Adopt and enforce additional policies to minimize secondhand smoke exposure and the impact of tobacco waste on the environment. California government bodies at all levels

Local Smoke-Free Policies in California

As of October 2010:

- 37 California cities and counties had passed comprehensive ordinances to prohibit or restrict smoking outdoors, including in entryways, service areas, sidewalks, worksites, outdoor dining areas, recreation areas, and at public events.

As of January 1, 2011:

- 85 California municipalities had passed ordinances to restrict smoking in at least some outdoor dining areas.
- 273 California municipalities had adopted policies to restrict smoking in at least some recreation areas beyond the requirements set by state law.

As of November 2011:

- 45 California cities and counties had passed an ordinance prohibiting smoking in part or all outdoor common areas of multi-unit housing complexes, such as outdoor eating areas, play areas, courtyards, and swimming pools.

For further information and updates, go to http://www.center4tobaccopolicy.org.

should be encouraged to adopt and enforce additional policies to protect the public from secondhand smoke. One approach would be to encourage more local jurisdictions to implement tobacco-free areas. Businesses, unions, civic and philanthropic organizations, resident associations, and other groups should also be encouraged to adopt voluntary policies that limit tobacco use. Community members who have not yet voluntarily adopted tobacco-free policies for their homes should be persuaded to join the growing number of Californians who have done so.

Statewide legislation can comprehensively protect all Californians from secondhand smoke exposure. Closing the exemptions and loopholes in California's smoke-free workplace law is a first step, but other policy areas which can provide substantial benefit include multi-unit housing and outdoor smoke-free policies. Statewide legislation is needed to eliminate smoking in state parks not only to protect the public but also to reduce environmental damage, including forest fires.

Conduct research and disseminate findings to advance knowledge about the harms of tobacco use. TRDRP should encourage and support research on questions about the harmful effects of tobacco use on people and the environment, and on changing social norms for a tobacco-free California. One priority is studying the effects of environmental tobacco smoke on priority populations such as residents of low-income multi-unit housing. Scientific studies also are needed to assess the health, environmental, social, and economic harms of new and alternative tobacco products, including flavored little cigars and cigarillos, hookah, and e-cigarettes. Studies are also needed on emerging additional risks from use of dissolvable tobacco products.

Additionally, investigations are needed on the health, environmental, and economic effects of tobacco product litter. Based on an assessment conducted in San Francisco, direct abatement costs are estimated to range from $0.5 million to $6 million per year without considering the

Secondhand Smoke Exposure and Breast Cancer Risk

The classification of secondhand smoke as a Toxic Air Contaminant by the California Air Resources Board was based on part A of a report it prepared for the California Environmental Protection Agency (Cal/EPA). Part B, prepared by Cal/EPA's Office of Environmental Health Hazard Assessment, concerned the health effects of exposure to environmental tobacco smoke. This section included pooled risk estimates of association between exposure to secondhand smoke and breast cancer, concluding that these could represent a significant number of breast cancer cases. The full report was approved by a Scientific Panel on Toxic Air Contaminants in June 2005.[54]

Recent analysis of data from the California Teachers Study suggest that cumulative exposures to high levels of side stream smoke may increase breast cancer risk among postmenopausal women who themselves have never smoked tobacco products.[55]

A Canadian Expert Panel recently concluded that the association between secondhand smoke exposure and breast cancer among younger, primarily premenopausal women who have never smoked suggests a cause and effect relationship.[56]

economic effects of tobacco waste on tourism and environmental pollution.[57] Studying policy options for covering the costs of dealing with litter is important, especially since the passage of Proposition 26 makes it more difficult for local jurisdictions to levy fees for this purpose.[58, 59]

Research is also needed on third-hand smoke, the cocktail of toxins that clings to skin, hair, clothing, upholstery, carpets, and other surfaces long after cigarettes or cigars are extinguished and secondhand smoke dissipates.

Existing evidence provides strong support for pursuing research to close gaps in the current understanding of the chemistry, exposure, toxicology, and health effects of third-hand smoke, as well as related behavioral, economic, and socio-cultural consequences.[60] Effects on children are a particular concern because they frequently touch and put their mouths on contaminated surfaces, breathe at a faster rate, have smaller lung capacity, and thus ingest about twice as much dust as adults.

Analysis of citations in 1,877 articles on secondhand smoke published between 1965 and 2005 revealed a gap in the continuum between the discovery of risk factors and the delivery of interventions to reduce them. The quality and speed with which scientific discoveries are translated into practice needs to be improved. Research summaries, such as Surgeon General's reports, were cited frequently and appear to bridge the discovery-delivery gap.[61]

To hasten the translation of research into practice, findings from investigations on these and other topics related to the harms of tobacco use and exposure should be disseminated as soon as possible through the media and other channels to policy-makers, advocates, health and school personnel, scientists, and the general public.

OBJECTIVE 5: Prevent the Initiation of Tobacco Use

- Encourage collaborative community-school programs to prevent tobacco use.
- Increase the number of tobacco-free schools.
- Engage youth and young adults in tobacco control.
- Build capacity for preventing tobacco use.
- Counter tobacco industry actions.
- Support research and evaluation to strengthen tobacco use prevention.

During the past 23 years, California's comprehensive tobacco control program has led to a decline in the prevalence of youth smoking and an increase in the average age of initiation. This important trend can be accelerated through enhanced coordination of CTCP, CDE, and TRDRP efforts; increased collaboration among community tobacco control programs, schools, and youth organizations throughout the state; and resource leveraging at all levels.

Promising strategies for preventing the onset of tobacco use are identified below. These approaches are supported by the principles identified in this Master Plan and complemented by its other objectives.

- Increasing the tobacco tax would make it more difficult for price-sensitive young adults to purchase tobacco and for children and adolescents to ask that others buy it for them.[62]
- Increasing the involvement of priority populations in tobacco control would provide at-risk youth with both opportunities to contribute to these efforts and positive role models.
- Expanding the adoption and enforcement of tobacco-free laws and policies would accustom more children and youth to tobacco-free environments and decrease role-modeling of tobacco use.[63]
- Reducing the influence and activities of the tobacco industry would disrupt its concerted efforts to recruit new generations of addicts.

Encourage collaborative community-school programs to prevent tobacco use. The knowledge, attitudes, and behaviors of young people are influenced by what they learn and observe in their homes, schools, and communities. Accordingly, collaborative community-school programs should be undertaken to prevent tobacco use, particularly in poor and underserved areas with high numbers of young people from priority populations.

Public and private schools of all types are candidates for involvement in preventing tobacco use. CDE's, Local Education Agencies (LEAs), which include County Offices of Education (COEs), K-12 public schools, and direct-funded charter schools, should be encouraged to develop school-community collaborations. Other possibilities include partnerships that involve K-12 private schools, youth drug and alcohol prevention programs, continuation schools, technical and vocational schools, military schools, colleges, and

universities. Community-based participants in these partnerships could include not only tobacco control programs and coalitions, but also youth organizations, sports and recreation departments, agencies serving young adults, those working with school drop-outs, and specialized training programs.

To develop these collaborations, opportunities should be created for schools and community organizations to share observations, insights, ideas, resources, and concerns related to tobacco control. A prime focus of discussion should be how groups can support, reinforce, and complement each other's efforts. Training and technical assistance should be provided to help interested parties develop, sustain, grow, and learn from school-community partnerships. Youth and their families, friends, and neighbors should be involved in meaningful tobacco control activities.

As recommended by the Guide to Community Preventive Services,[64] community mobilization should be combined with additional interventions to reduce tobacco use among youth. These additional interventions could include community-wide education, policies that restrict retail sales of tobacco products, and enforcement of policies against youth purchase, possession, or use of tobacco. Experiences and outcomes of collaborative programs should be shared at local, regional, and state levels.

Increase the number of tobacco-free schools. Achieving tobacco-free certification for 100 percent of LEAs and increasing the number of other schools that adopt and enforce a tobacco-free policy should be priorities for prevention during 2012-2014. *All* schools should be tobacco-free to protect students, provide peer and adult role models who do not use tobacco, limit youth access to tobacco, and

A Community-School Partnership in Stanislaus County

PHAST—pronounced "fast"—is a youth coalition dedicated to Protecting Health And Slamming Tobacco through peer education and advocacy projects in schools and communities throughout Stanislaus County. Coalition goals are to:

- build skills in peer tobacco education through participation in training events such as the annual PHAST Tobacco Slam, Youth Quest, and local community advocacy trainings.
- conduct peer education activities on campus through classroom presentations and events such as the Great American Smokeout, Lose the Chew Day, and Kick Butts Days.
- conduct community education and advocacy activities such as making off-campus presentations to middle and elementary school students; hosting educational booths at Farmers Markets, parades, and other community events; participating in health promotion programs such as Turlock Family Fun Day and Relay for Life; and educating civic organizations, community leaders, and elected officials about the importance of supporting tobacco prevention efforts in the community.

discourage the formation of groups brought together by tobacco use on school grounds and at school events. Therefore, communities should collaborate with LEAs not certified as tobacco-free —as well as private schools, technical and vocational schools, military schools, and colleges and universities —to adopt and enforce policies prohibiting tobacco use in school buildings, on school grounds, and in school vehicles.

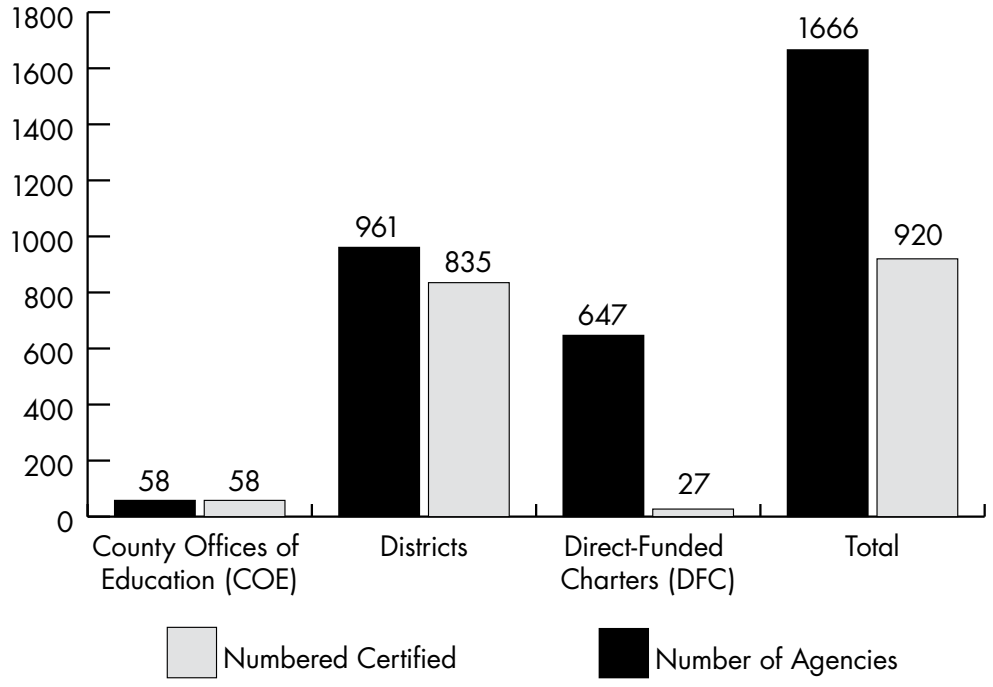
Research has shown that consistently enforced tobacco-free school policies are associated with decreased smoking prevalence among adolescents.[65] Nevertheless, at present, California legislation requires only LEAs that receive Proposition 99 funding for tobacco use prevention education (TUPE) to have and enforce comprehensive tobacco-free school policies. Cuts in CDE funding have reduced the number of schools that must meet this requirement.

The Coordinated School Health and Safety Office (CSHSO) of the CDE has guidelines on its Web site to support LEAs in developing, adopting, enforcing, and monitoring tobacco-free school policies. The CSHSO also has developed a process for certifying schools as being in compliance with tobacco-free requirements. As of 2011, approximately 55 percent of LEAs in California have adopted a tobacco-free policy and the LEAs that enforce this policy serve 92 percent of the K-12 student population in California public schools. In addition, all County Offices of Education, 87 percent of school districts, and four percent of direct-funded charter schools currently are certified as tobacco-free (see Figure 9).

The CSHSO guidelines can be used by schools, parents, and community coalitions to help educational institutions outside the CDE become tobacco-free. For more information visit: http://www.cde.ca.gov/ls/he/at/tupe.asp.

Engage youth and young adults in tobacco control. Encourage schools, communities, youth organizations, and advocates to involve youth and young adults in tobacco control activities appropriate for their age, interests, and skills. This

Figure 9



Close Loopholes in Tobacco-Free School Legislation

Health and Safety Code Section 104220(n)(1)&(2)requires only County Offices of Education, School districts, and direct-funded charter schools that receive Proposition 99 funding for tobacco use prevention education to adopt and enforce a tobacco-free campus policy. These legislative loopholes create health inequities in California's public schools and schools not eligible for Proposition 99 funding, such as private schools.

is important to develop California's next generation of tobacco-free advocates who will support future tobacco control efforts.

Youth development strategies[66] should be used to involve middle- and high-school students in advocacy for tobacco-free policies, peer education about the deceptive practices of the tobacco industry and the harms of tobacco use, school and community tobacco control surveys, and other activities such as Stop Tobacco Access to Kids Enforcement (STAKE) Act enforcement.

To ensure that recipients of Tobacco Use Prevention Education (TUPE) grants engage and involve significant numbers of youth from priority populations in tobacco control efforts, CDE should require them to annually report the number of youth, disaggregated by priority population, that have participated in tobacco-related youth development programs.

Youth who are not in school are at higher risk for tobacco use, so special efforts are needed to engage them in prevention programs.

Because the age of tobacco use onset has increased and the prevalence of young adult smoking is high, developing effective ways to involve this age group in tobacco use prevention programs and tobacco control activities is another priority.[67]

California Youth Advocacy Network

The California Youth Advocacy Network (CYAN), an organization founded to provide meaningful opportunities for youth leadership and involvement in California's revolutionary tobacco control program, engages youth and young adults, whether in or out of school, in tobacco control activities. Current initiatives include:

- uniting youth against the tobacco industry.
- promoting tobacco-free colleges and universities in California.
- building a collaborative bridge between military and civilian tobacco control.
- leading the Tobacco and Hollywood Campaign to eliminate smoking from movies rated G, PG, and PG-13.

Build capacity for preventing tobacco use. CDE is encouraged to provide training and technical assistance to increase the capacity and cultural competence of personnel in schools and community-based organizations to prevent tobacco use among youth and young adults. Assistance should be provided to schools to focus prevention efforts on youth whose school performance is at or below average, who are rebellious, who are "sensation seeking," and who are otherwise at high risk for using tobacco. More importantly, prevention efforts should be targeted to youth who begin smoking cigarettes at or before seventh grade. Early onset cigarette smoking among youth has become a marker for other risk behaviors and problems.[68]

An analysis of 2003-2005 data from the California Healthy Kids Survey (CHKS) involving over 560,000 students across California indicates that current smokers are significantly more likely than nonsmokers to engage in alcohol and other drug (AOD) use, be involved in violence and gang membership, and experience school-related problems and disengagement.[69] To a lesser extent, current smokers are also more likely than nonsmokers to be victims of violence and harassment, feel unsafe at school, and experience incapacitating sadness and loneliness.[70]

These results suggest that efforts to reduce student smoking will be more successful if embedded in approaches that address a broad range of risk behaviors and problems. Cigarette smoking is a marker for other problem behaviors especially among seventh graders, suggesting that early onset smokers are particularly in need of a broad range of prevention services.

Counter tobacco industry actions. All organizations involved in tobacco control should urge the United States Food and Drug Administration (FDA) to ban menthol cigarettes and all other flavored tobacco products. Menthol flavoring is considered the tobacco industry's "starter" ingredient[71] because its anesthetizing effect masks the harshness of tobacco smoke, making it "smooth" and easier to inhale.[72] A wide variety of little cigars, smokeless tobacco, and other tobacco products also are available in menthol.

California's social norm change approach to tobacco control includes challenging the film industry's portrayal of tobacco use in movies, especially those popular among young viewers. Important progress has been made in reducing the depiction of smoking in top-grossing youth rated films, but in 2010, youth-rated movies still accounted for more than 40 percent of the smoking impressions delivered to U.S. theater audiences.[73] These data indicate that the State of California must stop paying subsidies to film producers in the state who show tobacco use in movies and television productions.

TUPE grantees should be prohibited from using smoking prevention materials produced, sponsored, or distributed by the tobacco industry, and their use by all other LEAs, schools, and community organizations should be strongly discouraged.[74] All institutions and agencies that involve or serve youth and young adults should reject funding from the tobacco industry. Helping organizations to develop alternative sources of funding may be an effective intervention.

Support research and evaluation to strengthen tobacco use prevention. Increasing the number of LEAs that conduct the California Healthy Kids Survey, will assist with evaluating the outcomes of tobacco use prevention interventions and identifying the program components, processes, other variables that contribute to or compromise effectiveness. A key goal is to develop and implement a plan to disseminate the results of tobacco-related youth prevalence measures throughout California.

Evaluate the outcomes of tobacco use prevention interventions and identify the program

components, processes, other variables that contribute to or compromise effectiveness. It is important to implement programs to discourage initiation of tobacco use by youth from priority populations, and to evaluate the effectiveness of these programs when used by diverse populations in many different environments.

Since the release of the first Healthy People report,[75] many school and community-based interventions have been developed to prevent the onset of tobacco use. Evaluations over more than two decades have identified important directions to pursue, as well as strategies to be avoided.[76, 77, 78, 79, 80] Although the fidelity with which these prevention programs are implemented is still a concern,[81] more emphasis is needed on translation and dissemination. Evaluations should examine how programs are adapted for youth and environment with different characteristics, and the resulting outcomes. Success stories and model programs should be widely publicized.

Research should be conducted to identify factors that contribute to the resilience of youth and young adults against tobacco use, especially when their environments put them at high-risk of experimentation and development of addiction. Another area for investigation is the relationships between the onset of tobacco use and the initiation of other risky behaviors, including alcohol and marijuana use.

Developing Novel Strategies for School Based-Tobacco Prevention

With funding from TRDRP, Bonnie Halpern-Felsher, Ph.D, is leading the development of a Consortium committed to tobacco control education and to the development of novel, developmentally appropriate, and comprehensive school-based prevention strategies. Partners include:

- elementary, middle and high schools,
- youth and parents,
- county tobacco control coordinators and health educators,
- representatives from CDE, TEROC, and CTCP,
- investigators at the University of California, San Francisco.

The Consortium will analyze and synthesize results of focus groups held with teachers, middle and high school students, parents of K-12 students, and school officials. During this process, novel tobacco education messages and delivery strategies will be identified, and the best forum for applying these findings will be identified. Stakeholders will ensure that new programs developed will meet school guidelines and are developmentally appropriate, feasible within the school setting, and acceptable to funding agencies.

OBJECTIVE 6: Increase the Number of Californians Who Quit Using Tobacco

- Boost the number and frequency of quit attempts across populations.
- Expand the availability and utilization of cessation aids and services.
- Engage health care providers in helping patients quit.
- Promote tobacco cessation through multiple channels.
- Conduct research and evaluation to strengthen cessation interventions.

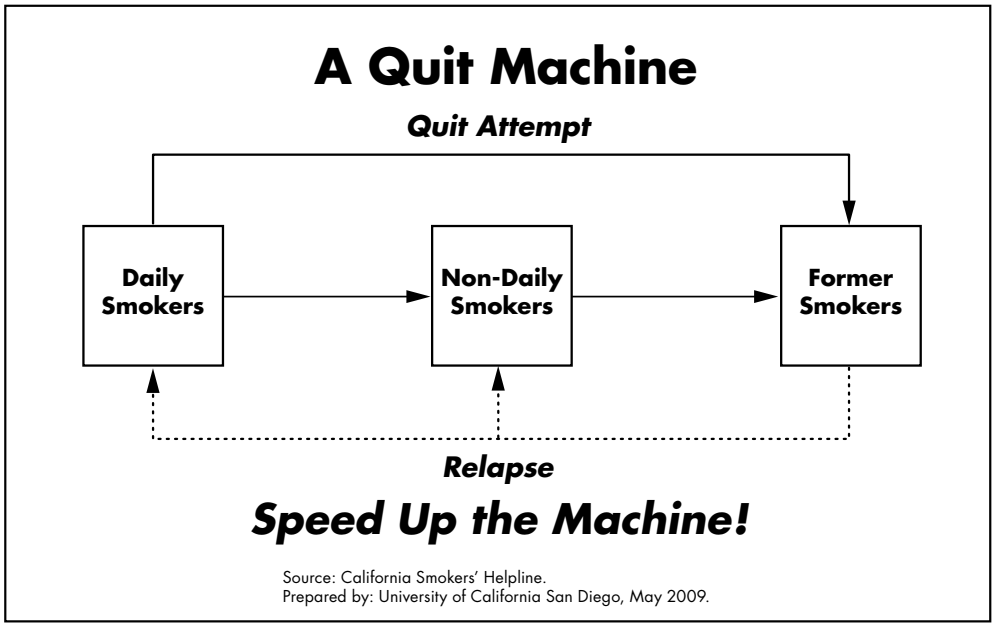
The population-based *Tobacco Quit Plan for California*,[82] developed during a landmark cessation summit convened by the CTCP in May 2009, has been an important influence on the formulation of this objective and key strategies to achieve it. A central theme of the summit was the need to increase both aided and unaided quit attempts, since it is the frequency—not efficacy -- of quit attempts which is the primary determinant of cessation on the population level. Strategies recommended in the *Tobacco Quit Plan* are designed to have a ripple effect throughout the state and create "positive turbulence" for tobacco cessation.[83]

Substantial reductions in the prevalence of tobacco use in California, an increase in the proportions of light and non-daily smokers, and demographic data indicating that tobacco users are increasingly likely to be members of racial/ethnic minority communities also have influenced the shaping of this objective.

In addition, developments at the federal level were considered. The new Prevention and Public Health Fund, created by the Patient Protection and Affordable Care Act of 2010, may continue to augment state investments in cessation. The FDA plans to require that cigarette packs display large graphic warnings and the national 1-800-QUIT-NOW telephone number which routes calls to state quitlines, including the California Smokers' Helpline. The Centers for Medicare and Medicaid Services (CMS) has given state Medicaid programs authority to claim up to 50 percent of state quitline administrative costs associated with providing cessation services to Medicaid insurees. As part of the Medicaid Incentives for Prevention of Chronic Diseases program, CMS has awarded California $10 million to incentivize quit attempts among Medi-Cal beneficiaries.

Boost the number and frequency of tobacco quit attempts across populations. On a population level, increasing the number and frequency of quit attempts is the most effective strategy for achieving tobacco cessation. The process by which tobacco users cycle through cessation and relapse has been characterized as a "Quit machine" (See Figure 10).[84] Daily smokers either quit altogether and become former smokers or reduce their smoking and become low rate or non-daily smokers. The latter often go on to quit altogether. Among recent smokers, relapse is common. They may relapse to non-daily smoking or go back to daily smoking. But their desire to quit usually remains, leading them to cycle through the process repeatedly till they become former smokers long enough to be less vulnerable to relapse. It takes 12-14 quit attempts, on average, before tobacco users quit for good.[85]

Figure 10



The overarching goals of this objective are to get all tobacco users into the "Quit Machine" and to help them cycle through it as expeditiously as possible, till they have successfully quit. Anything that can speed up the machine, motivating relapsed smokers to make fresh quit attempts, will result in increased cessation rates. Intervention activities should be designed to increase the desirability of quitting, to increase the sense of urgency about quitting earlier in life, and to reach all groups of tobacco users.

Other objectives and strategies in this Master Plan can stimulate quit attempts. For example, when the price of tobacco products increases or when new restrictions are placed on tobacco use, cessation increases. Policies that have the effect of de-normalizing tobacco use may be the most important underlying motivators for quit attempts. And as the percentage of Californians who do not use tobacco increases, those who still use tobacco have all the more reason to quit, in order to fit in.

In 2010, 56.8 percent of California smokers reported a quit attempt in the previous 12 months.[86] While policies should be adopted to increase the availability and utilization of cessation aids and services, quitting without such assistance is by far the most common route to success, despite its low efficacy rate.[87] "Cold turkey" quitting is still a critical element of population based tobacco cessation.[88]

Expand the availability and utilization of cessation aids and services. According to the Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, clinicians should "strongly recommend the use of effective tobacco dependence counseling and medication treatments to their patients who use tobacco, and recommends that health care systems, insurers, and purchasers assist clinicians in making such effective treatments available."[89] Treatments to be recommended to patients are individual, group, and telephone counseling, and various first-line medications including nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, bupropion SR (Zyban), and varenicline (Chantix).

The availability and utilization of FDA-approved quitting aids should be increased, especially among uninsured smokers. Individual and group cessation counseling should be widely available. Awareness and use of the California Smokers' Helpline should be

increased. Culturally and linguistically appropriate educational materials should be widely disseminated.

Health insurers and health systems should be urged to realize their critical roles in tobacco cessation by providing comprehensive coverage of effective treatments, supporting their delivery, motivating repeated quit attempts, and otherwise helping patients be successful in quitting. Health care reform creates opportunities to heighten awareness of the importance of cessation. Relevant themes from the reform movement include an emphasis on prevention and wellness rather than simply on treating disease, the importance of cost efficiency in treatment selection, the benefits of coordinated chronic disease management, the need to address disparities in access to treatment, the promise of cost savings from improved care, and keeping pace with the competition.

New health plans should be informed that pursuant to the Affordable Care Act, they are required to cover preventive health care without co-payment. Alerting existing plans that they will be required to provide coverage by 2018 may convince some to offer it sooner.

Training and technical assistance should be provided to help hospitals, clinics, Federally Qualified Health Centers, mental health facilities, and substance abuse treatment centers adopt smoke-free campus policies, implement systematic approaches to cessation, and ensure that tobacco cessation is well supported by electronic medical records. *The Tobacco Quit Plan for California* provides a useful summary of recommended strategies for health care system change, engaging health care providers and engaging other systems to promote cessation.[92]

The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), is a not-for-profit organization that accredits over 19,000 health care organizations and programs in the United States, including 82 percent of hospitals. Hospitals should be advised that the Joint Commission has adopted guidelines that require hospitals selecting tobacco cessation as one of their quality measures to screen all adult inpatients for tobacco use, provide cessation medications and counseling, and follow up with them after discharge.

A Model Example

Kaiser Permanente Northern California (KPNC) has identified tobacco cessation as a quality goal. The organization's comprehensive systems approach includes:

- smoke-free medical campuses
- clinical practice guideline development
- practice tools and staff training
- FDA-approved pharmacotherapies
- behavioral support through group classes, individual counseling, and an online program
- performance measurement, physician feedback, and incentives for good performance

Results have been remarkable. The adult smoking prevalence among KPNC members decreased by one-quarter in just a few years, from 12.2 percent in 2002 to 9.2 percent in 2007.[90, 91]

New Tobacco Cessation Measures for Hospital Accreditation

Because tobacco use is the leading preventable cause of death in America, The Joint Commission developed and pilot-tested a new measure set to improve performance in this area. The new measures do not target a specific diagnosis and are broadly applicable to all hospitalized inpatients 18 years of age and older: It includes:

- **Assessment** – all adult patients will be assessed for tobacco use.
- **Treatment** – tobacco users will be offered evidence-based counseling to help them quit and FDA-approved quitting aids during their hospital stay, unless contraindicated.
- **Treatment at discharge** – current tobacco users will be referred to evidence-based outpatient counseling and offered a prescription for quitting aids upon discharge.
- **Treatment follow-up** – current tobacco users will receive a follow-up call within two weeks after hospital discharge to ascertain their tobacco use status.

Engage health care providers in helping patients quit. Physician advice to quit smoking increases the likelihood that patients will quit and remain tobacco-free a year later.[93] The consult can be as simple as *Asking* patients if they use tobacco. *Advising* those who do to quit, and *Referring* them to the California Smokers' Helpline or other evidence-based treatment (see Figure 11).

Efforts should be made to expand the number and diversity of health professionals who routinely assist their patients in quitting tobacco, by helping nurses, physician assistants, dentists, dental hygienists, respiratory therapists, pharmacists, optometrists, and others to see this as part of their mission. All schools for health professionals should include training on tobacco cessation in their curricula and provide this training to practitioners through continuing education.

Promote tobacco cessation through multiple channels. California's three tobacco control agencies should work collaboratively with each other and with state, regional, and local partners to develop and disseminate culturally appropriate tobacco cessation messages and services, especially to priority populations.

Figure 11

Tobacco users who have mental illness or a substance abuse disorder consume 44 percent of all cigarettes and account for 200,000 of the 443,000 tobacco-related deaths in the United States each year.[94] They should be considered a priority population for the California Tobacco Control Program. Although provider and patient perspectives are changing, smoking historically has been an accepted part of mental health treatment settings. Quitting tobacco should become a new norm in mental health and substance use disorder systems.

Place-based campaigns should be used to reach concentrated populations of low socioeconomic status. Other funding agencies such as First 5 California should be encouraged to increase financial support of programs and mass media that address cessation and secondhand smoke exposure in its target populations.

Social service organizations, employers, labor groups, the military, schools, and colleges, should be encouraged to promote cessation and to make referrals to the California Smokers' Helpline or local cessation services. Cessation activities by these groups should be publicized and others should be encouraged to emulate them.

Media and public relations should be used to show that not using tobacco has become the norm in California and to generate social support for cessation. Smokers and other tobacco users should be made to feel hopeful about their chances of quitting successfully. Friends and family members who do not use tobacco should be provided with tips to effectively support quit attempts by those who do. Encouraging quit attempts through social media is another promising strategy to support each other in quit attempts. Efforts should be made to increase quit attempts among younger smokers, as quitting before the age of 30 avoids most of the long term health effects of tobacco use.[95]

Conduct research and evaluation to strengthen cessation interventions. Research should be conducted to analyze the effectiveness of various approaches for promoting and supporting cessation with priority populations. The rate at which health care providers help patients quit should be tracked, and various approaches to increasing provider interventions should be evaluated. Access, awareness, and utilization of cessation treatments should likewise be tracked. Messages and methods for increasing quit attempts and tobacco cessation among youth and young adults should be tested.[96]

Investigators should explore the extent to which media campaigns and other tobacco control strategies prompt aided and unaided quit attempts and normalize social support for cessation among nonsmoking friends, family members, and health and social service providers. Research should evaluate whether tobacco control efforts in California succeed at creating self-reinforcing quitting norms among tobacco users. The impact on California of federal programs, such as the FDA-mandated warning labels on cigarette packs, should be carefully evaluated (See Figure 12).

Efforts should be made to ensure that future revisions of the *Tobacco Quit Plan for California* reflect up-to-date realities about tobacco use and cessation in the state and keep California on the leading edge of research and practice in this area.

Figure 12

OBJECTIVE 7: Minimize Tobacco Industry Influence and Activities

- Monitor and expose tobacco industry spending and activities.
- Increase adoption and enforcement of laws that regulate the sale, distribution, and marketing of tobacco products.
- Support and enhance tobacco regulation by the FDA.
- Increase refusals of tobacco industry funding, sponsorships, and partnerships.
- Make all tobacco use and the tobacco industry socially unacceptable.

The tobacco industry relentlessly fights tobacco control efforts at the local, state, and federal levels. It continually develops new products and promotes them through crafty marketing targeted to young people, priority populations, and others at-risk for tobacco use or already addicted. The tobacco industry spent over eight times more on marketing in California than the state spent on tobacco control in 2008.[97]

However, the tobacco industry's attempts to undermine tobacco control goes far beyond marketing their deadly products. It fights proposed increases in the tobacco tax and challenges proposed legislation to weaken it or derail it altogether. Over the past decade, Big Tobacco—led by Philip Morris—spent nearly $100 million lobbying legislators and contributing to campaigns in California. A large portion of that--$62 million—went into defeating Proposition 86 in 2006. That statewide ballot initiative would have imposed a $2.60 tax on each pack of cigarettes, and lost by just 289,331 votes.[98, 99]

More recently, the industry increased lobbying expenditures to oppose a $1.75 per pack tobacco tax increase intended to fund healthcare reform (ABX1-1). During a six months period, from October 1, 2007 to March 31, 2008, Philip Morris USA Inc. alone spent $887,286 to lobby against this tax increase and two other bills.[100] As the Legislature considered a cigarette tax during 2009 budget talks, the tobacco industry spent $750,000 in lobbying expenses in the three-months period from April through June.[101] After San Francisco instituted a mitigation fee to cover the costs of cleaning up tobacco waste, Philip Morris contributed $1.75 million to support Proposition 26, a successful 2010 ballot initiative that prevents other cities from imposing such fees.[102]

TEROC supports strong regulation of the tobacco industry at every level of its operation. In order to save lives and save money, Californians must work together to increase the tax on tobacco, to support strong tobacco control, and to limit the products, activities, and influences of the tobacco industry. The following recommended strategies are critical to countering Big Tobacco's influence.

Monitor and expose tobacco industry spending and activities. The Tobacco industry continues to outspend the state's Tobacco Control Program eight-to-one on their marketing efforts and because of this their influence is all around us.[103] Tobacco industry marketing strategies are designed to

be integrated with lifestyle activities so that the industry's influence on norms around tobacco use may go unnoticed.

These lifestyle marketing activities continue today. For example, smoking in movies is a powerful pro-tobacco influence on young people. Kids also encounter promotion of tobacco products in retail environments. Adolescents who are exposed to cigarette advertising and tobacco product displays in the retail store environment were more than twice as likely to initiate smoking than those not exposed.[104, 105] Another venue for tobacco marketing is in sporting and outdoor events. In 2008, 45 percent of California youth in grades 9-12 reported seeing advertisements for cigarettes or chewing tobacco when they attend sports events, fairs, or community events.[106]

The tobacco industry's aggressive marketing is constantly evolving and for this reason it is critical to track their spending and activities to identify new trends. In addition, the tobacco industry, its front groups and allies continue to work to undermine tobacco control policies. Implementing innovative rapid-response surveillance systems to assess changes in tobacco industry spending on marketing and political activities will help advocates fight this influence. These surveillance systems may also provide information about the industry's aggressive targeting of priority populations and other specific communities.

The tobacco industry targets priority populations and specific communities through new product development, marketing and advertising, promotions, price manipulation, and the density of tobacco retailers. They also have a history of targeting priority populations with their sponsorship and sampling practices. For example, Skoal's sampling tents at the National Association for Stock Car Racing demonstrate the tobacco industry's interest in rural and low socioeconomic status populations.

Monitoring and exposing the tobacco industry's spending and activities will increase awareness of the industry's current tactics. In addition to surveillance, innovative approaches to counter tobacco industry marketing and political strategies are needed.

Increase adoption and enforcement of laws to regulate the sale, distribution, and marketing of tobacco products. TEROC supports strong regulation of the tobacco industry in order to limit the availability of tobacco products, and to decrease

On-line Information about the Tobacco Industry

Many Web sites have information about the tobacco industry's

- front groups and allies
- strategies, tactics, and deceptive practices
- sponsorships and contributions

Two resources with links to many additional sources of on-line information are:

- Tobacco's Dirty Tricks, Get the Facts. Americans for Nonsmokers' Rights - www.no-smoke.org/getthefacts.php.
- Watching and Regulating the Industry, Tobacco Free Initiative (TFI) World Health Organization - www.who.int/entity/tobacco/en/.

the negative health effects of tobacco use. Statewide legislation that preempts stronger local tobacco control ordinances should be opposed because it weakens local efforts to regulate the sale, distribution, and marketing of tobacco products. In addition, tobacco control advocates should work with the California Attorney General to promote increasing enforcement of all state and local tobacco control laws which will increase the likelihood of success.

Three out of four adult smokers started using tobacco before the age of 18.[107] Therefore, it is reasonable to make efforts to limit tobacco sales to minors. These efforts may include retailer policies that prevent illegal sales of tobacco to minors or conditional use permits and zoning laws to address tobacco retailer density in California communities. Strong policies must include appropriate fees to adequately fund their enforcement.

Increasing the cost of tobacco is one of the most powerful public health interventions available to decrease cigarette consumption and smoking prevalence.[108] Tobacco Industry price manipulation strategies, retail price promotions, free or low-cost coupons, rebates, gift cards, and gift certificates are used to recruit and retain smokers by artificially lowering the price of cigarettes. These strategies target populations that are sensitive to price, such as youth or low socioeconomic populations. Policies are needed to prohibit these price manipulation strategies to help reduce the number of cigarettes consumed by current tobacco users and discourage uptake of tobacco by new users.

Studies show that the density of tobacco retail outlets in communities has an impact on the prevalence of smoking. Significantly higher smoking rates have been found in lower socioeconomic communities with higher density of tobacco retailers.[109] Also, students are more likely to experiment with smoking when there is a higher density of stores that sell tobacco near high schools in urban areas.[110] Eliminating tobacco retailers near schools and reducing the density in areas with priority populations will decrease exposure and access to tobacco products.

"Harm reduction" refers to use of cigarette alternatives that may be promoted as being less harmful or as having reduced risk of certain tobacco-related diseases. Recently, there has been an increase in the variety of alternative tobacco products available on the market, newer smokeless tobacco products like "snus," dissolvable tobacco products, and electronic cigarettes. These products are promoted as a way to circumvent smoking bans and provide an alternative to cigarettes that is less obtrusive and/or lower in price. New alternative tobacco products may undermine tobacco control strategies by prolonging the quitting process or even preventing quit attempts.[111] TEROC recommends prohibiting the promotion and sale of tobacco products for "harm reduction" as either substitutes or as cessation aids.

Health care institutions should not support tobacco use in any way. Any entity that provides health education, health services, dispenses medications and/or is involved in the Affordable Care Act should be prohibited from the sale or promotion of tobacco products. All institutions and public officials should be encouraged to adopt policies that establish

Partnership with the California Attorney General's Office

Between 2000 and 2009, enforcement of state laws and the Master Settlement Agreements by the California Attorney General's Office resulted in more than $24 million in payments, penalties, and fees paid by tobacco companies. Nearly $1.9 million of this total was earmarked for tobacco control.[112]

tobacco-free campuses if they receive, or disburse health, welfare, education, or community development funding from national, state, local, or regional authorities. In addition, public institutions and officials should be prohibited from selling or promoting tobacco products and not allowed to collaborate with, or accept funds from, any tobacco company, its representatives, subsidiaries or front groups.

Support and enhance tobacco regulation by the FDA. The Family Smoking Prevention and Tobacco Control Act was passed in 2009 to provide the FDA with the authority to regulate tobacco products. Based on recommendations, the FDA banned 13 specific flavorings in cigarettes, but menthol was exempt from the ban. Menthol is popular among youth and beginner smokers due to the feeling of coolness provided by menthol that masks the harshness of tobacco.[113] Menthol cigarettes represent 20 percent of the market share.[114] Mentholated cigarettes were originally developed and promoted to women.[115] Since then, the tobacco industry has used a unique combination of advertising, packaging, pricing, and distribution channels to target particular groups, such as youth and young adults, women, African Americans, and other priority or ethnic populations.

The FDA has the ability to prohibit menthol as an ingredient in cigarettes and other tobacco products. Therefore, TEROC recommends encouraging the FDA to ban menthol cigarettes and all other flavored tobacco products, including smokeless tobacco and cigars.

The tobacco industry provides incentives to retailers to display "power walls" – extensive rows of cigarette packages in quantities that far exceed what is needed to meet short term purchase levels. These displays are commonly visible as a backdrop to the cash register as cigarette advertising.[116] Studies have shown that individuals exposed to tobacco product displays are more likely to smoke and to smoke more.[117] The FDA should be encouraged to extend the current requirements for tombstone cigarette advertising, limiting the number and size of tobacco advertisements at retail outlets, and eliminating "power walls." Local and state action to monitor, restrict, and regulate the time, place and manner of tobacco advertising should also be encouraged.

Ban Menthol in Cigarettes and Other Tobacco Products

Menthol smokers tend to be female, younger, members of ethnic minorities, have only a high school education, and buy packs rather than cartons.[118]

Today, menthol cigarettes are the overwhelming favorite tobacco product among African Americans. More than 80 percent of African Americans prefer to smoke menthol cigarettes compared to only about 20 percent of White smokers. The rate is even higher among young African American adults ages 26-34 years, 90 percent of whom smoke menthols.[119]

Tobacco sampling is the giving away of free product to expose potential new consumers to tobacco products and retain customer support and loyalty. The FDA completely bans free samples of cigarettes, but permits the sampling of smokeless tobacco at adult only facilities. Sampling of cigars, cigarillos, hookah tobacco, and dissolvable tobacco products remains legal. TEROC recommends expanding the definition of sampling to include coupons, rebate offers, gift certificates, or any other method of reducing the price of tobacco to a nominal cost. It is also recommended that the FDA ban on cigarette sampling be extended to all tobacco products.

Increase refusals of tobacco industry funding, sponsorships, and partnerships. The Tobacco Industry spends millions of dollars on trying to influence California policymakers through campaign contributions and lobbying expenditures. Tobacco interests spent $9.3 million on campaign contributions and lobbying during the 2009-2010 election cycle.[120] The tobacco industry uses its spending power to influence policymakers as well as to oppose bills and ballot initiatives that would reduce tobacco use. TEROC recommends encouraging public officials to sign a pledge that they will not accept funds from the tobacco industry or its front groups. Contributions from these sources should be monitored and the names of public officials who accept them should be publicized.

The number of universities and public schools that adopt tobacco-free policies should be increased, including refusal of funds from the tobacco industry. All organizations should be encouraged to refuse tobacco industry advertisements, donations, event sponsorships, funded research and the use or distribution of tobacco industry curriculum or materials.

TEROC recommends that partnerships between tobacco control programs and tobacco companies be prohibited. Tobacco companies are trying to position themselves as part of the solution by partnering with tobacco control efforts. In particular, tobacco companies are seeking involvement in partnerships on the science of harm reduction. It is critical to point out that partnering with the tobacco industry does not further the health, welfare, or the economy of California.

Obtain Pledges to Refuse Funds from the Tobacco Industry

In 2004, the San-Francisco Coalition of Lavender-Americans on Smoking and Health (CLASH), the nation's first Lesbian, Gay, Bisexual, and Transgender (LGBT) tobacco control organization, initiated a campaign to persuade California LGBT elected officials and community organizations to sign a statement that they would not accept contributions from the tobacco industry or its affiliates.

By 2011, such a statement had been signed by 41 elected officials and 39 organizations. CLASH co-founder Naphtali Offen said, "Getting leadership on the record helps inoculate them against tobacco industry influence."

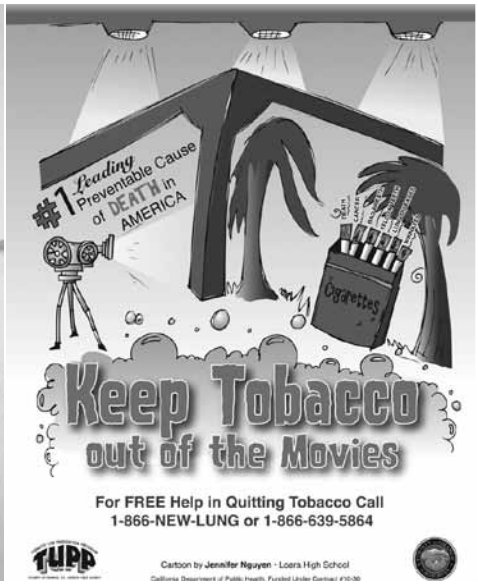
CLASH promotes a tobacco-free norm by publicizing its ongoing efforts to isolate the industry and hopes that others will urge their leaders to take a similar stand against the industry.

For more information visit:
http://www.lgbttobacco.org/files/PledgefromCalifornia.pdf.

Make all tobacco use and the tobacco industry socially unacceptable. As discussed earlier, the tobacco industry maintains a pervasive influence in our communities and is all around us - including in movies, retail stores, sports, fairs, and other community events. The tobacco industry strives to make tobacco a part of everyday life in order to normalize tobacco use. The social norm change model used in California tobacco control efforts seeks to make tobacco less desirable, less acceptable, and less accessible.[121] We must continue to support efforts to denormalize tobacco use, and to counter pro-tobacco influences, including efforts to renormalize tobacco use through the promotion of novel or alternative tobacco products. Our efforts should focus on community and youth development, and integrate more new media activities such as social media, popular music, and other participatory communication modes.

We must continue to support the scientific efforts needed to decrease the social acceptability of tobacco use and the tobacco industry. Research should be conducted to help guide the efforts of the FDA as it regulates tobacco products. For example, compliance with new regulations, tobacco industry adaptations to them, and impacts on tobacco use should be evaluated. Another area for research is studying the impact of California's new high-tech tax stamp in reducing tax evasion, counterfeiting, and smuggling.[122] Other research should be funded to monitor and expose the constantly changing maneuvers of the tobacco industry and its persistent efforts to counter tobacco control.


Don't
Be
A
Butt-Head.


#1 Leading Preventable Cause of DEATH in AMERICA
Cigarettes
Keep Tobacco out of the Movies
For FREE Help in Quitting Tobacco Call
1-866-NEW-LUNG or 1-866-639-5864
TUPP
Cartoon by Jennifer Nguyen - Loara High School


Don't let the movie magic trick you
Make-ups done!
Title:
Production:
Director:
Date
Scene
Take
For FREE Help in Quitting Tobacco Call
1-866-NEW-LUNG or 1-866-639-5864
TUPP
Cartoon by Ashley Sakahara - La Vista High School

Appendices

Significant Tobacco Control Legislation, 2009-2011

California Legislation

Legislation* Assembly Bill (AB), Senate Bill (SB), or Ballot Proposition (Prop) and Author	Description	Effective Date
AB 33010- Blakeslee	Authorizes the Director of the Department of Mental Health to prohibit smoking by patients and staff at any of the five state mental hospitals upon request of the hospital's director.	January 1, 2009
SB 53- DeSaulnier	Authorizes the Attorney General to negotiate amendments to the Master Settlement Agreement.	August 5, 2009
SB 882 – Corbett	Makes sales of electronic cigarettes to minors illegal.	September 25, 2010
Prop 26	With a number of exceptions, city, county, or state charges formerly considered regulatory fees requiring a majority vote now are considered taxes; passage of a "special tax" by local governments requires two-thirds vote; passage of a new state tax requires a two-thirds vote by each house.	November 2, 2010
SB 2496 – Nava	Reduces evasion of Master Settlement Agreement and cigarette tax payments.	January 1, 2011
AB 2733– Ruskin	Changes tobacco retailer licensing laws.	January 1, 2011
AB 795– Block	Strengthens enforcement of tobacco policies at state colleges and universities.	January 1, 2012
SB 332– Padilla	Authorizes landlords to prohibit smoking in rental units.	January 1, 2012
SB 796 – Blakeslee	Create penalties for delivering prohibited items in state hospitals.	January 1, 2012

* AB: Assembly Bill
SB: Senate Bill
PROP: Proposition on state-wide ballot

Federal Legislation

Act	Description	Effective Date
The Children's Health Insurance Program Reauthorization Act	Raises Federal cigarette tax from $0.39 to $1.01 a pack, an increase of $0.62.	April 1, 2009
The Prevent All Cigarette Trafficking (PACT) Act	Regulates sale of tobacco products over the internet and mail; enforces tax laws on vendors.	June 29, 2010
Family Smoking Prevention and Tobacco Control Act ("Tobacco Control Act")	Gives the Food and Drug Administration (FDA) Regulatory authority over tobacco products	June 22, 2009
	• Bans all flavored cigarettes except menthol and the use of misleading descriptors such as light, low, and mild for cigarettes and smokeless tobacco.	June 22, 2009
	• Imposes sponsorship, advertising and sampling restrictions.	
	• Requires FDA approval of new and imported tobacco products.	
	• Requires tobacco companies to disclose all cigarette ingredients.	December 19, 2009
	• Requires product warning labels on 50 percent of front and back of cigarette packaging and 20 percent of advertisements.	
	• Establishes the FDA Center for Tobacco Products and the FDA Tobacco Products Scientific Advisory Committee.	March 22, 2010
	• Allows States to restrict or regulate the time, place, and manner (but not the content) of cigarette advertising and promotion.	September 2012
The Patient Protection and Affordable Care Act (Affordable Care Act)	Creates a new Prevention and Public Health Fund that will expand and sustain prevention, wellness, and public health programs.	March 23, 2010
	Expands smoking cessation coverage for pregnant Medicaid beneficiaries and enhances prevention initiatives by offering financial incentives to States to provide optional services that encourage healthy behaviors by Medicaid beneficiaries.	October 1, 2010

Achievements

Master Plan 2009-2011

The TEROC Master Plan goals for 2009-2011 were established to achieve smoking prevalence rates of 10 percent for adults and eight percent for high-school age youth by the end of 2011. The three-year plan established the following five objectives as guidance for the California Department of Public Health, CTCP; CDE, Safe and Healthy Kids Program Office; and the University of California, TRDRP to comprehensively implement tobacco control in California. Achievements by agency are summarized below, with highlights of major accomplishments and trends.

Objective 1: Strengthen the California Tobacco Control Program.
California has fallen behind the rest of the nation in tobacco excise tax rates. Declining Proposition 99 revenues limit the ability of California's tobacco control agencies to comprehensively address tobacco control issues in all communities. Measures have been taken to address declines in funding, to identify research priorities, and to build organizational capacity.

- CTCP successfully obtained more than $13.2 million in federal funding for the period of March 2009 to March 2014, through the Centers for Disease Control and Prevention procurements: *Collaborative Chronic Disease, Health Promotion, and Surveillance; Communities Putting Prevention to Work; Affordable Care Act, and Conference Support*. With these funds, CTCP is addressing new areas, including policy efforts to decrease barriers in accessing cessation services, particularly among populations with high rates of smoking; including Medi-Cal beneficiaries, people with mental illness, young adults, and military personnel.

- CTCP collaborated with the Department of Health Care Services (DHCS) to successfully obtain federal funding from the Centers for Medicare and Medicaid Services to expand cessation service utilization through the California Smokers' Helpline. Incentives are now provided to Medi-Cal beneficiaries to call the Helpline and enroll in cessation counseling services.

- TRDRP funded and disseminated public policy research to understand the need to increase the state's cigarette surtax. The research conducted by three University of California scientific teams demonstrated that an increase to the state's cigarette tax of $1 per pack with $0.20 allocated to tobacco control would result in billions of dollars of savings in health care expenditures and thousands of lives saved.[123, 124] These key findings provide the foundational evidence in support of the 2012-2014 Master Plan's objective to raise the cigarette surtax. TRDRP sponsored a legislative briefing at the State Capitol on May 12, 2011 to disseminate these findings to policy makers. In addition, local tobacco control advocates throughout the state have been actively disseminating these findings at the community level.

- In September 2011, TRDRP identified and announced new research priorities, reflecting an evolving scientific and regulatory context as well as the need to target the program's limited resources. The new research priorities

resulted from an extensive input and consensus process involving a broad range of program stakeholders as well as tobacco-related disease and tobacco control investigators. Effective 2012, TRDRP's five research priorities are in the areas of: Environmental Exposure, Early Diagnosis, Regulatory Science, Disparities and Equity, and Industry Influence.

- In 2010, the Sacramento Area Human Resource Association and the Sacramento Bee awarded CTCP the *Sacramento Workplace Excellence Leader Award* for a small government organization.

- The National Public Health Information Coalition (NPHIC) recognized eight anti-tobacco communication efforts created by CTCP and funded local and statewide agencies with top honors in 2009, and three in 2010, in their Awards for Excellence in Public Health Communication.

Objective 2: Eliminate Disparities and Achieve Parity in all Aspects of Tobacco Control.
California's tobacco control agencies continue to strengthen tobacco control efforts with priority populations through research, education, building agency capacity and funding.

- CDE started an initiative with TUPE grantees to adopt a mission to develop California's next generation of tobacco-free advocates. All TUPE grantees are now required to adopt youth development strategies that included youth in anti-tobacco efforts as leaders with active roles and experiential participation in tobacco prevention. Grantees are also encouraged to specifically target youth from priority populations for participation in youth development strategies. School Districts, such as San Mateo-Foster City, Westminster, and Chico are working specifically with African Americans, Hispanics, Vietnamese, and LGBT youth in anti-tobacco advocacy projects.

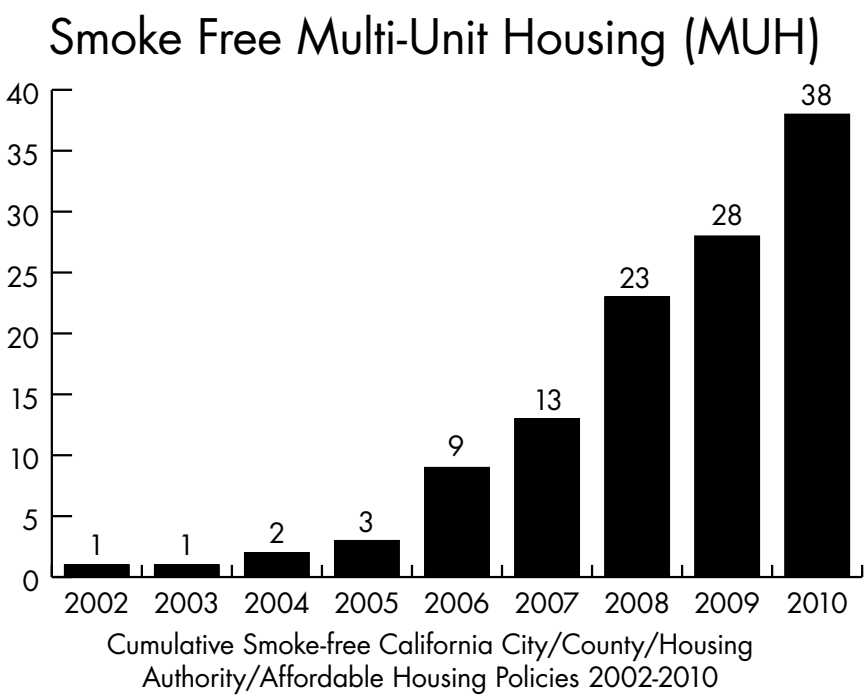
- CTCP produced 62 new television, radio, and print ads that aired in all major general and ethnic media markets in California; many were trans-adapted and aired in other languages. Ads were developed through population-specific, in-person testing and supported local intervention efforts by addressing secondhand smoke exposure in multi-unit housing, worksites, and outdoor environments; cessation; and countering pro-tobacco influences.

- CTCP was awarded the grand prize in the 2009 Association of National Advertising Awards of Excellence for the Asian advertising campaigns: *Your Child* and *Deadliest*. Additionally, *Trapped*, a Hispanic print ad, was awarded Commercial Image of the Year in *American Photo Magazine's* 2009 Images of the Year Competition.

- CTCP awarded $16.2 million (FY 2010-13) in competitive grant funding for 37 projects seeking to reduce tobacco-related disparities among these priority populations and communities: African American; American Indian/Alaska Native; Asian; Hispanic; labor; Lesbian, Gay, Bisexual, and Transgender; low socioeconomic status; people with mental health and substance abuse issues; and rural residents.

Objective 3: Decrease Secondhand Smoke Exposure.
Decreasing exposure to secondhand smoke where Californians live, work and play continues to be an area of considerable progress in California. Since 2008, there has been an increase in the number of local smoke-free policies, as well as in research that supports the elimination of secondhand smoke as a strategy to improve the health and wellness of the public.

Figure 13



- There has been an increase in the number of local community policies protecting against secondhand smoke exposure in multi-unit housing. In 2010, 38 city, county, housing authority, and affordable housing policies were enacted or strengthened (See Figure 13).

- In 2010, 85 municipalities passed ordinances to restrict smoking in at least some outdoor dining areas; and 273 municipalities had passed ordinances stronger than state law to restrict smoking in recreation areas.

- In 2011, approximately 87 percent of school districts and 100 percent of County Offices of Education have been certified as tobacco-free. More importantly, the LEAs that enforce the tobacco-free policy are serving 92 percent of California's student population.

- CDE created a new web page at http://www.cde.ca.gov/ls/he/at/tobaccofreecert.asp that supports LEA efforts to enforce and monitor tobacco-free school policies. The web page includes a list of LEAs that are certified as tobacco-free.

- TRDRP funded a statewide consortium of California researchers to conduct scientific research on third-hand smoke (THS) and its effects on public health. The first of its kind in this relatively nascent area, the research holds high relevance and potential to inform a new generation of tobacco control efforts. The funded consortium brings together investigators in a broad range of disciplines from across California institutions (University of California, San Francisco; Lawrence Berkeley National Laboratory; University of California, Riverside, and San Diego State University) with strong research backgrounds in the characterization, exposure and health effects of tobacco smoke and its potential economic and policy implications.

Objective 4: Increase the Availability and Utilization of Cessation Services.

California tobacco control agencies continue to create innovative ways to increase the availability and utilization of smoking cessation services in California.

- CTCP convened a Cessation Summit in May 2009 to identify program and policy strategies that could be implemented in California to promote quit attempts and increase tobacco cessation at the population level. *Creating Positive Turbulence: A Tobacco Quit Plan for California* outlines strategies designed to achieve the goals of tobacco cessation in California. The plan is available at: http://www.cdph.ca.gov/programs/tobacco/Pages/Ca_Tobacco_Quit_Plan_.aspx.

- A campaign, including print and digital media and health care provider outreach, encouraging health care providers to ask all of their patients about tobacco use, advise them to quit, and refer them to the Helpline for free telephone counseling was successful in increasing the proportion of callers referred to the Helpline through health care providers from 44.2 percent in 2009 to 51.2 percent by the end of 2010.

- CTCP produced the TV ad *Don't Stop Fighting*, in collaboration with the California Smokers' Helpline, based on a new strategy; encouraging repeated quit attempts vs. directly driving calls to the Helpline.

- CTCP and the DHCS partnered to improve cessation benefits for Medi-Cal beneficiaries. The duration of coverage for nicotine replacement therapy was increased from 10 weeks to 14 weeks, and a requirement for prior authorization for nicotine replacement therapy products was eliminated.

- The California Healthy Kids Resource Center (CHKRC) is administered by the CDE to provide high-quality TUPE) instructional materials, and technical assistance to California LEAs, and teacher preparation institutions. The CHKRC also promotes the use of *Research-Validated* instructional programs and research-based strategies such as youth development. A number of curricula have been designated as *Research-Validated*, indicating they have empirically demonstrated reductions in tobacco-use behaviors at least six months after the completion of the program. In addition, the curricular materials must be complete, available, and ready to be implemented at school sites in California. The *Research-Validated* programs list is available at http://www.californiahealthykids.org/rvalidated.

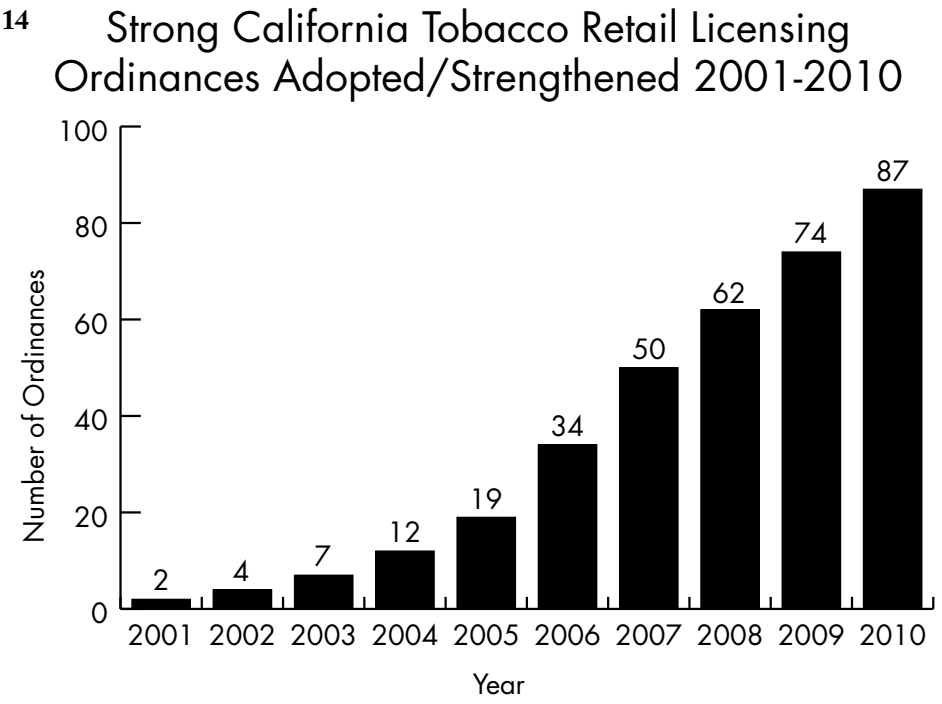
Objective 5: Limit and Regulate Tobacco Industry Products, Activities, and Influence. In California, the tobacco industry's marketing outspends the California Tobacco Control Program 8 to 1. Additionally, in the 2009-2010 election cycle, tobacco interests spent $9.3 million on campaign contributions and lobbying in California to promote and maintain pro-tobacco use interests.[125] Limiting and regulating the tobacco industry, their strategies, funding and influence remains a significant challenge in California.

- CTCP published and disseminated the *Tobacco Retail Price Manipulation and Policy Strategy Summit* proceedings in April, 2009. The proceedings contain policy recommendations to counter tobacco industry price manipulation and have provided a foundation for developing policy efforts to raise the price of tobacco products and have contributed to renewed national interest in minimum price laws. This document is available at: http://1.usa.gov/lW434Z.

- The statewide rate of illegal tobacco sales to minors declined from 17.1 percent in 2002 to 5.6 percent in 2011.

- Since the launch of the Strategic Tobacco Retail Effort (STORE) Campaign in 2002, California has seen a significant increase in

Figure 14

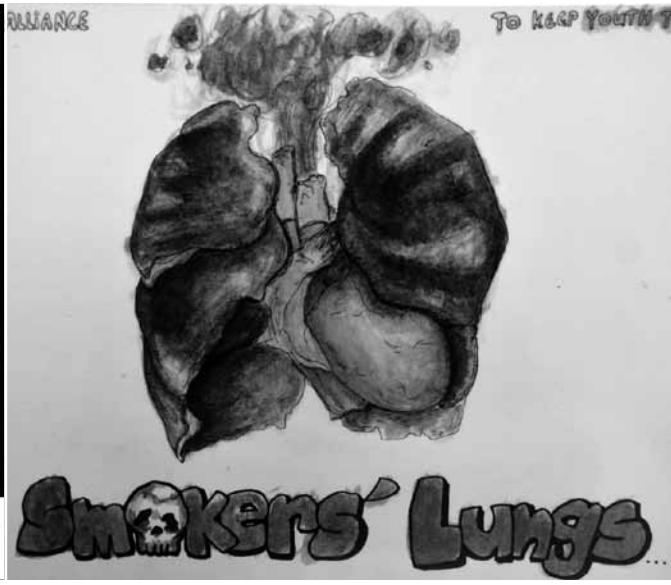


the number of local Tobacco Retail Licensing (TRL) laws (See Figure 14). Local jurisdictions are using TRL polices to regulate the types of stores that may sell tobacco, where stores may be located, the density of retailers, and the types of tobacco products that may be sold.

- **Innovative Use of Tobacco Retail Licensing Policies at the Local Level**. In 2008, San Francisco passed the first law in the United States that bans tobacco sales by pharmacies. In response to a state appeals court ruling, the law was expanded in 2010 to apply more broadly to include grocery and other stores with pharmacies. The City of Richmond passed a comparable ordinance in 2009.

In 2010, Santa Clara County enacted a tobacco retail licensing ordinance which prohibits issuing a license to any retailer where pharmacy services are provided, within 1,000 feet of a school, and within 500 feet of another tobacco retailer; however, existing retailers are exempted. The ordinance additionally prohibits the sale of all flavored tobacco products other than those containing menthol.

Designed By: Haley Miles
12th Grade Center High School MCA Student



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