

TRADITIONAL TOBACCO

Historically, tobacco has been an essential element in the ceremonial aspects of many American Indian communities and has taken on many sacred roles throughout the culture. Culturally, tobacco was, and is, a sacred plant used for spiritual, emotional, mental and physical guidance. It is understood that if used in positive ways it had the power to heal and protect; but if abused, it also had the power to harm and hurt.

Commercially manufactured tobacco has taken on this destructive and deadly role, and has exploited its uniqueness through commercialization and industrialization. And to make matters worse, tobacco companies have used American Indian and Alaskan Native culture as a marketing tool to sell these products to the AI/AN people.

Although tobacco is still used traditionally in it's historic manner by many tribes and by many Native people, the continued abuse of the commercial tobacco is much more frequent and has taken its toll on the Native people's health. And for many health advocates, there is an incredible amount of difficulty in explaining how this sacred, and powerful gift has been shape-shifted and became the cause of such deadly consequences.



TRADITIONAL TOBACCO

History of Traditional Tobacco:

- Most Indigenous nations have traditional stories of how tobacco was introduced to their communities.
- Many stories emphasized the sacredness of the plant and its powers to both heal if used properly and to harm us if used improperly!
- Some say that the original tobacco was discovered about 18,000 yrs ago
- Used for both healings and blessings
- Used as a smudge
- Used to ward off pests
- As a gift when welcoming guests to the community
- Gifted to those requested to pray/share their wisdom
- Used in creation stories
- Other stories involve the trickster Coyote
- Used in prayer, purification and cleansing, along with Sage, Cedar, and Sweet grass (Corn pollen in SW)
- The tobacco that spread to Europe and the rest of the world, *Nicotiana tabacum*, originated in South America and was noted for its richer taste and higher potency (i.e., the ability to produce hallucinations and supernatural visions)
- Traditional tobacco not only encompasses the Nicotiana plant, but also includes kinnick-kinnick and mountain tobacco.
- Many tribes use other plants in their kinnick-kinnick mixture to alter the taste—some northwest tribes use huckleberry bark to enhance the flavor.

Medicinal Uses:

- Asthma
- Childbirth pain
- Toothaches
- Earaches
- Insect bites
- Coughs
- Open wounds
- Snake-bites
- Headaches
- GI disorders
- Rheumatism
- Convulsions





Fact Sheet

Fact sheet information provided by the National Tribal Tobacco Prevention Network, a project of the Northwest Portland Area Indian Health Board, www.tobaccoprevention.net



USE OF NATIVE AMERICAN IMAGES TO SELL TOBACCO PRODUCTS

Approximate Length:

45 Minutes

Intended Audience:

Health Providers, Tobacco Educators, and Trained Counselors

Summary:

This 26-slide presentation offers information on tobacco advertising companies and their impact on American Indian and Alaska Native people. It gives background information on Traditional Tobacco (such as its uses, origin, and sacredness). The presentation then supplies statistical and factual information about the prevalence of tobacco usage among AI/AN people as well as prevalence statistics specifically from Oregon, Washington, & Idaho. This presentation can be used for giving trainings to health professionals or to provide a quick overview of traditional tobacco and the issues concerning commercialized tobacco.

- **History to Traditional Tobacco Use**
Healing, Gifting, Prayer, & Origination
- **Tobacco Prevalence among AI/AN Teens and Adults**
Highest rate among all other ethnicities the Nation
- **Adult Prevalence Rates in Oregon, Washington, & Idaho**
Higher rates in Oregon & Idaho
- **Tobacco Companies**
Made over \$50 billion in 1998
Spend \$11.5 billion on advertising each year

- **Tobacco Facts and Statistics**
40,000 people die each year from other people's smoking
4,000 youth try smoking every day
- **Principles of Proper Living**



Presentation Summary

Respect, Vision, Courage, Action, Humility, Hope, Compassion, Truth, &
Generosity





HISTORY OF TOBACCO USE

Approximate Length:

30 Minutes

Intended Audience:

Health Providers, Tobacco Educators, and Trained Counselors

Summary:

This 14-slide presentation is meant to provide a quick overview of the history of tobacco use both traditionally and commercially. This presentation is meant to show how tobacco has been commercialized to the AI/AN populations, while it exploited the culture at the same time. This presentation offers suggestions of areas of priority for tobacco prevention coordinators.

- **History to Traditional Tobacco Use**
Healing, Gifting, Prayer, & Origination
- **Commercialized Tobacco**
Nicotiana tabacum
- **Principles of Proper Living**
Respect, Vision, Courage, Action, Humility, Hope, Compassion, Truth, & Generosity
- **Best Practices**
Recognition and Respect





Presentation Summary



TOBACCO 101

Without a foundation a structure cannot exist. This is true for the field of tobacco education and prevention. The basic components of tobacco education from the American Indian Alaska Native (AI/AIN) perspective touch on several of the elements you will find throughout this guidebook. We emphasize traditional tobacco, commercial tobacco (smoking), smokeless tobacco, secondhand smoke, and the health effects of tobacco abuse.

American Indians and Alaska Natives (AI/AN's) have the highest rate of commercial tobacco use among all racial ethnic groups. With a smoking prevalence rate of 40.8% little needs to be said regarding the social norm change that must take place. Teaching about the traditional use of tobacco can be a powerful means for tobacco education and prevention in Indian Country. Respecting the tobacco plant has been a part of many Native cultures throughout the Northwest for thousands of years. Maintaining that custom necessitates that the plant not be abused by using it in a recreational way.

Teaching community members about commercial tobacco is another key feature of health education and tobacco prevention. The tobacco that is used in traditional ways is free of the impurities added by the tobacco industry. These contaminants include chemicals, metals, carcinogens, and poisons. The tobacco industry adds them for a number of reasons such as keeping the product fresh, enhancing flavor, and making the product more addictive.

Although much of the focus in tobacco prevention and education is on smoking, it is important to remember that smokeless tobacco is not a safe alternative. Many of the same dangers that put smokers at risk are also present for smokeless tobacco users. Prevalence rates for smokeless tobacco use among AI/AN youth are quite high and attention should be given to this aspect of the field.

Much of the focus in tobacco prevention and education is currently aimed at policy development, in particular the rules and regulations surrounding limitations placed on the rights and freedoms for smokers in public places. Because smokers put the health and well-being of non-smokers at risk, restricting secondhand smoke (SHS) has become the primary target for a great deal of effort. In recent years the dangers of SHS have come to light and legislators have reacted strongly. For Indian Country the challenges become more difficult as most of the laws do not apply on reservations and land owned by tribes. Thus, working with tribal governments becomes central to the prevention efforts in this area.



TOBACCO 101

Many indigenous nations have stories that tell how tobacco was introduced to their people and explain its power and importance.

Tobacco is/was used traditionally in many ways: as a smudge to ward off pests; in ceremonies and prayers; as a gift when welcoming guests or offering thanks; and as an offering to The Creator.

There are more than 4000 chemicals, 40 carcinogens, and 500 poisons in cigarette smoke.¹

Nicotine is a known addictive poison. Abuse results in emotional dependence.²

Some of the ingredients in cigarette smoke: carbon monoxide, tar, arsenic, acetone, ammonia, formaldehyde, lead, mercury, and silver.³

“Commercial tobacco kills more Americans each year than alcohol, cocaine, crack, heroine, homicide, suicide, car accidents, and AIDS combined.”⁴

AI/AN’s have the highest prevalence rate of smoking:⁵

- | | |
|-------------------------------------|-------|
| ➤ AI/AN’s | 40.8% |
| ➤ African Americans | 22.4% |
| ➤ Whites | 23.6% |
| ➤ Hispanics | 16.7% |
| ➤ Asian American/ Pacific Islanders | 13.3% |

It is estimated that 40% of AI/AN deaths can be attributed to commercial tobacco use.

Smoking is a major cause of lung cancer.⁶

Smoking and diabetes are a lethal combination.⁷

Among people with diabetes that require amputations 95% are smokers.⁷

Smoking raises blood sugar levels, making it harder to control diabetes.⁷

The combined cardiovascular risks of smoking and diabetes are as high as 14 times greater than either smoking or diabetes.





At the current cost of cigarettes a pack-a-day smoker will spend about \$1680 a year, that's over \$33,000 in twenty years.

Approximately 1 in 5 AI/AN students in BIA funded schools are current users of smokeless tobacco, compared to 1 in 12 students at all teenage high schools.⁸

Effects of smokeless tobacco: tooth abrasion, gum disease and recession, heart disease and stroke, cancer of the mouth, pharynx, esophagus, and pancreas, increased heart rate and blood pressure

Secondhand smoke (SHS) is responsible for approximately 53,000 deaths each year.

38% of children aged 2 months to 5 years are exposed to SHS in the home.

SHS exacerbates the symptoms of asthma and is responsible for thousands of additional hospital visits and missed school days each year.

An average sized "dip" of smokeless tobacco (when held in the mouth for thirty minutes) has as much nicotine as 2-3 cigarettes.

Pregnant women that smoke are putting their children at increased risk for a number illnesses and possible death due to SIDS.

The health benefits of quitting commercial tobacco use begin almost immediately.





References

1. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.
2. Liberty Science Center. The Science Behind Tobacco. Available at: <http://www.lsc.org/tobacco/health/addiction.html>.
3. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.
4. Centers for Disease Control and Prevention. Tobacco Information and Prevention Source. Available at: http://www.cdc.gov/nccdphp/aag/pdf/aag_osh2004.pdf
5. CDC Tobacco State Report:
http://www.cdc.gov/tobacco/statehi/html_2002/Idaho_text.htm
6. Centers for Disease Control and Prevention. Tobacco Information and Prevention Source. Available at: http://www.cdc.gov/nccdphp/aag/pdf/aag_osh2004.pdf
7. American Diabetes Association. Available at: <http://www.diabetes.org>.
8. CDC, MMWR 52(44), November 7, 2003. Available at:
<<http://www.cdc.gov/mmwr/PDF/wk/mm5244.pdf>>







TOBACCO 101

COMMERCIAL PRODUCTION

Approximate Length:
1.45 Hours

Intended Audience:

Health Professionals, Tobacco Educators, Trained Youth & Counselors.

Summary:

This informative presentation offers an abundance of facts from the creation of commercial tobacco to the effects of using the commercial tobacco. It consists of 35-slides including graphic pictures of mouth cancer and various internal organ damages. This presentation is meant for a mature, informed audience that can comprehend the significance of commercial tobacco usages.

- How Tobacco is Made
- Tobacco Harvest, Tobacco Curing, Tobacco Grading & Buying, Primary Processing, Casing, Contents in Commercial Tobacco, & Cigarette Manufacturing
- What is in a Cigarette
- Chemicals, Carcinogens, & Poisons
- Nicotine
- More addictive than cocaine and heroin
- Carbon Monoxide
- A Compound in Car Exhaust
- Tar
- Contains one of the Deadliest Cancer Causing Agents Known
- Chemicals
- Acetone, Ammonia, Arsenic, Cadmium, Methane, & Formaldehyde
- Metals
- Aluminum, Magnesium, Silicon, Silver, Copper, Mercury, Lead, Zinc, Titanium, & Heavy Metals
- Health Effects of Tobacco Use
- Vessel Constriction, Cardiovascular Disease, Asthma, Chronic Obstructive Pulmonary Disorder (COPD), Emphysema, & Lung Cancer.
- Statistics







TOBACCO 101

Approximate Length:
2 Hours

Intended Audience:

Health Professionals, Tobacco Educators, Trained Youth & Counselors, Women's Conference Participants

Summary:

This general introduction to the field of tobacco prevention and education is an excellent resource and contains information relevant to women's health and smoking. The presentation does not explore the topics in depth, rather it points to important facts and statistics from the major areas of interest for AI/AN tobacco education and prevention specialists.

➤ **Traditional tobacco**

- Stories about the introduction of tobacco
- The sacred plant can heal and, when used improperly, harm
- Discovered 18,000 years ago
- Used by Medicine People for healings and blessings
- Used as a smudge
- Given as a gift and offering

➤ **Contents of commercial tobacco**

- 4000 chemicals, 40 carcinogens, 500 poisons
- Nicotine: legal addiction, controls everyday responses to life, mood leveler
- Carbon monoxide
- Tar

➤ **Hard habit to quit**

- Milligram for milligram more addictive than heroin and cocaine
- Over-learned behavior
- Withdrawal symptoms

➤ **Health effects**

- Commercial tobacco kills more Americans each year than alcohol, cocaine, crack, heroine, homicide, suicide, car accidents, and AIDS combined.



- **Facts and stats**
 - 40% of AI/AN deaths attributable to commercial tobacco use
 - Teens are 3 times more likely to smoke if their parents or siblings smoke
 - AI/AN's have the highest prevalence of smoking at 40.8%
 - 85% of teens that smoke, and get over initial discomfort, will become regular smokers
 - Costs of commercial tobacco use, societal and personal
- **Smokeless tobacco facts and stats**
 - An average sized “dip” is equivalent to 2-3 cigarettes
 - 43% of Indian youth in the Northwest use smokeless tobacco
 - Contains 28 carcinogens
- **Effects of smokeless tobacco**
 - Tooth abrasion
 - Gum disease and recession
 - Heart disease and stroke
 - Cancer of the mouth, pharynx, esophagus, and pancreas
 - Increased heart rate and blood pressure
- **Tobacco and cancer**
 - Lung cancer is the #1 cause of cancer death among AI/AN women
 - About 90% of all lung cancer deaths are attributable to smoking
 - Smoking is a major cause of cancer of the oropharynx and bladder among women
 - Smokers infected with HPV have greater risk of developing invasive cervical cancer than nonsmokers with the virus
 - Indian women have cervical cancer rates 3.5 times higher than the national average
- **Tobacco and diabetes**
 - Smoking and diabetes both reduce the amount of oxygen reaching you bodily tissues
 - Smoking raises blood sugar level making diabetes difficult to control
 - Among people with diabetes that require amputations, 95% are smokers
 - Smoking and diabetes increase cholesterol level in the blood
 - The combined cardiovascular risk of smoking and diabetes is 14 times as high as either independently

➤ **Secondhand smoke**

Smoke breathed out by smoker and from the burning end of cigarette, cigar, or pipe

38% of children aged 2 months to 5 years are exposed to SHS in the home

Puts children at increased risk for ear infections, episodes of bronchitis, pneumonia, asthma, eye irritation, sore throats, and colds

Pregnant women that smoke are passing carcinogens along to their unborn baby and puts them at risk for low birth weight, miscarriage, premature birth, and SIDS

➤ **Effects of quitting**





YOUTH

Each day, more than 4,000 kids try their first cigarette. Of those, 2,000 will become daily smokers.

24.4 % of all children are current smokers by the time they leave high school. Smoking as a youth increases the likelihood of illegal drug use.

4.5 million youth under the age of 18 are current smokers.

More than 6.4 million children under the age of 18 alive today will eventually die from smoking-related disease.

Currently, 11% of all boys in U.S. high schools and 2.2% of high school girls use spit tobacco products.

Over 30,000 births each year are effected by tobacco use.

Smoking and exposure to secondhand smoke among pregnant women causes spontaneous abortions, entopic pregnancies, still-born births, low-birth-weight babies, and other pregnancy and delivery complications causing neonatal intensive care.

During childhood, exposure to tobacco products increases the chances of sudden death syndrome (SIDS), respiratory disorders, ear and eye problems, growth and mental retardation, attention deficit disorder, and other learning and development problems.

Each year, 280 children die from respiratory illness caused by second hand smoke.

A 1997 study, exposure to secondhand smoke also leads to 500,000 physician visits for asthma and 1.3 million visits for coughs.

The same study also revealed that tobacco use causes more than 115,000 episodes of pneumonia, 260,000 episodes of bronchitis and two million cases of ear infections.

The 1999 Youth Risk Behavior Survey of 9th-12th graders by the CDC found that 54.5% of youth who had smoked in the past 30 days usually purchased their cigarettes; 23.5% bought their cigarettes from a store, 1.1% used a vending machine,





29.9% gave money to others to make their purchase, and 30% of youth smokers bum their cigarettes from others.

Numerous research studies have found that making cigarettes as inconvenient, difficult, and expensive reduces the number of youth who try or regularly smoke cigarettes.

Tobacco companies spend more than \$11.22 billion per year (\$30.7 million per day) to promote their products.

85% of youth smokers prefer the three most heavily advertised brands, Marlboro, Camel and Newports. These brands make up only 1/3 of the consumption of adult smokers over age 26.

A survey in March 2004 found that youth were more than twice as likely as adults to recall tobacco advertising.

Cigarette use among high school students in BIA schools is 56.5%, more than double the smoking prevalence rate among all high school students (22.9%).

20% of all students in BIA funded schools are smokeless tobacco users. This is compared to 1 in 12 at all U.S. high school



YOUTH TOBACCO USE SURVEY

A number of different survey tools exist that can help you quantify tobacco-use among your adolescent community members. By gathering this information, you will be able to monitor trends over time, assess the success of your tobacco prevention and education efforts, identify areas requiring further attention, validate the efforts of your program, and gain a greater understanding of the factors that influence tobacco use in your community.

This particular tool was found to be useful by communities that have used it. It is important, however, that you shape whatever tool you choose to use to fit the needs of your Tobacco Control Program. Determine what information would be most valuable to the success of your program, and then be sure your questions are capable of generating the needed results





Template

Community Name, Date

1. What is your grade level? Circle one:

3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th Not in School

2. What is your gender?

Male Female

(Do you want to know about Tribal Membership?)

3. Have you ever tried (even once):

Cigarettes:	Yes	No
Smokeless tobacco:	Yes	No
Cigars, Bidis, Cigarillos:	Yes	No

4. Have you ever used tobacco for traditional ceremonies?

Yes No

5. How old were you when you first...

Smoked a whole cigarette? _____
Used chewing tobacco, snuff, or dip such as Redman, Levi Garrett, Beechnut, Skoal, or Copenhagen? _____

6. Have you used any commercial tobacco products in the past 30 days?

Yes No





7. Have you smoked more than 100 cigarettes in your lifetime?

Yes No

8. If you tried to buy cigarettes in the past 30 days, did anyone ask for proof of age, and also refuse to sell to you because of you age?

Yes No Did not try to buy tobacco in past 30 days

9. How do you usually get your tobacco?

- I buy it at a store myself.
- I give someone else money to buy it for me.
- I borrow money from someone.
- A person 18 years or older gives it to me.

10. Please check the appropriate box for each question:

	Definitely Yes	Probably Yes	Don't know	Probably No	Definitely No
Do you think you will smoke a cigarette during the next year?					
Do you think you will be smoking 5 years from now?					
If one of your best friends offered you a cigarette, would you smoke it?					
Can people get addicted to cigarette smoking just like they can to a drug?					
Do you think young people who smoke have more friends?					
Do you think smoking cigarettes makes young people look cool or fit in?					
Do you think it is safe to smoke for only a year or two, as long as you quit after that?					
Do you think that you would be able to quit if you wanted to?					



11. Have you seen a doctor in the past 12 months?

Yes No

If yes, did he/she talk to you about the dangers of commercial tobacco use?

Yes No

12. Have you seen a dentist in the past 12 months?

Yes No

If yes, did he/she talk to you about the dangers of commercial tobacco use?

Yes No

13. Have you ever attended a program to quit using commercial tobacco?

Yes No Never Used Used but never tried to quit

If yes, where was the program?

In school only In community only In school and community

14. In the past school year, did you practice ways to say NO to tobacco in school?

Yes No

15. Have you participated in community events in the past 12 months that discourage tobacco use?

Yes No

16. Please check the appropriate box for each question:

	Don't watch TV/movies	Most of the time	Some of the time	Hardly ever	Never
How often do you see TV/movie actors smoking?					
How often do you see athletes smoking?					
	Definitely Yes	Probably Yes	Probably Not	Definitely Not	
During the past 12 months, did you buy or receive anything with a tobacco company picture on it?					
Would you wear/use something with a tobacco name on it?					

17. Please check the appropriate box for each question:

	0 days	1-2 days	3-4 days	5-6 days	7 days
In the past 7 days, on how many days were you in the same room with someone who was smoking cigarettes?					
In the past 7 days, on how many days were you in the same room with someone who was smoking cigarettes?					
	Definitely Yes	Probably Yes	Probably Not	Definitely Not	
Do you think the smoke from other people's cigarettes is harmful to you?					
Besides yourself, does anyone who lives in your home smoke cigarettes now?					
Besides yourself, does anyone who lives in your home use chewing tobacco, snuff or dip now?					

YOUTH

- **Create an Educational Video:** The NPAIHB's Western Tobacco Prevention Project collects and distributes educational videos on a variety of topics surrounding Tobacco and Health. Educational videos can be designed to target a broad spectrum of audiences, from teens to adults, policy makers to cessation group members, and may cover a wide variety of topics. These films serve as an important medium for sharing information, sparking discussion, and encouraging and motivating viewers into action against tobacco use. Audiences often find educational videos to be most entertaining and relevant when the films were specifically designed and created with them in mind. (We've all had to sit through films narrated by an old man in a suit with elevator music from the 70's playing in the background. No one wants to sit through something like that!) Consequently, it is important that we have Tobacco Education videos that are particularly relevant to you and the pressures you face. Unfortunately, no videos exist that target American Indian High School students. Your film may want to include one or more of the following:

Facts about Tobacco use and potential health consequences, personal experiences with tobacco and trying to stop, how Native communities are targeted by the Tobacco Industry in their advertisements and marketing strategies, dealing with peer and social pressures, how to stop using tobacco, healthy decision making, issues that relate to second hand smoke, and information about traditional tobacco use in Native communities.

To do this, you may want to gain input from teen smokers, teen non-smokers, Tribal cessation counselors, tobacco educators, Tribal elders, and doctors. You might also seek to collaborate with your local TV station or film Production Company – both may be able to help you create a quality film that you would be proud to share with others.

- **Create a Public Service Announcement:** Public Service Announcements (PSA's) are generally 30 seconds or a minute long – just like a commercial – whose intent is to educate the community about a particular health or safety topic. These short clips can be made for either TV or Radio broadcast. Just like a longer video, you might want to address teen tobacco issues such as facts about Tobacco use and potential health consequences, personal experiences with tobacco and trying to stop, how Native communities are targeted by the Tobacco Industry in their advertisements and marketing strategies, dealing with peer and social pressures, how to stop using tobacco, healthy decision making, issues that relate

to second hand smoke, or information about traditional tobacco use in Native communities. The challenge in creating an effective PSA is finding a way to make a big statement with only a few seconds! You would need to investigate the steps involved with producing and marketing a PSA. This project would probably require collaboration with your State and Local health departments and/or broadcasting companies in order to get your finished product out on the air.

- **Design Tobacco-Related Artwork:** If you are artistically inclined, consider using your grant to produce Tobacco-related posters, brochures, stickers, comic books, coloring books or advertisements (Newspapers, magazines and many movie theaters allow you to purchase advertising space – Movie theater ads are shown as slides prior to the start of the movie). Consider the audience you seek to reach with your message – who do you want your art to impact and how best can you get their attention? Young children may be drawn to coloring books; some teens might like comic books or posters. This project would probably require collaboration with printing or advertising companies in order to get your finished product out in your community.
- **Host a Tobacco Free Event** (invite media):
 - Family bowling night
 - Movie night
 - Open Gym night
 - Roller-skating night
 - Host a Fun Run or Walk
 - Pot Lucks
 - Basketball Tournament: “You smoke you croak tournament”
 - Dance with a theme
 - One night pow-wow with a presentation about tobacco issues, or with an “MC” providing tobacco facts every hour.
 - Skit during assembly and then within the community
- **Make a Teen-Oriented Cessation Guide:** A number of booklets have been made to help adults when they decide to quit. Unfortunately, very few guides have been made by teens – for teens. We have resources from which you can draw ideas. This would involve learning more about how tobacco users quit and then designing a way to share that information with teens.
- **Address Policy Change:** Teens have the power to guide and shape the policies that affect everyone in our community. First, choose a topic of interest – Are you concerned about Secondhand smoke in public places? Are you concerned about teen access to Tobacco products in your community? Are you concerned about

Tobacco Industry advertising in shops or at community events? Second, learn about the policies that already exist in your community and think about ways that you can influence change. Research the topic – how have other communities addressed this problem? Next, help write a resolution that can be ratified by your tribal board. Talk to board members and those that will be affected by the policy to gain their support. Talk to those that will have to enforce the policy. You can make an important difference!

- **Encourage Teen Involvement in State Prevention Summit(s):** Promote and enable participation of teens in attendance of State Prevention Summit(s).
- **Promote involvement in Youth-Driven Tobacco Prevention Activities:** Assist youth in becoming involved in youth-driven activities such as “Camp Speak Out” and “Teens Against Tobacco Use (TATU)” presentations.
- **Develop a Webpage:** Create a web page. Focus on Indian youth issues around tobacco.
- **Have a Tobacco Prevention/Wellness Fair or Implement Tobacco Prevention Activities in Current Tribal Fair(s):** Purchase anti-tobacco materials and travel to different schools in the community hosting tobacco prevention fairs with different booths/prizes/other activities to encourage being tobacco free. Address specific tobacco related issues in your area. Coordinate with youth to implement youth-oriented tobacco prevention activities in current Tribal fair(s) or wellness fairs.
- **Involve Youth in the Coordination of Special Events:** Provide youth with opportunities to assist in the development and implementation of Tobacco Prevention Activities for special events such as “Kick Butts Day”, “World No Tobacco Day”, and “Great American Smokeout”. A youth canoe journey that could consist of training sessions including teamwork & communication, spirituality, physical wellness, tribal history, ancestry, & community celebration.
- **Start a “Tobacco Free Club” at School(s):** Gather teams to work together to promote commercial tobacco prevention in the community. Develop a tobacco prevention program/training to present to elementary school(s).
- **Create an Anti-Commercial Tobacco CD:** Assist youth in the development of anti-commercial tobacco materials such as music CD’s, which they will enjoy creating, enjoy listening to, and will want to distribute it to their peers.



- **Incorporate a Tobacco Education Component in an Already Existing Camp or Cultural Activity:** Distribute tobacco education materials at already existing events, or partner with an event in order to give presentations or educational booklets to the participants.

- **Research Traditional Tobacco Use Among the Tribal People in Your Area:** Create a community presentation of how people traditionally used tobacco and why. Advertise your presentation for the entire community and provide snacks/food for those who attend.
 - Host Tobacco Free Basketball Tournament where youth have to participate in tobacco education classes in order to participate in the event
 - Host a Mini pow-wow where a presentation is given about the dangers of commercial tobacco OR an MC would announce tobacco related statistics once every hour
 - Incorporate a tobacco education component in an already existing "camp" or cultural activity
 - Create an anti-commercial tobacco music CD
 - Host a commercial tobacco free dance
 - Coloring/Art contest where youth design commercial tobacco prevention messages on their art (could then be hung up at a dance or in grocery store)

Resources

1. Creating Indigenous Resource Cooperatives Through Leadership Education (CIRCLE Project)

2. National Tribal Tobacco Prevention Network.





SPEAK YOUR MIND

Approximate Length:

45 Minutes

Intended Audience:

Tobacco Educators, Coordinators, and Young Adults.

Summary:

The “Speak Your Mind” presentation provides a 13-slide outline for public speaking. It offers suggestions for possibly becoming more credible and sincere. It may allow speakers to feel empowered by increasing the self-confidence when giving a presentation or in basic one-on-one conversations with others. This workshop highlights the main steps in gathering other people’s attention and ensuring that the focus is on what is being said, rather than who is saying it.

- Step 1 - Give up paragraphs and learn to love outlines
- Step 2 - Know your topic
- Step 3 - Remember your audience
- Step 4 - Back up your points with stories
- Step 5 & 6 - Speak clearly and speak up
- Step 7 - Get it right- pronunciation
- Step 8 - Expressiveness and eye contact
- Step 9 - Rehearse, rehearse and then rehearse
- Step 10 - Deliver
- Step 11 - Q & A





NICOTINE- A LEGAL ADDICTION

Approximate Length:

1 hour

Intended Audience:

Adolescent Youth/ Young Adults

Summary:

“Nicotine- A Legal Addiction” is a PowerPoint presentation that consists of 19 slides about Nicotine and how it impacts an individual’s body before and after usage. This presentation is very influential on any audience, but is specifically tailored to adolescent youth. It includes only factual information on the issues concerning nicotine.

- **What defines addiction**
Reinforcing, Tolerance, Altered Behavior, and Dependence
- **Why Nicotine is addicting**
Withdrawal, and Production of Stimulants
- **How Nicotine impacts your emotions**
Mood Leveler and Dependence
- **Why Nicotine is such a hard habit to quit**
10 times more potent than heroin
- **The withdrawal symptoms of Nicotine**
Main symptoms: Anxiety, Difficulty Concentrating, Tobacco Cravings, Irritability, and Restlessness
- **Timeframe for ending Nicotine habits**
Physical symptoms, craving, and emotional/behavioral adjustments
- **Smoking Prevalence Rates**
Higher than any other ethnicity
- **Statistics and Facts**





N-O-T (NOT ON TOBACCO) TEEN CESSATION SMOKING PROGRAM

Approximate Length:

1.25 hours

Intended Audience:

Teens and Young Adults

Summary:

This 23-slide presentation is tailored to teens and young adults who would like to become involved in a teen cessation smoking program called N-O-T (Not On Tobacco). This presentation includes the following:

- How to be an effective facilitator
- Prevalence data among teens
- Addiction and teens
- Effect of tobacco during adolescents
- Benefits of N-O-T
- Key Features of N-O-T
- Who N-O-T is for
- Overview and components of program
- Evaluation Results and secondary outcomes
- N-O-T in school and community settings
- Format for N-O-T sessions





TOBACCO AND ADVERTISING

Approximate Length:

1.5 Hours

Intended Audience:

Tobacco Educators, Counselors, and Young Adults

Summary:

This 39-slide presentation provides information regarding common facts about tobacco companies and advertisements. It gives background on the money that tobacco companies spend on their advertising and who they are targeting with these advertisements. It also gives facts about the effectiveness of tobacco advertisements in movies and magazines. This informative presentation can be used to assist in the training of tobacco educators and counselors, but may also be effective when shown to Young Adults and Teens to illustrate how they are being targeted.

- **What is in Cigarettes**
Chemicals, Carcinogens, and Poisons
- **Money Spent on Tobacco Advertising**
Spend more than 3 times that of an annual IHS Budget
- **Tobacco Advertising in Movies**
Advertising Facts
Influence of Tobacco Use in Movies on Teens
- **Perceptions and Deceptions**
Tobacco companies want to show tobacco use as more common and acceptable
- **Tobacco and Teens**
Influence of Tobacco Advertising on Teens





WORKING WITH TEENS ON TOBACCO ISSUES

Approximate Length:

1.75 Hours

Intended Audience:

Tobacco Educators, Counselors, and Health Providers

Summary:

This is a 29-slide comprehensive presentation about working with teens on tobacco issues. This presentation covers many aspects on teen involvement and recruitments. The purpose of this presentation is to provide a guideline for Tobacco Educators, Counselors, and other Health Providers in gaining help and support from teen leaders.

➤ **Fundamental Rules for Success**

- Do not Use teens
- Give decision making to teens
- Make projects fun
- Offer meaningful opportunities
- Encourage teen/adult partnership
- Offer training that is relevant, experiential and interactive
- Provide opportunities for reflection & feedback
- Acknowledge teens personally & publicly

➤ **Nuts and Bolts of Working with Teens**

Recruitment

➤ **Making the Approach**

Honesty, Sincerity, and Peer Education

➤ **Incentives**

Food, Certificates, Prizes, etc...

➤ **Training**

Materials Concise, Attractive and Relevant
Lecture Short and Humorous

➤ **Potential Barrier**

Transportation, Safety, Unpredictability, and School





- **Menu of Possibilities for Teen Involvement**
- **Roles and Responsibilities**
Teen and Adult



SECONDHAND SMOKE

Among tobacco use health topics Secondhand Smoke (SHS) is unique because it draws our attention away from those that abuse commercial tobacco and focuses on friends, co-workers, and loved ones of the tobacco user. Because most non-smokers would choose not to be around secondhand smoke (if given the choice) we must be careful to maintain respectful communication with smokers. Much of the work currently being done in the realm of SHS (also known as Environmental Tobacco Smoke, ETS) is centered on policies relating to tribal facilities, vehicles, and gaming facilities in addition to home and personal vehicle pledges.

SHS is defined as the mixture of the smoke given off by the burning end of tobacco products (sidestream smoke) and the smoke exhaled by smokers (mainstream smoke). It contains over 4000 chemicals, more than 50 of which are known or probable human cancer-causing agents (carcinogens).^{1,2} For nonsmoking adults exposed to SHS there is an associated increase in risk for developing lung cancer and coronary heart disease.^{1,2,3} Secondhand smoke is a known human carcinogen.^{2,3} Young children are particularly susceptible to the risks associated with SHS because their lungs are not fully developed. Exposure to secondhand smoke is associated with an increased risk for sudden infant death syndrome (SIDS), asthma, bronchitis, and pneumonia in young children.^{1,4} SHS exacerbates symptoms associated with asthma, even the stale odor of cigarette smoke can trigger an asthma attack.

It is estimated that 18.6% of Idaho, 20.1% of Oregon, and 17.7% of Washington children are exposed to SHS in the home.⁵ Children whose parents smoke in the home can inhale the equivalent of 102 packs of cigarettes by age five. Nationwide, children exposed to secondhand smoke in the home miss 39% more school days every year.⁶

In the United States about 60% of non-smokers show biological evidence of SHS exposure.⁷ Among adult nonsmokers in the United States SHS is responsible for an estimated 3,000 lung cancer deaths and more than 35,000 coronary heart disease deaths annually.⁶



SECONDHAND SMOKE

Secondhand smoke (SHS), also known as environmental tobacco smoke (ETS), is the smoke given off by the burning end of cigarettes, cigars, or pipes and the smoke exhaled from the lungs of smokers that is inhaled by nonsmokers.¹

Secondhand smoke contains a complex mixture of more than 4,000 chemicals, more than 50 of which are cancer-causing agents (carcinogens).^{2,3}

Secondhand smoke is classified as a Group A carcinogen, which means it causes cancer in humans.⁴

Children and adolescents with at least one smoking parent have a 25% - 40% increased risk of chronic respiratory symptoms such as cough, wheeze and breathlessness.⁵

Secondhand smoke is estimated to cause 3,000 lung cancer deaths in nonsmokers each year.⁴

Exposure to secondhand smoke has been linked to an increased risk for Sudden Infant Death Syndrome (SIDS).⁶

Approximately 53,000 non-smoking Americans die from secondhand smoke each year.⁷

Fact sheet information provided by the National Tribal Tobacco Prevention Network, a project of the Northwest Portland Area Indian Health Board, www.tobaccoprevention.net





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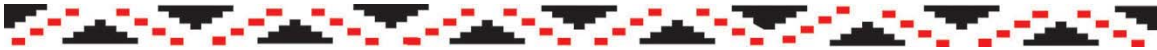
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SECONDHAND SMOKE

- **Protect the health of your children and relatives.** Keep your home smoke-free. If guests or household members must smoke, ask them to take it outside. If smoking must take place in the house, designate a smoking room with working windows that is away from the living area and children's rooms, however keep in mind that smoke can travel through the smallest of cracks and still be extremely harmful.
- **Make sure that your child's school, babysitter, or daycare is smoke-free.**
- **Take care of your family and friends.** Don't allow smoking in the car.
- **Talk to your tribal council.** Approach your tribal council about passing policies to make tribal buildings smoke-free.
- **Request non-smoking hotel rooms when you travel.**
- **Support smoke-free casinos.** choose non-smoking gaming areas.
- **Talk about the dangers of secondhand smoke with your relatives** Ask them not to smoke around your children.
- **Encourage your employer to pass a smoke-free workplace policy**
- **Choose non-smoking restaurants.** Thank them for providing clean air. Or tell the manager at your favorite restaurant you'd like them to go smoke-free.
- **Find a respectful way to talk with your elders about the dangers of secondhand smoke.**
- **Collaborate with tribal or community tobacco prevention programs.** Make an effort to address secondhand smoke in your community.

Fact sheet information provided by the National Tribal Tobacco Prevention Network, a project of the Northwest Portland Area Indian Health Board, www.tobaccoprevention.net.



SECONDHAND SMOKE

Approximate length:

1 ½ hours

Intended audience:

Health/Tobacco Educators, Clinicians, Tribal Leaders, and Community members

Summary:

This presentation is a general overview of: the contents of SHS; the health effects of SHS on American Indian/Alaska Natives, children, pregnant women, and the wider U.S. population; and a brief discussion on developing Tribal Tobacco Policies. While the presentation contains several statistics it can be tailored to suit different audiences.

- **Definition of SHS**
Sidestream smoke & mainstream smoke
- **Contents of SHS**
Chemicals, Carcinogens, & Poisons
- **Rates of exposure to SHS**
- **Common places of SHS exposure**
Home, Workplace, Bars, Bowling alleys, & Restaurants
- **Health effects associated with SHS**
Lung cancer, Coronary heart disease, Cardiovascular disease
- **Facts**
Tobacco is the leading cause of death in the US, 2000
- **Asthma**
Definition & explanation
- **Relationship between asthma and SHS**
Indoor asthma trigger, exacerbated symptoms, etc.



- **Health effects of SHS for young children**
Associated with an increased risk for SIDS, bronchitis, pneumonia, allergies, flu, etc...
- **Effects of smoking in pregnant women and their fetus**
Premature birth, low birth weight, lifelong breathing problems, & congenital malformations
- **Smoke-free Home Pledge**
- **Tribal Tobacco Policies**
Types and brief explanation of the process for implementation





SECONDHAND SMOKE

A HEALTH HAZARD TO CHILDREN

Approximate length:

1 hour

Intended audience:

Health/tobacco educators, clinicians, Tribal Leaders, and community members, new parents

Summary:

SHS is particularly dangerous to fetuses and young children. Pregnant women that smoke are adversely affecting the health of both the mother and the child. Smoking during pregnancy raises the risk of a number of poor pregnancy outcomes (i.e. neonatal mortality and stillbirth, SIDS, and premature childbirth). Children born to mothers that smoked during the pregnancy are also more likely to have low birth-weight. Because their lungs are not fully developed they have risks beyond those of adults when exposed to SHS.

➤ **SHS FAQ's**

38 percent of children aged 2 months to 5 years are exposed to SHS in the home

Risk factors of SHS for pregnant women and their children: miscarriage, premature birth, low birth weight, SIDS, upper respiratory infections, coughing and wheezing, soar throats and colds, eye irritation, and hoarseness

Children younger than one year whose mother's smoked were almost four times as likely to be hospitalized

Infants with two parents who smoke were more than twice as likely to have had pneumonia and bronchitis

- **Explanation of asthma** SHS is an indoor asthma trigger
- **Smoke-free home pledge**
- **Resources**





CESSATION

As Health Professionals working in the field of commercial tobacco prevention and education, one of our primary objectives is to help people to quit using commercial tobacco. There are many programs available to smokers and counselors to aid in the quitting process. Choosing the right program depends largely on your target population. Some are based on personal counseling sessions to focus on the needs of the individual while others utilize group sessions to foster support and understanding. Following are some common strategies present in almost all cessation programs:

- **Why do you want to quit?** Make a list of the reasons for quitting. Remember that motivation will make quitting a little easier and will help to keep focused.
- **Set a quit date.** Prepare mentally. Tell friends and family so they are aware of the decision. Make a note of the date in a calendar.
- **Know the triggers.** Desire/need for a cigarette fluctuates throughout the day and is often “set off” by moods, feelings, places, or things we do. Knowing triggers can help us stay away from things that tempt us to smoke. It can prepare us to fight the urge when we are tempted.
- **Know your supporters.** Whether family members, a counselor, or a support group are supporters in the quit effort, keep these people in mind as we can rely upon them in times of need.
- **Know the options.** A “cold turkey” quit attempt is not the only option available. Other possibilities include tapering use, nicotine replacement therapy (i.e. “the patch”, gum, and inhaler), and other pharmacotherapy (i.e. Wellbutrin, Bupropion)
- **Know the stages of behavior change.** Although people frequently move back and forth between the stages of change it is useful to remember that others have shared similar feelings and struggles. The accepted stages of change are: Precontemplation, Contemplation, Preparation, Action, Maintenance, and Relapse.

Nicotine, the psychoactive drug in tobacco products that produces dependence,¹⁻³ is the most common form of chemical dependence in the United States.³ Research suggests that nicotine is as addictive, milligram for milligram, as heroin, cocaine, and alcohol.⁴ Examples of nicotine withdrawal symptoms include irritability, anxiety, difficulty concentrating, and increased appetite.¹ Quitting tobacco use is difficult and may require multiple attempts,² as users often relapse because of withdrawal symptoms.^{1,2} Tobacco dependence is a chronic condition that often requires repeated intervention. It is estimated that smokers will average seven quit attempts before finally succeeding in a long-term quit.



CESSATION

Smoking Cessation means beating tobacco dependence by quitting smoking.

Tobacco dependence is considered to be a chronic condition that usually requires repeat intervention. 70% of the smokers in the United States today have tried to quit at least once. Most smokers make several quit attempts before they successfully kick the habit.¹

Current recommended smoking cessation treatments include nicotine replacement therapies (NTRs) in the form of gum, inhaler, nasal spray, and patch (“the patch”), as well as the pharmacotherapy, Bupropion.¹

Person-to-person or over the phone treatments are an important part of a quit process. These may include counseling, cessation group social support, and support from family and friends.¹

The benefits of quitting smoking are both immediate and long term. The former smoker’s risk of stroke will begin to decrease steadily. He or she will have lower risk for illnesses such as colds, flu, bronchitis, and pneumonia; will cough less; feel less tired and less short of breath; and have less congestion.²

One year after quitting smoking, a person’s risk of coronary heart disease, characterized by heart attack, decreases by half.²

Ten years after quitting smoking, a person’s risk of lung cancer drops to nearly half that of a smoker.²

Smokers who quit before or early in pregnancy reduce their risk of miscarriage or of having a low birth-weight baby. Smokers who quit before or early in pregnancy reduce the risk of Sudden Infant Death Syndrome (SIDS) in their babies.²

Fact sheet information provided by the National Tribal Tobacco Prevention Network, a project of the Northwest Portland Area Indian Health Board, www.tobaccoprevention.net





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CESSATION

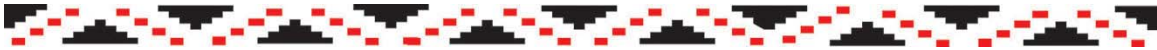
- **Organize a “Tribal Quit Day”.** on the same day as another important event (i.e. World No Tobacco Day, Kick Butts Day, a Pow Wow, opening of new facilities, etc.)
- **Hold a “Cessation Fair”.** Invite cessation professionals to give informational speeches, display products, etc...
- **Call a Tobacco Quit Line,** if your state has one, and talk to a phone counselor about quitting.
- **Talk to your clinician.** Ask him or her to suggest a nicotine replacement therapy right for you. The following treatments are currently recommended as smoking cessation aids: nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch (“the patch”). Bupropion SR is another treatment available, but must be administered by a physician.
- **Get involved in a smoking cessation support group.** Your clinic, tribal or community center likely offers cessation services. Social support will increase your likelihood of quitting and staying quit.
- **Get involved in a smoking cessation program.**

For Clinicians

Excerpted from: U.S. PHS. *Treating Tobacco Use and Dependence*. Fact Sheet, June 2000.

- Tobacco dependence is a chronic condition that often requires repeated intervention.
- Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment. There is a strong dose-response relation between the intensity of tobacco dependence counseling and its effectiveness.
- Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered a first or second line pharmacotherapy combined with counseling or behavior therapy whenever possible.
- It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.

Activities information provided by the National Tribal Tobacco Prevention Network, a project of the Northwest Portland Area Indian Health Board, www.tobaccoprevention.net





SECOND WIND

Approximate length:

4 hours

Intended audience:

Trained Counselors, Health Providers, and Tobacco Educators

Summary:

The Second Wind program is designed specifically to help American Indian and Alaska Native people stop smoking and remain smoke free. The Second Wind program consists of a Facilitators manual and a Participants manual. It is suggested that the facilitator also explore the use of replacement pharmacotherapy's, traditional medicines and other remedies. Appropriate referrals to alternate healthcare providers can be of significant value during the cessation process. The curriculum was designed by Cynthia Coachman of the Muscogee (Creek) Nation within the Tobacco Prevention and Control Program. If you have any questions about the content or effectiveness of the program, please address them to her:

*Cynthia Coachman, RN
Muscogee (Creek) Nation
Tobacco Prevention and Control Program
1801 East 4th St (Lackey Hall Building)
Okmulgee, Oklahoma 74447
1-800-782-8291 ext. 287
cynthia.coachman@mail.ihs.gov*

You are free to make additional copies as needed. Please credit Ms. Coachman for her work.

- **Six one-hour group sessions meeting every two weeks for a total of three months**
 - (1) Basic tobacco facts, (2) Why people smoke, (3) Relaxation and coping skills, (4) Danger situations, (5) Personal support network, (6) Long term benefits of quitting.
- **Facilitator responsibilities, role, and skills**
 - Knowledgeable, Promote Cohesion, & Leadership
- **Incentives and barriers**
 - Timing of classes and demonstration of support for smokers.







FREEDOM FROM SMOKING

Approximate length:

1 hour

Intended audience:

Trained Counselors, Health Providers, and Tobacco Educators

Summary:

Freedom From Smoking is a group counseling cessation program developed by the American Lung Association (ALA). The underlying premise of the clinic is that smoking is a learned habit and therefore to quit it is necessary to unlearn the behavior. Freedom From Smoking does this by utilizing group dynamics and support. The program offers techniques to aid in the quit process that are based on pharmacological and psychological principles. The facilitator's primary role is to introduce the techniques of the program and motivate the participants. A Guide for Clinic Facilitators can be obtained through your state's ALA chapter. You can find your local chapter on the ALA's national website: <http://www.lungusa.org>

- **Philosophy**
- **Four stages of behavioral change**
 - (1) Hanging on, (2) Letting go, (3) Starting over, (4) Re-stabilizing
- **Creating an effective learning environment**
 - Inclusion → Trust → Commitment/Change/Content
- **R.A.P. Rule**
 - Real, Active, Participatory
- **Format and content of sessions**
 - (0) Thinking about quitting, (1) On the road to freedom, (2) Wanting to quit, (3) Quit day, (4) Winning strategies, (5) The new you, (6) Staying off, (7) Let's celebrate!
- **Nuts/Bolts**
 - Mediators, Smokers in General, & 5 stages of quitting
- **Evaluation**







ONE-ON-ONE TOBACCO CESSATION PROGRAM AN INDIVIDUALIZED APPROACH

This presentation was developed by the Puyallup Tribal Health Authority

Approximate length:
1 hour

Intended audience:
Trained Counselors, Health Providers, and Tobacco Educators

Summary:

The Puyallup Tribal Health Authority's smoking cessation program is a one-on-one individualized program that is theory based, client driven, respectful and flexible. The program has been evaluated and revised over the past four years to increase retention and success rates. The one-year success rate for program graduates (six or more visits and not smoking for three months) is 82% and the success rate for participants who attend six or more sessions is 64% at one year.

Focus groups with program graduates documented the importance of the client/counselor relationship as a key component for long-term success. The materials reviewed were seen as helpful but not the most important part of the program. Clients gave high marks to having regular appointments, being listened to and being able to lead their own process as very important to success. This presentation outlines the program. A manual is available from the Health Authority for those interested in designing an individualized approach to smoking cessation.

- **Research on smoking cessation in native communities**
Get native people involved



- **CDC guidelines for smoking cessation programs**
Skill building, Social support, Problems solving, & Medications
- **PTHA program general principles**
Theory based, Client driven, Flexible format, Respectful
- **Structure**
- **Participant profile**
Chronic disease associated with tobacco use
- **Basic principles**
The process is the clients- not the counselors
- **Key ingredients**
Relationships between client & counselor
- **Client centered approach**
- **The process**
Initial & overall
- **Theories and models applied**
Social Learning Theory, Health Belief Model, Stages of Change Model, Motivational Interviewing Strategies, Relapse Prevention Model
- **PTHA six step process**
Assessment, Setting the quit date, Day before quit date, Maintaining the quit, Graduation, Maintenance
- **Evaluation**
32% all participant enrollees; 64% participants with 6 or more visits, 82% program graduates

COUNTERMARKETING

Every day the tobacco industry loses some customers who quit using their products and others who die (many as a result of the use of their products). Because of this, they must continually recruit new tobacco users. The majority of new customers are found during their youth. Each day, nearly 4,400 young people between the ages of 12 and 17 years initiate cigarette smoking in the United States and an estimated 2,000 of these become daily cigarette smokers.¹ To achieve this goal the tobacco industry uses marketing techniques targeted to youth and other specific populations. Simply put, the industry uses what they know about different groups to make them want to smoke.

Maintaining their profits is not easy for the tobacco industry. In fact, in 2001, cigarette companies spent \$11.2 billion, on advertising and promotional expenses.¹ That's more than \$30 million per day or \$241 for each adult smoker (throughout the year).^{1,2} From 1989-1993 the three tobacco companies that outspent the others were Marlboro, Camel, and Newport.³ These were also the three companies most preferred by smokers (during the same period) aged 12–18 years who reported usually buying their own cigarettes.³ The correlation is no accident. The tobacco companies know that getting smokers to switch brands is a difficult task so it is important to hook young people on their products early.

The goal of tobacco counter marketing is to nullify the efforts of the marketing strategies employed by the tobacco companies. We can do this through a number of different approaches. Many commercials and advertisements portray smokers as beautiful, intelligent, popular, and sophisticated. Showing the facts about tobacco use demonstrates the inaccuracy of those images. When people (especially youth) discover that marketing plans have been devised to influence their behavior, specifically to use tobacco, they often become angry and want to make sure they are not “tricked” into commercial tobacco abuse. They may even want to help others avoid the manipulation of false advertising.



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COUNTERMARKETING

Some of the goals of tobacco advertising are to get youth to start smoking, to get smokers to switch brands, to get the public to recognize brand names, to build brand loyalty, and to get people familiar and comfortable with tobacco products in their everyday lives.

Tobacco advertising includes pow-wow give-aways and promotional items, billboards, magazine ads for cigarettes or dip, clothes ads in which people are smoking or dipping, rodeo and other sport and team sponsorships, samples, store signs and displays (which are often placed at a child's eye-level,) coupons, movies in which people are using tobacco, and entertainment sponsorships.

The tobacco industry spends \$11.22 billion per year advertising their products, that's \$30.7 million per day or \$21,319 per minute--more than any U.S. industry except automobile makers!^{1,7}

To build its image and credibility in the community, the tobacco industry funds cultural events such as pow-wows and rodeos.⁸

To target American Indians for future customers, some tobacco companies use American Indian images and cultural symbols in their advertising, such as warriors, feathers, regalia and words like "natural" in the brand names.²

Natural American Spirit Cigarettes are not owned or made by American Indians. In fact, the company is owned and manufactured by the second-largest tobacco company in the U.S.--R.J. Reynolds Tobacco Company, who make about one of every four cigarettes sold in the United States.³

Children and teenagers make up the majority of all new smokers, and the tobacco industry's advertising and promotional campaigns target young people.⁴

Marlboro is the cigarette brand preferred by 50% of teenage smokers, followed by Newport and Camel.⁵ These are also the brands most heavily advertised in the U.S.⁶

Fact sheet information provided by the National Tribal Tobacco Prevention Network, a project of the Northwest Portland Area Indian Health Board, www.tobaccoprevention.net.





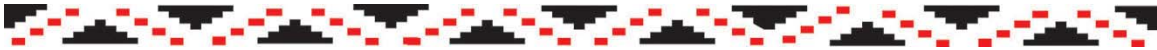
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COUNTERMARKETING

- **Information on marketing techniques.** A good place to start in countermarketing is to educate your population about the efforts of the tobacco industry. Highlighting the major tactics (i.e. print, billboard, movies, etc.) of big tobacco will foster understanding of how advertising and marketing work.
- **Letters to the editor and newsletter articles.** Both groups and individuals can write letters to the editors of local papers or submit articles to newsletters. These can focus on recent studies, current or proposed smoking policies, tobacco-free events, or any other tobacco related topic or event.
- **Promote events as “Tobacco-free”.** If your tribe is holding an event try to convince the leaders of the event to make it “Tobacco-free”. Then integrate a tobacco-free message into the event and promote a healthy lifestyle.
- **Taking back our images.** The tobacco industry uses the images of American people to sell their product. Get your community excited about fighting the exploitation of our ancestors and culture.
- **Talk to your Tribal Council.** Approach your Tribal Council with suggestions about commercial tobacco use and marketing. Create an official policy against Tribal acceptance of funds from tobacco companies or restrict advertising in Tribal stores to non-tobacco merchandise.
- **Create a campaign.** A comprehensive tobacco campaign can be a lot of work but it can also achieve great success. Partner with another organization to create a counter-marketing campaign to combat the efforts of the tobacco industry.
- **Conduct a community assessment of tobacco advertising and promotion practices.** After gathering the marketing data educate businesses about the health effects of commercial tobacco. Ask retailers to remove in-store displays and signs placed at children’s eye-level.



RAISING AWARENESS IN TRIBAL COMMUNITIES

Approximate length:

1 hour

Intended audience:

Health/Tobacco Educators, Clinicians, Community Members, and Youth Leaders

Summary:

Why should we create a media campaign? How does media advocacy work? This presentation answers these questions along with others. There are several types of media that can be utilized for your campaign and a number of different resources available (especially online). There are also some useful tips and hints for creating your own media project.

- **Media Advocacy**
The strategy and broad-based use of media for advancing social or public policy issues.
- **Why should we consider media advocacy?**
It's a long-term plan; Sets a standard for healthy behaviors; Emphasizes public health; Reaches large numbers of people; Institutionalizes community norms
- **What is the desired outcome?**
Short term and long term objectives
- **Know your intended audience**
Policy makers & community members
- **Types of media for a campaign**
Print, Radio, Film, & Outdoor advertising
- **Resources**
CDC National Media Campaign Resource Center, National Youth Anti-Drug Campaign, State Resource Clearinghouse
- **Create & Identify your message**





SMOKE SIGNALS

THE TRUTH BEHIND TRICKSTER AND TOBACCO

Approximate length:

1 hour

Intended audience:

Health/Tobacco Educators, Tribal Leaders, and Community Members

Summary:

The Big Tobacco companies use AI/AN culture, words, and images to get people addicted to their product, just so they can make a profit. Their intentions are pretty clear, but when looking at their internal documents and what they say about their product we should begin to be even more skeptical about them. This presentation contains quotes by executives in the tobacco industry among other informative items about how the industry sees youth as the next generation of smokers.

- **What big tobacco really thinks**
“We don’t smoke this crap, we just sell it...”
- **Facts to consider**
\$11.2 billion spent on tobacco advertising, marketing, and promotions in 2001
“Today’s teenager is tomorrow’s potential regular customer...”
- **Myth-Advertising**
Does not affect overall consumption or persuade smokers to quit
- **Strategies aimed at AI/AN people**
Big tobacco says that smoking commercial cigarettes is: traditional, culturally appropriate, the “Indian” thing to do, and ceremonially acceptable
- **American Indian imagery used on tobacco products**
- **Tips for challenging the tobacco industry**
Know the facts
- **Examples of counter-marketing**





- **Successes in Tribal programs**
Get youth involved
- **Principles of native leadership for tobacco education and prevention** respect, vision, courage, action, humility, hope, compassion, truth, and generosity





TOBACCO ADVERTISING

Approximate length:

1 hour

Intended audience:

Health/Tobacco Educators, Tribal Leaders, Community Members, Youth Leaders, and Youth

Summary:

In 1971 the FCC banned tobacco advertisements on TV and the radio. As a result of this landmark decision the tobacco industry began searching for other avenues for advertising its product. They came up with a strategy that is extremely subtle and seems to work quite well. The idea is to place smoking celebrities in the eye of the public whenever possible. One of the primary sources of this new advertising is in movies.

➤ **Graphs**

Domestic cigarette advertising and promotional expenditures
Tobacco industry spending 2001 (\$30.7 million per day, \$110.6 million on sports and sporting events, 3.9 billion cigarettes given away)

➤ **Tobacco Industry & Movies**

“...a film is much better than any commercial...the audience is totally unaware of any sponsor involvement”

➤ **Graph**

Tobacco events per hour in movies

➤ **Just the facts**

95% of the 250 highest grossing movies had actors using tobacco (from 1988-1997)

➤ **Graph**

Exposure to movie tobacco use and youth that have tried smoking

➤ **Smoking in the real world**

Kills, families suffer, SHS harms non-smokers





- **Smoking in movies** Makes smoking appear to be the norm
- **Tobacco industry spokesman**
“Every industry has to recruit new customers. We recruit our new customers once they're over the age of 16. Of course they see the advertising before that age, of course they see people smoking before that age. They make up their ... their decisions perhaps before that age.”
- **Perception & Deception**
- **Counter-marketing and youth use of tobacco**





TOBACCO ADVERTISING

REFUSE TO PLAY THE PART THE INDUSTRY HAS ASSIGNED TO YOU

Approximate length:
45 minutes

Intended audience:

Health/Tobacco Educators, Tribal Leaders, Community Members, Youth Leaders, Youth

Summary:

This presentation provides a basic introduction to advertising and marketing in the tobacco industry. It touches on some of the deceptive images that the industry creates about smoking.

- **Broken Promises**
Youth directed advertising: magazines, convenience stores, movies
- **Deception**
People who smoke are: interesting, successful, sexy, role models
Smoking is the norm, youth perceptions of smoking rates among youth and adults
- **Smoking in movies**
Powerful advertising
- **Pie chart**
Commercial tobacco and mortality
- **Connection**
Youth smoking and advertising
- **Counter-marketing**
Communicates true health and social costs of tobacco use, portrays smoking as unacceptable, and highlights tobacco-free lifestyle as the majority lifestyle of interesting and popular people.





PARTNERSHIPS

A partnership exists when there is a relationship between two or more entities (programs) conducting business for a mutual benefit. There are many benefits to forming tribal partnerships. However, maintaining partnerships can be extremely challenging.

Tribal tobacco prevention programs frequently lack resources, funding, and personnel time dedicated to the tobacco project. There is often a struggle between implementing the programs or services and having enough resources to make the program worthwhile for the community. Through collaboration and teamwork, partnerships can be formed to help alleviate some of the challenges Tribal Tobacco Coordinators are faced with.

Partnerships can provide your tribe with many of the following benefits:

- Build supportive networks through relationships and trust
- Provide more solutions to a given problem
- Require fewer resources from your program
- Better understanding of each other’s programs
- Enable increased learning to take place: person-to-person, program-to-program, and agency-to-agency
- Less funding required by each program/agency
- More personnel to assist in activity coordination
- More information provided to participants
- Overall increased tribal efficiency

Through partnerships and collaboration, more doors will be opened for your program. Better understanding can be developed and your program may show continuous growth. Partnerships have proven to be beneficial and should be used to their full potential.



PARTNERSHIPS

Possible types of partnerships:

State and Tribal- Your State has likely established a unique partnership with your tribe's tobacco program. Refer to the contract at the beginning of this resource guide for more information on the specific goals and activities that your program has agreed to fulfill.

Partnerships with External Organizations- These include any collaboration formed with a group outside the immediate tribal community. These include partnerships with non-government organizations such as NPAIHB, American Cancer Society, American Lung Association, and local school districts.

Inter-Tribal Partnerships- Tribes often work with other groups and health promotion programs at the tribal level, such as Head Start program, the clinic, or the diabetes program. Working together on mutually beneficial projects can reduce the cost of activities, and can send a more comprehensive tobacco prevention message to community members.

- Partnerships allow for a trusting, more open-minded atmosphere as you work with one another keeping your ultimate goal in mind.
- Partnerships require less funding and other resources from each program or agency.
- They allow for more information to be provided to the participants.
- Provide a better understanding of one another's program or agency.
- Enable increased learning to take place: person-to-person, program-to-program, and agency-to-agency.
- They provide more personnel to assist in the coordination and implementation of events and activities.
- Partnerships build supportive networks through relationships and trust.
- They provide more solutions to any given problem.
- Partnerships increase overall tribal efficiency.
- When beginning partnerships, first determine what programs currently exist that you could possibly partner with, who the contacts are for those programs, and what resources the programs may have.

Common barriers include:

- Lack of understanding
- Lack of communication





- Lack of trust
- Lack of experience/guidance
- Assumptions
- Own agenda
- Secrets/misleading/disingenuous

To assist in overcoming these barriers and sustaining a strong partnership, it is important that you are honest, flexible, and open-minded.

It is also helpful to communicate and collaborate on a continual basis, and focus your attention on the mutual goals of your partnership.

Resources

Building Effective Partnerships - The National Institute of Adult Continuing Education:
www.niace.org.uk/information (2001)

Society of Information Technology Management – Private Public Partnerships
<http://www.bradfordunison.org.uk/docs/Socitm%20-%20Private%20Pub%20Partners.htm>

Deborah Parker (Tulalip Tribe)

Diane Pebeahsy (Yakama Indian Nation)

Joyce Oberly (Confederated Tribes of Warm Springs)

Kathy Charles (Lummi Tribe)

Sue Hynes (Lower Elwha Klallam Tribe)



PARTNERING

January

- **National Birth Defects Prevention Month** → Congenital malformations implicated by exposure to cigarette smoke include heart defects, cleft palate, hernias, and abnormalities to the central nervous system.
- **National Eye Care Month** (National Eye Institute) and **National Glaucoma Awareness Week** (19-25th) → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and nuclear cataract. The evidence is suggestive but not sufficient to infer a causal relationship between smoking and atrophic age-related macular degeneration.
- **Cervical Cancer Month** (Cancer Information Service) → According to the Surgeon General, there is sufficient evidence to infer a causal relationship between smoking and cervical cancer.
- **Healthy Weight Week** - January 18-24

February

- **American Heart Month** (American Heart Association) → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and coronary heart disease.
- **National Children's Dental Health Month** → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and periodontitis, and is suggestive but not sufficient to infer a causal relationship between smoking and root-surface caries.
- **National Girls and Women in Sport Day** - In the first week of February - The popularity of youth sports in the United States continues to explode. That is why sports activities are great ways to reach our nation's young people with information about how to make important health decisions related to tobacco use, physical activity, and good nutrition.
- **National Child Passenger Safety Awareness Week** (9-15th) – Secondhand Smoke exposure among child passengers.

March

- **National Nutrition Month** (American Dietetic Association)
- **American Diabetes Alert** (American Diabetes Association) → The combined cardiovascular risks of smoking and diabetes are as high as 14 times those of either smoking or diabetes alone. Smoking increases a diabetic's likelihood of getting kidney damage by 50%, and raises a person's blood sugar level making it harder to control their insulin levels. **National Kidney Month** (800-



622-9010) → According to the Surgeon General, there is sufficient evidence to infer a causal relationship between smoking and renal cell, renal pelvis, and bladder cancers.

- **Cataract Awareness Month, Save Your Vision Week (2-8th) (314-991-4100) and Workplace Eye Health and Safety Month (800-331-2020)** → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and nuclear cataract. The evidence is suggestive but not sufficient to infer a causal relationship between smoking and atrophic age-related macular degeneration.
- **National Collegiate Health and Wellness Week (303-871-2020)**
- **Children & Healthcare Week (16-22nd)**
- **National PTA Alcohol & Other Drug Awareness Week (12-18th)**

April

- **Kick Butts Day:** The Campaign for Tobacco Free Kids' annual celebration of youth leadership and activism – April 13th 2005
- **National Public Health Week (8-13th) (www.apha.org)**
- **National Alcohol Awareness Month (212-206-6770)**
- **Women's Eye Health and Safety Month (408-624-3058)** → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and nuclear cataract. The evidence is suggestive but not sufficient to infer a causal relationship between smoking and atrophic age-related macular degeneration.
- **Cancer Control Month and National Minority Cancer Awareness Week (13-19th)** → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and lung cancer, Laryngeal Cancer, Oral Cavity and Pharyngeal Cancers, Esophageal Cancer, Pancreatic Cancer, Bladder and Kidney Cancers, Cervical Cancer, Stomach Cancer, Colorectal Cancer, Acute Leukemia, and Liver Cancer.
- **Earth Day (22nd)** → Pick up cigarette butts
- **National YMCA Healthy Kids Day (10th)**
- **National Youth Sports Safety Month**
- **World Health Day (7th)**

May

- **World No Tobacco Day (May 31st)**
- **World Asthma Day, Asthma & Allergy Awareness Month, and Breathe Easy Month** → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between active smoking and asthma-related symptoms (i.e., wheezing) in childhood and adolescence, all major respiratory



symptoms among adults, including coughing, phlegm, wheezing, and dyspnea, and poor asthma control.

- **Mother's Day**
- **National High Blood Pressure Month** (301-251-1222) Smoking is the “most important of the known modifiable risk factors for heart disease in the U.S.”
- **National Physical Fitness and Sports Month** (202-690-9000)
- **Older Americans Month** (202-401-1451) and **National Senior Health & Fitness Day** (28th)
- **Stroke Awareness Month** (800-STROKES) → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and stroke.
- **National Running and Fitness Week** (11-17th) (301-913-9517)
- **National Employee Health and Fitness Day** (21st) (317-237-5630) → The evidence is sufficient to infer a causal relationship between smoking and diminished health status that may manifest as increased absenteeism from work and increased use of medical care services.
- **National Senior Health and Fitness Day** (800-828-8225)
- **National Alcohol & Other Drug-Related Birth Defects Week** (11-17th) → Congenital malformations implicated by maternal exposure to cigarette smoke during pregnancy include heart defects, cleft palate, hernias, and abnormalities to the central nervous system.
- **National Digestive Diseases Awareness Month** - The evidence is sufficient to infer a causal relationship between smoking and peptic ulcer disease in persons who are *Helicobacter pylori* positive
- **National Osteoporosis Prevention Week** (11-17th) → According to the Surgeon General, there is sufficient evidence to infer a causal relationship between smoking and hip fractures, and among postmenopausal women, a causal relationship between smoking and low bone density. In older men, the evidence is suggestive but not sufficient to infer a causal relationship between smoking and low bone density.
- **National SAFE KIDS Week** (3-10th)
- **National Sight-Saving Month** → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and nuclear cataract. The evidence is suggestive but not sufficient to infer a causal relationship between smoking and atrophic age-related macular degeneration.

June

- **Stand For Children Day** (1st)
- **Cancer Survivorship Awareness Month**
- **Father's Day**

- **National Men's Health Week** (610-967-8620)
- **National Safety Month** → Cigarette's as a cause of fires?

August

- **Clean Air Month** → Prevent and educate community about exposure to Secondhand smoke.
- **World Breastfeeding Week** → Chemicals in cigarettes enter breast milk and can cause a decrease in the supply of breast milk, a decrease in the amount of Vitamin C found in breast milk, and colic, vomiting, diarrhea, and increased heart rate for the child. Instead of being relaxed, babies are stimulated by the nicotine and may become fussy and cranky.
- **Foot Health Month** (703-856-8811) → Tobacco and Diabetes

September

- **Women's Health Month**
- **National Cholesterol Education Month**
- **Healthy Aging Month** (203-834-9888) and **Grandparent's Day** (September 10th) – Encourage wellness among elders.
- **Family Health and Fitness Day** (800-828-8225)
- **Baby Safety Month** – Infant exposure to Secondhand smoke → Toxins in cigarette smoke depress the immune system resulting in twice as many colds, sore throats, middle ear infections, asthma attacks, bronchitis, allergies, and flu. And children exposed to ETS have more hospitalizations during first year of life.
- **Back to School/Child Passenger Safety Weekend** – Secondhand Smoke exposure among child passengers.

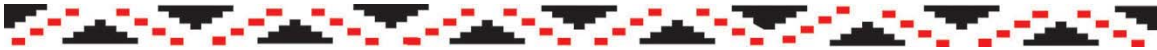
October

- **Healthy Choice American Heart Walk** (www.americanheart.org)
- **National Dental Hygiene Month** (312-479-8608) → According to the Surgeon General, the evidence is sufficient to infer a causal relationship between smoking and periodontitis, and is suggestive but not sufficient to infer a causal relationship between smoking and root-surface caries.
- **National Family Health Month** (www.aafp.org)
- **Talk About Prescriptions Month** (202-347-6711) → Nicotine Replacement Therapies?
- **National Health Education Week** (19-25th) (www.nche.org)
- **Child Health Day and Child Health Month** – Protect children from exposure to secondhand smoke

- **Healthy Lung Month** → The evidence is sufficient to infer a causal relationship between smoking and lung cancer and both acute and chronic respiratory diseases.
 - **National Campaign for Healthier Babies Month**
 - **National Fire Prevention Week (5-11th)**
 - **National Liver Awareness Month**
 - **National Youth Health Awareness Day (22nd)**
 - **Sudden Infant Death Syndrome Awareness Month** → Nearly 70% of women who have lost a baby to SIDS smoked during pregnancy. The risk of SIDS is over 4 times higher if the infant stays in the same room as the smoker, and over 12 times higher if the mother smokes more than a pack per day.
- November**
- **Child Safety & Protection Month** – Protect children from exposure to secondhand smoke
 - **Great American Smokeout (20th)**
 - **National Diabetes Month (www.diabetes.org)**
 - **Diabetic Eye Disease Month (www.preventblindness.org)**
 - **National Family Week (www.fsnet.org)**

December

- **Colorectal Cancer Education and Awareness Month** - According to the Surgeon General, the evidence is suggestive but not sufficient to infer a causal relationship between smoking and colorectal adenomatous polyps and colorectal cancer.
- **National Stress-Free Family Holidays Month**



RESEARCH TO SUPPORT PARTENRING WITH OTHER HEALTH PROGRAMS

Diminished Health Status

- The evidence is sufficient to infer a causal relationship between smoking and diminished health status that may manifest as increased absenteeism from work and increased use of medical care services.
- The evidence is sufficient to infer a causal relationship between smoking and increased risks for adverse surgical outcomes related to wound healing and respiratory complications.

Cardiovascular Diseases

Smoking and Subclinical Atherosclerosis

- The evidence is sufficient to infer a causal relationship between smoking and subclinical atherosclerosis.

Smoking and Coronary Heart Disease

- The evidence is sufficient to infer a causal relationship between smoking and coronary heart disease.

Smoking and Cerebrovascular Disease

- The evidence is sufficient to infer a causal relationship between smoking and stroke.

Smoking and Abdominal Aortic Aneurysm

- The evidence is sufficient to infer a causal relationship between smoking and abdominal aortic aneurysm.

Cancer

Lung Cancer

- The evidence is sufficient to infer a causal relationship between smoking and lung cancer.
- Smoking causes genetic changes in cells of the lung that ultimately lead to the development of lung cancer.

- Adenocarcinoma has now become the most common type of lung cancer in smokers. The basis for this shift is unclear but may reflect changes in the carcinogens in cigarette smoke.

Laryngeal Cancer

- The evidence is sufficient to infer a causal relationship between smoking and cancer of the larynx.
- Together, smoking and alcohol cause most cases of laryngeal cancer in the United States.

Oral Cavity and Pharyngeal Cancers

- The evidence is sufficient to infer a causal relationship between smoking and cancers of the oral cavity and pharynx.

Esophageal Cancer

- The evidence is sufficient to infer a causal relationship between smoking and cancers of the esophagus.
- The evidence is sufficient to infer a causal relationship between smoking and both squamous cell carcinoma and adenocarcinoma of the esophagus.

Pancreatic Cancer

- The evidence is sufficient to infer a causal relationship between smoking and pancreatic cancer.

Bladder and Kidney Cancers

- The evidence is sufficient to infer a causal relationship between smoking and renal cell, renal pelvis, and bladder cancers.

Cervical Cancer

- The evidence is sufficient to infer a causal relationship between smoking and cervical cancer.

Ovarian Cancer

- The evidence is inadequate to infer the presence or absence of a causal relationship between smoking and ovarian cancer.

Endometrial Cancer

- The evidence is sufficient to infer that current smoking reduces the risk of endometrial cancer in postmenopausal women.

Stomach Cancer

- The evidence is sufficient to infer a causal relationship between smoking and gastric cancers.

Colorectal Cancer

- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and colorectal adenomatous polyps and colorectal cancer.

Prostate Cancer

- The evidence for mortality, although not consistent across all studies, suggests a higher mortality rate from prostate cancer in smokers than in nonsmokers.

Acute Leukemia

- The evidence is sufficient to infer a causal relationship between smoking and acute myeloid leukemia.
- The risk for acute myeloid leukemia increases with the number of cigarettes smoked and with duration of smoking.

Liver Cancer

- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and liver cancer.

Respiratory Diseases

Acute Respiratory Illnesses

- The evidence is sufficient to infer a causal relationship between smoking and acute respiratory illnesses, including pneumonia, in persons without underlying smoking-related chronic obstructive lung disease.
- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and acute respiratory infections among persons with preexisting chronic obstructive pulmonary disease.

Chronic Respiratory Diseases

- The evidence is sufficient to infer a causal relationship between maternal smoking during pregnancy and a reduction of lung function in infants.
- The evidence is suggestive but not sufficient to infer a causal relationship between maternal smoking during pregnancy and an increase in the frequency of lower respiratory tract illnesses during infancy and early adulthood.
- The evidence is suggestive but not sufficient to infer a causal relationship between maternal smoking during pregnancy and an increased risk for impaired lung function in childhood and adulthood.

- The evidence is sufficient to infer a causal relationship between active smoking and impaired lung growth during childhood and adolescence.
- The evidence is sufficient to infer a causal relationship between active smoking and the early onset of lung function decline during late adolescence and early adulthood.
- The evidence is sufficient to infer a causal relationship between active smoking in adulthood and a premature onset of and an accelerated age-related decline in lung function.
- The evidence is sufficient to infer a causal relationship between active smoking and respiratory symptoms in children and adolescents, including coughing, phlegm, wheezing, and dyspnea.
- The evidence is sufficient to infer a causal relationship between active smoking and asthma-related symptoms (i.e., wheezing) in childhood and adolescence.
- The evidence is suggestive but not sufficient to infer a causal relationship between active smoking and a poorer prognosis for children and adolescents with asthma.
- The evidence is sufficient to infer a causal relationship between active smoking and all major respiratory symptoms among adults, including coughing, phlegm, wheezing, and dyspnea.
- The evidence is suggestive but not sufficient to infer a causal relationship between active smoking and increased nonspecific bronchial hyper responsiveness.
- The evidence is sufficient to infer a causal relationship between active smoking and poor asthma control.
- The evidence is sufficient to infer a causal relationship between active smoking and chronic obstructive pulmonary disease morbidity and mortality.

Reproductive Effects

Fertility

- The evidence is inadequate to infer the presence or absence of a causal relationship between active smoking and sperm quality.
- The evidence is sufficient to infer a causal relationship between smoking and reduced fertility in women.

Pregnancy and Pregnancy Outcomes

- The evidence is suggestive but not sufficient to infer a causal relationship between maternal active smoking and ectopic pregnancy.
- The evidence is suggestive but not sufficient to infer a causal relationship between maternal active smoking and spontaneous abortion.
- The evidence is sufficient to infer a causal relationship between maternal active smoking and premature rupture of the membranes, placenta previa, and placental abruption.

- The evidence is sufficient to infer a causal relationship between maternal active smoking and a reduced risk for preeclampsia.
- The evidence is sufficient to infer a causal relationship between maternal active smoking and preterm delivery and shortened gestation.
- The evidence is sufficient to infer a causal relationship between maternal active smoking and fetal growth restriction and low birth weight.

Congenital Malformations, Infant Mortality, and Child Physical and Cognitive Development

- The evidence is suggestive but not sufficient to infer a causal relationship between maternal smoking and oral clefts.
- The evidence is sufficient to infer a causal relationship between sudden infant death syndrome and maternal smoking during and after pregnancy.

Erectile Dysfunction

- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and erectile dysfunction.

Dental Diseases

- The evidence is sufficient to infer a causal relationship between smoking and periodontitis.
- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and root-surface caries.

Loss of Bone Mass and the Risk of Fractures

- In postmenopausal women, the evidence is sufficient to infer a causal relationship between smoking and low bone density.
- In older men, the evidence is suggestive but not sufficient to infer a causal relationship between smoking and low bone density.
- The evidence is sufficient to infer a causal relationship between smoking and hip fractures.

Eye Diseases

- The evidence is sufficient to infer a causal relationship between smoking and nuclear cataract.
- The evidence is suggestive but not sufficient to infer a causal relationship between current and past smoking, especially heavy smoking, with risk of exudative (neovascular) age-related macular degeneration.
- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and atrophic age-related macular degeneration.

- The evidence is suggestive but not sufficient to infer a causal relationship between ophthalmopathy associated with Graves' disease and smoking.

Peptic Ulcer Disease

- The evidence is sufficient to infer a causal relationship between smoking and peptic ulcer disease in persons who are *Helicobacter pylori* positive.
- The evidence is suggestive but not sufficient to infer a causal relationship between smoking and risk of peptic ulcer complications, although this effect might be restricted to nonusers of nonsteroidal anti-inflammatory drugs.

CASE STUDY: TRIBES AND EXTERNAL AGENCIES

Abstract:

Since 2000, the 29 federally recognized tribes of Washington State have contracted for tobacco prevention funds through the state Department of Health (DOH). This funding has allowed tribes to develop or enhance internal capacity to conduct culturally appropriate, tribe-specific tobacco prevention and control activities. Fulfilling the state's obligation to recognize tribal sovereignty, this collaborative relationship has been promoted as a model for states working with tribes, and has provided the foundation needed to establish effective tobacco control partnerships between tribes and external agencies.

The Historical Relationship between Tribal and Non-tribal Tobacco Prevention Programs in Washington State:

Since July 2000, the Washington State Department of Health's Tobacco Prevention and Control Program (TPC) has made funding available to all federally recognized tribes of Washington State (currently 29 tribes) through non-competitive contracts. In accordance with culturally appropriate protocol and the provisions of the 1989 Centennial Accord¹, the DOH discussed all aspects of the proposed contract with the American Indian Health Commission (an organization that represents the health policy interests of Washington's tribes) and with the Northwest Portland Area Indian Health Board (a health service organization directed by the 43 tribes of Washington, Idaho and Oregon) before implementing this contracting process.

Upon receipt of State funds from the Master Settlement Agreement (MSA), Washington Secretary of Health Mary Selecky convened a Tobacco Prevention and Control Council to create a strategic tobacco plan for the state. During the development of this plan funds were earmarked to support tribal tobacco prevention efforts. During the first two state fiscal years (SFY), \$408,000 was available for use by Washington tribes. Based on the

¹ The Accord that acknowledges the government-to-government relationship between Washington State and Tribes, requiring tribal consultation on all matters of mutual concern

experience of Oregon's state tobacco program and upon the request of the American Indian Health Commission, funds were distributed to tribes using a 30:70 formula. According to this funding scheme, 30% of the total amount was divided evenly among all tribes and 70% was distributed based on the tribe's population size (calculated using "Active User Population" numbers generated by the IHS). Under this formula, contract levels ranged from \$6,000, for small tribes (later raised to \$8,000), to \$58,000 for larger tribes. Twenty-three of the then 28 tribes across Washington State chose to contract with DOH. This enabled many to initiate and develop internal capacity for tribe-specific, culturally appropriate tobacco prevention and education.

In November 2002, the citizens of Washington State voted to increase the state tax on tobacco products. This allowed the DOH to increase each tribe's funding level by 25% in SFY 2003, raising the minimum funding level for small tribes to \$12,000. Since 2003, 26 tribes have contracted annually with the DOH. A total of \$558,000 is currently distributed annually, with contracts ranging from \$12,000 to \$72,500 per tribe. In 2004, there was strong support within DOH tobacco program and among all its county and school-based contractors to increase the minimum level of tribal funding in SFY 2006 to around \$25,000, totaling nearly \$774,000 for the 27 tribes under contract.

Funded wholly or in part by the Washington State Department of Health, tribal tobacco programs have successfully established clinic-based cessation programs, youth advocacy and education groups, community-based media campaigns, tobacco-free community events, and have aided in passing a variety of tribal tobacco-related policies. Each program's priorities have been established in relation to self-identified community needs, and activities have been designed with a first-hand knowledge of culturally effective and appropriate practices. As a result, current smoking rates among American Indian and Alaska Native adults in Washington State have slowly decreased in the past five years.

In the past, few partnerships successfully emerged between tribal tobacco programs and external tobacco control agencies in Washington. Prior to state funding, this division was largely due to a lack of capacity within Washington tribes to engage in such partnerships. Without tribal personnel dedicated to tobacco prevention and education, external agencies did not know whom to contact within their local tribe(s) to explore ways they might work together. While Tribes expressed knowledge about external programs after state funding was established, tribal leaders and program managers were often hesitant to pursue relationships with outside agencies, citing distrust, conflicting agendas or a history of unsuccessful relationships with non-tribal entities. Community-based and governmental agencies were historically slow to form partnerships with tribes due to their unfamiliarity with the systems, culture, norms, history, and limitations unique to tribal communities. Moreover, unstable partnerships were further perpetuated by fluctuating acknowledgement of and respect for tribal sovereignty by state and county health departments.

Barriers to Positive Working Relationships:

Upon reflection, tribal tobacco coordinators and external agencies identified a number of conditions that impeded the development of positive working relationships.

Prior to funding, many tribes did not have tobacco prevention and education programs with the capacity to form working relationships with external programs. As these programs were created, time and again, tribes felt like they were approached by external agencies seeking to meet their own funding mandates to address health disparities without truly hearing or acknowledging the tribe's goals, priorities, or needs. Meetings often unfolded with an externally designed plan for what the tribe "could" or "ought" to be doing. When external agencies came to the table with a pre-determined agenda, interactions with tribal members felt paternalistic and dismissive of the priorities and culturally appropriate activities already in place within the tribe. These interactions lead to unsuccessful attempts to build external relationships, and fostered and reinforced tremendous distrust between the tribes and external groups.

For state and county governments and other external agencies, unfamiliarity with the tribe's priorities, customs, limitations and protocols added to the complexity of building such partnerships. A lack of knowledge about tribal sovereignty, and the relationship between tribal health and tribal economics, often led to tensions about the need for tobacco-related policies governing casinos and smoke shops. Likewise, procedures, staffing, and timelines that were successfully used to engage other communities were not effective when working with tribes, and heightened frustration and disinterest in future partner building.

For both groups, positive interactions were hindered by differing or conflicting expectations about what the partnership should look like, what the relationship would entail, and conflicting expectations from supervising program managers and administrations. The time and energy needed to foster this unique relationship also served as a barrier, as many tribes and agencies were already strapped for staff time and the resources needed to actively engage in face-to-face relationship building.

Bridging Differences and Sustaining Partnerships:

Trust and Communication - Above all, the first step needed to bridge tribal and organizational differences is to establish and sustain open and honest communication. Trust can only be built on the foundation of frequent communication, through meetings, phone calls, emails, presentations, activities, and events. Trust is absolutely necessary for relationships to evolve into working partnerships. Relationships with both the tribe's staff and the tribe as a whole must be built, requiring multiple face-to-face interactions.

Tribal tobacco coordinators often manage or oversee multiple projects or health services. Thus, external agencies must be mindful of their limited time and travel budgets. Whenever possible, face-to-face meetings should be held at the tribe or another location chosen by the tribal coordinator. Once a personal relationship has been established, phone calls and emails will be better received and understood.

Acknowledge Differences - Because all matters affecting the welfare of the tribe are within the jurisdiction of the tribe's governing body, permission to engage in partnering activities may require additional time. Similarly, time may be needed to educate decision makers about new project goals or activities. Partnering activities must also be mindful of traditional cultural events and activities, including powwows, feasts, celebrations, and mourning periods will affect timelines. Timelines that work effectively for non-tribal partnerships may not be effective in Indian Country. Be flexible and willing to modify customary processes.

Public health agencies are increasingly required to implement only *best practice* activities (practices that have been evaluated and proven effective). Given that there has been little evaluation of tribal practices, tension can occur between partners when external agencies require that only best practices be used. Partnerships need to be flexible and willing to implement *evidence-based* practices, which rely on quantitative and qualitative information to determine efficacy in tribal communities.

Sensitivity must also be shown for the tribe's traditional relationship with sacred tobacco, and for the role of tobacco sales within the tribe's current economy. For many tribes throughout North America, the use of traditional tobacco plants for spiritual, ceremonial, and medicinal purposes goes back thousands of years. Many traditional stories emphasize the sacred properties of the plant, containing both the power to heal if used properly and the power to cause harm if used improperly. Mainstream media messages that portray tobacco as "bad" will be found culturally offensive. Likewise, efforts to alter tribal tobacco sales will be seen as an affront to sovereignty unless approached by supporters from within the tribal community.

Embrace Similarities – The ultimate goal of tribal tobacco prevention and education partnership is to improve the health and well being of American Indian and Alaska Native communities. It is important to focus initial conversations on this mutual goal, and to highlight the strengths and resources that each party can bring to the partnership. Establishing shared, overarching goals and objectives before discussing individual activities will enable the partnership to work most effectively.

External agencies/organizations who want to develop effective partnerships with tribes must value and continually seek tribal opinion and input throughout the “agenda-setting” process. There must be opportunities for ideas and suggestions to be shared, heard, and considered by all participating parties, and for members to educate one another about each organization’s unique worldview. Each partner brings valued skills and knowledge to the collaboration, which should be reinforced throughout the process. These steps will ensure tribal boundaries are acknowledged and respected, and will demonstrate to the tribal members that the partnership is truly about the well being of the community.

Thriving Examples:

The positive working relationship between Washington’s tribes and the Washington State DOH was shaped with the state’s respect for tribal sovereignty and consultation in mind, a willingness to provide non-competitive funding to all interested tribes adapt mainstream materials and approaches for unique tribal circumstances, and to allow tribes to implement culturally appropriate activities that frequently deviate from the science-based norm. This funding provided tribes with the capacity needed to establish effective tobacco control partnerships with external agencies, and has been promoted as a model for states working with tribes.

In Eastern Washington, the Yakama Nation and the American Cancer Society joined forces to develop and implement a native youth SpeakOut curriculum. Based on a shared desire to build capacity among youth as effective community advocates, the partnership has trained nearly 20 Yakama youth on topics regarding tribal tobacco use. This successful project has empowered teens to “speak out” to local newspaper and television stations, and has opened the door for additional program partnerships.

In the Coastal region, collaborations have developed between the Tulalip Tribes and the Snohomish County Health District. The county health district applied for and received a \$75,000 “enhancement grant” from the state tobacco program to help the tribe build capacity for tobacco prevention and control. Though the partnership was initially challenged by many of the barriers discussed above, each party’s commitment to a successful partnership led to greater inter-cultural understanding and mutually beneficial outcomes. This partnership eventually became well received by both the Tribe and the County health district, and has been recognized as an effective model by the Washington

State Department of Health, the Northwest Portland Area Indian Health Board, and the Center for Disease Control and Prevention.

In Northwestern Washington, the Nooksack Tribe and the Nooksack Valley School District have partnered to provide tobacco education classes to tribal and non-tribal eighth grade students. Through this collaborative effort, six, one and one half hour interactive presentations were developed and are now being taught to students each school year. The partnership successfully educates students about both the health risks associated with tobacco use and the traditional role of tobacco within the tribe, serving the needs and goals of both organizations.

Additionally, the Western Tobacco Prevention Project (WTPP), a support center within the Northwest Portland Area Indian Health Board, collaborates with both the Washington State DOH and Washington's Tribes to provide culturally appropriate technical assistance, training, advocacy, guidance and program support. The WTPP works with tribes to develop and disseminate culturally appropriate tobacco education information, cessation guides and material resources, and actively seeks to support and improve state, county, and tribal partnerships. As a result of the strong partnership that has developed between the State DOH and the WTPP, the Western Tobacco Prevention Project was awarded a contract with the Washington State DOH in 2003 and 2004 to serve as a tobacco liaison to the tribes. Through this contract, the WTPP provides guidance and support to DOH, and ongoing training and assistance to Washington's tribes. Through this partnership, the WTPP has been able to conduct a comprehensive community assessment of all the Washington tribes, has written a workbook to assist tribes in changing tribal tobacco policies, and has developed culturally appropriate social marketing materials for Washington's tribes.

These are just a few of the many successful partnerships that now exist between Washington's tribal tobacco programs, and State and County health departments, local and national tobacco control agencies, and external tribal health organizations.

The Benefits of Partnerships Between Tribal Nations and Non-Tribal Agencies/Organizations

Strong and effective partnerships can help meet the needs and goals of both entities. For states or counties, tribal partnerships can help agencies address governmental or organizational mandates to eliminate health disparities. For tribes, these partnerships provide access to additional resources, expertise, and manpower to protect or improve the health of the community. Though different, by listening to the needs and protocols that guide decision making for each group, such partnerships can stretch limited budgets, lend additional personnel to needed tasks, bring new perspectives and program ideas to the



External partnerships

forefront, provide opportunities for additional program partnerships, and, most importantly, improve community health.

This Case Study was written by the Western Tobacco Prevention Project, a project of the Northwest Portland Area Indian Health Board. Information contained in this document was obtained during interviews with tribal tobacco program coordinators in Washington State, and through key informant responses to a structured questionnaire. To ensure that the Case Study accurately reflects the views and experiences of those portrayed within, the document was distributed to all parties for their approval prior to distribution.





Internal partnerships



INTERNAL PARTNERSHIPS WITHIN TRIBAL PROGRAMS

A partnership exists when there is a relationship between two or more entities (programs) conducting business for a mutual benefit. There are many benefits to forming tribal partnerships. However, it is sometimes challenging to begin or maintain a partnership for many different reasons. The information provided will hopefully guide your program in the appropriate direction as you consider beginning a new partnership.

Benefits of Partnering with Tribal Programs:

Tribal partnerships can provide each program involved with several benefits depending on the activity they partner in. For example, if two programs partner in an event the programs could benefit by the following:

- Increased community member outreach
- Less funding required by each program
- More personnel to assist with activity
- More information provided to participants
- Provide a better understanding of one another's program.
- Enable increased learning to take place: person-to-person, program-to-program.
- Build supportive networks through relationships and trust.
- Provide more solutions to a given problem.
- Less overall resources needed from each program
- Increase overall tribal efficiency.

These benefits enable program partnerships to increase their overall tribal efficiency. Kathy Charles of the Lummi Tribe explains in detail, the *“greatest challenge is all programs have very limited staffing and resources. We need to work together to jointly share our resources for prevention activities.”*

Through increased communication and cooperation tribal programs can grow closer. Partnerships enable increased learning to take place from person-to-person, and program-to-program, while building supportive networks through relationships and trust¹.

How to Begin a Tribal Partnership:

When forming Partnerships within your tribe, it is important to first determine:

- What programs currently exist?
- Who are the contacts for these programs?
- What resources do these programs have?

For example, your tribe may have one or more of these programs that you could look into partnering with:

Abuse	Mental Health
Alcohol	Nutrition
Alzheimer's/ Dementia	Legal Services
Cancer	Police
Chemical Dependency	Recreation
Dental	Reproduction
Diabetes	SIDS
Education	Substance Abuse
Environmental Services	Tribal Council
Family Services	Tribal Head Start
Health (General)	Vision
HIV/STD/AIDS	WIC
Housing	Women's Health
Human Services	Youth Advocacy/Prevention

A good place to find out if your tribe offers any of these programs are through your tribe's website or tribal directory. These are also good resources for discovering who your program contacts are. Once this information is determined, ideally the next step is to speak to the program contact/coordinator(s). This person would generally be the most knowledgeable about the resources available to them. After these tasks are completed, it is imperative to find out what the program contact/coordinator needs or wants for their program. As Angela Mendez from the Shoshone-Bannock Tribe states, *"You really have to consider what your partner needs and what works best."* In order for your program to look appealing, it is important to offer the other program what they want. For example, your program might recognize that the Tribal Head Start program needs more supplies for the children. To begin building this relationship, you might purchase pencils, crayons, and markers with commercial tobacco free messages for the program. This minor sign of good faith can help build the partnership that you are looking for. The Head Start program in the example above may realize your genuine interest in their program and in return for the supplies you donated may invite your program to give a

presentation on the danger of second hand smoke during an event most parents are expected to attend. The end result would be a partnership that builds awareness about the tobacco program in your respective community.

Follow the FIND OUT steps as you look toward forming a partnership.

FIND OUT:

- F Find out if they are interested
- I Inquire whether or not they have had any partnering experience (they may be a good resource for you to get more information)
- N Negotiate how you would like to begin a partnership
- D Decide if that program would fit well with your program
- O Outline upcoming events or activities that you could partner in
- U Utilize each other's resources when planning for events
- T Teamwork will be your key to success.

Barriers or Problems that May Occur with Tribal Partnerships

Beginning and/or maintaining a partnership is not always easy. You may be faced with barriers and problems that you will have to overcome. For example, the program you wish to partner with may have its own agenda, or its own need that may compromise your agenda. The partnership should not be disregarded because of minor discrepancies or conflicts of interest. However, it is essential to understand that larger issues may very well impede the partnership, and it is important to distinguish the difference between the two.

Another problem you may experience is a lack of understanding and/or a lack of communication from the program you wish to partner with. One example of this type of problem is explained by Deborah Parker-George from the Tulalip Tribe who explains, *“Once forged, we realized our partnership ideas, goals, beliefs and foundations were not fully appreciated, recognized or understood.”* Furthermore, *“The partnership did not begin in a positive manner. Preconceptions and disagreements tended to plague the partnership from the beginning.”*

It is also possible that you may encounter the problem of resistance from other programs. A reason for this could be a misunderstanding. A misunderstanding can lead to many

other problems that may eventually destroy a good partnership. Lack of trust is one of these problems. It is essential to develop a strong trusting relationship with the programs that you are developing a partnership with. Do not make assumptions (about what the other program needs or wants). It is important to get the facts about their program to determine whether the partnership should move forward. Clarifying your intentions and allowing them to discuss their intentions is helpful and should be done early in the relationship. Become as honest and open as you would expect them to be with you.

As your program may be overwhelmed and busy, it is not uncommon that the program you would like to partner with is undergoing the same obstacles. It is important to continue your effort and demonstrate that the partnership is not meant to create more work. A good way to get some time with a busy program contact would be to schedule a lunchtime appointment, and provide a nice lunch while you are discussing the details of the potential partnership. This will enable your potential partner to feel not so rushed, and he/she may become more open to your ideas. Joyce Oberly who works for the Confederated Tribes of Warm Springs explains that, *“With medical (staff), you have to work around their schedules. Physicians are always busy and have little spare time to help with programs. This goes for pharmacists as well.”*

Another frequent barrier that you may encounter when forming your partnership is a lack of experience and/or guidance². Partnerships must start somewhere, and it is not unlikely for someone to have little or no experience with partnering. It may be necessary for you to explain previous partnering relationships that you’ve had that have benefited both programs in the partnership. It will likely take patience, understanding and some guidance to help the new partnership grow. Negotiation skills may very well be imperfect and imbalanced. To begin your partnering relationship, it is not unlikely that your program may have to show more support to the program with which you desire to partner. After this relationship has been forged, and trust is gained, support should begin to be distributed more equally.

Many new partnerships find difficulty in direction and may become stumped easily. It is essential to work together and gain more experience about the program you are working with to determine similar values or objectives your programs share. By finding commonalities and sharing experiences about ideas for potential or ongoing partnerships, your goals and objectives for the partnership may become clearer.

A key problem, specifically in tobacco prevention is constantly having to defend the purpose of your program. Unfortunately, tobacco prevention is not always seen as a significant issue. Joyce Oberly explains that one of her obstacles in gaining the support of other tribal programs was *“trying to relate tobacco to other health issues and justify its importance. Also, to keep people interested in learning about tobacco”*. This seems to be a common theme in trying to develop partnerships from tobacco prevention programs

in tribal settings. Diane Pebeahsy from the Yakama Indian Nation expresses her concern of *“having the tribe see that this program is to benefit and to help the Native People”*. She states, *“There are so many issues that are on the table with the tribe, they haven’t seen tobacco prevention as an essential part of the community so far. If I had funding cut, I know this program would not become a Tribal program because the tribe doesn’t see it as important yet.”* This may be an ongoing problem for tobacco prevention. Continuing our efforts in promoting wellness and providing education on the harmful effects of commercial tobacco is important in overcoming this problem. Diane Pebeahsy further explains that *“bringing awareness about tobacco by showing justice on how it is related to a person’s everyday life” is one way to show the importance of tobacco prevention.* It is critical to find out what a person is attached to or may see as important in their life, and then find a way to link whatever that may be to tobacco related issues.

Another way to justify the importance of tobacco awareness is to show that tobacco is much more than just smoking. Tobacco represents part of a culture that at one time was kept sacred. The tobacco plant traditionally would not be exploited through commercial use. The sacredness of tobacco represents a culture that can be brought back to the old traditions and values. The issue of prevention should be seen not only as tobacco use, but bringing back to a culture what could have been lost.

Sustaining Tribal Partnerships:

Trust and communication are the most important qualities to sustain a partnership. Trust is often the foundation of a productive relationship between two or more programs. Continuous communication is vital to a successful partnership. It is important that the program partners have continuous collaboration and meet regularly to ensure that everyone is on the same page. As Joyce Oberly explains, *“Through continuous collaboration... It’s important to keep everyone in the loop, even if nothing is really going on. It helps foster relationship and keeps your progress moving in the right direction if everyone’s on the same page.”* Diane Pebeahsy states that tobacco prevention programs need to have *“communication to show that the program is stable and that it is meant to improve the Indian Nation.”*

While maintaining your partnership and relationship, it is essential to remain flexible and adjust to your partner’s schedule. Sue Hynes who works for the Lower Elwha Klallam Tribe advises, *“It is important that you remain flexible with the other programs. You also need good problem solving skills to find that there are more solutions than just one.”* It is essential to realize that both parties will have important strengths, and just as important, both parties will have weaknesses. Embrace the similarities that your programs have. Focus your attention on the mutual goals of your programs (such as the overall wellness for your tribal community). Highlight what strengths each program has

(such as resources or knowledge) and build your goals and objectives around these strengths.

Acknowledge your differences. Every program will have specific goals that may very well be different than yours. But be flexible, understanding, and do not be pushy. It is important to listen to other people's ideas. Be open-minded and allow for any outcome to be possible.

Examples of Partnerships Within Tribal Programs:

Tulalip Tribes

- Baby shirt that reads, “If you can read this, Turn me over” on the back (SIDS program), and “Please don’t smoke around me” on the front (Tobacco Program). Shirts are given to all new babies born at the Tribe.

Confederated Tribes of Warm Springs

- Partnership with the Community Wellness Program. Tobacco program assists with fitness activities, and in return Tobacco program is able to give tobacco education at sports camps.
- Pharmacy provides referrals to cessation classes; in return Tobacco program provides referrals to pharmacy for NRT’s.
- Specific activities that have taken place because of the partnering programs: cessation class referrals, pharmacy referrals, Great Warm Springs Smoke Out, Monthly Walk for Diabetes, Asthma Awareness Month activities, Women of Wellness monthly forum, and the I.H.S. Pedometer Challenge

Lower Elwha Klallam

- Partnering with Tribal Council to form a “Smoke Free” resolution.
- Partnership with Recreation and Elders Program to do a Tobacco Free Annual Softball Tournament. (Recreation provides field and helps coordinate event, Elders Program provides a meal).

Lummi

- Partner with the Diabetes program and offer smoking cessation classes for Diabetes patients who smoke.
- Work with local schools to do youth empowerment & leadership trainings.
- Assist the Maternal Child Health by offering training courses on tobacco related issues to their staff such as nurses, WIC coordinators, and outreach workers.

Yakama Indian Nation

- Worked with air quality and asthma program to present information on second hand smoke at 5 different schools and in return supplied them with prizes for their poster contest.
- Worked with ICWA to council foster kids and foster parent on tobacco and second hand smoke.
- Partnered with Workforce Development to do a presentation on Second Hand Smoke in the workplace. Purchased pencils and pens for event.

Conclusion:

Inter-Tribal Partnerships work with other groups and health promotion programs at the tribal level, such as Head Start program, the Health Clinic, or the diabetes program. Working together on mutually beneficial projects can reduce the cost of activities, and can send more comprehensive tobacco prevention message to community members.

PARTNERSHIPS

- Allow for a trusting, more open-minded atmosphere as you work with one another keeping your ultimate goal in mind.
- Require less funding and other resources from each program.
- Allow for more information to be provided to the participants.
- Provide a better understanding of one another's program.
- Enable increased learning to take place: person-to-person, program-to-program.
- Provide more personnel to assist in the coordination and implementation of events and activities.
- Build supportive networks through relationships and trust.
- Provide more solutions to a given problem.
- Increase overall tribal efficiency.

When beginning partnerships, first determine:

- What programs currently exist?
- Who are the contacts for those programs?
- What resources do those programs may have?
- F I N D O U T

Common barriers include:

- Lack of understanding
- Lack of communication

- Lack of Trust
- Lack of experience/guidance
- Assumptions
- Personal program agenda
- Secrets/Misleading/Disingenuous

To assist in overcoming these barriers and sustaining a strong partnership, it is important to be:

- Honest
- Flexible
- Open-minded.

It is also helpful to communicate and collaborate on a continual basis, and focus your attention on the mutual goals of your partnership.

Resources:

1. Building Effective Partnerships - The National Institute of Adult Continuing Education: www.niace.org.uk/information (2001)
2. Society of Information Technology Management – Private Public Partnerships: <http://www.bradfordunison.org.uk/docs/Socitm%20-%20Private%20Pub%20Partners.htm> (Accessed June 27, 2005)
3. Deborah Parker - Education Coordinator for the Tulalip Tribe
(*Tulalip*)
4. Diane Pebeahsy- Tobacco Prevention Coordinator for the Yakama Indian Nation
(*Yakama & Comanche*)
5. Joyce Oberly - MPH Public Health Educator for the Confederated Tribes of
(*Comanche*) Warm Springs
6. Kathy Charles – Public Health Educator for the Lummi Tribe
(*Lummi & Omaha*)
7. Sue Hynes – Community Health Director for the Lower Elwha Klallam Tribe
8. Angela Mendez – Tribal Health Director for the Shoshone-Bannock Tribe
(*Shoshone-Bannock*)

USING PARTNERSHIPS TO SUPPORT PREVENTION

Approximate Length:

1.5 Hours

Intended Audience:

Tribal Coordinators and Health Professionals

Summary:

This 26-slide presentation provides a comprehensive guide to forming and maintaining partnerships for the purpose of prevention. It gives example of both State and Tribal Partnerships as well as Tribal Partnerships with External Agencies. This presentation includes challenges that may arise, and requirements for continuing a partnership. This presentation has been created for the purpose of training Tribal coordinators and other health professionals in the area of partnerships.

- **Elements of a Positive Relationship**
Comprehensive vision, commitment, and Resolution
- **Commitments and Inclusion**
Face-to-Face Interaction and Honesty
- **Overcoming Challenges**
Pre-Determined Agendas, and Lack of Familiarity & Knowledge.
- **Learning From the Past**
Trust, Communication, Acknowledge Differences, Embrace Similarities
- **Programs and Activities**
Awareness Activities, Program Activities, Local Policy & Regulation
- **State and Tribal Partnerships (Oregon, Washington, & Idaho)**
- **Tribal Model**
Integration of Tobacco Education Programs into Existing Tribal Health and Family Services.
- **Tribal Partnerships with External Organizations**
- **State & Tribal Partnerships with NPAIHB**
Collaborations



- **Inter-Tribal Partnerships**
Collaborations
- **Partnering Activities**
Partnership Exercise





Establishing Effective Tobacco Control Partnerships Within Tribal Programs

Approximate Length:

45 Minutes

Intended Audience:

Tribal Coordinators and Health Professionals

Summary:

This 13-slide presentation gives a quick overview on beginning a partnership with a program of the same tribe. It discusses the many benefits of this as well as the possible barriers that may be faced. This presentation further provides examples of existing partnerships that various tribes have formed.

- **Benefits of partnering with tribal programs**
More Resources, More Information, Increased Learning, Increase Overall Efficiency
- **How to begin a tribal partnership**
Existing Programs, Contacts, & Resources
- **Barriers or problems that may occur with tribal Partnerships**
Lack of Understanding, Communication, Trust, & Experience
- **Sustaining tribal partnerships**
Honesty, Trust, Communication, Flexibility, & Open-Mindedness
- **Examples of partnerships within tribal programs**
Lower Elwha Klallam, Confederated Tribes of Warm Springs, Yakama Indian Nation, & Tulalip Tribe





- Secondary Data is data collected by other groups or organizations, but made available to the general public. National statistics, data gathered from RPMS (Resource and Patient Management System), and previous surveys are all examples of secondary data.

STEPS IN PROGRAM EVALUATION

Defining Program Evaluation

Program Evaluation can be thought of as the comparison of what is observed about a program with what was expected from it. In order to find these measurements, we must first ask 2 questions: How do we know what to expect from this program and Where and How should we look for observations?

It is important to note that Program Evaluation is not something you do one time, at the end of a program. Evaluation is a process that is best started at the beginning of a program and maintained throughout program completion.

Phases of Evaluation

1. **Assessment** – this is the period of preparation. It is important to have a clear understanding of the purpose of the evaluation, and what will happen with the results of the evaluation. Ask these questions:
 - Who wants the evaluation carried out?
 - What is wanted from the evaluation?
 - Why is evaluation wanted? Why now?
 - What will be done with the results?
 - When are the results from the evaluation expected?
 - Are resources available for evaluation?
 - **Logic Models** are an excellent tool for outlining what the program expects to achieve and how it is expected to work. Instructions on developing a Logic Model can be found on page 5.
2. **Selecting Methods for Evaluation** –

Who? Decide if the evaluation will be done by someone within the project, or by an outside consultant. An outside consultant is generally preferred, because they will look at your program from a different perspective. An outside consultant does not have to be someone outside the organization. Someone within the organization, but not working directly on the project, might serve this purpose. They will not have

personal interest in the outcome, and might be able to work more objectively than someone within the project.

What? In order to decide which tools to use, determine the definitions of success or failure for your program. Once these have been defined, think about how these definitions can be measured.

In general, components of program evaluation can be categorized into three areas:

Process – this refers to how the program is implemented. For example, how many trainings is the program expected to provide each year? What activities will be completed?

Impact – this refers to the immediate effects of the program. If a training was provided, were the participants satisfied with the material? Did they learn something new?

Outcomes – this refers to the achievement of overall program objectives. A tobacco program might wish to lower the smoking rate within a community- what this accomplished as a result of program implementation?

3. Collecting and Analyzing Information

After determining which component the program intends to evaluate, the next step is to decide how to measure. There are several tools that can be used in program evaluation.¹ These include:

Testing –participant’s knowledge, attitudes, or behaviors regarding the topic.

Interviews –surveys, in-depth interviews, opinion polls, group interviews, focus groups, comparison groups, or expert opinions

Reports – medical records and charts, special studies

Observations – professional on-site by trained evaluators, checklists, guides, “yes/no” evaluations

Samples – observe examples, assess the product or outcomes

Screening Results – compare clinical and paper-and-pencil tests, compare pretests and posttests

Questionnaires – use pretest and posttest comparisons

Goals and Objectives – use to determine whether goals and objectives and the expected outcomes are reached

At this point, decide what types of data collection instruments you will need. Will you be interested in quantitative data, qualitative data, or both? For a detailed discussion on the various types of data collection materials, see the following section on “Steps in Data Collection.”

4. Reporting

Once you have collected and analyzed your evaluation data, these results can be used to improve your program, justify the need for continued funds, and increase the awareness and support for your activities within the community. A standard evaluation report will include the following sections: ¹

- I. Executive Summary – a one to four page section that summarizes the key points. This must include the most essential information on the purpose of the evaluation, key findings, and any recommendations. Include contact information in this section.
- II. Purpose – Explain the reasons you conducted this evaluation, including the questions you hoped to answer and who initiated the evaluation.
- III. Background – Provide information on your program’s structure, history, and goals.
- IV. Methodology – Explain the design of the evaluation, including what data collection tools and methods you used.
- V. Summary of Results – Provide a summary conclusion about the key questions your evaluation intended to answer.
- VI. Principal Findings – More details on the findings that support the summary conclusions. Include charts or tables where applicable.
- VII. Considerations/Recommendations – Discuss the implications of the evaluation findings. Include what actions might be needed if the program is succeeding or failing.
- VIII. Attachments – Information that is important but too cumbersome or long for the main report. Such as: profiles of residents, copies of data collection tools, detailed results, or testimonials.

References

1. Delmar Thompson Learning. *Community Health Education and Promotion Manual, Second Edition*. New York, NY: Aspen Publishers, 2002. Available at http://www.cdc.gov/tobacco/sgr/sgr_1988/index.htm

LOGIC MODELS

Logic Model Definition

A Logic Model is a diagram showing the relationship of program components to each other and the intended outcomes.

Basic Components of a Logic Model

- **Resources** – includes everything the program already has available. This can include funding, staff, materials, a motivated community, partnerships, etc.
- **Activities** – major things that will be done with those resources. For example, trainings, newsletters, rallies, etc.
- **Results** – immediate effects of the activities. These might be behaviors you expect from participants following tobacco training, such as share tobacco information with others.
- **Outcomes** – short, intermediate, and long-term effects of the results. For example, if participants share information with others, you would expect tobacco awareness to grow in the community
- **Goal Attainment** – there is generally only one goal for the program as a whole, this should be related to your program mission statement.

A Logic Model is not...

Intended to provide detail about a program, OR the series of steps necessary for completing program activities.

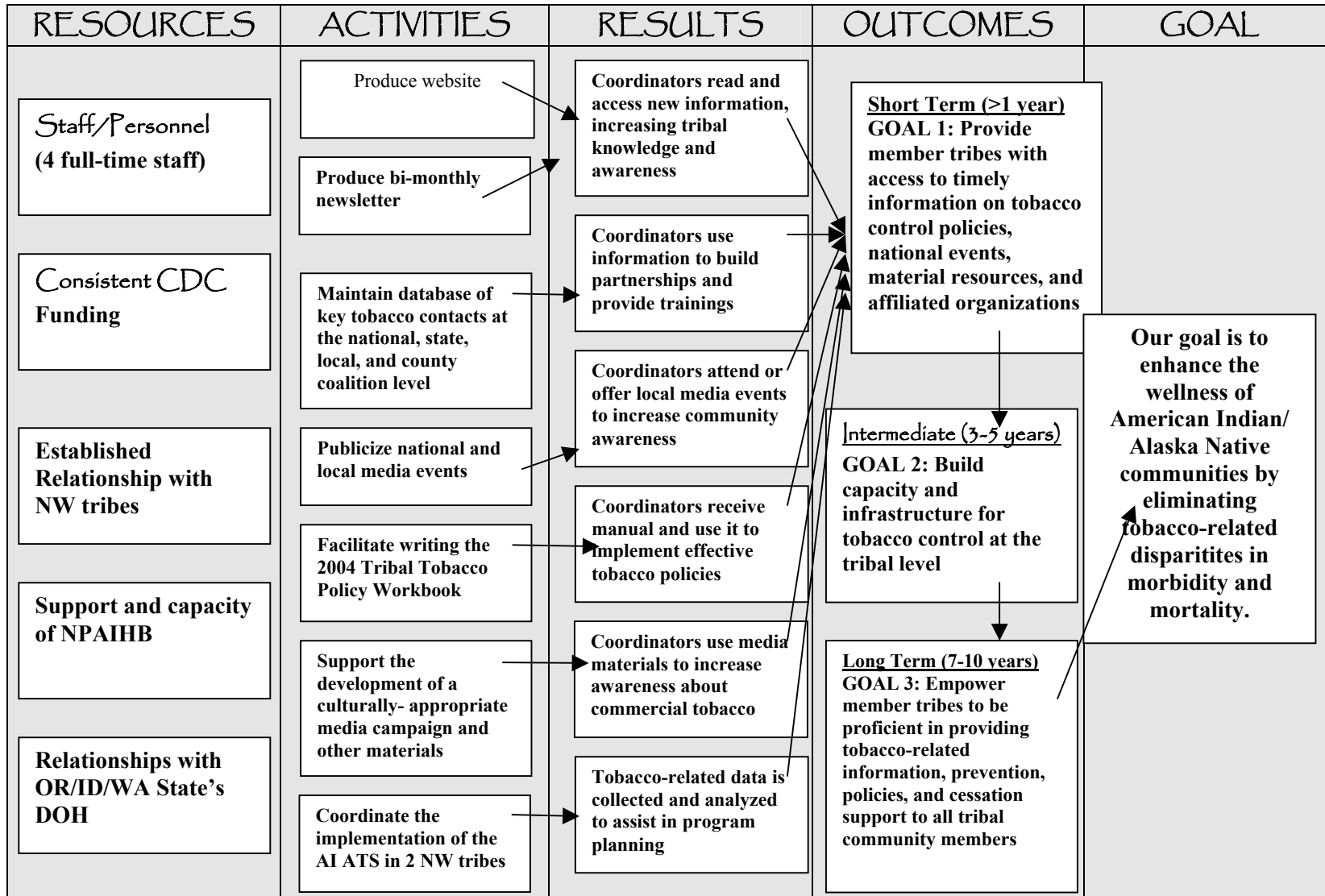
Logic Models can be used to:

- Provide an overview of the key program elements
- Illustrate the rationale behind program activities
- Identify critical evaluation questions
- Show how a program fits into the bigger picture

Example Logic Model

Following is an example of a logic model developed by the Western Tobacco Prevention Project (WTPP) that was used for developing its program evaluation plan.

Example Logic Model



STEPS IN DATA COLLECTION

[Adapted from the Tobacco
Technical Assistance Consortium (TTAC)]¹

Before you begin

While data collection can be rewarding, much work is required to be sure it is done well so that the data you collect truly reflect the impact of your program. To be sure this process is organized and credible, follow these steps before you begin:

1. Identify existing data sources
2. Determine Credibility of Existing Sources
3. Determine the best method for Collecting Data
4. Select or Create Data Collection Instruments
5. Determine Instrument Validity and Reliability
6. Determine how much Data to collect
7. Establish Procedures for Collecting Data

1. Identifying Existing Data Sources

Before you decided how to collect the data, you will need to decide where the data will come from and whether you must obtain new information, or whether you can use existing data. Existing data refers to data that other people have collected. This could be statistics that are already published, or using existing records to find new information. For example, you may wish to use the RPMS system to generate information on what percent of diabetics in your community are also smokers. On page 19 of this document you will find a list of secondary data sources for NW tribes.

When appropriate, there are advantages to using existing data rather than going through the expense and energy of collecting new information. To determine whether it is possible to use existing data, ask yourself these questions:

- Can I find existing data for my purposes?
- How well will the existing data answer my specific questions?
- How well do the existing data represent my target population?

- How available is the existing data?

Even if the existing data fits your purposes, you may need to decide whether it will be better to use these existing data or collect new data. To make this decision, ask yourself these three questions:

- What data sources, existing or new, are likely to provide the most accurate information for this target population?
- What data sources will allow the least costly and most rapid data collection?
- Will the collection of information be a burden on your resources?

Of course, the most accurate information is desirable, but at what cost in terms of money and time? Also, it is important to remember that some forms of existing data (like patient medical records), require authorization from the appropriate sources before using them for your own purposes.

2. Determine the Credibility of Existing Data

****Credibility is especially important if you plan to distribute the results to your funding source***

Having the most accurate data sources possible is the most important factor for any successful evaluation. But, what makes one source more credible than another? Sometimes it's difficult to know. For example, carefully maintained records may be more accurate than the memory of an individual. On the other hand, overworked professionals may not attend to detail when recording information, especially if the record systems were not intended to provide evaluation data. Furthermore, different persons may record differently, creating inconsistencies in the record system.

There are two ways to assess the accuracy of data: Reliability and Validity.

Data Reliability is a measure of the degree to which the data can be reproduced, or replicated. If two different people are collecting the same information, would their results be similar? If so, the data is considered reliable.

Data Validity is a measure of the degree to which the data actually measure what they are intended to measure. Conversely, if medical records indicate that 12 percent of pregnant Latina teens smoke, but 18 percent report smoking when interviewed, the medical records data have not been validated.

Other Credibility Factors

In addition to validity and reliability, several other factors contribute to the credibility of a data source. One factor is whether or not those who collected the data have political, or other interests, that might be likely to influence the data collection methods or results.

Another factor is the reputation of the organization collecting the information among tobacco prevention and control advocates. For example, data from the Centers for Disease Control and Prevention (CDC) or the National Institutes of Health are viewed as highly credible. Efforts are made to see that their data are accurate, and both organizations are well known. In contrast, data from medical records can be suspect as they are rarely validated, and often collected for treatment purposes.

3. Determine the Best Method for Collecting Data

Once you have determined whether your data will come from new or existing sources, it is important to select the data collection methods that will be the most appropriate for achieving your objectives. If you are using existing data sources, the main questions will be "What information do I select from the source?" and "How do I record it for your evaluation purposes?" When you are collecting new data, there will be many more decisions to make. The first of these is whether to use qualitative methods, quantitative methods, or both. In the "*Steps in Evaluation*" section, we introduced these two types of data collection.

Qualitative methods are open-ended and allow the evaluator unlimited scope for probing the feelings, beliefs, and impressions of the people participating in the evaluation, and to do so without prejudicing participants with the evaluator's own opinions. They also allow the evaluator to judge the intensity of people's preference for one item or another. Such methods include:

- Individual interviews
- Observation
- Focus groups

Quantitative methods are ways of gathering objective data that can be expressed in numbers (e.g., a count of the people with whom a program had contact or the percentage of change in a particular behavior by the target population). Unlike the results produced by qualitative methods, when correctly gathered, the results produced by quantitative methods can be used to draw conclusions about the target population. Such methods include surveys using:

- Respondent-completed instruments (e.g., questionnaires) administered by direct distribution or through the mail, web, or e-mail

- Interviewer-completed instruments administered face-to-face or through telephone surveys

Choosing the method best suited for your audience and objective(s) requires an understanding of what each method can reveal about your program. Here are some examples of when each method might be used in a program to promote smoke-free environments.

In choosing a data collection method, the CDC recommends that you consider the following:²

- **The purpose of the evaluation**
Which method seems most appropriate for your purpose and the questions that you want to answer?
- **The users of the evaluation**
Will the method allow you to gather information that can be analyzed and presented in a way that will be seen as credible by your intended audience? Will they want standardized quantitative information from a data source such as the Adult Tobacco Survey, or descriptive, narrative information from "real people", or both?
- **The respondents from whom you will collect the data**
Where and how can respondents best be reached? What is culturally appropriate? For example, is conducting a phone interview or a more personal, face-to-face interview more appropriate for certain population groups?
- **The resources available (time, money, volunteers, travel expenses, supplies)**
Which method(s) can you afford and manage well? What is feasible? Consider your own abilities and time. Do you have an evaluation background or will you have to hire an evaluator? Do program funds and relevant policies allow you to hire external evaluators?
- **The degree of intrusiveness-interruptions to the program or participants**
Will the method disrupt the program or be seen as intrusive by the respondents? Also consider issues of confidentiality if the information that you are seeking is sensitive.
- **Type of information**
Do you want representative information that applies to all participants (standardized information such as that from a survey, structured interview, or observation checklist that will be comparable nationally and across states)? Or, do you want to examine the range and diversity of experiences, or tell an in-depth story of particular people or programs (e.g., descriptive data as from a case study)?
- **The advantages and disadvantages of each method**
What are the key strengths and weaknesses in each? Consider issues such as time

and respondent burden, cost, necessary infrastructure, access to sites and records, and overall level of complexity. What is the most appropriate?

4. Select or Create Data Collection Instruments

An important part of data collection is using the same data collection instrument to get information from all of your information sources. If you are gathering information from files or other records, rather than from people, the instrument may be a form designed so that you can record all of the information needed from each file. In the case of interviews and focus groups, the instrument may be a general outline of topics to be covered. This is known as an *interview/focus group guide*. In the case of surveys, the instrument is usually composed of a series of carefully worded questions or statements for the respondent to answer. Often the answers are selected from answer choices that are provided on the instrument.

Creating a good data collection instrument can be difficult and time-consuming. For that reason, before you create a new instrument you should see if a suitable instrument already exists.

Whether you decide to use an existing instrument or to develop your own, the instrument you use should meet the following criteria.

- It should include questions that can be used to measure the concepts addressed or affected by your program (e.g., knowledge of tobacco prevention methods).
- It should be appropriate for your participants in terms of age or developmental level, language, and ease of use. Questions should be written in simple and easy-to-understand language. These characteristics can be checked by conducting focus groups of participants or pilot testing the instruments.
- It should respect and reflect the participants' cultural backgrounds. The definitions, concepts, and items in the instrument should be relevant to the participants' community and experience.
- It should be possible to complete in a reasonable timeframe. Again, pilot testing can reveal these issues.

5. Determine Instrument Validity and Reliability

The instrument you choose to collect data must be able to collect the information you need to answer your questions about your program. Just as with data, the instrument must be valid and reliable.

Instrument Reliability is a measure of the degree to which an individual's responses are reproducible, or consistent, both over time and within the instrument. For example,

suppose a question at the beginning of a data collection instrument asked, "Do you support increased tobacco taxes?" and 67% of respondents said, "Yes". Suppose that another question, toward the middle of the same instrument asked, "Are you in favor of increasing taxes on tobacco?" and 66% of respondents said, "Yes". This would suggest that the data were reliable.

Instrument Validity is a measure of the degree to which the instrument actually measures what it is intended to measure. If the instrument is supposed to measure knowledge about tobacco prevention and control, then we would expect people who attended a tobacco use prevention course to get higher scores than people who did not attend such a course. If they do, this is evidence that the instrument is valid. If they do not, this suggests that the instrument is not valid.

6: Determine How Much Data to Collect

How much data you collect will depend upon the balance between your needs and the resources available.

There are two ways to think about the quantity of information you will need to collect:

- How many questions do you need to ask?
- How many people do you need information from (the sample size)?

How many questions do you need to ask?

The questions you ask should be restricted to those that are necessary to answer your evaluation questions with an acceptable level of detail. In general, the more questions you ask, the less people will be willing to take the time to provide complete information.

How many people do you need information from?

How many people you need to ask (i.e., the sample size) depends, again, on the level of detail you are interested in, as well as the types of comparisons you want to make.

Your study must have a certain minimum quantity of data to detect a specified change produced by your program. In general, detecting small amounts of change requires larger sample sizes. For example, detecting a 5% increase would require a larger sample size than detecting a 10% increase. If you use tobacco data sources such as the Youth Tobacco Survey, the sample size has already been determined.²

**If you are designing your own evaluation tool, you will need the help of a statistician to determine an adequate sample size. **

7. Establish Procedures for Collecting Data

Once you decide what type of instrument you will use to collect evaluation information, you must establish a set of procedures so that data will be collected in a standard manner.

Everyone involved in collecting evaluation information must be trained in these procedures:

- **What instrument will be used to collect the information?** Each data collector should be trained in the use of the instruments.
- **When will you collect the information?** The timeframe during which the data are to be collected must be clearly specified. There is some information that may need to be collected before the program starts and other information that needs to be collected at the end of the program.
- **Where will you collect the information?** As discussed earlier, you will need to determine the sources from which the information will be collected. In some instances you may be using program records, while in other instances you may be relying on participants' coming to a specific location to complete the survey instrument or to participate in a group discussion about their experiences.
- **Who will collect the information?** This responsibility must be clearly specified or you will risk having some data collection not get completed. Choose data collectors carefully, and determine a list of characteristics that are necessary. For example, they may need to be familiar with the culture or the language of the individuals they are interviewing or observing. If the questionnaire is being administered by interviewers (for example, residents hired and trained to conduct interviews), those persons must be properly trained to administer the questionnaire. Training will ensure that the interviewers are familiar with the survey instrument.

Data Analysis

Once you have collected the data, it will need to be analyzed, interpreted, and prepared into a report. If no one in your organization has been trained in data analysis, you may contact the Western Tobacco Prevention Project for further information on resources for data analysis.



Data Collection



BASIC STATISTICS:

INTERPRETING CONFIDENCE INTERVALS

What is a “confidence interval”?

- The reported value is probably a little different than the “true” value for any survey data (anytime you ask “some people” something and want to say that is true for “everybody”)
- We are “95% confident” (really pretty sure) that the “true” value is within a range called the “confidence interval” or “margin of error”
- Confidence intervals can be displayed a couple of ways – means the same thing:
 - $X\% \pm Y\%$ (for example, $10\% \pm 2\%$)
 - $X\% [A, B]$ (for example, $10\% [8\%, 12\%]$)
 - Or on a chart as $X\%$ with a “dumbbell” to show the interval

Why do I care about certainty?

Usually you’re looking at data and asking yourself some questions – you need to know how accurate your data are in order to answer the following kinds of questions:

- Are we better or worse than we ought to be?
- Are we better or worse than someone else? (like the state as a whole)
- Are we better or worse than we were before? (before you started a program, or something else changed, or “what direction” the data are heading in recently)
- Are we just plain not happy with whatever the data are saying? (this percent of kids who don’t turn in their homework on time isn’t higher than anyone else’s, or worse than it was before, or really very high compared to other things, but it’s just too high for what we want it to be!)

Without confidence intervals you might look at data and think that some results are definitely “bigger” or “worse” than other results, but it wouldn’t be true.

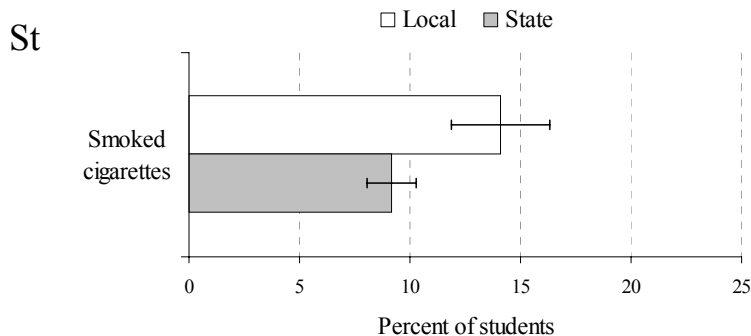
Note: with confidence intervals you might see differences that are not “statistically significant”, but they are real differences – if you use a confidence interval test and only say things are really different when they pass that test you will say (wrongly) that there are not differences.

What else should I know about confidence intervals?

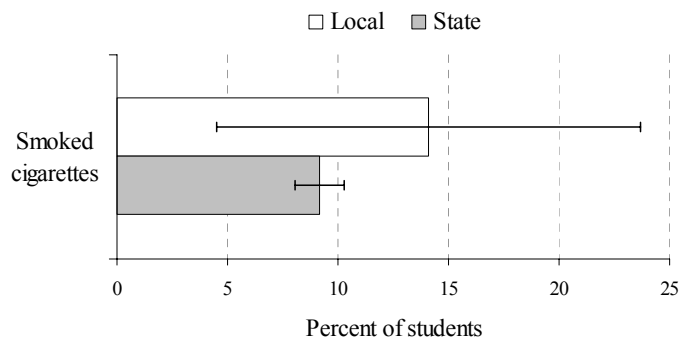
- The smaller the number of data points you have, the bigger the confidence interval – this means you’ll be less likely to see “significant” differences, but the values can still be important for communicating about your data (advocacy)
- A confidence interval is a measure of *precision* and it protects you from coming to incorrect conclusions about what the data say when estimates are unstable
- Confidence intervals don’t compensate for bad survey design or other problems with surveys (sometimes people think that if they display confidence intervals that they’ve done everything possible to be technically accurate – that’s kidding yourself!)

How do I interpret confidence intervals for comparing data?

These differences (below) are definitely statistically significant – the lower bound of the county estimate and the upper bound of the state estimate do not overlap. So we can say for sure that more students in the county smoke cigarettes than do statewide, according to our data.



These differences (below) are definitely not significantly different – the measured value for the state is within the confidence interval of the county estimate. So we say that there is no difference between the local and state rates of youth smoking, according to our data.



The Gray Area: if the edges of the confidence intervals overlap, but the point estimates for both are outside each other's confidence intervals, then we don't know for sure whether the differences are significant.

Questions you can ask about anyone's data that will make you sound really smart (and you can ask yourself these questions too – especially when using data to apply for grants!)

- **How was the survey designed?**
 - Based on some other (research) survey?
 - Comparable to national or other established data?
 - How was the sample of respondents generated? (from a list or registry – a 'random' sample, or some other 'convenience' sample)
- **How were the data collected?**
 - Who was surveyed?
 - How were surveys done (in person, phone, paper)?
 - When were the data collected?
- **How many people were surveyed?**
 - What was the "total N"? (number of people who answered)
 - What was the response rate? (number of people we wanted to survey or tried to survey vs. how many we completed)
- **What kind of analysis did you do?**
 - Which statistical package did you use to analyze the data?
 - What is the margin of error?
 - How were your variables defined?
- **What are the limitations of your data?**
 - Anything from above topics that didn't work out like you wished they would
 - What effect you think any limitations have on your conclusions

Using your data to communicate a message

A few general rules:

- Unless you have a really, really big survey, round your percentages to the nearest whole number
- Better yet, translate into speaking terms if possible
 - "11.5% of youth"
 - "12% of youth"
 - slightly more than one in ten youth
- Always best to say "about" or "estimated" or "approximately" – these are survey data, so that means it's not an exact science (refer to our earlier discussion about 'confidence intervals')

Specific to your audience:

- You need to convince them that you are giving important information
 - Can you quantify into numbers of people?
 - Can you “paint a picture” with the words?
“300 youth currently smoke cigarettes in our community, and 1 in 3 of them will die an early death because of it”

 - Can you relate your data to another issue of importance in the community?
“twice as many youth will be hospitalized for asthma attacks – compounded by secondhand smoke exposure - than will be hospitalized for broken limbs”

- You need to convince them that you are giving them accurate information
 - If you’re writing a grant that will be reviewed by a research panel, you need to have data that are scientific, valid, with “technical” wording to describe your points.
 - If you’re speaking to a leadership group of elders, maybe the same information is better as spoken words from youth who conducted their own (non-scientific) survey in the community.

Tips:

- Figure out the message first – then use the data to support that (don’t just talk about data because data is cool)
- Practice saying it out loud if you’re going to be talking about it
- If you do any fancy calculatin’, make sure you triple-check your figures, and keep a record of how you did the calculations
- ALWAYS get someone you trust to check your figures, or bounce it off of a data geek – make sure you’re using the numbers right
- “Data” are plural – “datum” are singular. But so many people get it wrong that it might not matter....

Resources

1. Tobacco Technical Assistance Consortium [TTAC] (2005). *The Power of Proof: An Evaluation Primer*. Rollins School of Public Health at Emory University. Atlanta, Ga. Available at: <http://www.ttac.org/power-of-proof/index.html>

1. Centers for Disease Control and Prevention. (2001). Gather credible evidence. In *Introduction to program evaluation for comprehensive tobacco control programs* (pp. 49-56). Atlanta, GA. Available at: http://www.cdc.gov/tobacco/evaluation_manual/ch4.html

3. Julia Dilley, Epidemiologist. Evaluation Coordinator, Steps to a Healthier WA. Washington State Department of Health. Personal Correspondence 2005.



Data Collection



SECONDARY DATA SOURCES:

1. **National Statistics** – National statistics on tobacco use can be found through a number of organizations, many of which are available on the Internet. Following are a few good web sites:

www.cancer.org - American Cancer Society- (prevalence and incidence rates for various cancers)

www.oas.samhsa.org - U.S. Department of Health and Human Services –

www.who.int/research/en/ - World Health Organization www.lungusa.org - American Lung Association

www.cdc.gov/tobacco/ - Center for Disease Control

2. **Behavioral Risk Surveillance System (BRFSS, “Bur-Fuss”)** - this is an ongoing telephone survey of U.S. adults with phones. The survey collects information about tobacco use and other health indicators. The same survey was done in 7 northwest tribes in 2001, using face-to-face interviews rather than phone interviews. This information is tribal specific and the surveys were designed to be culturally sensitive. Data from this study is available on the Northwest Portland Area Indian Health Board website at: www.npaihb.org/epi/brfss/webpage_brfss.htm

3. **State Statistics** - Different states are able to provide different sources of information. Some examples of data available by states include the Healthy Youth Survey, Quitline Caller Information, and Statewide Adult Tobacco Survey data. Many of these data sources can generate reports specific to the AI/AN population in your state. For more information, contact your state’s Department of Health Tobacco Program.

4. **RPMS system** – For those clinics who use the Registered Patient Management System, it can be a useful source of information that is also easily accessible. You can use this system to get information on the number of current tobacco users in your community, the prevalence of tobacco-related diseases, and other useful data. Request this type of information from your Tribal Health Director, or contact the staff person who usually produces RPMS reports. On page 21 of this section, you will find a template letter to the Health Director, requesting this data.



If you are interested in being trained on the RPMS system, trainings are provided by NPAIHB, visit the website for more information:
www.npaihb.org/training/2002training.html



THE AMERICAN INDIAN ADULT TOBACCO SURVEY

- WHO?** The Western Tobacco Prevention Project (WTPP), the Center for Disease Control (CDC), and 6 Tribal Tobacco Support Centers working with several tribal communities.
- WHAT?** The American Indian Adult Tobacco Survey (AI ATS) is a questionnaire of people's knowledge, attitudes, and behaviors regarding tobacco use. The original Adult Tobacco Survey (ATS) was implemented in individual states using telephone interviews. The Center for Disease Control has worked in collaboration with the seven tobacco Tribal Support Centers (TSC) to develop a comprehensive, culturally appropriate survey instrument to assess American Indian/Alaska Native tobacco use. Extensive cognitive interviews and focus group testing has been done on the survey instrument in American Indian/Alaska Native communities throughout the nation.
- WHEN?** The development of a culturally appropriate survey tool began in 2002. Project completion is anticipated for fall of 2005.
- WHY?** While we have some national, regional, and state-level tobacco related data broken down by age, gender, and urban or rural populations, factors affecting tobacco use within tribal communities is still largely unknown. National studies show American Indians/Alaska Natives as having the highest tobacco use rate of all ethnic groups. There is a need for a better understanding of the social, cultural, economic, and environmental factors that make tribal communities and American Indian tobacco prevalence rates differ drastically from national rates. These factors have not been comprehensively evaluated in American Indian communities, and may be critical in developing effective, culturally appropriate prevention and cessation programs for tribal communities.
- WHERE?** The AI ATS is currently being implemented in a number of tribal communities throughout the US. Upon project completion, the survey instrument will be available for use in all interested tribal communities.

***For further information on this project, contact the Western Tobacco Prevention Project, or visit the website at: www.western tobaccoprevention.org



Data Collection



[Your address]

August 16, 2005

[Recipient's Address]

Dear [Health Director]:

As the coordinator for the [Tribal Health Tobacco] grant, I am writing to request access to the tobacco-related data that is currently tracked by our RPMS system. As you know, commercial tobacco use is the primary cause of preventable death and disease among the American Indian population, contributing to nearly 40% of all deaths in Indian Country. Consequently, the IHS now estimates that it spends over \$200 million a year to treat tobacco-related illness. Unfortunately, due to the limited availability of data, very little is known about the true extent of this problem here in our own community.

More specifically, I am interested in gaining access to the RPMS data that monitors [our tribe's current commercial tobacco-use prevalence rates, the prevalence of asthma, rates of exposure to secondhand smoke, the use of commercial tobacco products by those who have diabetes...etc.]. I do not need access to any individual identifiers while generating this query, [nor do I seek to carry out this query myself]. I ask only for population-level prevalence rates that are categorized by gender and age (when appropriate).

By using the RPMS database to access information about our tribe's current commercial tobacco use and tobacco-related health outcomes, the [tobacco education program] will be better able to prioritize its future activities to meet our tribal health needs, and will be better able to monitor trends and evaluate the efficacy of our program's efforts over time. We will be able to foster community awareness about important tribal health issues, and will be able to support external grant writing activities that require baseline measurements to substantiate funding needs within our community. This data will serve as a powerful tool to strengthen the efforts carried out by the [tobacco education program].

Please feel free to contact me with any questions you have about this request. I would be happy to provide you with additional details.

Sincerely,

[Your Name]
[Your Job Title]



Data Collection



GLOSSARY OF DATA TERMS

****When you are gathering data information, you may run into many technical terms that you are unfamiliar with. Following is a list of the most common terms you may encounter****

Abstract - A very brief summary or digest of the study and its results. It should tell you what the study tried to show, how the researchers went about it, and what they found. The abstract can be very misleading though. This is often the only part of the content of an article that will show up on a database.

Association - A known link, or statistical dependence, between two or more conditions or **variables**: eg, statistics demonstrate that there is an association between smoking and lung cancer. A 'positive' association is one where the incidence of one condition increases if the other condition or variable increases (as with smoking and lung cancer). There is a 'negative' association when an increase in one thing is apparently associated with a decrease in something else.

Bias - Something that introduces a difference or trend that distorts (or could distort) results of a study. Bias introduces **systematic error** into a study, because what is being observed may not be the effect of the treatment being studied, but rather it may be the effect of bias.

Big Tobacco or tobacco industry - Term often used derogatorily to refer to the network of tobacco manufacturers, distributors, marketers and sometimes even retailers.

BRFSS - Behavior Risk Factor Surveillance System, an annual household telephone survey conducted by each state's health department and coordinated by CDC (see HSC).

Case study or series - A case study is a report of a single example (generally this is an anecdote about one 'interesting' or 'unusual' person or situation). A case series is a description of a number of such 'cases'.

CDC - Centers for Disease Control and Prevention, a federal agency within US DHHS, which provides part of the funds for the TPP and is a valuable resource providing technical assistance.

Cessation or quitting (like smoking cessation or quit smoking programs) - Cessation from the word *cease*; quitting smoking, quitting spit tobacco use or other tobacco use.

Coalition - A group of people who come together (coalesce) to take action on a specific issue; in the Division for Tobacco Prevention, the issues would include any tobacco prevention efforts, such as youth empowerment, enacting clean indoor air regulations, community smoking cessation, etc. In WV there are local coalitions and the state level coalition (Coalition for a Tobacco Free West Virginia - CTFWV).

Cohort (study) - A 'cohort' is a group of people clearly identified: a cohort study follows that group over time, and reports on what happens to them. A cohort study is an **observational study**, and it can be **prospective** or **retrospective**.

Confidence levels - Statistical results and estimates are usually calculated at the '95% confidence level'. This means that if someone were to keep repeating the study in other populations, 95% of the time a similar result would occur: ie, a result that falls somewhere between the upper and lower limit of the **confidence interval**. Sometimes, researchers who want to be more confident about a result will do calculations at a 99% confidence level. Sometimes, results will be calculated at a 90% level of confidence. However, the 95% confidence level is the most usual one.

Confounder or confounding variable (See also **variable**) - Another factor or effect that confuses the picture. A confounder distorts the ability to attribute the cause of something to the treatment, because something else could be influencing the result. Eg, if people are receiving a mixture of therapies, it would be possible to confuse the effect of one with the other. Or if a group of people who did poorly also all lived in the same street, while everyone who did well lived on the other side of town, their worse outcome might be the result of socioeconomic or environmental factors, not the treatment.

Consumption - By DTP, refers to the amount of tobacco smoked or used. Ex: most adult smokers report smoking about 1 pack/day.

Convenience sample - A population being studied because they are conveniently accessible in some way. This could make them particularly unrepresentative, as they are not a **random sample** of the whole population. A convenience sample, for example, might be all the people at a certain hospital, or attending a particular support group. They could differ in important ways from the people who haven't been brought together in that way: they could be more or less sick, for example.

Cost-benefit analysis - Studies of the relationship between project costs and outcomes, with both costs and outcomes expressed in monetary terms.

Cross sectional study - Also called prevalence study: an observational study. It is like taking a snapshot of a group of people at one point in time and seeing the **prevalence** of diseases, etc, in that population.

Descriptive - A study that describes the current situation.

Effectiveness - The extent to which an **intervention** does people more good than harm. An effective treatment or intervention is effective in real life circumstances, not just an ideal situation.

Efficacy - The extent to which an **intervention** improves the outcome for people under ideal circumstances. Testing efficacy means finding out whether something is capable of causing an effect at all.

Epidemiology - The study of the health of populations and communities, not just particular individuals.

Evaluation - The results of a program or project which often determines the effectiveness of the activity: formative evaluation produces information used in the developmental stages of a program to improve it, particularly useful in early stages of program when a program can change; undertaken during the design and pretesting of programs to guide the design process.

Experimental - An experimental study (a 'trial') is one in which the investigators are testing something, and they are determining the conditions of the experiment. In a controlled trial, the people receiving the treatment being tested are said to be in the experimental group or **arm** of the trial. (See also **controls** and **arm**)

Impact evaluation - Assesses the overall effectiveness of a program in producing favorable effects in the target population, usually right after the program is completed or the intervention is over; impact evaluation is linked to specific objectives (for example: compared to a control group, did significantly fewer adolescents start smoking because of the intervention?).

Outcome evaluation is data/information that measures a change in behavior of the target group, such as how many people were still not smoking six months after attending a program.

Process evaluation is information such as how many people attended a program on what date, conducted by what group, to what purpose.

Family income - Categories:

Poor: Persons having family incomes below the Federal poverty level.

Near poor: Persons having family incomes between 100-199 percent of the Federal poverty level.

Middle income: persons having family incomes at least 200 percent of the Federal poverty level but less than \$50,000.

High income: Persons having family incomes at least 200 percent of the Federal poverty level and at least \$50,000.

Generalizability - Whether or not the results of a study are applicable or relevant to another group of people or population. (See also **external validity**)

High risk youth - Individuals ages 12-24 in sub-populations who have high rates of tobacco use and are exposed to other conditions or circumstance associated with risks for tobacco use and other physical, emotional, or psychological health problems (see at risk youth).

Hypothesis - A theory or suggestion that is being tested with a piece of research. For an **experimental study** to properly test a hypothesis, it needs to be prespecified and clearly articulated so that the design, conduct, and interpretation of the study can properly test it. A prespecified hypothesis is also called a 'prior hypothesis'. Studies are often framed to test what is called the 'null hypothesis': that is, that the treatment in question has no effect.

Impact - The net effects of a program.

Intervention - A program or communication designed to reach a target group to influence behavior or attitude change in that group.

Incidence - The number of occurrences of something in a population over a particular period of time: eg, the number of cases of a disease in a country over one year.

Internal/external validity - Internal validity is the extent to which a study properly measures what it is meant to: whether the conclusions are 'true' for the people in the study. External validity is the extent to which the results of a study can apply to people other than the ones that were in the study (how **generalisable** the results are to others, or how applicable they are in the real world - whether the results will be true for people outside the study).

Mean - The average. (Add up the results of something for each participant, and divide by the number of people to find the average - or mean - outcome for people in the study.)

Monitoring - Assessing the extent to which a program is (1) undertaken consistent with its implementation plan or design and (2) directed at the appropriate target population.

Morbidity - Illness or harm. (See also **co-morbidity**)

Mortality - Death.

Needs assessment - Systematic appraisal of the type, depth, and scope of a problem.

Nonsmokers - Anyone, including children, who does not smoke any form of lighted tobacco.

Objective - A defined result of a specific activity to be achieved in a finite period by a specified person or group; objectives state who will experience what change or benefit by how much and by when (see goal).

Observational study - A survey or non-experimental study. The researchers are examining and reporting on what is happening, without deliberately intervening in the course of events.

Odds ratio (OR) - This is a common way of estimating the effect of a treatment. An OR greater than one (> 1) means the treatment is estimated to increase the odds of something: < 1 , and it decreases the odds. If the OR is exactly 1, then the treatment appears to have no effect on that outcome. Eg, a treatment with this estimate: an OR 2.0 (95% CI: 1.0-3.0), apparently increases the odds of a person experiencing this effect, while an OR of 0.5 is an estimated decrease in the chances of experiencing that result. This is similar to a risk of experiencing something - but not exactly the same thing. (See also **confidence interval, confidence limits, relative risk**)

Outcome - The measurable result of a program or intervention.

P value - The findings of a study may be just an unusual fluke. Calculating the *p* value can determine whether or not the results of the study are likely to be a fluke or not. The *p* (probability) value shows whether or not the result could have been caused by chance. If the *p* value is less than 0.05, then the result is not due to chance. A result with a *p* value of less than 0.05 is **statistically significant**. The 0.05 level is equal to odds of 19 to 1 (or a 1 in 20 chance). (See also **confidence level, power, and probability**)

Population - In research, this term is applied to the group of people being studied, which may or may not be the population of a particular geographical area. The population in question in a research study, for example, may be 'all those people with cancer'. The study of the health of populations, as opposed to health of individuals, is **epidemiology**.

Prevalence - The proportion of a population having a particular condition or characteristic: eg, the percentage of people in a city with a particular disease, or who smoke.

Protocol - Both **randomised controlled trials** and **systematic reviews** should be undertaken according to a clearly defined protocol, which **prospectively** sets out what is being tested, why, and how it will be done. The trial or review should then adhere strictly to the pre-set actions in the protocol to maintain uniformity and minimise **bias**.

Random sample - When a group of people is being selected for study, one of the ways to try and ensure that the group studied is **representative**, is to try and recruit people who have been selected randomly from the population. This means that everyone in the population has an equal chance of being approached to participate in the survey, and the process is meant to ensure that a sample is as representative of the population as possible. It is a method that has less **bias** than the other option, which is to use a **convenience sample**: that is, a group that the researchers have more convenient access to.

Rates of use - The % of the population that uses a product. Ex: 41% of high school students reported smoking at least one day/month.

Relative risk (RR) - Also called the 'risk ratio'. It is a common way of estimating the risk of experiencing a particular effect or result. A $RR > 1$ means a person is estimated to be at an increased risk, while a $RR < 1$ means a person is apparently at decreased risk. A RR of 1.0 means there is no apparent effect on risk at all. Eg, if the $RR = 4.0$, the result is about 4 times as likely to happen, and 0.4 means it is 4 times less likely to happen. The RR is expressed with **confidence intervals**: eg, $RR\ 3.0\ (95\%\ CI: 2.5 - 3.8)$. This means the result is 3 times as likely to happen - anything from 2.5 times as likely, to 3.8 times as likely. It is **statistically significant**. On the other hand, $RR\ 3.0\ (95\%\ CI: 0.5 - 8.9)$, means it is also estimated to be 3 times as likely, but it is not statistically significant. The chances go from half as likely to happen (0.5 a decreased chance), to nearly 9 times as likely to happen (8.9 an increased chance). (See also **confidence interval, confidence limit, odds ratio**)

Risk behaviors - Behaviors that increase the probability that an individual will experience an injury, disease, or specific cause of death.

Risk factors - Characteristics of individuals (genetic, behavioral, and environmental exposures and socio-cultural living conditions) that increase the probability that they will experience an injury, disease, or specific cause of death.

Smokers or cigarette smokers - Anyone who uses lighted tobacco products. The TPP advises that we consider smokers and tobacco users as victims of manipulation by the industry and not adversaries to our efforts.

Socioeconomic status - Relative indicator of a person's education, income, and occupational status.

Spit tobacco or smokeless tobacco - Includes snuff, chewing tobacco, plug tobacco; incorrectly believed to be a safe alternative to cigarettes. The industry coined the phrase Asmokeless@ tobacco to infer Aharmless@. The DTP prefers the term Aspit tobacco@.

Standard deviation - A set measure of how far things vary from the average result (the mean). The mean shows where the value for most people was centred. The standard deviation is a way of describing how far away from this centre, or average, the values spread. Eg, a mean waiting time in a hospital emergency room might be two hours, but to cover most people's waiting time, you might have to give or take an hour: the waiting time is therefore 2 hours \pm 1 hour. That extra one hour is the standard deviation. A person who waited 4 hours to be seen would therefore be 2 standard deviations from the mean.

Statistical significance - The findings of a study may be just an unusual fluke. A statistical test can determine whether or not the results of the study are likely to be a fluke or not. That test calculates the probability of the result being caused by chance: it provides a *p* value (probability). If the *p* value is less than 0.05, then the result is not due to chance. A result with a *p* value of less than 0.05 is statistically significant. The 0.05 level is equal to odds of 19 to 1 (or a 1 in 20 chance). (See also *p* value, confidence level, power, and probability)

Surveillance (2) - To watch over or investigate a person, office or place (such as undercover inspections of tobacco retailers for illegal sales to youth).

Surveillance (1) - The process of conducting a survey within a population; surveillance and evaluation is the process of obtaining baseline data for a population or target group, and collecting outcome data for that group after an intervention has been completed, then analyzing the data to evaluate the intervention as to its effectiveness in achieving change.

Survey - Systematic collection of information from a defined population, usually by means of interviews or questionnaires administered to a sample of persons in the population. (like asking adults questions from the BRFSS or asking the youth questions from the YRBS or YS surveys).

Target problem - The conditions, deficiencies, or defects at which an intervention is directed.

Target population - The persons, households, organizations, communities, or other units at which an intervention is directed.

Target - The unit (individual, family, community, etc.) to which a program intervention is directed.

Tobacco-related diseases/tobacco-related deaths - Disease and death caused or exacerbated by tobacco use; includes lung diseases, cancers, heart disease & stroke, diabetes, osteoporosis, SIDS, premature birth; disease and death caused by exposure to secondhand smoke, etc. **Variable** A variable is a factor which differs among and between groups of people. Variables include things like age and gender, as well as things like smoking or employment. There can also be treatment or condition variables, eg in a childbirth study, the length of time someone was in labour. All these factors can potentially have an impact on outcomes. (See **confounding variables**)

YRBS - Youth Risk Behavior Survey; a national survey coordinated by CDC and administered in odd years (since 1993) by the WV Department of Education; the survey consists of 14 tobacco use questions for grades 9-12.

YTS - Youth Tobacco Survey; a national survey coordinated by CDC and administered in even years (since 2000) by the WV Department of Education in collaboration with the WV Bureau for Public Health; the survey consists of over 50 questions for grades 6-12.

Validity - The degree to which a result is likely to be 'true' and free of **bias**. (See also **internal/external validity**)

Variable - A variable is a factor which differs among and between groups of people. Variables include things like age and gender, as well as things like smoking or employment. There can also be treatment or condition variables, eg in a childbirth study, the length of time someone was in labour. All these factors can potentially have an impact on outcomes. (See **confounding variables**)



TOBACCO FACTS & STATS

Approximate length: 1 hour

Intended audience: Tribal councils, Health workers, Community members, Youth, Funders

Summary:

This presentation reveals the current situation of commercial tobacco, with emphasis on American Indian/Alaska Native communities. This presentation can be used in almost any venue, as it focuses primarily on the facts of tobacco use. You could use this presentation when speaking with the tribal council, to stress the importance of the tobacco program, or when discussing a change in tribal policy. It can also be used during a community event to educate participants.

The following topics are highlighted in this presentation:

- Disparities in commercial tobacco use between racial/ethnic groups in the US
- Racial/Ethnic commercial tobacco use broken down by state
- Tobacco use among American Indian teens
- Tobacco-related diseases
- Percent of deaths related to commercial tobacco use
- Financial costs of commercial tobacco use
- Social costs of commercial tobacco use
- Possible solutions to address the issue of commercial tobacco use
- Facts about tobacco industry spending
- Other interesting information





PROVIDING TOBACCO TRAININGS

Organizing a training is an essential part of educating a community about tobacco. There are certain steps that will help make your message interesting and provide for group interaction.

Instructors need to be prepared for teaching/facilitating sessions. This includes becoming familiar with:

- Curriculum
- Teaching materials
- Icebreakers
- Questions to facilitate discussion
- Audiovisual equipment and materials

Group classes may be structured in a variety of ways. Instructors may consider the following suggestions:

Before the session

- Arrange chairs in a circle to encourage discussion and sharing of stories
- Provide flipchart or whiteboard to list participant responses, questions, concepts, etc.
- Provide participants with notebooks to hold class materials
- Provide note paper with session title and the key concepts for that session

During the session

- Take attendance
- Have visuals for each session
- Provide health snacks
- Include a brief stretch/physical activity

After the session

- Have participants evaluate each class or session
- Include instructor's contact information for participants
- Thank them for participation

How to invite people to your training

Trainings can be advertised using the following methods:

- Newsletter: Submit the training date and agenda to the publisher of the newsletter. Make it eye-catching and include native imagery.
- Contact: Newsletter Editor
- Mailings: Insert the training registration form into organizational mass mailings. Work with the Project Assistant to coordinate these mailings. Send the mailings out as early as possible to give participants advance notice.
- Contact: Project Assistant or support staff
- E-mail: Promote trainings on a network list-serve. Advertise three months in advance (when possible), and each month thereafter.
- Contact: Project Assistant or support staff
- Posters/Flyers: Post flyers at key locations in the community, advertising the training. Make it eye-catching and include native imagery. Recruit a local artist.
- Contact: Support staff at community centers, stores, etc.
- Public Announcements: Visit local events and organizations and inform people of the upcoming training. If it is for youth, make an announcement at the school assembly. If it is for adults, visit the tribal council meeting and ask them to spread the word.
- Contact: Tribal Council, School Principals

Where is the training going to be?

There may be times when you need to provide a training at a remote location other than tribal offices. When this happens, it is important to investigate the new location and determine how you may need to modify your training based on what is available.

If you are not familiar with the location, ask the following questions:

- Can the facility accommodate the number of people?
- Is there a room rental cost? If so, is the price waived if food is ordered?
- Is there adequate parking for participants? Is there a cost for parking?
- Is the room comfortable (lighting and temperature)?
- Is there enough room for overheads and flipcharts?
- Is there an overhead or LCD projector?
- Who is the technical support contact person?
- Who is the contact person for registration?
- Who is responsible for any food provided?
- What is the easiest route to the facility? Can they provide a map to participants?
- Can they provide a map of the nearest hotels and restaurants?

What resources do you need for the training?

Food and refreshments:

- In Native communities, food is often a symbol or gesture of giving and sharing. It is an essential part of community and social events.
- The food that is provided should reflect that this training is about making healthy choices by not using commercial tobacco. We also make healthy choice by eating foods that provide our body with essential nutrients. In other words, serve food that is healthy and reflects the traditional diet of the community (if possible).
- Recommended snacks:
 - Tea
 - Fruit juice
 - Water
 - Coffee
 - Cottage cheese
 - Fresh Fruit
 - String Cheese
 - Yogurt
 - Muffins
 - Carrots
 - Bagels
 - Celery
 - Granola bars

Recognition and nametags:

- Present participants with a certificate of completion. This is a nice way to recognize their efforts.
- Prepare nametags for each participant. It looks professional and will help you to remember people's names. It also helps people get to know each other
- Distribute a sign-in sheet at the beginning of the session.
- Verify the spelling of people's names prior to preparing certificates, nametags, etc.

Handouts:

- The Agenda
- Copies of Powerpoint presentations
- Note paper
- Evaluation forms
- Any other pertinent information

LCD or overhead projectors:

- Check the overhead or LCD projector availability and reserve the projector for your training. Prior to the day of the training, test the LCD projector with the computer that will be used during the training.

Flip charts:

- Have flip charts available to note all questions the participants may have during training. Flip charts are an excellent tool to visualize ideas and instructions to the participants.

Pens/pencils/notepads:

- Have pens, pencils, and notepads available for the participants. Also, have a spare dry erase marker available.

Sample Training Agenda

The following is an example of a training schedule. The times and tasks should be altered to reflect your specific activities. Prior to the training, be sure to make copies of the agenda and distribute it to all participants.

Time – Day 1 (8:30am – 4:30pm)	Primary Task
8:30am – 9:00am	Participant sign-in
9:00am – 9:30am	Blessing and Introductions
9:30am – 10:30am	Presentation 1 [Topic & Speaker]
10:30am – 10:45am	Break
10:45am – 11:00am	Warm-up/Energizer
11:00am – 12:00pm	Presentation 2 [Topic & Speaker]
12:00pm – 1:00pm	Lunch
1:00pm – 2:30pm	Presentation 3 [Topic & Speaker]
2:30pm – 2:45pm	Break
2:45pm – 3:00pm	Warm-up/Energizer
3:00pm – 4:00pm	Presentation 4 [Topic & Speaker]
4:00pm – 4:30pm	Group Sharing/Closing Remarks

Training Organization



NAME OF PROGRAM HOSTING TRAINING		
<i>PHOTO/ LOGO</i>	<i>TITLE OF TRAINING DATE</i>	<i>PHOTO/ LOGO</i>

LOCATION OF TRAINING

TRAINING OBJECTIVES:

- ▶ Establish relationships with participants for leadership support
- ▶ Increase awareness of American Indian/Alaska Native tobacco related issues
- ▶ Provide prevention information about the use of commercial tobacco products among Native people
- ▶ Incorporate conference objectives through fun & challenging games

TIME	EVENT	DATE	ROOM	PRESENTER
8:30am-9:00am	Participant sign-in			
9:00am-9:30am	Blessing and Introductions			
9:30am-10:30am	Presentation 1			
10:30am-10:45am	Break			
10:45am-11:00am	Ice Breaker/Warm-up/Energizer			
11:00am-12:00pm	Presentation 2			
12pm-1:00pm	Lunch			
1:00pm- 2:30pm	Presentation 3			
2:30pm-2:45pm	Break			
2:45pm-3:00pm	Ice Breaker/Warm-up/Energizer			
3:00pm-4:00pm	Presentation 4			
4:00pm-4:30pm	Group Sharing/Closing Remarks			

Pre-Training Checklist :

- Arrange date for training
- Determine cost of the training / Prepare purchase order
- Prepare staff/volunteer responsibility checklist
- Reserve training room
- Inform all necessary parties (tribal council, tribal health director, school principal, etc.)
- Arrange for meals and/or snacks
- Circulate flyers and announcements
- Disseminate registration forms
- Reserve PowerPoint and LCD projector
- Identify presenter and objectives of the training
- Prepare presentation and any other handouts
- Develop sign-in sheet
- Create evaluation forms
- Create certificates and nametags
- Confirm participants by telephone
- Distribute list of hotels and directions to participants
- Prepare and review agenda
- Gather supplies and materials (flip chart paper, pens, tape, scissors, tobacco educational items)
- Prepare prizes for any icebreakers
- Prepare gifts for presenters and/or people giving a blessing
- Have fun!

Evaluation Form

[Name of Training, date]

~Use colored paper when you print the evaluation form~

Please take a few moments to fill out this training/workshop evaluation form. Your feedback will help us assess our effectiveness, and will provide valuable information for future planning. When finished, please return this form to our training staff. Thank you!

PLEASE RATE THE FOLLOWING:	Poor	Fair	Average	Good	Excellent
1. Quality of training materials	1	2	3	4	5
2. Knowledge of the training staff	1	2	3	4	5
3. Opportunity to participate & ask questions	1	2	3	4	5
4. Opportunity to network with others	1	2	3	4	5
5. Usefulness of the information	1	2	3	4	5
6. Was the information provided in this training/workshop relevant to tobacco prevention efforts in your community/agency?					
	YES	NO			
7. Did the information presented in this training/workshop increase your knowledge about the subject?					
	YES	NO			
8. Does the information provided in this training/workshop have the potential to help prevent tobacco use in your community/agency?					
	YES	NO			
9. Will you employ these methods to prevent tobacco use in your community/agency?					
	YES	NO			
10. Will you share these materials with other professionals in your community/agency to promote tobacco prevention?					
	YES	NO			
11. How will you use the information presented in this training?					
12. Please share any comments below, or on the back of this form. Thank you!					

Training Organization

Tobacco Awareness Pre-Test

[Name of Project]

1. Commercial tobacco smoke contains how many chemicals? (circle one)

200 1,000 4,000 200,000

2. Secondhand smoke causes: (circle all that apply)

Asthma High blood pressure Ear infections Cancer Bronchitis

3. Please circle all plants that were gifted by the Creator for ceremonial uses.

Sage Cedar Tobacco Sweet Grass

4. The leading cause of death among all American Indians/Alaska Natives is:

Cancer Cardiovascular disease Diabetes Accidents

5. Counter-marketing is a strategy to off-set tobacco advertising.

True False

6. The hardest addiction to quit, according to drug users is?

Caffeine Cocaine Heroine Chocolate Smoking

Training Organization

Ice Breakers and Group Games

1. "Birthday Lineup"

Purpose: non-verbal communication, working together, just fun

Ask everyone to stand up. Instruct the group that they are to line up according to the month and day of their birth without ANY talking. This should inspire some interesting means of communication towards a common goal.

2. "Ball Toss"

Purpose: material review, energizer

This is a good exercise when covering material that requires heavy concentration. Have everyone stand up and form a circle. It does not have to be perfect, but they should all be facing in, looking at each other. Toss any kind of ball or bean bag to a person and have them tell what they thought was the most important learning concept. They then toss the ball to someone and that person explains what they thought was the most important concept. Continue the exercise until everyone has caught the ball at least once and explained an important concept of the material just covered.

3. "Dance Your Name"

Purpose: getting to know each other, energizer, just fun

This is a great activity near the beginning of training, because it will help everyone learn names. Have everyone gather in a circle. Explain that you are going to introduce yourselves by spelling your names with your hips. You go first, by standing in the middle and drawing imaginary letters with your hips. It will look like you are coming up with a new dance move! Encourage people to not be shy. You could even bring music and clap with the rhythm. Continue around the circle until everyone has had a turn. This is really fun and gets everybody laughing!

4. "Draw and Tell"

Purpose: getting to know each other

This is a wonderful activity that really helps people share things about themselves that most people won't know. Give everyone a sheet of flip chart paper and one or two colored markers. Instruct the group that they are to draw a picture (or several pictures) that shows who they are and what is important to them. Make sure that people know this

is NOT an art contest. Stick figures are OK!! When finished, have everyone tape their paper to a wall and go around the room for people to share their picture. Be sure to allow a little extra time for this activity, people really get into it.

5. "Fry Bread Hands"

Purpose: energizer, just fun

Have everyone gather in a circle. Have each person put his or her left hand up (like they are holding a bowl of soup-arms to their sides.), and right hand down (they will place their right hand over the left hand of the person next to them-like they are covering that bowl of soup). When you say "go", you will tap the top of the person's right hand (with your right hand) to your left and they will follow suit to the person next to them. Make sure after the person has tapped the person next to them, they put their hand back to the starting position. It will act like a domino or wave affect. Practice this.

Once the wave begins, you will look away and say "stop" after a few seconds. Whoever is in mid slap will be eliminated from the game. Make sure you have an incentive to give away to the last two competitors. Start doing a couple practice rounds, telling each time to go as fast as they can. Explain that they don't want to get eliminated because you have a prize for the winner. You may want to pull yourself out of this game after you've done the demonstration rounds so you can say "stop" and "go" without having to play. You can also judge who was in mid-slap when you've said stop. Continue until there are only two standing.

6. "I Love My Neighbor"

Purpose: energizer, just fun

Have everyone bring their chairs to the middle and sit in a circle, including yourself. Once formed, eliminate your chair so everyone has a seat except you. Explain that you will say "I love my neighbor that..." followed by a description of something. Everyone that meets your description must get up and go across the circle and sit in a different chair. An example would be-you say; "I love my neighbor that has brown hair". Everyone that has brown hair would get up and find a chair across from them, including you! Since you've pulled your chair out of play, there is one less place for someone to sit. Whoever is left standing gets to pick the next "I love my neighbor..." statement. When working with you, you may want to explain that they aren't to run or wrestle. You can do this as long as you like or when you notice people getting bored.

7. "If You Love Me Baby Smile"

Purpose: energizer, just fun, getting to know each other

Have everyone bring their chairs to the middle and sit in a circle. Ask for a volunteer. Once you have a volunteer, explain that the goal is to get someone to smile by saying, "if you love me baby, smile" without touching the person at all. They can make funny faces, sing songs, or dance for them, just no tickling or touching! The person must reply by saying "I love you baby, but I just can't smile for you" WITHOUT cracking a smile. If the person succeeds, the person they made smile moves on, and if they lose, they have to go to another person.

8. "Knots"

Purpose: energizer, working together

Divide the group into clusters of eight. Have each cluster stand in a circle facing into the center. Instruct them to shake hands with person directly across from you and continue to hold hands. Then instruct them to join left hands with a different person in the group. Now tell the group they must untangle the human knot without letting go of hands.

9. "Make it Rain"

Purpose: energizer, just fun, working together

Have everyone gather in a circle. Ask the group if they believe the group can make it rain. Talk to them about the last time it rained, what it smelled like, what the sky looked like, sounds. Ask them to close their eyes for a few minutes and visualize that. When finished, explain that you will help them make it rain.

Begin by rubbing your hands together and having the person to your left follow what you do. Explain that each person must begin one by one and the person next to you cannot begin until the person to their right has begun. Everyone keeps rubbing their hands together until the person to their right begins something different.

Once the hand rubbing has gone all around the circle, begin snapping your fingers. The directions are the same as above and the person does not begin until the person on their right has begun. Once the finger snapping gets back to you, start lightly clapping your hands. After that has gone around, start patting the top of your thighs. Next, keep patting your thighs and begin stomping your feet.

Lastly, return to start in descending order, patting your thighs, clapping your hands, snapping your fingers, and then rubbing your hands. It should sound like a summer cloud burst!

10. "Out of the Box"

Purpose: Quick, physical energizers, encouraging healthy activity

Prior to your training, assign everyone a number and include it on each nametag. Cut up slips of paper and write the numbers on them. Put them in a hat. Cut up more slips of paper and write a different activity on each one. For example, “jumping jacks”, “deep breathing and stretching”, or “arm circles”. Put the activity slips in a different hat. Tell your participants that throughout the training, you will be drawing random numbers, and the person who has that number will need to come up and lead the group in an activity that they will draw from the activity hat. This will energize everyone throughout training, as they anticipate their number being chosen!

11. “Paper Bag Skits”

Purpose: material review, energizer, working together

Split your group into teams consisting of three to six members. Give each team a paper bag filled with assorted objects. These objects can be almost anything, i.e. a wooden spoon, a screw, a bar of soap, a computer disk, etc... The object of the game is for the groups to present a skit using all of the props provided. The props may be used as they would be in normal life, or they may be imaginatively employed. Give each group a topic to base their skit on that is related to the training. For example, you may ask their skits to be about tobacco cessation. When all the skits have been planned and rehearsed they are performed for the amusement of all.

12. “Princesses, Warriors and Bears”

Purpose: energizer, just fun, getting to know each other

Instruct the group to find a partner- someone they don’t already know. Once paired, explain that the goal of this game is to read each other’s mind. To begin, you must teach all participants three “poses”. Demonstrate the poses to the group and ask them to copy your pose. The princess strikes a pose with one hip out and one hand behind their head, warriors act like they are shooting a bow, and a bear has two arms up in a claw position and growls. Practice these poses with the group by yelling out a pose and having everyone get into position.

Then, have the partner stand together, back-to-back. Explain that each person should think about the poses, and try to figure out what pose their partner wants to do. Tell them send messages to their partner through their brain waves- no talking! After about 30 seconds, tell everyone to turn around quickly and make one of the 3 poses. If they make the same pose, they are successful and get to stay in the game. If they are different poses, they are eliminated. Continue this until only 1 group is left.

13. "Wink"

Purpose: energizer, just fun

Arrange participants into partners, including you. Instruct each group to bring one chair and form a circle. Partners should arrange themselves with one person sitting in the chair, and the other standing behind them. You should be sitting in the chair. Once arranged, you leave your partner. This person is "it". Tell this person that they are to wink as unobtrusively as possible at one of the seated persons in the circle. If a seated person gets winked at, they must run quickly to take the empty chair. The person behind his or her chair can prevent it by placing his or her hands on the person's shoulders. They must keep their hands by their sides until the person tries to run. Play until many people have been winked at, then have the standing people sit, and vice versa.

Ice Breakers

GRANT WRITING

Approximate Length: 1 hour

Intended Audience: Tribal Coordinators and Health Professionals

Summary:

This presentation provides a short outline for grant writing. It gives definitions of certain terms a person may need to know as well as tips for writing the grant along with many other helpful suggestions.

- **Grant writing terms**
- **Information in an RFP**
- **Writing tips**
 - The #1 reason for proposals that don't get funded is unclear writing
- **Needs Assessment**
 - Explores what is happening in the community
- **Project Goals**
 - Describe your intentions for the project
- **Outcomes**
 - Outcome objectives describe a specific change you want to achieve in your target population
- **Activities**
 - What will you do to accomplish your objectives
- **Budget**
 - External contracts, Rentals, & Supplies
- **Evaluation**
 - Determines the value of your project