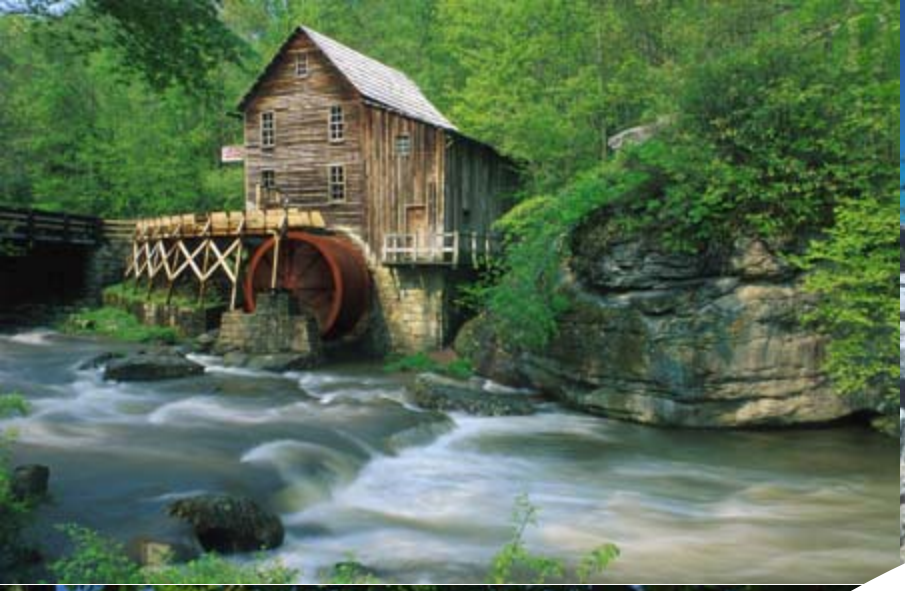

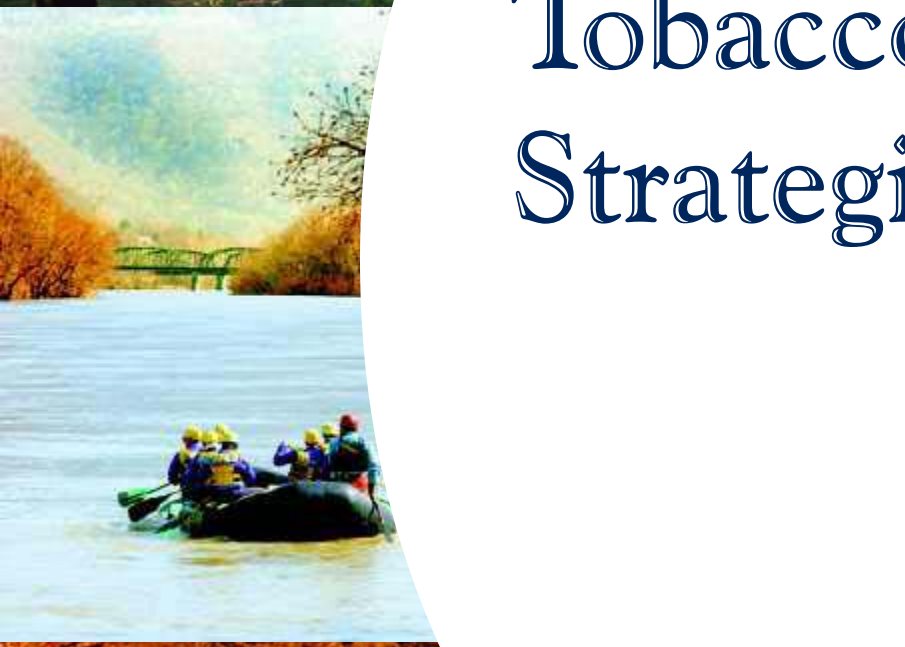

West Virginia Tobacco Prevention Strategic Plan

2003-2008

Division of Tobacco Prevention
WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

West Virginia Tobacco Prevention Strategic Plan 2003-2008

Division of Tobacco Prevention
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West Virginia
Division of Tobacco Prevention
Strategic Plan
2003-2008

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-INTRODUCTION-

The Purpose of a Plan

Despite the fact that the consequences of tobacco use are well-known to West Virginians, residents continue to use tobacco in alarming numbers. Tobacco use is the number one preventable cause of premature death and disease.

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs. The comprehensive plan focuses on four goals:

1. Prevent the initiation of tobacco products among young people.
2. Eliminate exposure to secondhand smoke.
3. Promote quitting among adults and young people.
4. Eliminate tobacco-related disparities among different population groups.

The following plan will serve as the framework for West Virginia's comprehensive tobacco prevention program over the next five years.

History of Tobacco Prevention in West Virginia

In 1989 the National Cancer Institute (NCI), in partnership with the American Cancer Society (ACS), announced the funding opportunity for a seven-year ASSIST grant (American Stop Smoking Intervention Study for Cancer Prevention) from the National Cancer Institute. The West Virginia Department of Health and Human Resources, Division of Health Promotion, eagerly prepared and submitted its proposal. West Virginia was one of 17 states to receive funding. West Virginia's new program, the Tobacco Control Program (TCP), received funding of up to $800,000 per year over an eight-year period. It was composed of a staff of eight. This program expired in the fall of 1998. Because of the high levels of funding sustained over many years, the ASSIST project established infrastructure within the TCP in the following program areas:

- policy initiatives in tobacco prevention, especially clean indoor air regulations, workplace policy development, excise taxes, and cessation
- public education through media
- identifying specific populations and channels to use in reaching them for behavior change
- collaborative relationships
- coalition building
- evaluation and strategic planning.

Prior to 1991, West Virginia did not have funding from either state government or the federal government or private foundations to conduct tobacco prevention programming. The Centers for Disease Control and Prevention funded one position in the Bureau for Public Health's health promotion office to address two health issues -- cardiovascular health and physical fitness. Any tobacco prevention activities conducted in West Virginia were led by not-for-profit state-level organizations, mainly the American Lung Association and the American Cancer Society.

During the eight years of ASSIST, the TCP provided funding to establish county tobacco control coalitions serving 42 of our 55 counties -- no county was ever rejected for funding. With local support from these coalitions and technical assistance from the TCP, clean indoor air regulations were passed covering 39 counties that protected 76% of the public and workers from exposure to secondhand smoke.

Also using ASSIST funding, the West Virginia Bureau for Public Health (WVBPH) helped to establish the West Virginia Tobacco Control Coalition (WVTCC) in 1989. This coalition served as an advisory group to the WVBPH, with members recruited by invitation from the Commissioner of Public Health, William T. Wallace, M.D.

The primary role for the WVTCC for the first two years of the ASSIST Project was to develop a strategic plan for tobacco control for the state, based on guidelines required by NCI. The WVTCC established committees that focused on policy, media advocacy and program services and conducted activities and projects throughout the ASSIST contract period. A key focus of the WVTCC was the establishment and nurturing of local coalitions whose key priority was passage of local clean indoor air regulations.

The Coalition gradually evolved into serving as something more than an advisory group to the TCP and changed its name to the Coalition for a Tobacco-Free West Virginia (CTFWV). At this time the WVBPH agreed that the Chair of the Coalition could be someone other than an appointed employee of WVBPH, as was previously the case.

When the ASSIST project expired, the TCP submitted a proposal for funding to the Centers for Disease Control and Prevention (CDC). The proposal was funded with an annual budget of about $1.1 million through the National Tobacco Control and Prevention Program. The TCP continued its programming and was able to add a cessation focus. In order to show a more positive representation, the name was changed to the Tobacco Prevention Program (TPP).

With the signing of the Master Settlement Agreement (MSA) in 1998, West Virginia joined 45 other states in obtaining settlement funds reimbursing the state for “current and future economic impact” from tobacco use. West Virginia receives about $60 million annually as a result of the MSA.

The Legislature has annually allocated half of this money to the Settlement Medical Trust Fund, which may be spent on a variety of health measures, including tobacco prevention. This money is currently held in a trust fund and has not been used. The other half is allocated directly to health-related activities -- including $5.85 million per year to the WVTPP since fiscal year 2001. Funding recommendations from the CDC's *Best Practices* indicate that West Virginia should provide and sustain annual funding of $14.1 million to $35.3 million in tobacco prevention. The CTFWV developed the 1999 document *Saving Lives and Saving Money: Blueprint for a Comprehensive Tobacco Prevention and Control Program for West Virginia* and strongly advocated for sustained funding at significant levels for a statewide comprehensive tobacco control and prevention program.

In 2000, the Coalition officially became an independent entity no longer attached to the WVBPH. Some funding from the Robert Wood Johnson Foundation SmokeLess States project that was granted to the West Virginia Youth Tobacco Prevention Campaign was directed to meet some of the needs for the Coalition. The mission for the Coalition has since been redefined to focus strictly on tobacco control policy, and the Coalition is now recognized as an established, credible resource related to tobacco control policy in West Virginia.

In 2002, the Healthcare Education Foundation of West Virginia, a subsidiary of the West Virginia Hospital Association, was awarded a two-year grant from the SmokeLess States National Tobacco Control Policy Initiative to fund the policy efforts of the Coalition. With these significant resources, along with a hard cash match of more than $191,000, the Coalition, working with West Virginia Governor Bob Wise and representatives of the West Virginia Department of HEalth and Human Resources conducted a public education and policy campaign related to an increase in the tobacco tax, resulting in an increase in the cigarette tax from 17 cents to 55 cents per pack.

The Coalition works in collaboration with the WVBPH on tobacco control issues as appropriate but has also assumed the role of "friendly watchdog" to attempt to insulate the tobacco control movement from political influence when necessary.

On a national level, the MSA established the American Legacy Foundation in 1999 to prevent the initiation of tobacco use among youth. The Legacy Foundation funded the TPP at levels of $750,000 for each fiscal year 2001 to 2003. The focus of this grant was to directly reach the youth population and establish tobacco prevention youth empowerment opportunities.

Because of increased levels of funding from state government, federal government and private foundations, the Office of Epidemiology and Health Promotion implemented a reorganization plan that elevated the TPP to division status as the Division of Tobacco Prevention (DTP). The DTP now comprises 15 staff.

Tobacco prevention in West Virginia includes a variety of collaborative relationships including other programs within the Division of Health Promotion, the Division of Maternal, Child and Family Health, the Department of Education, the Division on Alcoholism and Drug Abuse, the Division of Juvenile Justice Services, etc. Collaboration also involves the major universities and not-for-profit organizations that share the common goal to reduce tobacco use in West Virginia and to protect its citizens from secondhand smoke. Surveillance and epidemiological support are provided by the West Virginia Health Statistics Center, and evaluation monitoring is provided by the Evaluation Oversight and Coordinating Unit (EOCU) at West Virginia University (WVU).

The Importance of Partnerships

The West Virginia tobacco prevention community is proud of the partnerships it has established. Partnerships include a variety of organizations including not-for-profits, the CTFWV, private sector businesses, and government agencies. At the state level, the DTP sponsors meetings in order to regularly coordinate with state partners and their programs through advisory committees. Advisory committees include the Youth Empowerment Team, the Clean Indoor Air Partnership, the Communications Advisory Group, the Cessation Advisory Group and the Evaluation Advisory Group. The purpose of Advisory Committees is to coordinate activities and events among the numerous partners and to handle challenges within a collaborative framework.

The Youth Empowerment Team (YET) meets bimonthly to coordinate all youth activities within the state. Members include the DTP, the American Lung Association, the West Virginia Department of Education, thembcgroup (now the Manahan Group), the West Virginia Department of Health and Human Resources media consultant; and the West Virginia Youth Tobacco Prevention Campaign. These organizations have a formal memorandum of understanding outlining how they work together.

The Clean Indoor Air Partnership meets quarterly to discuss issues related to clean indoor air regulations. Members include the DTP, the American Lung Association, the American Cancer Society, the Coalition for a Tobacco-Free West Virginia, representatives from local health departments, representatives from local boards of health, representatives from county coalitions and legal counsel.

The Communications Advisory Group meets once a month to discuss publications, communications, media, public relations and press conferences. Representatives include the DTP, thembcgroup, the West Virginia Department of Education, the West Virginia Health Statistics Center, the CTFWV, and the chairperson of each of the other advisory groups representing youth, clean indoor air, cessation and evaluation.

The Evaluation Advisory Group meets quarterly to discuss evaluation strategies. This group is comprised of the DTP, West Virginia Health Statistics Center, the counter-marketing evaluator and the EOCU at WVU. The DTP plans to add community representation to this group in the near future. Our collaborative evaluation efforts are designed to determine whether program goals are met, what prevention and reduction approaches are most effective and what can be done to improve outcomes. The five-year strategic plan will provide information that will be used to guide evaluation activities, including major goals and directions for DTP efforts. The EOCU will use the strategic plan to finalize the evaluation plan for the DTP.

Communication with external partner organizations is accomplished through electronic list serves, newsletters, conference calls, regular committee meetings, biannual retreats with partners, an annual statewide conference, workshops and web site postings.

Vision Statement

“West Virginians live tobacco free.”

-THE CHALLENGE-

Current Needs

As with most states, West Virginia needs more funds for prevention and cessation efforts. Overall funding will significantly decrease with the expiration of the American Legacy Foundation grant. Currently, West Virginia is assessing alternative funding sources and is implementing cost-saving ideas.

The Burden

Youth Tobacco Use

Smoking prevalence among high school students in West Virginia showed a **statistically significant decline of 20%** from 1999 (42% measured by Youth Risk Behavior Survey--YRBS) to 2002 (34% measured by Youth Tobacco Survey--YTS). Though West Virginia has consistently ranked among the top five states in youth smoking, recent data reveal that a **declining trend** has begun. In 2000, West Virginia ranked the highest in the country at 39% (measured by YTS). Smokeless tobacco use among male high school students in West Virginia showed a similar **decline of more than 30%** from 1997 (31% measured by YRBS) to 2002 (22% measured by YTS). In 1999,West Virginia ranked third highest in the country in smokeless tobacco use among male high school students. ***Note:*** *The use of spit tobacco by adult women is less than 1% (2001 BRFSS) and it is 2.5% (2002 YTS) among high school girls. We have not seen increases in these rates so we approach spit tobacco use as a male behavior and do not include women and girls in reporting of these data.*

Adult Tobacco Use

West Virginia consistently ranks among the top six states nationwide in adult smoking prevalence. In 2001, West Virginia ranked fourth highest in the country with a rate of 28%, while the U.S. average was 23% as measured by Behavioral Risk Factor Surveillance System (BRFSS). Among all age groups, **young adults aged 18-24** had the highest increase among all adults, a 39% increase from 2000 (30%) to 2001 (41%). This accounted for almost two-thirds of the total increase in rates among all adults between 2000 and 2001.

Smokeless tobacco use among adult men in West Virginia, however, **has started to decline**. The prevalence **decreased by 4%** from 2000 (17.9%) to 2001 (17.1%). The 2000 rate was the highest in the nation among 18 states, and was more than twice the national average. West Virginia has ranked #1 in adult male spit tobacco use every year since 1990.

Maternal Smoking

In 1999, West Virginia ranked first nationwide in smoking during pregnancy with a prevalence rate of 26%. This was more than twice the U.S. maternal smoking prevalence rate of 12% according to *Smoking During Pregnancy in the 1990's*, published by CDC, National Center for Health Statistics, National Vital Statistics System, 2001. Unpublished focus group data involving pregnant smokers in West Virginia, conducted in 2000 and funded by the West Virginia Office of Maternal, Child and Family Health, illustrated the challenges we have in reaching this population. Many pregnant women indicated that their physicians had not counseled them to quit smoking, or had condoned their smoking as long as it was 10 cigarettes or less per day. It is critical for us to improve patient counseling by physicians and conduct public education campaigns to reduce smoking during pregnancy.

Exposure to Secondhand Smoke

In 1998-1999, about 64% of the West Virginia workforce was protected from secondhand tobacco smoke by work-site smoking policies, compared to 69% nationwide. In the residential setting, about 43% of West Virginians restrict smoking in their homes, compared to 61% of people nationwide, a difference of 30%. Forty-nine (September 2003) of West Virginia's 55 counties are covered by clean indoor air regulations. This means that approximately **1,637,794** (91%) of the state's 1,808,344 residents are provided with **some level of protection** from secondhand smoke in public places and workplaces.

Health Consequences of Tobacco Use

Approximately 4,000 West Virginians die each year from smoking-related diseases. **One in 5 deaths** in West Virginia is due to smoking. In 1999, the rate of smoking-attributable death was 20% higher than the national rate. It is estimated that, in West Virginia in 1999, smoking accounted for 1,262 (80%) of all deaths due to cancers of the trachea, lung or bronchus. It is also estimated that smoking accounted for 827 (17%) of all deaths from heart disease and 945 (80%) of all deaths due to chronic obstructive pulmonary diseases.

Measured in economic terms, the estimated annual direct health care costs from smoking-related diseases in West Virginia was $897 million in 2001. This does not include economic costs of lost productivity from premature deaths of smokers, which is estimated at another $906 million in 2001 in *Tobacco Is Killing and Costing Us*, published by WVBPH, 2002.

Women and Smoking

In West Virginia from 1980-2000, the death rate due to cancer of the lung and bronchus increased by 93% among females, compared to only a 9% increase among males. In the same time period, the death rate from emphysema increased by 94% among females, while the rate among males actually decreased by 50%.

Environment

The environment for tobacco prevention in West Virginia has changed dramatically over the last 14 years. We have come from a funding level of $10,000 per year to $7.7 million annually. The legislature passed the first state excise tax on smokeless tobacco products in 2001 and increased the state excise tax on cigarettes from 17 cents to 55 cents during the 2003 legislative session. West Virginia has protected local authority to regulate public health measures every year and county clean indoor air regulations are becoming stronger. The state has implemented major policy initiatives with Medicaid and the Public Employees Insurance Agency, covering cessation services for their tobacco users. The primary barrier to implementing a comprehensive statewide program is insufficient funding. West Virginia is funded at 54.6% of the minimum CDC recommended level ($14.1 million).

During the 2000 legislative session, the TPP was allocated $5.85 million from the state's MSA money to enhance tobacco control efforts -- the first time any West Virginia state funds were invested for this purpose. That same year, the TPP also received a grant award for $750,000 per year for a three-year period from the American Legacy Foundation to implement a youth empowerment program through the West Virginia Youth Tobacco Prevention Campaign (WVYTPC). When combined with an award of $1.1 million per year from the CDC, this brought the total funds available for tobacco prevention and control to $7.7 million annually.

During June of 2000, the leadership for the TPP hosted a planning caucus to determine how the newly acquired MSA funds should be spent. The CDC's *Best Practices for Comprehensive Tobacco Control Programs* and the CTFWV's *Blueprint* guided this meeting. At that time, it was determined that the primary focus of these funds would be directed toward youth. It was also recommended that a portion of these funds should continue to support clean indoor air activities, cessation services should be established and the effectiveness of projects funded by the TPP should be monitored and assessed.

A major counter marketing campaign was launched in May 2002 and thousands of teens have signed up to participate in youth empowerment activities. In July 2000 the EOCU was created to monitor and assess the effectiveness of projects funded by the DTP, and as of July 2003, 49 of 55 counties were protected from secondhand smoke and quit line services were available at no cost to many West Virginia citizens.

While it is statistically significant that youth tobacco prevalence rates have decreased 20% since 1999, West Virginia continues to struggle with adult smoking and smokeless tobacco use, and hopes to apply more resources to these issues in the future.

There are many factors that may contribute to high rates of tobacco use in West Virginia:

- Although West Virginia receives about $60 million each year from the Master Settlement Agreement, less than 10% ($5.85 million) of that supports the budget for a statewide comprehensive tobacco prevention program. The minimum level recommended by CDC is $14.1 million annually.

- In the year 2001, Campaign for Tobacco-Free Kids reported that the tobacco industry was spending $60 million per year promoting its products in West Virginia -- twice as much as they spent in 1999.

- For 25 years low taxes helped to keep tobacco affordable, especially for youth. These low prices allowed many to become addicted before the excise taxes were increased. The excise tax on cigarettes had not been increased since 1978 until March of 2003. In May 2003 the tax increased from 17 cents to 55 cents. West Virginia was one of the last states to impose an excise tax on other tobacco products, equivalent to 17 cents on a can of snuff, in 2000.

There are many factors advantagous to West Virginia in helping to work toward achieving tobacco prevention success in the state:

- West Virginia was among the 17 ASSIST states, receiving significant funding from the National Cancer Institute from 1991-1998. The ASSIST project trained us in policy issues, which still remains the most cost-effective of all program components.

- There is a positive collaborative environment among all partners in West Virginia. The statewide Coalition for a Tobacco-Free West Virginia is a very strong organization with years of policy experience and successes.

- Because West Virginia demonstrates strong collaborative relationships, an ability to show need and a history of successfully implementing workplans, we are in a better position to obtain funding from many sources, including CDC and private foundations.

-CESSATION-

Goal: Promote quitting among adults and youth.

Justification: The Public Health Service guidelines stress that system changes are critical to the broad-based success of cessation interventions. Programs that successfully assist youth and adult smokers in quitting can produce quicker and larger short-term public health benefits than any other component of a comprehensive tobacco control program. In addition, the cost savings from reduced tobacco use resulting from the implementation of moderately priced, effective smoking cessation interventions would more than pay for these interventions within 3-4 years.

Cessation Healthy People 2010 Objectives

West Virginia Healthy People 2010 Objective		Baseline
27.1.a	Reduce the prevalence of cigarette smoking among adults aged 18+ to 20% or lower.	28% in 1998 27% in 1999 26% in 2000 28% in 2001
27.1.b	Reduce the prevalence of cigarette smoking among adults aged 18+ in the lower socioeconomic level (12 years or less of education and a household income of less than $25,000) to 28% or lower.	36% in 1998 35% in 1999 35% in 2000 35% in 2001
27.4.	Increase to at least 60% the proportion of adult tobacco users who have been advised to quit using tobacco products in the past 12 months by a doctor, nurse or other health professional.	48.6% in 2000 50.2% in 2001
27.6.	Increase to 80% the proportion of health plans that offer treatment of nicotine addiction.	2 Health Plans in 2002
27.7.	Reduce smokeless tobacco use among adult men aged 18+ to 13% or lower.	18% in 1998 18% in 1999 18% in 2000 17% in 2001
27.9.	Increase state excise taxes on cigarettes so state excise tax is at least 30% of retail price.	7% in 1999 6% in 2002*
27.10.	Increase state excise taxes on non-cigarette tobacco products so state excise tax is at least 25% of retail price.	0% in 1999 5% in 2002
27.11.a	(Developmental) Increase to 85% the percentage of students in grades 6-8 attempting smoking cessation.	66% in 2000 63% in 2002
27.11.b	(Developmental) Increase to 85% the percentage of students in grades 9-12 attempting smoking cessation.	62% in 2000 62% in 2002

** The state excise tax on cigarettes increased from 17 cents to 55 cents per pack in 2003, but the retail price of cigarettes decreased. Therefore, in the state excise tax is estimated to be over 15% of retail price.*

Cessation Intermediate Objectives

	Data Source
By June 2008, 30 primary care centers, hospitals, or primary care physician offices will implement an office-wide system that ensures that at every clinic visit tobacco use status is queried and documented.	DTP Program Monitoring Forms
By June 2008, 40% of high schools will implement an active science-based youth cessation program.	DTP Program Monitoring Forms

Cessation Short-term Objectives

	Data Source
By June 2006, 10 primary care centers, hospitals, or primary care physician offices will implement an office-wide system that ensures that at every clinic visit tobacco use status is queried and documented.	DTP Program Monitoring Forms
By June 2006, a science-based youth cessation program will be implemented in 30% of high schools at least one time each year.	DTP Program Monitoring Forms

Cessation Strategies

Channels	Strategies
Community Interventions: Programmatic interventions to enable individuals to make behavior consistent with being tobacco free. Provide access to effective cessation services.	Provide local cessation clinics. Maintain telephone quit line. Provide provider education. Provide middle and high school student education. Implement provider reminder systems. Provide primary care provider education. Offer cessation in public high schools.
Counter-Marketing: Countering pro-tobacco influences and increasing pro-health messages throughout a state, region or community. Includes media advocacy, media relations, counter-advertising, reducing tobacco industry sponsorships and promotions and exposing tobacco industry tactics.	Collect earned media. Participate in health fairs and other public venues with displays. Implement grassroots marketing. Develop and implement paid media.
Program Policy/Regulation: Conducting policy analysis and education for decision-makers and the public on the importance and benefit of public health policies.	Increase cessation coverage. Increase smoke-free policies. Increase taxation. Implement health science policies (provider education as part of the curriculum). Provide incentives/disincentives. Further develop the working relationship of the cessation advisory group.
Surveillance and Evaluation: Surveillance - Continuous monitoring of measure over time to inform program and policy direction and interventions. Evaluation - Point-in-time assessment to measure effectiveness of programmatic, policy and media efforts.	Continue to implement statewide adult and youth survey instruments. Collect program data. Document policy passage and implementation.

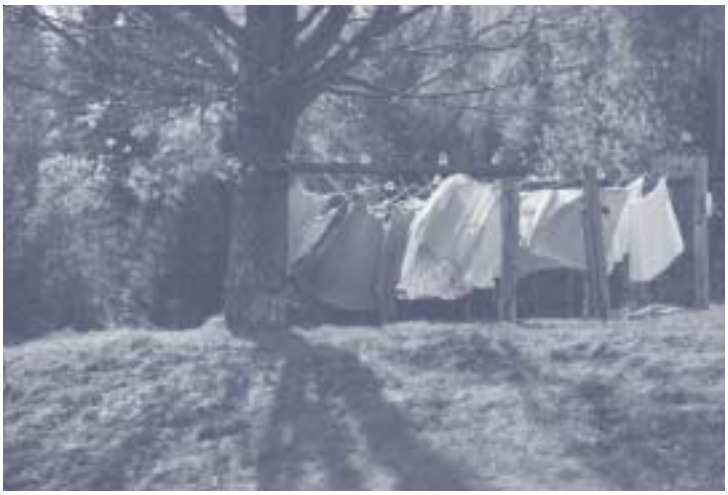
-CLEAN INDOOR AIR-

Goal: Eliminate exposure to secondhand smoke.

Justification: The health of nonsmokers is protected by the enforcement of public and private policies that reduce or eliminate exposure to secondhand smoke. Enforcement of work-site smoking bans protects nonsmokers and decreases the number of cigarettes employees smoke during the workday. Funding local programs produces measurable progress toward statewide tobacco control objectives. Local programs have been instrumental in the adoption of an increasing number of local ordinances or other provisions restricting smoking in public places.

CIA Healthy People 2010 Objectives

Healthy People 2010 Objectives		Baseline
27.16.	(Developmental) Increase to 95% the number of employers (with 10 or more employees) with written and enforced tobacco restriction policies for the workplace, designed to protect workers from exposure to secondhand smoke (SHS).	87% in 2002
27.17a.	Increase the number of counties covered by clean indoor air (CIA) regulations to 52.	43 in 2000 46 in 2002 49 in 2003
27.17b.	(Developmental) To protect the public and workers from secondhand smoke, increase to 30 the number of counties which require 100% smoke-free restaurants through implementation of clean indoor air regulations.	4 counties in 1999 13 counties in 2003
27.17c.	Protect local authority to regulate public health measures including clean indoor air.	Local authority protected through 2003



CIA Intermediate Objectives

	Data Source
By June 2008, increase to 90% the number of employers (with 10 or more employees) with written tobacco restriction policies for the workplace, designed to protect the workers from exposure to SHS, with plans to begin enforcement phase over the next four years.	Private survey data
By June 2008, increase the number of counties covered by CIA regulations to 51.	DTP Program Monitoring Forms
By June 2008, increase to 25 the number of counties that require 100% smoke-free restaurants through implementation of clean indoor air regulations, to protect the public and workers from SHS.	DTP Program Monitoring Forms

CIA Short-term Objectives

	Data Source
By 2005, develop and maitain an active tobacco control coalition in all counties without a regulation or a 50/50 regulation.	DTP Program Monitoring Forms
By 2006, develop and maintain an active tobacco control coalition in all counties without a regulation inclusive of 100% restaurant coverage.	DTP Program Monitoring Forms

CIA Strategies

Channels	Strategies
Community Interventions: Programmatic interventions to enable individuals to make their behavior consistent with being tobacco free.	Raise public awareness of the risks of secondhand smoke. Develop local coalitions. Further develop local infrastructure with expertise in clean indoor air.
Counter-Marketing: Countering pro-tobacco influences and increasing pro-health messages throughout a state, region or community. Includes media advocacy, media relations, counter-advertising, reducing tobacco industry sponsorships and promotions and exposing tobacco industry tactics.	Earn pro-health media coverage. Conduct paid media campaigns.
Program Policy/Regulation: Conducting policy analysis and educating decision-makers and the public on the importance and benefit of public health policies.	Promote smoke-free policies. Insure compliance in areas covered by smoke-free policies. Educate policymakers and community leaders on the health effects of secondhand smoke. Make available model smoke-free policies. Further develop the local/state working relationship of the CIA Partnership.
Surveillance and Evaluation: Surveillance - Continuous monitoring of measures over time to inform program and policy direction and interventions. Evaluation - Point in time assessment to measure effectiveness of programmatic, policy and media efforts.	Monitor community activities and policy implementation. Track number of CIA regulations in place and their variations

-YOUTH-

Goal: Prevent initiation of tobacco products among youth.

Justification: Five thousand young people under age 18 become regular smokers each day in West Virginia. More than 40,000 youths who are teenagers today in West Virginia will die prematurely from emphysema, lung cancer, heart disease or other tobacco-related illnesses. In 2003, the tobacco industry targeted youth by promoting and advertising their deadly products at a rate of $11.5 billion nationally. Published research studies have found that kids are three times more sensitive to tobacco advertising than adults.

Programs that prevent the onset of smoking during the school years are a vital part of a comprehensive tobacco prevention program, because most people who begin smoking start before 18 years of age.

School-based tobacco prevention programs that determine social influences that promote tobacco use among youth and that teach skills to resist these influences can greatly reduce or delay adolescent smoking. Tobacco use prevention education must be provided in elementary school and continued through middle and high school grades, because many students begin using tobacco before high school and impressions are formed much earlier about tobacco use.

Youth Healthy People 2010 Objectives

West Virginia Healthy People 2010 Objectives		Baseline
27.1d.	Reduce the proportion of youth in grades 9-12 who report smoking in the previous month to 32% or lower.	42% in 1999 38% in 2000 34% in 2002
27.1e.	Reduce the proportion of youth in grades 6-8 who report smoking in the previous month to 12% or lower.	18% in 2000 16% in 2002
27.8a	Reduce the proportion of young men in grades 6-8 who report smokeless tobacco use to 10% or lower.	14.9% in 1999 12.9% in 2002
27.8b	Reduce the proportion of young men in grades 9-12 who report smokeless tobacco use to 19% or lower.	28.6% in 1999 26.5% in 2000 21.5% in 2002
27.12a	Reduce the proportion of students in grades 6-8 who report smoking cigarettes on school property to 3% or lower.	5% in 2000 5% in 2002
27.12b	Reduce the proportion of students in grades 9-12 who report smoking cigarettes on school property to 10% or lower.	19% in 1999 17% in 2000 13% in 2002
27.13.	Enforce state and federal laws that prohibit tobacco sales to minors to 10% noncompliance or less.	33.7% in 1999 20.1% in 2000 11.9% in 2001 10.1% in 2002
27.14.	(Developmental) Enact state or local laws requiring licensure of tobacco retailers, behind-the-counter displays, and restrictions on advertising, violations that may result in revocation of license.	N/A
27.15.	(Developmental) Increase to 95% the percentage of 6th grade students who associate harm with tobacco use; ensure that comprehensive tobacco prevention curricula are taught in public schools.	87% in 2000 87% in 2002
27.18.	Establish a statewide evidence-based comprehensive tobacco prevention and control program for West Virginia, funded by state funds to at least CDC-recommended minimum levels ($14.1 million per year) with sustained funding for at least five consecutive years.	$5,650,592 in 2000 $5,650,592 in 2002 $5,650,592 in 2003

Youth Intermediate Objectives

	Data Source
By June 2008, reduce the proportion of youths in grades 9-12 who report smoking in the previous month to 33% or lower.	YTS and YRBS
By June 2008, reduce the proportion of youths in grades 6-8 who report smoking in the previous month to 13% or lower.	YTS and YRBS
By June 2008, reduce the proportion of students in grades 9-12 who report smoking cigarettes on school property to 11% or lower.	YTS and YRBS
By June 2008, reduce the proportion of students in grades 6-8 who report smoking cigarettes on school property to 3.5% or lower.	YTS and YRBS
By June 2008, reduce the proportion of young men in grades 9-12 who report smokeless tobacco use to 19.5% or lower.	YTS and YRBS
By June 2008, reduce the proportion of young men in grades 6-8 who report smokeless tobacco use to 10.5% or lower.	YTS and YRBS
By June 2008, enforce state and federal laws that prohibit tobacco sales to minors to 10% noncompliance or less.	Retailer Inspection Data
By June 2008, increase to 93% the percentage of 6th grade students who associate harm with tobacco use and ensure that comprehensive tobacco prevention curricula are taught in schools.	YTS

Youth Short-term Objectives

	Data Source
By June 2006, reduce the proportion of youths in grades 9-12 who report smoking in the previous month to 33.5% or lower.	YTS and YRBS
By June 2006, reduce the proportion of youths in grades 6-8 who report smoking in the previous month to 14% or lower.	YTS and YRBS
By June 2006, reduce the proportion of students in grades 9-12 who report smoking cigarettes on school property to 12% or lower.	YTS and YRBS
By June 2006, reduce the proportion of students in grades 6-8 who report smoking cigarettes on school property to 4.5% or lower.	YTS and YRBS
By June 2006, reduce the proportion of young men in grades 9-12 who report smokeless tobacco use to 20.5% or lower.	YTS and YRBS
By June 2006, reduce the proportion of young men in grades 6-8 who report smokeless tobacco use to 11.5% or lower.	YTS and YRBS
By June 2006, enforce state and federal laws that prohibit tobacco sales to minors to 10% noncompliance or less.	Retailer inspection data
By June 2006, increase to 90% the percentage of 6th grade students who associate harm with tobacco use and ensure that comprehensive tobacco prevention curricula are taught in schools.	YTS

Youth Strategies

Channels	Strategies
Community Interventions: Programmatic interventions to enable individuals to make behavior consistent with being tobacco free.	Train regional coordinators, regional tobacco prevention specialists, and youth in key youth prevention activities. Maintain an active and well informed Teen Advisory Committee. Develop and maintain 55 Raze chapters. County coordinators will meet with local Regional Tobacco Prevention Specialists quarterly. One teen representative will join each adult county coalition. Teens will conduct operation storefront in each region. Provide research-proven effective tobacco prevention curriculum to all students grades K-12. Establish partnerships with the West Virginia Deptartment of Education, Regional Tobacco Prevention Specialists and Regional Tobacco Prevention Coalition Coordinators. Establish and maintain school-based tobacco prevention programs as outlined in CDC's *Best Practices*. Maintain an active Youth Empowerment Team. Conduct Raze commotions.

Channels	Strategies
Counter-Marketing: Countering pro-tobacco influences and increasing pro-health messages throughout the state, region or community. Includes: media advocacy, media relations,counter-advertising, reducing tobacco industry sponsorships and promotions and exposing tobacco industry tactics.	Provide anti-tobacco messages and information through a paid statewide media campaign. Promote tobacco-free policies at athletic events. Recruit teens to join local chapters via presentations in schools, radio, website and TV advertising and statewide conferences. Earn media coverage for youth-related events.
Program Policy/Regulation: Conducting policy analysis and educating decision-makers and the public on the importance and benefit of public health policies.	Convene groups of teens to provide education on taxes, retailer compliance, and school policy to parents, other students and community leaders. Teen advocates will work with school personnel to enforce smoke-free policies. Work with partners to support retailer inspections.
Surveillance and Evaluation: Surveillance - Continuous monitoring of measures over time to inform program and policy direction and interventions. Evaluation - Point-in-time assessment to measure effectiveness of programmatic, policy and media efforts.	Assess retailer compliance with MSA advertising restrictions. Determine number of students participating in youth chapters and number of teen chapters. Assess number of schools known to promote tobacco-free schools policy at athletic events. Determine number of youths involved in adult coalitions. Determine how many adults and youth were trained in tobacco prevention. Determine the number of commotions performed yearly. Determine how many "operation storefronts" were conducted. Determine the percentage of students that received the tobacco education curriculum.

-DISPARITIES-

Goal: Identify and eliminate disparities related to tobacco use and its effects among different population groups.

Justification: There are a variety of reasons why some populations may have higher smoking or spit tobacco use rates than the general population. The populations may feel disenfranchised and unresponsive to standard educational or media programs or the population may be separated physically or culturally (as in skills levels) from the general population. The first step in reaching these groups is to identify them and collect baseline data on use rates. Ethnicity, age, occupation, income, gender, health status and at-risk health issues can all be considered in designing campaigns, programs or policy initiatives to affect tobacco use behaviors.

Factors in Prioritizing Populations with Tobacco-related Disparities

The following factors can be considered in prioritizing populations with tobacco-related disparities:

- The size of the population.
- The health impact of direct tobacco use on this population (rate of cigarette smoking or spit tobacco use among this group, compared to West Virginia rates or U.S. rates, or increased use illustrated by trend data).
- The health impact of one population exposed to secondhand smoke, as a result of tobacco use by another group.
- The ability to reach the group with programs and the cost of reaching them.
- The ability to achieve a behavior change in this population.
- The cost if we do nothing compared to the cost savings if we achieve behavior change.
- The ability to break the cycle of tobacco use within family units or culture groups.
- The vulnerability of a group to marketing pressures or other influences that could increase rates of use.

Fourteen populations with tobacco-related disparities were defined in planning meetings, and, of those 14, five have been identified for intervention. Those five populations include pregnant women, women of childbearing age, children under age 18 exposed to secondhand smoke, African-Americans and blue-collar workers.

Populations with Disparities
Healthy People 2010 Objectives

Pregnant Women

West Virginia Healthy People 2010 Objectives		Baseline
27.2	Reduce the prevalence of cigarette smoking among pregnant women to 17% or lower.	26.0% in 1999 26.2% in 2000 26.7% in 2001
27.3	Increase smoking cessation during pregnancy, so that at least 60% of women who are cigarette smokers at the time they become pregnant quit smoking in pregnancy.	14.3% in 1998

Women of Childbearing Age

Healthy People 2010 Objectives		Baseline
27.1c	Reduce the prevalence of cigarette smoking among women aged 18-44 (i.e., childbearing ages) to 25% or lower.	36.4% in 1998 31.7% in 1999 32.5% in 2000 37.9% in 2001

Children under Age 18 Exposed to Secondhand Smoke

West Virginia Healthy People 2010 Objectives		Baseline
27.19	Increase to 70% the number of homes with children where a voluntary policy prohibits smoking anywhere inside the home.	56.1% in 2001

African-Americans

West Virginia Healthy People 2010 Objectives		Baseline
27.20	Reduce the prevalence of cigarette smoking among African-American adults aged 18+ to 20% or lower.	31.8% in combined years 1998-2000

Blue-Collar Workers

West Virginia Healthy People 2010 Objectives		Baseline
27.1a	Reduce the prevalence of cigarette smoking among adults aged 18+ to 20% or lower.	27.9% in 1998 28.2% in 2001
27.1b	Reduce the prevalence of cigarette smoking among adults aged 18+ who are in the lower socioeconomic level (12 years or less of education and a household income of less than $25,000) to 28% or lower.	36% in 1998 35% in 2000 35% in 2001
27.7	Reduce smokeless tobacco use among adult men aged 18+ to 13% or lower.	17.5% in 1998 17.1% in 2001

Populations with Disparities Intermediate Objectives

Population	Intermediate Objective	Data Source
Pregnant Women	By June 2008, decrease the rate of cigarette smoking by pregnant women to 19% or less.	WV Vital Statistics
Women of Childbearing Age	By June 2008, decrease the rate of cigarette smoking by women aged 18-24 to 26% or less.	BRFSS
Children under 18 Years of Age Exposed to Secondhand Smoke	By June 2008, increase to 70% the number of homes with children where a voluntary policy prohibiting smoking inside the home exists.	BRFSS
African-Americans	By June 2008, decrease the rate of cigarette smoking among African-American adults to 27% or less.	BRFSS
Blue-Collar Workers	By June 2008, decrease the rate of smoking among adults aged 18+ in the lower socioeconomic level (12 years or less of education and a household income of less than $25,000) to 29% or less.	BRFSS

Populations with Disparities
Short-term Objectives

Population	Short-term Objective	Data Source
Pregnant Women	By June 2006, decrease the rate of cigarette smoking by pregnant women will be 21% or less.	WV Vital Statistics
Women of Childbearing Age	By June 2006, decrease the rate of cigarette smoking by women aged 18-44 to 27% or less.	BRFSS
Children under 18 years of Age Exposed to Secondhand Smoke	By June 2006, increase to 68% the number of homes with children where a voluntary policy prohibiting smoking inside the home exists.	BRFSS
African-Americans	By June 2006, decrease the rate of cigarette smoking among African-American adults to 28% or less.	BRFSS
Blue-Collar Workers	By June 2006, decrease the rate of smoking among adults aged 18+ in the lower socioeconomic level (12 years or less of education and a household income of less than $25,000) to 31% or less.	BRFSS

Populations with Disparaties Strategies

Channels	Strategies
Community Interventions: Programmatic interventions to enable individuals to make behavior consistent with being tobacco free.	**All:** Conduct tobacco cessation training for health care professionals. **Pregnant Women:** Increase funding to provide cessation counseling to all pregnant smokers. **Children under 18:** Conduct education campaigns among daycare centers and home daycare providers. **African-Americans:** Conduct an education campaign to inform African-Americans about the health risks of using tobacco. **Blue-Collar Workers:** Conduct education and cessation programs through labor organizations and other worksites.
Counter-Marketing: Countering pro-tobacco influences and increasing pro-health messages throughout the state, region, or community. Includes: media advocacy, media relations,counter-advertising, reducing tobacco industry sponsorships and promotions, and exposing tobacco industry tactics.	**All:** Conduct paid media campaigns. **Pregnant Women:** Conduct local and state level earned media efforts. **Women of Childbearing Age:** Conduct local and state level earned media efforts. **Children under 18:** Conduct paid media campaign on secondhand smoke exposure and children.

Channels	Strategies
Program Policy/Regulation: Conducting policy analysis and educating decision-makers and the public on the importance and benefit of public health policies.	**Pregnant Women:** Seek policy change among health insurers to cover cessation for pregnant women. **Women of Childbearing Age:** Seek policy change among health insurers to cover cessation for women. **Children under 18:** Enforce "no smoking regulations" for daycare centers; encourage families to declare their homes smoke free. **African-Americans:** Train community leaders on policy advocacy on local and state level; seek voluntary policy change in homes, churches, organizations and local businesses. **Blue-Collar Workers:** Seek voluntary policy change among businesses not covered by local CIA regulations.
Surveillance and Evaluation: Surveillance - Continuous monitoring of measures over time to inform program and policy direction and interventions. Evaluations - Point-in-time assessment to measure effectiveness of programmatic, policy and media efforts.	**All:** Maintain state and federal level surveillance instruments. **Children under 18:** Collect baseline data on children's exposure to SHS in the home.