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Purpose and Use of this Guide

The Centers for Disease Control and Prevention (CDC) has developed *Best Practices for Comprehensive Tobacco Control Programs*, which documents the tobacco control program components recommended for states to obtain optimal results in promoting tobacco-free communities.¹ Like state health departments, local public health agencies (LPHAs) need to develop a strong infrastructure to support a broad range of tobacco control activities at the community level. *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs* have refined the CDC's *Best Practices* to better address the specific needs and realities of tobacco control programs at the local level. This manuscript will help inform local decision-makers and health planners about selecting and funding evidence-based interventions for reducing and preventing tobacco use, identifying and eliminating health disparities related to tobacco use, and protecting people from secondhand smoke. These *Guidelines* will also enable localities to assess the adequacy of current program breadth and estimate funding deficits for each component. To achieve the recommended funding ranges, support for each program component may come from a variety of federal, state, local, and even private sources.

The funding formulas presented here are approximate estimates based on successful statewide programs and populations. It is important that LPHAs apply local analyses in order to prioritize spending allocations for each recommended component. Using available data sources, local needs assessments

should include a demographic and epidemiological profile as it pertains to tobacco use and its associated risk factors. Depending on the make-up of the community, the degree of tobacco use, and other important variables, estimated spending levels could vary considerably.

Tobacco-related health disparities among minority populations and groups of lower socio-economic status are severe and must be addressed by communities.² In areas with greater concentrations of populations with disparities, increased spending per capita will be required across program components. A number of strategies are successfully being employed in several states to reach diverse audiences. Developing the tobacco control capacity of community-based organizations, establishing minority networks and special task forces to increase inclusion and access to programs and services, creating specialized educational materials and skill-building resources to support activities in each population, attracting skilled professionals to work in underserved settings, and conducting a culturally appropriate counter-marketing campaign are just a few examples of activities that could increase expenditures and enhance health benefits of interventions in jurisdictions with disproportionately affected populations.

Acknowledgments

NACCHO is the national nonprofit membership organization representing all 3,000 local public health agencies. It promotes national policy, develops resources and programs, and supports the development of effective local public health practice and systems that protect and improve the health of communities.

NACCHO's Tobacco Prevention and Control Project provides education, information, research, and technical assistance to local public health agencies, and facilitates partnerships among local, state, and federal agencies in order to promote and strengthen local public health agency capacity to engage in tobacco use prevention and control.

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County Health Department, NC; Gladys Branic, DSW, MD, MPH, Director, Manatee County Health Department, FL; Gary L. Edwards, MS, CHES, Southwest Utah Public Health Department, UT; Willa Fisher, MD, MPH, Bremerton-Kitsap County Health District, WA; Maurice Mullet, MD, Holmes County Health Department, OH; John Poundstone, MD, MPH, Lexington-Fayette County Health Department, KY; Sue Zuidema, MPA, Hennepin County Community Health Department, MN.

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For additional information or copies, contact:

Tobacco Prevention and Control Project
National Association of County & City
Health Officials
1100 17th Street, NW, Second Floor
Washington, DC 20036
Tel. (202) 783-5550

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Executive Summary

Tobacco-related deaths constitute an estimated 430,000 lives lost annually, and cost this country between \$50 and \$73 billion. Every day 3,000 teenagers in the United States become smokers, one third of whom will eventually die from tobacco related disease.³

The \$206 billion tobacco industry settlement with the states' Attorneys General, signed in November of 1998, represents only a small portion of the actual past and anticipated future Medicaid costs related to tobacco. The public sector now has an historic opportunity to impact future health care expenditures and save lives by applying a significant portion of those dollars towards reducing and preventing tobacco use.

Local governments have a statutory responsibility to address tobacco use as a dominant threat to the health of their communities, especially among vulnerable young people. Local public health agencies (LPHAs) can fulfill their appropriate leadership role in the community by ensuring that local tobacco control efforts are supported by a strong infrastructure based on the required capacities articulated in *Blueprint for a Healthy Community: A Guide for Local Health Departments*.⁴ With a fully-developed and functioning infrastructure as a foundation, the LPHA will be well-positioned to adequately

assure the availability of the *10 Essential Public Health Services* as they relate to preventing and reducing tobacco use in the community.⁵

Evidence from tobacco control programs in California, Massachusetts, Oregon, and Florida indicate that the most successful

The public sector now has an historic opportunity to impact future health care expenditures and save lives by applying a significant portion of those dollars towards reducing and preventing tobacco use.

approaches to reducing tobacco use and exposure to secondhand smoke include a multi-faceted, community-based program funded at levels between \$2.50 and \$10.00 per capita. The Centers for Disease Control and Prevention (CDC) has issued *Best*

Practices for Comprehensive Tobacco Control Programs to inform the design and funding of research-supported interventions to reduce tobacco use in states.¹ *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs* builds on CDC's recommendations and adapts them to fit the needs of LPHAs.

In general, LPHAs serving rural jurisdictions will require the highest amounts per capita to conduct effective programs, while LPHAs in urban areas will require the least per person. Total estimates of per capita funding for comprehensive tobacco control programs in LPHAs are \$8.00-\$10.00 for programs in rural areas, \$6.00-\$8.00 for programs in mixed urban to rural jurisdictions, and \$4.00-\$6.00 for programs with urban catchment areas (see Table 1).

The National Association of County and City Health Officials (NACCHO) recommends that public health agencies at the local level establish tobacco use prevention and control programs that fund the following seven components within the stated expenditure ranges. Each agency will need to adjust the funding amounts based on local analyses.

1. Community Programs

\$.70 to \$2.00 per capita per year for local governments and community-based organizations

For meaningful change to occur in the way tobacco products are marketed, sold, and used, community involvement is essential. These community interventions influence societal organizations, systems, and networks to encourage individuals to stay or become tobacco-free.

2. School Programs

\$4.00 to \$6.00 per student in grades K-12 for annual awards to school districts

Over 90 percent of adult smokers report initiating tobacco use as teens.³ Since many youth begin using tobacco products prior to high school and attitudes about tobacco form even earlier, tobacco use prevention must start in kindergarten and continue through middle and high school.¹ Modifying the school environment by adopting policies that support tobacco use prevention curricula is also critical.

3. Counter-Marketing

\$.50 to \$1.50 per person, per year

There is considerable evidence that paid anti-smoking advertisements are effective in reducing tobacco consumption.^{4,5} A well-coordinated mass media campaign, designed to reach a wide range of market

segments, can promote cessation and prevent initiation in the general population and hard to reach groups. Media messages can also have a powerful influence on public support for tobacco control policies and help reinforce school and community efforts.³

4. Cessation

\$1.00 per adult for assessment of smoking status, \$2.00 per smoker for brief counseling, \$137.50 per smoker served per year for publicly supported cessation programs

More than two out of three adults report a desire to quit smoking.³ As societal efforts to reduce tobacco use continue, more people will be struggling with tobacco addiction and seeking assistance to quit. Cessation programs may offer the quickest and largest short-term public health benefit compared to any other component of the comprehensive tobacco control program.¹

5. Enforcement

\$.43 to \$.80 per person, per year for enforcement of tobacco control policies and regulations at the local level

The limited data available on the effects of active enforcement of youth access laws suggest that enforcement is an essential component of a comprehensive strategy to reduce tobacco use among youth.¹ The enforcement of public policies that restrict access to tobacco products and reduce exposure to secondhand smoke discourages youth from initiating tobacco use and protects the health of nonsmokers. This approach is also necessary to ensure that businesses comply with laws and to send a strong societal message about the unacceptability of youth smoking and

secondhand smoke. Note that costs may be increased in rural areas, due to the cost of traveling to distant locations.

6. Administration and Management

5 percent of program budget

Implementation of an effective tobacco control program requires strong administrative and management structures that can perform strategic planning, staffing, and fiscal management functions. Equally important is a well-trained work force that has the skills required to carry out the program's activities and functions. Program staff and the public also need efficient access to educational materials and other resources that advance the goals of the program.

7. Surveillance and Evaluation

10 percent of program budget

Surveillance and evaluation are essential elements of a comprehensive tobacco control program. A successful program should assess the use of tobacco in the LPHA jurisdiction, the impact of that use, local factors contributing to tobacco use, and the outcomes of the program.

Background

Each year in the United States, the use of tobacco products kills more people than car crashes, AIDS, illegal drugs, suicides, fires, and homicides combined. Tobacco-related deaths exceed 430,000 lives lost annually, and cost this country between \$50 and \$73 billion.¹ Every day 3,000 teenagers become smokers, one third of whom will eventually die from tobacco-related disease. If tobacco use rates remain stable, more than 5 million youth currently smoking in the U.S. will die prematurely from smoking.³ Between 1990 and 1994, more than 5.7 million years of potential life were lost due to tobacco use. That equates to approximately 13.4 years of life lost for each death due to smoking.⁷ Exposure to environmental tobacco smoke has been causally linked with respiratory illnesses including lung cancer, childhood asthma, sudden infant death syndrome, and lower-respiratory tract infections. Second-hand tobacco smoke also contributes significantly to morbidity and mortality from heart disease, the nation's leading cause of death.⁸

Despite the enormous costs of tobacco use to our society, federal funding for tobacco control programs has been minimal. Even after the deleterious health effects of smoking was clearly established by the Surgeon General in the early 1960s there was no significant federal support for state-based tobacco control activities for almost thirty years. In 1991, the National Cancer Institute's Project ASSIST (American Stop Smoking Intervention Study)

launched a major commitment to study the efficacy of community-based tobacco control programs in 17 states. Funding to ASSIST states averaged approximately \$1 million per state. The Centers for Disease Control and Prevention's IMPACT program (Initiative to Mobilize for the Prevention and Control of Tobacco Use) soon followed, with funding provided to the other 33 states and the District of Columbia, but at considerably lower levels of support than the ASSIST states.

During this period, states such as California and Massachusetts took the lead in addressing tobacco-related morbidity and mortality by allocating significant resources to reducing tobacco use. Funds for these states' programs were and continue to be generated from a portion of increased tobacco excise tax revenues at an amount mandated by state referenda.

Evaluation research to date from these state and federal programs show that the reduction in tobacco use by the population is commensurate to the resources dedicated for tobacco control programs. In other words, there is a dose/response-like relationship between funding for tobacco control programs and their impact on tobacco use. These data also demonstrate the effectiveness of a multi-faceted, community-based approach to tobacco control. Hence, research and experience indicate that **the more money available to support a well-managed, comprehensive tobacco use prevention and**

Tobacco-related deaths exceed 430,000 lives lost annually, and cost this country between \$50 and \$73 billion.

control program, the greater the reduction in tobacco use.

In October 1999, the Centers for Disease Control and Prevention (CDC) began funding a comprehensive tobacco use prevention and control program in all fifty states, the District of Columbia and the territories. Although funding for this new program is at ASSIST levels instead of the amounts available in states with dedicated tax revenue for tobacco control programs, this national commitment is a major step forward in protecting and promoting the public's health.

Another important development in tobacco control is the Master Settlement Agreement (MSA) between 46 states' Attorneys General and the tobacco industry which took place in November of 1998. The settlement provides \$206 billion to states over 25 years as unencumbered payments for past and future damages incurred by states for tobacco-related Medicaid expenditures. In California and New York, due to state-specific requirements, counties will receive a large portion of their state tobacco settlements. Local governments in many other states also have a large stake in the MSA. Counties, for example, play an explicit role in treatment and are legally responsible for indigent health care in over 30 states. Like California and New York, counties in 18 other states pay part of the nonfederal portion of Medicaid including the costs for treating tobacco-related illness. In addition, counties purchase health care for more than 2

million employees.⁹ The tobacco industry payments to states represent only a small portion of the actual past and anticipated future Medicaid costs related to tobacco.¹⁰ Nevertheless, the public sector has an historic opportunity to impact future health care expenditures and save lives by applying a significant portion of those dollars toward reducing and preventing tobacco use. At both the state and local levels of government,

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Local Public Health Agencies' Role in Tobacco Control

At the local level, the response to the tobacco problem varies widely depending on availability of funds for tobacco control from federal, state and other sources. Local politics and pressure from the tobacco industry have also influenced the degree of government involvement in addressing tobacco use as a health issue.

At present, there is limited data on the extent of local public health agency (LPHA) action in tobacco control. A 1992-93 NACCHO survey found that forty-five percent of LPHAs engage in or contract with others to conduct tobacco control activities. That proportion ranged from thirty-three percent in low population areas to sixty-nine percent in areas with populations greater than 500,000. The nature of these activities were not characterized in the report.¹¹

The NACCHO survey also found that eighty-six percent of LPHAs engage in or contract with other agencies to provide community outreach and education, and eighty-four percent report activity in the area of health education and risk reduction services. Though this information is not specific to tobacco control, it is clear that most LPHAs have the capacity to provide some degree of health education in their communities, despite their traditional focus on clinical services and environmental health. However, only thirty-seven percent report activities to monitor and ensure indoor air quality, and only twenty-four percent report involvement in occupational safety and health. Interestingly, of the LPHAs receiving complaints or requests

for assistance concerning occupational safety and health in the 12 months prior to the NACCHO survey, fifty-nine percent report inquiries related to indoor air quality.¹¹ Data like these demonstrate the heightened awareness and concern about exposure to environmental tobacco smoke during the past decade and the need for LPHAs to become more involved in the issue.

Undoubtedly, tobacco control activities conducted by LPHAs have increased alongside the country's growing concern over tobacco use and increasing availability of tobacco control resources in recent years. Clean indoor air policies have been widely implemented during the past several years. A 1996 survey of local governments on their role in enacting tobacco control policies found that the majority of LPHAs in states without preemptive state legislation were actively promoting clean indoor air rules and restrictions on tobacco sales to youth.¹² The limited data currently available on local tobacco control policies suggest that the majority of tobacco control legislation in the United States to date has been enacted at the local level. Local public health agencies are often important tobacco control partners in those communities. When there are local tobacco control coalitions, in most cases LPHAs are either the fiscal agent coordinating the effort (e.g., California, Oregon, and Florida) or at least a participating agency (e.g., Massachusetts).

Overall, municipal governments have been more active than county governments in enacting tobacco control ordinances, while local boards of health (LBOH) have been the most active government entities in promulgating tobacco control policies at the local level.¹³ This high level of board of health involvement is not surprising, since most LBOHs have the authority to modify sanitary codes to protect the health of the community. The NACCHO survey reported that seventy-three percent of LPHAs serve a jurisdiction with a LBOH. Moreover, eighty-eight percent of those local boards have the statutory authority to establish local health policy, fees, ordinances, and regulations in their jurisdictions. Although the statutory authority of LBOHs was found to be greater in jurisdictions under 100,000 people, these data indicate that considerable impact could be achieved by enacting tobacco control policies through local boards of health.

Building Local Public Health Agency Infrastructure for a New Millennium

State constitutions consistently include a statutory mandate to preserve the public's health. As an extension of state government, county, city, district, or metropolitan entities have the power and responsibility to promote and maintain healthy communities.⁴ Local government activities represent the front lines in safeguarding and enhancing the public's health.

In 1988, the Institute of Medicine issued its landmark report, *The Future of Public Health*, which outlined three core functions of public health. Since that time, many state and local public health agencies have committed themselves to improving their capacity to carry out the core functions—*assessment, policy development, and assurance*. Expanding on the core functions in 1994, NACCHO released the *Blueprint for a Healthy Community: A Guide for Local Health Departments*, in which the **Capacities Required in a Local Health Department for a Healthy Community** (*Capacities*) were described.⁴ They are:

- Health assessment
- Policy development
- Administration
- Health promotion
- Health protection
- Quality assurance
- Training and education
- Community empowerment

Also in 1994, the **Essential Public Health Services** (*Essential Services*) framework was developed by the Core Public Health Func-

tions Steering Committee, which included representatives of federal agencies within the Public Health Service and representatives of national public health organizations (including NACCHO).⁵ The *Essential Services* were developed to better identify and describe the processes used in public health to promote health and prevent disease. They are:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

As a result of this effort, a statement entitled *Public Health in America* was developed. This statement describes *what* public health seeks to accomplish and then presents the ten *Essential Services* to describe *how* to carry out

those basic responsibilities. All public health responsibilities – whether conducted by the local public health agency or another organization within the community – can be categorized into one of the services.

All but one of the *Essential Services* are aimed at keeping people healthy rather than treating them when they become ill. In many ways, the *Essential Services* symbolize the changing emphasis of LPHA services, from indigent patient care and environmental monitoring to population-based health promotion and disease prevention. Unfortunately, state-specific analyses suggest that many, if not most, LPHAs lack adequate capacity to perform these services.¹⁴ This finding is also reflected in the national Healthy People 2000 objective to increase to at least ninety percent the proportion of the population served by a LPHA that is effectively carrying out the core functions of public health.¹⁵

A New Tobacco Control Paradigm for Local Public Health Agencies

Tobacco use is the leading preventable cause of morbidity and mortality in the United States and in nearly all localities in the country, local governments have a statutory responsibility to address tobacco use as the dominant threat to the health of their citizens, especially among vulnerable populations such as young people.

LPHAs can fulfill their appropriate leadership role in the community to reduce the devastating effects of tobacco use by ensuring that local tobacco control efforts have a solid and complete infrastructure based on the *Capacities* articulated in the *Blueprint for a Healthy Community*. With a fully-developed and functioning infrastructure as a foundation, the LPHA will be well-positioned to adequately assure the availability of the 10 *Essential Services* as they relate to preventing and reducing tobacco use in the community (see Figure 1).

Developing partnerships to promote primary and secondary prevention in clinical settings is one way LPHAs can implement the *Essential Services* to reduce tobacco use and help develop healthy communities. In a time of dwindling health care dollars and restructuring toward managed care, LPHAs should be on the forefront of supporting the provision of preventive services among medical and dental providers in the community. In many areas, especially rural settings, LPHAs may represent one of few options available for preventive health care services. The 1995 NACCHO profile found that ninety-seven percent of the rural LPHAs operating in jurisdictions of less than 25,000 people were providing dental care, but only about half of those were involved in the control of cancer and cardiovascular disease.¹¹ These findings highlight important opportunities to reduce the toll of tobacco use in communities and close gaps in service provision. Each visit to a pediatrician or dentist, for example, provides a crucial opportunity to assess tobacco use and intervene to reduce it. To carry out this expanding role of enhancing local prevention efforts, LPHAs need more resources directed at preventing the nation's leading tobacco-related killers, cancer and heart disease.



Figure 1

Successful Practices in Tobacco Control

CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable. The goal of comprehensive tobacco control programs is to reduce disease, disability, and death as a result of tobacco use by:

- preventing the initiation of tobacco use among young people,
- promoting quitting among young people and adults,
- eliminating exposure to environmental tobacco smoke, and
- identifying and eliminating tobacco-related disparities among populations.

Evidence from tobacco control programs in California, Massachusetts, Oregon, and Florida indicate that the most successful approaches to reducing tobacco use and exposure to environmental tobacco smoke feature a multi-faceted, community-based strategy.

Evidence from tobacco control programs in California, Massachusetts, Oregon, and Florida indicate that the most successful approaches to reducing tobacco use and exposure to environmental tobacco smoke feature a multi-faceted, community-based strategy.^{1,15,16,17,18} California and Massachusetts initiated the country's first statewide comprehensive tobacco control programs as a result of referendums that dedicated a portion of tobacco tax revenue to these efforts. Between 1992 and 1996, tobacco consumption fell seventeen percent in California and twenty percent in Massachusetts while consumption declined only eight percent over the same

period nationally.¹⁶ Recent articles published in *Morbidity and Mortality Weekly Report*, presenting the evaluation results of Oregon's and Florida's tobacco control programs, support previous findings in other states. Two years after implementing a broad-based program in Oregon, the consumption of tobacco in that state fell 11.3 percent compared

to less than 3 percent in the rest of the nation. In Florida, 12 months after initiating a well-funded tobacco control program throughout the state, cigarette use among middle school students declined 18.5 percent to 15.1 percent. This reduction is extremely significant because it is larger than any annual decline

observed nationally in adolescent smoking since 1980.¹⁸ Analyses of these state programs, in conjunction with published research on tobacco control strategies, form the basis for the *Best Practices* guidelines from CDC.

Methods

To develop these recommendations for LPHAs, NACCHO relied on information from several sources including key informant interviews from states with comprehensive programs, formulas used to fund local programs in those states, and expert consultation from CDC and NACCHO representatives. Budget estimates and justifications were derived from the CDC “*Best Practices*” document and modified when necessary. For instance, CDC recommendations for fixed costs for infrastructure in state health departments were omitted. Thus, per capita funding estimates were utilized for all program components in this document to simplify the application of the formulas to local entities. Spending per person essentially remained the same as the ranges recommended by the CDC, except for *Counter-Marketing*, for which there were significant revisions to the CDC ranges as a result of inapplicability to LPHAs. Two components recommended by CDC for state programs were not included in this manuscript or were integrated into other program elements. The CDC component called *Statewide Partnerships* was converted to local partnerships and then was incorporated into *Community Programs* without increasing the budget amounts.

Program and Funding Guidelines for Comprehensive Local Programs

NACCHO recommends that health agencies at the local level establish multi-faceted tobacco control programs that contain these seven components:

1. **Community Programs**
2. **School Programs**
3. **Counter-marketing**
4. **Cessation**
5. **Enforcement**
6. **Administration and Management**
7. **Surveillance and Evaluation**

In the following section, the *Capacities* that relate to each tobacco control program component are bulleted within the text boxes. Each recommended component is then described and justified. Finally, the budget ranges and their rationale are presented.

1. COMMUNITY PROGRAMS

- Policy development
- Health promotion
- Health protection
- Community empowerment

Description: Local community programs involve a wide range of activities that discourage tobacco use and promote smoke-free environments. Some of these activities include developing partnerships with local organizations, conducting educational programs, and encouraging policies that support tobacco use prevention and cessation. Other examples of a community-based program are educating parents on the hazards

of environmental tobacco smoke on children, promoting smoke-free restaurants, and engaging youth in the planning of tobacco control activities.

Rationale: In order for meaningful change to occur, community involvement is required, especially for an accepted and highly prevalent behavior such as tobacco use. To achieve individual behavior change whole communities must change the way tobacco products are marketed, sold, and used. The formation of coalitions has been a powerful and effective tool to mobilize and empower the community to make the changes that support the nonuse of tobacco. These community interventions influence societal organizations, systems, and networks to enable them to assist many individuals to make tobacco-free behavior change.

Budget: To achieve lasting changes, programs in local governments require funds to hire staff, provide operating expenses, purchase educational materials and resources, conduct education and training programs, support communication campaigns, and recruit as well as maintain local partnerships. In smaller areas, partnerships might be centralized while large urban areas require more extensive networks of partners such as ethnic and other special population programs. Program funding levels range from approximately \$1.00 per capita in California to over \$2.50 per capita in Massachusetts; CDC's *Best Practices* recommends a range of \$.70 - \$2.00.

\$.70 - \$2 per capita per year for local governments and organizations

2. SCHOOL PROGRAMS

- Policy development
- Health promotion
- Health protection
- Community empowerment

Description: Implement *CDC's Guidelines for School Health Programs to Prevent Tobacco Use*, including tobacco-free policies, proven risk-reduction curricula, teacher training, parental involvement, in-school cessation support services, developing lessons in other subject areas that integrate and reinforce tobacco use prevention messages, and linking school-based efforts with community programs.

Rationale: Over 90 percent of adult smokers report initiating tobacco use as a teenager.³ Of adolescent daily smokers who thought they would not be smoking in five years, nearly 75 percent were still smoking five to six years later.³ These data support the need to focus prevention efforts on young people. Since many youth begin using tobacco products prior to high school and attitudes about tobacco form even earlier, tobacco use prevention must begin in kindergarten and continue through middle and high school years.¹

Social Cognitive Theory, which views learning as a social process influenced by interactions with other people, is increasingly being utilized to promote positive behavior change among youth. Self-efficacy, an essential component of the theory, is a person's belief that he or she is capable of performing a new behavior in a given situation.¹⁹ School-based programs that address social influences and enhance skills to counteract such influences

have been shown to be effective strategies to reduce and delay tobacco use in youth. It is important to start these types of behavioral strategies early and provide age-appropriate boosters throughout the school years.^{1, 15}

Modifying the school environment by adopting policies that support tobacco use prevention curricula is critical. Policies should be in place to assist students and staff with cessation, enhance and enforce tobacco nonuse regulations, and offer incentives to students to participate in local and school-based efforts that discourage tobacco use.

Budget: Because the onset of tobacco use among students increases most rapidly between the ages of 10 and 17, most states target a majority of their school funding at young people between these ages. In California, per student spending formulas vary from \$7 for every child in grades 4 through 8, to a competitive grant process used to selectively fund school programs at \$25 per student for grades 9 through 12. Expenditures per student are based on average daily school attendance. Experiences in several states dictate that funds be limited to school districts with well-defined objectives that are consistent with *CDC's Guidelines for School Health Programs to Prevent Tobacco Use*.

\$4 - \$6 per student in grades K-12 budgeted for annual awards to schools

3. COUNTER-MARKETING

- Policy development
- Health promotion
- Health protection
- Community empowerment

Description: Local television public service announcements and paid educational spots; community access cable productions; television, radio, print, billboards, and other types of paid advertisement placements; reducing or counteracting local tobacco industry sponsorship and promotions.

Rationale: There is considerable evidence that paid anti-smoking advertisements are effective in reducing tobacco consumption.^{3,6} Similar to other components, counter marketing has more impact when used as part of a multi-faceted approach. The content of the campaign should be professionally designed and scientifically based. A well-coordinated mass media campaign, designed to reach a wide range of market segments can promote quitting and prevent initiation in the general population and hard to reach groups. Media messages can also have a powerful influence on public support for tobacco control policy and help bolster school and community efforts.³

Budget: Based on successful campaigns in California, Massachusetts, Arizona, and Florida, CDC estimates that a comprehensive statewide counter advertising campaign costs between \$1.00 and \$3.00 per capita per year. The state campaign should help frame and support local tobacco control programs. When there is a strong umbrella of tobacco control messages communicated statewide, resources

at the local level can be spent addressing specific issues and initiatives pertinent to the community. In states with a weak or nonexistent counter-marketing campaign, local governments will need to expend significantly more to frame the issues, ensure adequate reach of diverse tobacco-free messages, and to promote local tobacco control efforts.

The cost to produce a high quality media product is essentially the same whether it is purchased at the state or local level. Without a base funding level for media, LPHAs serving small populations would have inadequate resources. However, the expense of purchasing media time and print space will be considerably lower in small media markets. Moreover, the diversity of the target populations and thus the scope of messages will be more limited than it would in a statewide campaign. That is especially true if the LPHA catchment zone does not include an area of dominant influence. In locations with an area of dominant influence, usually a large urban area, the complexity and expense of accessing local media rises dramatically. Many local governments will likely choose to use or adapt existing counter-marketing print, television, and radio spots to avoid production costs. Some localities may also collaborate and contribute media resources to a joint campaign, especially when the media market encompasses different cities or counties. Given all of these extenuating factors that can influence the need and cost for a local counter marketing campaign, NACCHO recommends 50 percent of the CDC formula for a statewide program to be budgeted for local media strategies.

\$.50 - \$1.50 per person per year

4. CESSATION

- Health promotion
- Health protection
- Community empowerment

Description: Promoting cessation policy development and implementation among health care providers; encouraging adequate cessation coverage by managed care and other health insurers; supporting evidence-based tobacco cessation programs; increasing the linkages to cessation programs for youth and adults attempting to access cessation information and services; and promoting the development, distribution, and training of providers of culturally sensitive, linguistically appropriate cessation programs and materials.

Rationale: According to national surveys, approximately one in four adults and one in three high school students report smoking cigarettes.⁷ In addition to the harm caused by direct or indirect contact with tobacco smoke, tobacco users send a strong message to susceptible individuals, such as children or peers, that tobacco use is acceptable behavior.

More than two out of three adults report a desire to quit smoking. Yet current estimates indicate that only 2.5 percent of smokers successfully stop smoking each year and most smokers who attempt to quit will do so several times before achieving success.³ Nonetheless, cessation programs may offer the best short-term benefit compared to any other component of the comprehensive tobacco control program.¹ Smokers who quit before the age of 50 cut their risk of dying by 50 percent in the 15 years after cessation.²⁰ Besides gains in lifespan and quality of life, there are

considerable economic benefits to cessation as well. Cost savings from reducing tobacco use as a result of a moderately priced, effective cessation program would more than pay for the intervention within a few years.²¹

As societal efforts to reduce tobacco use continue, more people will be struggling with their tobacco addiction and looking for assistance with quitting. Effective cessation strategies include advice from medical providers, counseling, and pharmacotherapy. Even more effective are intensive interventions that provide ongoing social support and behavioral training. Equally important, system changes such as clinician training, tobacco use screening, and eliminating cost barriers for cessation treatments are essential to increasing the efficacy of local cessation efforts.^{1, 22} Barriers, such as limited access to cessation products and services, can hinder a person's motivation to change and need to be addressed. Increased resources must be available to help move people through the stages of change and support those who are ready to break their nicotine addiction.¹⁹ In addition, special emphasis should be placed on reaching pregnant women and teens.

Budget: The annual budget for cessation services can be estimated based on the cost of identifying tobacco users, providing counseling, and reimbursing providers for cessation services. Cessation services through public clinics are conducive to local government reimbursement. System changes to reimburse for the assessment and counseling of smokers at the local level could prove more difficult since most providers are organized into state or regional health care structures.

\$1 per adult for assessment of smoking status, \$2 per smoker for brief counseling, \$137.50 per smoker served per year for a publicly supported cessation intervention. About 10 percent of all adult smokers use cessation services each year.

5. ENFORCEMENT

- Health protection
- Quality assurance
- Training and education
- Community empowerment

Description: Conducting vendor and retail organization education, employing extensive retailer compliance checks to identify violators of state and local laws that prohibit retailers from selling tobacco to youth; investigating complaints of clean indoor air policies, educating and imposing penalties on violators of these laws; establishing a hotline to take complaints regarding violations of clean indoor air policies and youth access laws.

Rationale: The enforcement of public policies that restrict access to tobacco products and reduce exposure to environmental tobacco smoke discourages youth from initiating tobacco use and protects the health of nonsmokers. Evidence indicates that enforcement of youth access laws has a greater impact on reductions of illegal tobacco sales to youth than education alone.²³ This approach is also necessary to ensure that businesses comply with the laws and to send a strong societal message about the unacceptability of youth smoking. The limited data available on the effects of active enforcement of youth access laws suggest that enforcement is an essential component of a comprehensive strategy to reduce tobacco use among youth.¹

Clean indoor air enforcement is critical to reduce the exposure of the public and employees to hazardous tobacco smoke. Data indicates that enforcing worksite smoking bans, for example, protects nonsmokers and reduces the numbers of cigarettes smoked

during the workday.¹ Consequently, enforcing smoke-free policies also supports the other tobacco control components such as cessation and community programs.

As new tobacco control policies are adopted locally there will be a need for the establishment of additional systems to enforce them. Some examples of new ordinances and regulations might include local permitting of tobacco vendors, tobacco advertising restrictions, and prohibitions on product placements.

Budget: California and Massachusetts address enforcement as part of their grants to local health agencies. Per-capita spending in Massachusetts for LPHAs to perform enforcement-related functions is estimated at \$.60 to \$1.04. Enforcement spending levels by Massachusetts is supported by key informant interviews with local enforcement officials in another state which independently estimated the cost of a fully-funded enforcement component at about \$.75 per person. Recently, the U.S. Substance Abuse and Mental Health Administration has developed a formula to fund enforcement of laws to reduce youth access to tobacco. Cost estimates are calculated based on the number of retail tobacco outlets and the expected rate of vendor noncompliance in that area. These enforcement cost estimates translate to \$.43 to \$.80 per person, which are compatible with the more comprehensive enforcement estimates previously presented.

In areas where there is a low population but a high number of tobacco vendors (i.e., tourist areas or interstate service areas) the upper end of the range should be applied.

\$.43 - \$.80 per person per year for all activities associated with enforcement of tobacco control policies and regulations at the local level.

6. ADMINISTRATION AND MANAGEMENT

- Administration
- Quality assurance
- Training and education

Description: Recruitment and staff development; awarding and monitoring program contracts; developing and maintaining a tobacco education clearinghouse and media center; provision of technical assistance and training to coalitions and outreach workers, establishment and maintenance of sound fiscal management systems; integration of tobacco control program components; and coordination with the state health department, other LPHAs, and various partner organizations.

Rationale: Implementation of an effective tobacco control program requires strong administrative and management structures that can perform strategic planning, staffing, and fiscal management functions. In many cases, there is a lack of training in the effective planning of public health programs, particularly in rural areas. The 1995 NACCHO Profile survey found that only about a third of LPHAs had long-term strategic plans. In addition, LPHAs serving larger populations are more likely to use the Healthy People national objectives and have a long-term health priority plan.¹¹ Adequate funding of this component should better ensure that the necessary planning takes place even at LPHAs with smaller jurisdictions. Equally important is a well-trained work force that has the human resource and project management skills required to carry out the program's activities and functions. Program staff and the public also need efficient access to educational

materials and other resources that advance the goals of the program. Local access to educational materials such as training manuals, videos, cessation modules, and activity kits can help empower outreach staff and the community in tobacco use prevention and control.

Budget: Experience dictates that roughly 5 percent of the total program budget be dedicated to program administration and management. These funds should be used to administratively support the coordination and functioning of all program elements. This amount is based on estimations for a statewide program. However, since the formula is a proportion of total program funding the estimated funding range for LPHA program administration and management should apply for local governments as well.

Five percent of total program budget

7. SURVEILLANCE AND EVALUATION

- Health assessment
- Policy development
- Administration
- Health promotion
- Health protection
- Quality assurance
- Training and education
- Community empowerment

Description: The Behavioral Risk Factor Surveillance System, the Youth Tobacco Survey and/or the Youth Risk Behavior Survey applied to a representative sample at the local level; special door-to-door surveys to assess the knowledge, attitudes, and tobacco use behaviors of high risk populations; outcome, impact, and process evaluation of the tobacco control program components; training and technical assistance pertaining to surveillance and evaluation; reporting and dissemination of data.

Rationale: Surveillance and evaluation are essential elements of a comprehensive tobacco control program. A successful program should assess the use of tobacco in the catchment area of the LPHA, the impact of that use, local factors contributing to the use, and the impact of the program to change tobacco use and the conditions that encourage it in the community.

Surveillance is the continuous monitoring of measures over time to inform program and policy directions. Most surveillance systems address primary outcomes well but do not adequately address intermediate measures. Ongoing data collection methods must be improved to better assess tobacco use prevalence among hard-to-reach populations (e.g., adults without phones, youth not in school, migrant populations). Due to funding limitations, few states have the capacity to obtain locally representative data on tobacco

use and other relevant risk factors. A well-funded surveillance capacity in LPHAs could be used to monitor local or regional changes in tobacco use over time and elicit the exact nature of those changes (i.e., brand use, reason for change, etc.). This information can be used to better inform program development and implementation when applied to specific populations within a jurisdiction.

Evaluation provides in-depth information about the status of intermediate outcomes, such as knowledge, attitudes, and policies, which are the short-term target of an intervention. The evaluation component also monitors program activities to ensure that they are conducted as planned. It is important to integrate evaluation with all other program elements and activities. Doing so will provide crucial process and impact data necessary for decision-makers to monitor and continually assess the efficacy of the program and the need for modifications. Clearly defined program objectives to achieve the goals must be developed and tied to evaluation mechanisms to determine program progress and success. LPHAs may perform the evaluation activities or contract with private evaluators such as a university.

Budget: In states with comprehensive tobacco control programs, *Best practices* supports using 10 percent of the total program budget for surveillance and evaluation activities. In California and Massachusetts, these funds were used for statewide functions as well as for increasing local capacity to conduct program evaluation. Every grantee in California must spend 10 percent of its budget on evaluation of its own activities. The 10 percent guideline is appropriate for smaller jurisdictions because it is proportionate to the total program budget.

Ten percent of total program budget

Sample Tobacco Control Budgets

The following tables apply the NACCHO *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs* to various types of local jurisdictions. Global per capita spending estimates based on population size provide a summary assessment of local spending needs (Table 1). These global estimates are consistent with the per capita spending identified in states with comprehensive tobacco control programs, which range

requirement, in programs serving rural areas. Sample budget tables have been calculated using demographic data on actual cities and counties in the United States. 1998 population figures were obtained from the U.S. Census Bureau. Students in kindergarten through grade 12 were extrapolated by adding the number of children between the ages of 5 and 18 years of age (per the 1990 census) and applying the proportion to the 1998 county

Table 1: Global Per Capita Spending Estimates for Tobacco Control Programs in Local Public Health Agencies			
Jurisdiction Type	Population Guide	Global Per Capita Spending Guide	
		Lower	Upper
Rural	<100,000	\$ 8.00	\$10.00
Mixed urban/ suburban/rural	101,000-500,000	\$ 6.00	\$ 8.00
Urban	501,000+	\$ 4.00	\$ 6.00
Sample	Est. 1998	Est. Program	Cost Range
Localities	Population	Lower	Upper
Rural	47,807	\$ 382,456	\$ 478,070
Mixed	265,300	\$ 1,591,800	\$ 2,122,400
Urban	641,715	\$ 3,850,290	\$ 5,133,720
Large urban	7,420,123	\$ 29,680,492	\$ 44,520,738

from \$2.50 to \$10.00 per person, per year. The cost of implementing a comprehensive tobacco control program in a rural setting is greater on a per-person basis due to the need for a minimum infrastructure in which to carry out the activities. Additionally, there is a larger burden of travel, and consequently a greater time

population estimates. Adults include people 19 years of age and older. The number of smokers was derived using 1997 tobacco use prevalence data from the Behavioral Risk Factor Surveillance Survey (conducted with adults) and applying it to the 1990 adult population in each location.

Table 2: Tobacco Control Budget Guidelines for Local Public Health Agencies Sample Rural-Type Jurisdiction				
Components	Per Capita Formulas		Sample County #1	
	Lower Est.	Upper Est.	Lower Est.	Upper Est.
	Est. 1998 Pop. 47,807		Est. Students K-12 7,544	
I. Community Programs	\$0.70	\$2.00	\$33,465	\$95,614
II. School Programs	\$4.00	\$6.00	\$30,176	\$45,264
III. Counter-marketing	\$0.50	\$1.50	\$23,904	\$71,711
IV. Cessation	\$1.00 per adult \$2.00 per smoker	\$1.00 per adult \$2.00 per smoker \$137.50*10% of smokers	\$34,309 \$15,988	\$34,309 \$7,994 \$109,917
Total Cessation Costs			\$50,297	\$152,220
V. Enforcement	\$0.43	\$0.80	\$14,390	\$26,772
Subtotal Program Costs (I-V)			\$152,231	\$391,581
VI. Surveillance and Evaluation	10% of interventions	10% of interventions	\$15,223	\$39,158
VII. Administration and Mgt.	5% of interventions	5% of interventions	\$7,612	\$19,579
Total Annual Program Costs	\$3.66	\$9.42	\$175,066	\$450,318
Global Per Capita Estimate	\$8.00	\$10.00	\$382,456	\$478,070

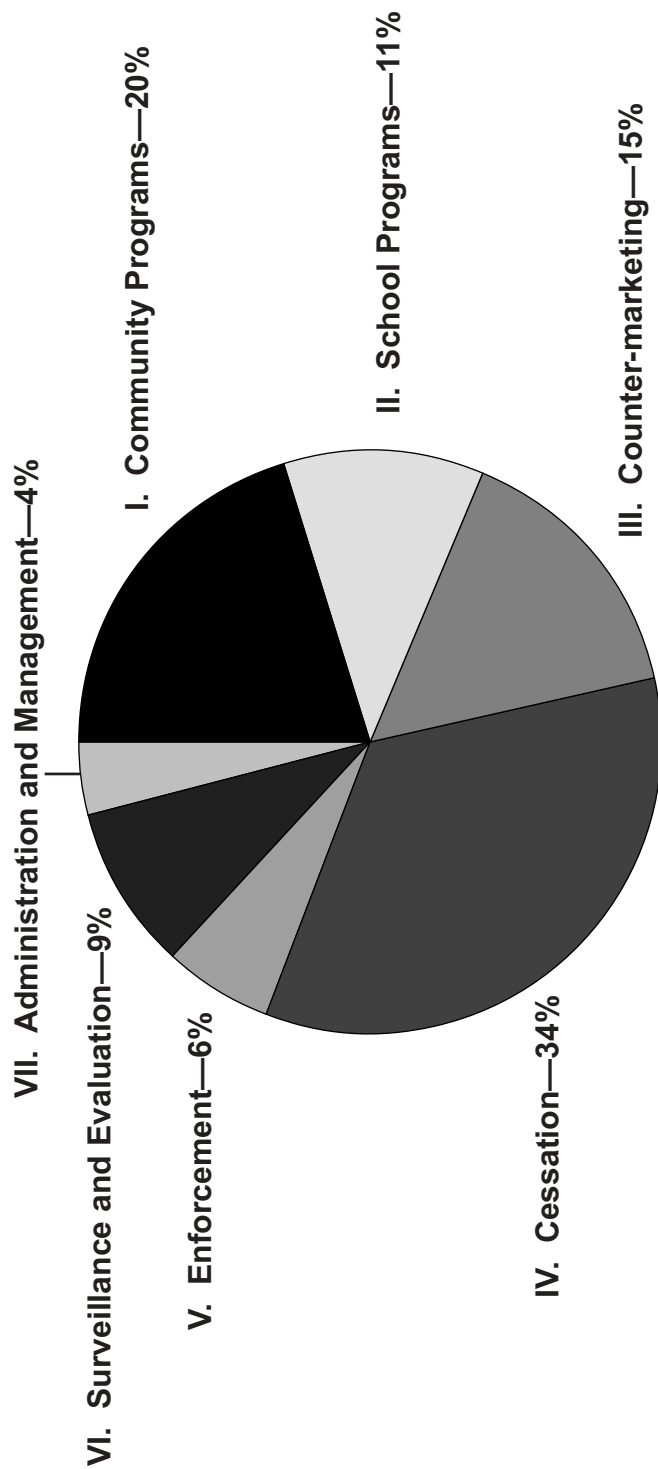
Table 3: Tobacco Control Budget Guidelines for Local Public Health Agencies Sample Mixed Urban/Suburban/Rural-Type Jurisdiction				
Components	Per Capita Formulas		Sample County #2	
	Lower Est.	Upper Est.	Lower Est.	Upper Est.
			Est. 1998 Pop. 265,317	Est. Students K-12 43,466
I. Community Programs	\$0.70	\$2.00	\$185,722	\$530,634
II. School Programs	\$4.00	\$6.00	\$173,864	\$260,796
III. Counter-marketing	\$0.50	\$1.50	\$132,659	\$397,976
IV. Cessation Assessment Brief counseling Cessation services	\$1.00 per adult \$2.00 per smoker	\$1.00 per adult \$2.00 per smoker \$137.50*10% of smokers	\$191,858 \$89,406	\$191,858 \$89,406 \$614,666
Total Cessation Costs			\$281,264	\$895,930
V. Enforcement	\$0.43	\$0.80	\$79,860	\$148,578
Subtotal Program Costs (I-V)			\$853,369	\$2,233,913
VI. Surveillance and Evaluation	10% of interventions	10% of interventions	\$85,337	\$223,391
VII. Administration and Mgt.	5% of interventions	5% of interventions	\$42,668	\$111,696
Total Annual Program Costs	\$3.70	\$9.68	\$981,374	\$2,569,000
Global Per Capita Estimate	\$6.00	\$8.00	\$1,591,902	\$2,122,536

Table 4: Tobacco Control Budget Guidelines for Local Public Health Agencies Sample Urban-Type Jurisdiction				
Components	Per Capita Formulas		Sample City #1	
	Lower Est.	Upper Est.	Lower Est.	Upper Est.
			Est. 1998 Pop. 641,715	Est. Students K-12 85,911
I. Community Programs	\$0.70	\$2.00	\$449,201	\$1,283,430
II. School Programs	\$4.00	\$6.00	\$343,644	\$515,466
III. Counter-marketing	\$0.50	\$1.50	\$320,858	\$962,573
IV. Cessation Assessment Brief counseling Cessation services	\$1.00 per adult \$2.00 per smoker	\$1.00 per adult \$2.00 per smoker \$137.50*10% of smokers	\$477,826 \$222,667	\$477,826 \$222,667 \$1,530,835
Total Cessation Costs			\$700,493	\$2,231,328
V. Enforcement	\$0.43	\$0.80	\$193,156	\$359,360
Subtotal Program Costs (I-V)			\$2,007,351	\$5,352,157
VI. Surveillance and Evaluation	10% of interventions	10% of interventions	\$200,735	\$535,216
VII. Administration and Mgt.	5% of interventions	5% of interventions	\$100,368	\$267,608
Total Annual Program Costs	\$3.60	\$9.59	\$2,308,454	\$6,154,980
Global Per Capita Estimate	\$4.00	\$6.00	\$2,566,860	\$3,850,290

Table 5: Tobacco Control Budget Guidelines for Local Public Health Agencies Sample Large Urban-Type Jurisdiction				
Components	Per Capita Formulas		Sample City #2	
	Lower Est.	Upper Est.	Lower Est.	Upper Est.
			Est. 1998 Pop. 7,420,123	Est. Students K-12 964,616
I. Community Programs	\$0.70	\$2.00	\$5,194,086	\$14,840,246
II. School Programs	\$4.00	\$6.00	\$3,858,464	\$5,787,696
III. Counter-marketing	\$0.50	\$1.50	\$3,710,062	\$11,130,185
IV. Cessation Assessment Brief counseling Cessation services	\$1.00 per adult \$2.00 per smoker	\$1.00 per adult \$2.00 per smoker \$137.50*10% of smokers	\$5,008,583 \$2,334,000	\$45,008,583 \$2,334,000 \$16,046,248
Total Cessation Costs			\$7,342,583	\$23,388,831
V. Enforcement	\$0.43	\$0.80	\$3,190,653	\$5,936,098
Subtotal Program Costs (I-V)			\$23,295,847	\$61,083,055
VI. Surveillance and Evaluation	10% of interventions	10% of interventions	\$2,329,585	\$6,108,306
VII. Administration and Mgt.	5% of interventions	5% of interventions	\$1,164,792	\$3,054,153
Total Annual Program Costs	\$3.61	\$9.47	\$26,790,244	\$70,245,514
Global Per Capita Estimate	\$4.00	\$6.00	\$29,680,492	\$44,520,738

Chart 1: Sample Budget Allocation

All Jurisdiction Types



Based on the mid-point of funding ranges for each program component. Percentages are accurate for all jurisdictions within 1-2 percentage points.

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Detailed Sample Tobacco Control Budget Justification

County of ABC

Budget Term: January 1, 2000 - December 31, 2000

NOTE: This budget was developed based on the median total budget for a county of the type denoted as "Sample County #2" in the Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs. Specifically, "County ABC" would represent a jurisdiction with a mixture of urban, suburban, and rural areas, with a population of 265,317, including 43,466 students in grades K-12, and approximately 44,703 adult smokers (about 17% of the total population, or 23.3% of the adults).

A. PERSONNEL

Subtotals

Program Director (1):

(\$1,731 bi-weekly x 100% x 26 pay periods)

\$45,000

Provide direct administration, supervision, and leadership to the county tobacco control program. Oversee day-to-day planning, development, and implementation of the plan. Supervise program staff, write reports, and provide general coordination of the program. Act as program point person for administrative and fiscal matters. Approve budget, invoices, cost reports, and staff changes. Serve as program liaison to county government. Perform other duties as required. Twenty percent of the Program Director's time will be spent overseeing and implementing the process and outcome evaluation component, and writing the evaluation report.*

Community Health Consultants (4):

(\$1,154 bi-weekly x 100% x 26 pay periods x 4 educators)

\$120,000

Act as program component liaison to the Program Director. The Consultants will work as a team to manage the day-to-day operation of the county tobacco control program. They will collaborate in writing program plans and performing program assessment, development, implementation, and evaluation. Together they will coordinate the activities of the local tobacco control coalition and mobilize the community to facilitate policy change.

	<u>Subtotals</u>
<u>Administrative Assistants (2):</u>	
(\$769 bi-weekly x 75% x 26 pay periods x 2 assistants)	\$30,000
Manage day-to-day workings of the office and take responsibility for staffing meetings, drafting minutes, scheduling program activities, and maintaining fiscal records, accounts, office records, equipment and files. Provide a range of clerical tasks (e.g., typing correspondence, manuscripts, statistical reports, invoices, etc.), act as telephone receptionist, and perform other duties as required.	
	<u>Subtotal Salaries:</u> \$195,000

<u>Fringe Benefits:</u>	
(approximately 23% of total salaries)	\$44,850
Fringe benefits covers the following: FICA, State Unemployment, State Disability Insurance, Worker’s Compensation, Health Insurance. Fringe benefits encompass regular compensation, based on percent of time spent on the program, paid to employees for vacation, sick leave, jury duty, military training, etc.	

<u>Temporary Employees (Extra Help)</u>	
(\$900 bi-weekly x 75% x 13 pay periods x 2 temps; no fringe benefits)	\$17,550
This line item will be used to supplement program staff when needed. Temporary employees may provide assistance with community mobilization, report writing, evaluation efforts, and other program activities.	

<u>TOTAL PERSONNEL SERVICES</u>	<u>\$257,400</u>
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B. OPERATING EXPENSES

1. Office Expenses:

Includes all general office supplies (pens, pencils, paper, etc.)	\$16,000
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2. Communications:

Includes installation and monthly costs related to telephone system and services, fax service, and internet connectivity costs.	\$10,400
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3. Postage and Shipping:

Includes expenses for postage costs for program mailings as well as general correspondence and materials.	\$10,000
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Operating Expenses (cont'd) **Subtotals**

4. Printing and Duplication:	Includes expenses for outside vendor printing and duplication (e.g., for professionally printed brochures, leaflets, forms, posters, etc.), as well as costs for internal, routine duplication performed on the health agency's copy machines, for program correspondence and materials.	\$30,000
5. Occupancy Expenses:	Includes rental costs for office space for all staff contributing to this program, in addition to a percentage of the cost of the common spaces (such as reception area, photocopy area, and mail room) and costs for maintenance of that office space, and is calculated as follows: 1,500 sq. ft. x \$1.10 per sq. ft. per month x 12 months = \$19,800	\$19,800
6. Equipment and Maintenance:	Includes the tobacco control program's prorated share of costs for the health agency's copy machines, computer systems, and other office equipment.	\$2,400
7. Vehicle Operation and Maintenance:	Includes the tobacco control program's prorated share of the county-owned vehicle estimated at \$1,000 per year.	\$1,000
8. Subscriptions:	This includes \$950 annually to subscribe to the Tobacco Industry Tracking Database developed by the American Nonsmokers' Rights Foundation as well as \$224 annually to subscribe to <i>Tobacco Control</i> , the primary journal in the tobacco control field.	\$1,174
TOTAL OPERATING EXPENSES:		\$90,774

C. TRAVEL AND TRAINING:

1. Local Travel and Training:	Includes travel and per diem expenses for a total of \$15,600 for travel in support of the work plan, as well as registration and fees for meetings and conferences attended by program staff for a total of \$3,900.	\$19,500
2. Required Travel and Training:	Includes travel and per diem expenses for unanticipated regional meetings and/or trainings or conferences within the state of XYZ.	\$4,500

Travel and Training (cont'd) **Subtotals**

\$500 travel expenses per meeting x 6 FTE staff = \$3,000

\$250 registration per meeting x 6 FTE staff = \$1,500

3. Specific Travel and Training: \$39,800

a. Program Directors Meetings (within the state), FY 1999/2000

\$700 travel x 2 staff (Prog. Director & other Mgr.) = \$1,400

\$200 training x 2 staff = \$400

b. World Conference on Tobacco and Health

\$1,500 travel x 5 staff (Prog. Dir. & all Mgrs.) = \$7,500

\$150 training x 5 staff = \$750

c. State/Regional Tobacco Control Conference

\$1,500 travel x 5 staff (Prog. Dir. & all Mgrs.) = \$7,500

\$150 training x 5 staff = \$750

d. Tobacco Use Prevention Summer Institute

\$1,500 travel x 4 staff (all Mgrs.) = \$6,000

\$500 training x 4 staff = \$2,000

e. NACCHO Annual Conference

\$1,500 travel x 2 staff (Prog. Dir. and 1 presenting Mgr.) = \$3,000

f. NALBOH Annual Conference

\$1,500 travel x 2 staff (Prog. Dir. and 1 presenting Mgr.) = \$3,000

g. APHA Annual Meeting

\$1,500 travel x 5 staff = \$7,500

TOTAL TRAVEL AND TRAINING: **\$63,800**

D. EQUIPMENT PURCHASES:

The tobacco control program needs to provide computers and software for the staff that will be joining the program this year, as well as replace the computers purchased several years ago and upgrade their software. The program also needs to purchase the following office equipment: 8 desks, 8 chairs, 8 storage cabinets, and one TV/VCR.

EQUIPMENT REQUEST/JUSTIFICATION:

<u>Item</u>	<u>Quantity</u>	<u>Estimated Cost</u>
Computer system	8	\$20,000

8 new computers are needed to provide new staff with appropriate equipment. The computers will be located in the tobacco program office and all tobacco program staff will have access to them. A high-speed internet connection will provide the program with access to valuable World Wide Web-based tobacco control resources and information (this cost is included in the Communications line item under Operating Expenses).

Hardware:

- IBM compatible Pentium III, 700 mHz CPU
- 120 megabytes of RAM, 15 gigabyte hard disk drive
- CD Rom 16X
- VGA color monitor, 17"

Software and upgrades: \$2,500

- MS Office-latest version
- MS Access
- MS Outlook
- MS PowerPoint
- Lotus 1-2-3 for Windows
- Epi-Info version 6

Office Equipment:

New office equipment is required to replace equipment that has been worn out or damaged beyond repair, or to provide appropriate equipment for new staff members.

Desks (8)	\$2,400
Chairs (8)	\$1,200
Storage cabinets (8)	\$2,400
TV/VCR (1)	\$ 800

TOTAL EQUIPMENT COSTS: \$29,300

E. EDUCATIONAL & COMMUNITY PROGRAMS: **Subtotals**

1. Educational Programs: \$276,732

- a. Educational Materials and Incentives (subtotal): \$66,732
 - i. Educational Materials: \$33,366
Includes the purchase of educational materials, such as brochures, pamphlets, posters, curricula, videos, slides or displays for use in a county tobacco resource library to be used by the tobacco program and made available to county groups and organizations for tobacco use prevention activities.
 - ii. Incentives: \$33,366
Includes items such as plaques, certificates, t-shirts, gift certificates, movie tickets, backpacks, sport bags, etc., provided to youth and adults participating in tobacco prevention and cessation activities.
- b. Media/Promotions (subtotal): \$210,000
 - i. Media: \$150,000
Includes tagging and duplicating public service announcements, developing and producing, placing and renting billboard ads to promote tobacco use prevention, cessation, and enforcement of youth access laws.
 - ii. Promotions: \$60,000
Includes costs for distribution of bumper stickers, pins, canvas bags, water bottles, etc., at county events.

2. Community Programs: \$980,000

- a. Special Populations Subcontracts: \$250,000
Includes agreements with ethnic specific subcontractors to provide effective, culturally sensitive and linguistically appropriate tobacco education, cessation and prevention services to selected population subgroups.
- b. Consultant Services: \$175,000
Includes arrangements or subcontracts with consultants to advise on programmatic issues, provide some direct cessation services, and/or provide training to group facilitators, educators, outreach workers, and staff. Also includes consultant services for assistance with the evaluation component of the tobacco control plan for approximately 400 hours,* as well as assistance with survey research, focus groups, and other surveillance and program planning efforts.

Educational & Community Programs (cont'd)

Subtotals

- c. Community Grants and Subcontracts: \$475,000
The program will provide a community grant program over the upcoming year to community based agencies and groups to support efforts to counter tobacco-promoting influences in the community and provide cessation services.
- d. Special Projects: \$75,000
These funds will be set aside for special projects that may occur throughout the program year that require immediate response from the county coalition. The XYZ State Tobacco Control Program will be notified when these projects are identified.
- e. Focus Group Costs: \$5,000
Includes focus group stipends and facilities costs for 20 focus groups with 5 participants per group at \$50 per participant.

TOTAL EDUCATIONAL AND COMMUNITY PROGRAMS: **\$1,256,732**

F. INDIRECT EXPENSES:

Calculated at 5% of total program costs, and includes the county's anticipated indirect costs for the Tobacco Control Program. Costs include administrative costs, personnel department, county counsel, accounting and payroll services, auditing expenses, insurance, utilities and building maintenance. \$77,182

GRAND TOTAL TOBACCO CONTROL BUDGET: **\$1,775,188**

* Evaluation synopsis

NOTE: The following is a synopsis of the distribution of the required 10 percent of the program budget for evaluation purposes:

- 1) *PERSONNEL: We are budgeting 20% of the Program Director's time for the program year to implement and oversee the evaluation component (20% x [\$45,000 salary + \$10,350 benefits] = \$11,070); and*
- 2) *CONSULTANT SUBCATEGORY: We are budgeting \$143,294 for consultant and survey research services to assist with the surveillance and evaluation component. This is subsumed in the Consultant Services line item in the Community Programs category.*

TOTAL EVALUATION COSTS (10% x Total Intervention Budget): \$154,364

Tobacco Control Resources

The following national organizations cover the expanse of tobacco-related resources and technical assistance available through the tools, information, and links to local affiliates and other organizations listed on each web site.

American Cancer Society: <http://www.cancer.org/>
The ACS Web site provides information on cancer and the health effects of tobacco as well as the organization's tobacco control programs and yearly events like the Great American Smoke-Out.

American Heart Association: <http://www.amhrt.org>
Provides information on heart disease risk, blood pressure, and cholesterol as they relate to smoking, as well as AHA's tobacco-related programmatic and advocacy efforts.

American Legacy Foundation: <http://www.americanlegacy.org>
The American Legacy Foundation, established to reduce tobacco usage in the United States as outlined in the Master Settlement Agreement, has set in motion a new legacy through the public education "truth" campaign, and provides grants and other assistance to local public health agencies.

American Lung Association: <http://www.lungusa.org>
Includes fact sheets, programs, press releases, and other resources on lung health, tobacco control, indoor and outdoor air quality, and asthma for consumers, as well as information on ALA's advocacy efforts.

Americans for Nonsmokers' Rights: <http://www.no-smoke.org>
The nation's premier organization devoted to assisting local organizations and individuals to fight pro-smoking legislation and develop and pass ordinances, workplace regulations, and other smoke-free policies.

Association of State and Territorial Health Officials: <http://www.astho.org>
ASTHO represents the state and territorial public health officials and is engaged in a wide range of legislative, scientific, educational, and programmatic issues and activities including tobacco use prevention and control.

Campaign for Tobacco-Free Kids: <http://www.tobaccofreekids.org>
Dedicated to protecting children from tobacco addiction and exposure to secondhand smoke, the Campaign's

Web site offers the most up-to-date defense against tobacco industry misinformation through press releases, reports, and fact sheets, and hosts the national Kick Butts Day.

CDC's Tobacco Information and Prevention Source: <http://www.cdc.gov/tobacco>
The Centers for Disease Control and Prevention TIPS page covers best practices, research and data, cessation standards, media campaigns, educational materials, and much more.

Environmental Protection Agency, Indoor Environments Division: <http://www.epa.gov/iaq>
Provides indoor air quality and asthma data and educational materials, including resources and guides for the public, school, and health officials concerning environmental tobacco smoke.

National Association of County and City Health Officials: <http://www.naccho.org>
NACCHO provides technical assistance and online resources for local public health officials, including this publication, a comprehensive tobacco policy statement in collaboration with state and local board of health officials, resolutions, links, the monthly resource newsletter for members, and other vital tobacco and public health practice resources.

National Association of Local Boards of Health: <http://www.nalboh.org>
NALBOH is committed to strengthening the ability of all 3,200 local boards of health to develop tobacco control policy efforts by providing educational materials, training, technical assistance, and information on tobacco control legal authority.

SmokeLess States Program: <http://www.ama-assn.org/special/aos/tobacco/main.htm>
Statewide coalition initiative, funded by the Robert Wood Johnson Foundation and administered by the American Medical Association, that supports 36 statewide coalitions, being expanded to 50 states in 2001.

Tobacco Bulletin Board System: <http://www.tobacco.org>
Tobacco BBS is a free resource center that covers comprehensive news from all sides of the tobacco control field and provides a special customized personal daily news briefing via e-mail.