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OVERVIEW

The Federal Centers For Disease Control and Prevention Office on Smoking or Health (CDC/OSH) provides funding to all 50 states, the District of Columbia, and seven territories through the National Tobacco Control Program (NTCP). Grantees are to use these funds to address the CDC/OSH's four goals:

1. Eliminating exposure to environmental tobacco smoke (ETS).
2. Promoting quitting among adults and youth.
3. Preventing initiation among youth.
4. Identifying and eliminating disparities related to tobacco use in population groups.

Over the last several years, the CDC recognized that states have broad and often inaccurate interpretations of goal #4, resulting in varied and frequently unsuccessful strategies to address the issue. This programmatic ineffectiveness usually stems from misunderstandings about the terms diversity and disparity. As defined in tobacco control work, there is a subtle but important difference that must drive program development. Diversity involves the commitment of a program to be inclusive of all populations (racial/ethnic, gender specific, etc.) Disparity, on the other hand, refers to specific and identifiable gaps revealed by an analysis of indicators such as tobacco use prevalence, exposure to second-hand smoke (ETS), relapse rates, access to prevention and cessation programs, tobacco industry marketing, and so forth. An analysis of these gaps reveals diverse communities that suffer from disparities but may also reveal diverse communities that do not.

To remedy the lack of progress towards addressing goal #4, the CDC created the Pilot Training Program and set aside funding for 13 states to develop tools and strategies to identify and define disparities, as well as to conduct a strategic planning process with community and state partners to address the identified disparities for each particular state. Oregon was awarded this funding and the resulting Tobacco Disparities Planning Project began in April 2002.

Oregon's Tobacco Disparities Planning Project was a collaborative process involving a diverse and inclusive workgroup consisting of tobacco and health professionals representing diverse groups from throughout the state. Workgroup members were representative of rural and urban Native Americans, Asian/Pacific Islanders, African-American, Hispanic, Gay and Lesbian communities, rural and low-income groups, as well as young adults. A roster of workgroup participants is available in Appendix A.

Over a period of nine months, the workgroup worked diligently to study both quantitative and qualitative data, prioritize critical issues emerging from the analysis, and make recommendations about how to address and eliminate disparities. Agendas for workgroup meetings are available in Appendix B and meeting notes follow in Appendix C. The workgroup's findings and recommendations are detailed in this Strategic Plan, Closing the Gaps: Identifying & Eliminating Tobacco-related Disparities in Oregon.

GUIDELINES

The Oregon Tobacco Disparities Planning Project, along with twelve other states funded by the Pilot Training Program, share a common vision and mission created by the Federal Centers For Disease Control and Prevention Office on Smoking or Health (CDC/OSH).

Vision

To identify and eliminate disparities related to tobacco use in population groups.

Mission

To enable each grantee to build its capacity for the identification and elimination of tobacco-related disparities by engaging a diverse and inclusive workgroup in a strategic planning process.

The resulting strategic plan will provide a framework for future programs, interventions, surveillance, and evaluation associated with tobacco-related disparities.

STRATEGIC PLANNING PROCESS

The strategic planning process utilized by the workgroup followed a format provided to grantee states by the CDC, which outlined three methods of qualitative and quantitative data collection to insure a complete analysis of existing disparities. These included an examination of available quantitative data gathered through the Oregon Department of Human Services (DHS) Program Design and Evaluation Services, a qualitative analysis using key informants in specific at-risk communities, and an analysis of the Strengths, Weaknesses, Opportunities and Threats (SWOT) of the systems charged with providing tobacco-related services to Oregon residents. Following this analysis, workgroup members worked to prioritize issues identified to formulate the final strategic plan.

Data Analysis: Quantitative

An exhaustive analysis of Oregon-specific data was conducted over three sessions. Program staff from the DHS Program Design and Evaluation Services joined the first meeting to discuss the type of data available and get feedback from the group about which information they would find of interest. Using preliminary data from 2000-2001, the evaluation team reviewed the most recent statistics available to assist the group in their effort to identify disparities in Oregon. The two subsequent meetings included presentations by the evaluation team and provided workgroup members an opportunity to ask follow-up questions. Where available, state prevalence rates by race, gender, region, income, age, education, occupation, health insurance status, and sexual orientation were presented. There was also an extensive discussion regarding the types of data that can be collected and the shortcomings of existing data gathering methods. Data reports generated for the purposes of this planning process are available in Appendix D.

The workgroup identified 30 issues from the data presentations, which primarily focused on prevalence rates and data collection issues. The complete list of issues identified in this process is available in Appendix E.

Population Assessment: Qualitative

Workgroup members identified population groups where the state's data analysis was inadequate to provide a complete overview of tobacco prevalence within the community or where additional qualitative data would assist in the development of an inclusive plan. Workgroup members worked individually and/or in groups to complete an assessment of those populations, which was subsequently presented to the workgroup utilizing a standardized format to encourage consistency. To view the format, please refer to Appendix F. Populations selected to be the focus of a population assessment included:

- African-American
- Asian/Pacific Islander
- Blue Collar Workers
- Gay, Lesbian, Bisexual, and Transgender
- Native American
- Oregon Health Plan Members
- Rural/Pendleton-area Residents

Individual population assessment reports for each of these groups are available in Appendix G.

The workgroup identified 54 issues as a result of the population assessments. In addition, many potential strategies for addressing high prevalence rates came out as a result of the presentations. The complete list is available in Appendix H.

Strengths, Weaknesses, Opportunities, and Threats (SWOT)

Workgroup members agreed to apply the SWOT analysis to the Oregon Department of Human Resources, Tobacco Education and Prevention Program (TPEP), the organization with the most potential for influencing the implementation of this strategic plan. TPEP staff and workgroup members with TPEP-experience were interviewed. The workgroup identified 22 issues as a result of its SWOT analysis. The complete list is available in Appendix I.

KEY FINDINGS

The data analysis, population assessment, and SWOT revealed a total of 106 issues related to disparities in Oregon. The workgroup then took on the task of examining the importance and potential impact of each issue through discussion groups and prioritizing activities. Ultimately, seven critical issues were identified as key findings and are outlined below, followed by a brief discussion. Additional substantiating information is available in the appendices to this report.

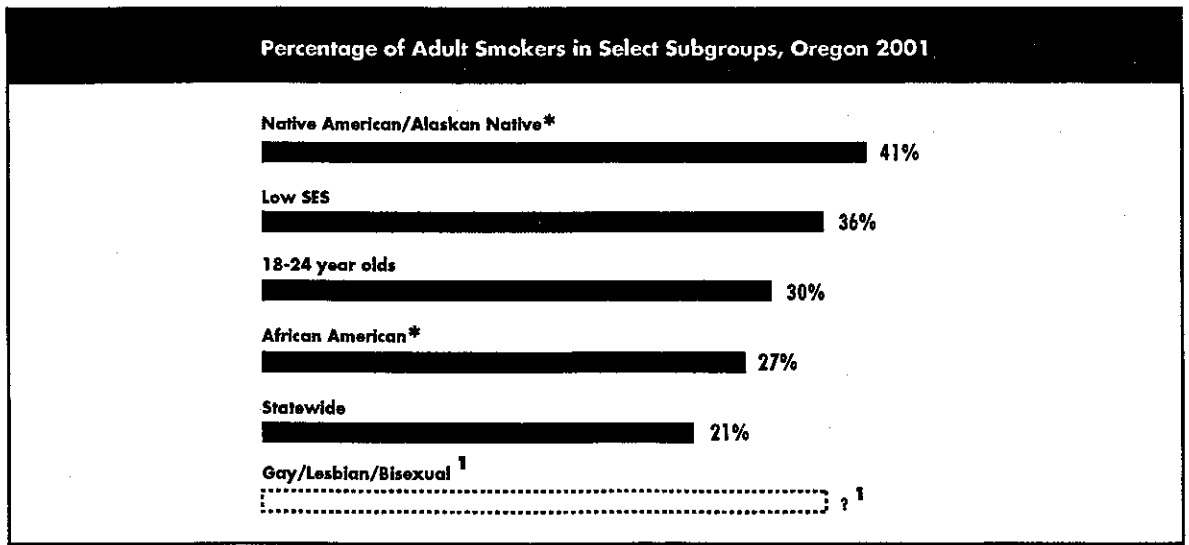
1. Lack of available best practices, locally or nationally, for working with disparate groups.

An analysis of methodologies currently available at the local and national levels revealed few, if any, practices that have been studied and proven effective to address tobacco use in disparate population groups. Without the development of expertise in this field, disparities will continue to exist.

2. Disparately high prevalence of tobacco use among African Americans, Native Americans, 18-24 year olds, some Asian/Pacific Islander groups, persons of low socioeconomic status and the Gay, Lesbian, Bisexual, and Transgender community.

- The data analysis of tobacco use in Oregon identified disparities within several groups. Native Americans (41%), persons of low socio-economic status (36%), 18 – 24 year olds (30%), and African- Americans (27%) had clear disparities when compared with the broader population's prevlence rate of 21%.

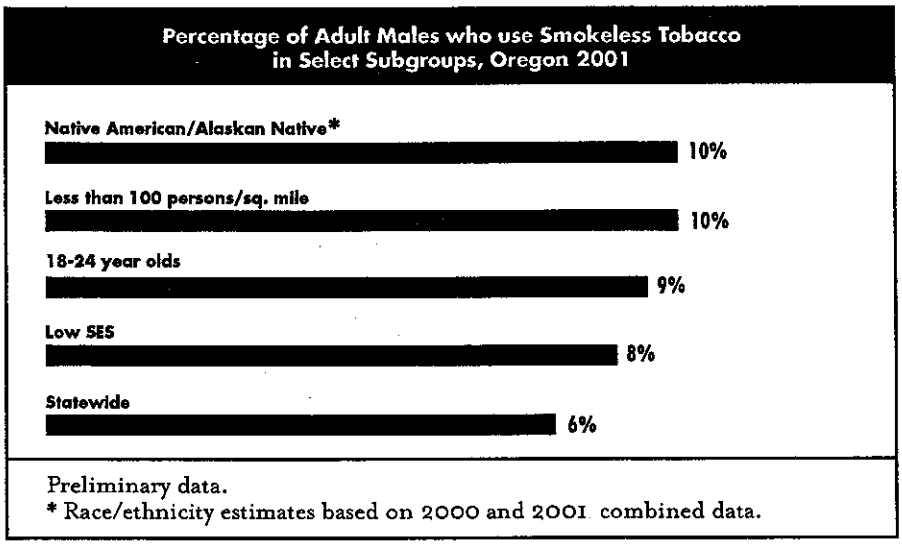
- Local population assessments and national data sources indicate that Gay, Lesbian, Bisexual, and Transgender individuals (between 11-50%) and some Asian/Pacific Islander communities (between 12-28%) have disparities when compared with the broader populations prevalence rate of 21%, despite the lack of Oregon specific data to substantiate it.



Preliminary data. * Race/ethnicity estimates based on 2000 and 2001 combined data.
[1] No Oregon-specific data is available for the GLBT population. A recent review of published studies estimates the smoking prevalence ranges from 25-50% in gay and bisexual men and from 11-50% in lesbian and bisexual woman (mid-point of the range for gay and bisexual men presented above). In all but one study, the rates were higher than those of the general adult population during the same period of time.

3. Disparately high prevalence of chew-tobacco use among Native Americans and rural males.

The analysis of Oregon prevalence data indicates that Native Americans and rural males have tobacco-related disparities of 10% each, compared to 6% in the general population.



4. Tobacco companies are aggressively targeting Hispanics, African-Americans, Native Americans, Asian/Pacific Islanders, the Gay, Lesbian, Bisexual, and Transgender community, and the 18-24 year olds to expand their markets.

This information is well substantiated by national reports and indicates a clear effort on part of the tobacco industry to support and potentially increase existing disparities in Oregon.

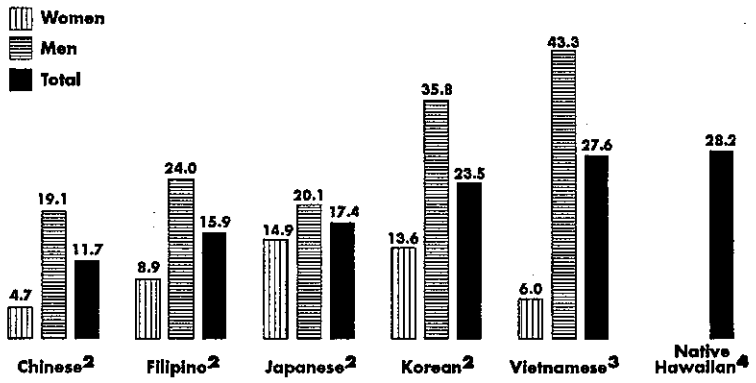
5. Existing data collection methods do not provide accurate data about tobacco prevalence within the Gay, Lesbian, Bi-sexual, Transgender community, and among sub-groups of Asian/Pacific Islanders.

The data presentation revealed that existing data collection methods do not allow the state to gather and analyze tobacco use rates among the Gay, Lesbian, Bisexual, and Transgender and Asian/Pacific Islander communities.

- At the time this workgroup was convened, Oregon data collection methods did not identify individuals as Gay, Lesbian, Bisexual, or Transgender—making it impossible to predict prevalence rates in the state. There is every reason to believe that there is a large enough population in Oregon to allow for accurate data using existing data collection methods. Since the onset on this workgroup, the state evaluation team has begun a pilot project to collect this data.

- The Asian/Pacific Islander population faces a somewhat different situation. Due to the low overall number of Asian/Pacific Islanders residing in Oregon, all Asian and Pacific Islander communities are lumped together for data collection purposes. Data collection by sub-group would not provide data samples sufficient to determine reliable prevalence rates. This sampling method results in a lower than average prevalence rate of 16% for the group as a whole. National data and the population assessment conducted by this workgroup indicate that certain sub-groups of the Asian/Pacific Islander population have extremely high smoking rates. The exact disparity in Oregon cannot be determined without data collection methods that separate this broad population group into smaller, more culturally relevant sub-groups.

Selected Findings from Studies Outside of Oregon: Percentage of Asian American and Pacific Islander Adults who Smoke Overall and by Gender, 1989-1992



Source: (2) Burns and Pierce 1992, (3) Wewers et al. 1995, (4) Blaisdell 1993

Asian Subpopulations, Oregon 2000

	Number of persons	Percent of population
Asian	**101,350**	**3.0**
Asian Indian	**9,575**	**0.3**
Chinese	**20,930**	**0.6**
Filipino	**10,627**	**0.3**
Japanese	**12,131**	**0.4**
Korean	**12,387**	**0.4**
Vietnamese	**18,890**	**0.6**
Other Asian**	**16,810**	**0.5**

Source: U.S. Census Bureau, Census 2000
** Other Asian alone, or two or more Asian categories

6. **Lack of funding for tobacco control programs within the Gay, Lesbian, Bisexual, and Transgender community, despite indications of extremely high prevalence.**

The Gay, Lesbian, Bisexual, and Transgender community is the only community with an identified disparity that does not have existing programs and/or funding streams in Oregon to support the development of community-based programming to address the problem. Given the cultural differences outlined in the population assessment conducted for the purposes of this plan, it is unlikely that the prevalence rate in this community can be addressed without strategies and programming targeted specifically at the community.

7. **Limited resources for tobacco control programs among communities with disparities.**

While Oregon is ahead of other states in funding and supporting culturally sensitive tobacco control programming, existing funds are not sufficient to develop the best practices and broad-based efforts needed to address the problems identified in the planning process.

PROJECT GOALS & STRATEGIES

An analysis of these seven key findings revealed six overarching goals with multiple related strategies. There is full agreement among workgroup members that these goals reflect the most critical tobacco-related disparities in Oregon. The related strategies are workgroup recommendations about how to address these disparities and bring about change.

Goal 1: **Identify, develop, and promote the use of Best Practices for eliminating tobacco-related disparities in Oregon.**

Strategies

a) Department of Human Services should aggressively gather and disseminate best practices developed by national networks, coalitions throughout Oregon, and other sources.
b) Identify gaps in information regarding best practices in populations with disparities.
c) Provide technical assistance on development and evaluation of innovative programs for disparate populations in Oregon.

Goal 2: **Develop and implement effective population-specific tobacco control programs directed at African Americans, Native Americans, 18-24 year olds, some Asian/Pacific Islander groups, persons of low socio-economic status, and Gay, Lesbian, Bi-sexual, and Transgender individuals who have disparately high prevalence of tobacco use, and Hispanics who, along with the above, are heavily targeted by the tobacco industry.**

Strategies

a) Continue to fund ethnic-specific networks for African-Americans, Native Americans, the Asian/Pacific Islander community, Hispanics, and all nine federally recognized tribes in Oregon to implement effective tobacco control programs including prevention, linkages to cessation, and counter marketing strategies.
b) Develop and incorporate into the TPEP annual plan specific objectives addressing tobacco use among Gay, Lesbian, Bisexual, and Transgender individuals, persons of low socio-economic status, and 18-24 year olds.

Goal 3: **Develop and implement specific programs to reduce the use of chew-tobacco by Native American and rural males.**

Strategies

a) Convene a workgroup of key partners in chew-tobacco prevention to identify existing effective interventions and identify service gaps.
b) Develop community-based, tribal, and statewide plans to incorporate chew tobacco intervention in Oregon.
c) Assure that state materials and trainings regarding tobacco cessation include chew-tobacco.

Goal 4: Assure that data collection efforts determine the prevalence of tobacco use within the Gay, Lesbian, Bi-Sexual, and Transgender community and sub-groups of the Asian/Pacific Islander populations.

Strategies

a) Convene a workgroup of technical people within DHS to identify potential data collection methods to differentiate Asian/Pacific Islander subgroups.
b) Assure that information about sexual orientation continues to be collected on Behavioral Risk Factor Surveillance System (BRFSS) and investigate additional data collection methods.
c) Identify community specific surveys within the Asian/Pacific Islander and Gay, Lesbian, Bisexual, and Transgender communities and advocate for the inclusion of a tobacco-related questions.

Goal 5: Fund effective community-based tobacco control programs for the Gay, Lesbian, Bisexual, and Transgender community.

Strategies

a) Allocate a portion of the TPEP budget to fund a Gay, Lesbian, Bisexual, and Transgender program.
b) Work with Gay, Lesbian, Bisexual, and Transgender community groups to develop a request for proposal (RFP) for the TPEP funds.

Goal 6: Increase the capacity of population groups with higher tobacco use prevalence and other tobacco-related disparities to apply for and secure funding within both existing and new funding streams.

Strategies

a) Develop and implement a process to monitor and disseminate information about availability of funds for tobacco control projects in disparately affected populations.
b) Provide agencies and/or individuals involved in tobacco-control efforts in disparately affected populations the tools and resources necessary to educate their agency and community leaders regarding the importance of tobacco prevention and control.
c) Provide technical assistance to community groups to develop tobacco control proposals that incorporate known or promising practices for disparately affected populations.

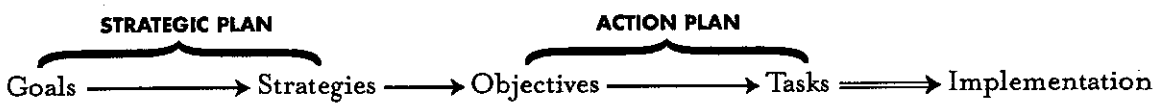
NEXT STEPS

While the process outlined in this Strategic Plan are critical first steps to bring about parity for disparate groups, they are not sufficient to implement necessary changes in Oregon's tobacco-control efforts. Funding provided by the CDC for this process was not intended or sufficient to complete the work at hand. However, the workgroup stands ready to partner with the State, community partners, and policy makers to carry out the crucial steps necessary to make this plan a reality. Additional funds are currently being sought to allow full implementation of these next steps and ultimately the strategic plan itself.

Recommended next steps include:

Create an Action Plan

A strategic planning process must have two major elements: the Strategic Plan, as outlined above, and an Action Plan, which serves to operationalize the strategic plan. Similarly, the Action Plan has two parts: objectives and tasks. It is only through the development of an Action Plan related to each goal and strategy can implementation occur. In short, the strategic plan and action plan are related as follows:



In order to create the Action Plans for this Strategic Plan, the workgroup recommends the creation of a coalition of workgroup members, state employees, and additional community groups to work in committee to identify and articulate objectives and tasks related to each strategy. These committees (one for each of the six goals) are intended to provide direction by establishing responsibilities, creating time lines, identifying management oversight, and creating feedback mechanisms. To facilitate the operationalization process, committees would work to answer the following questions for each strategy:

1. *Who is responsible for the achievement of the goal and strategy?* Assigning and clarifying responsibilities helps to ensure that strategic plans produce the desired result.

2. *What is the time line for the completion of the goal and strategy?* A time line is a simple guide to be used for assessing progress.

3. *Who will oversee the advancement of the goal and strategy?* Now that the goals and strategies have been established, it is essential to know who will take responsibility for their oversight.

4. *What are the mechanisms for feedback?* Effective reporting often serves as an excellent feedback mechanism. The need for feedback becomes critical in documenting what has been achieved thus far and what still needs to be addressed.

Committees would use the answers to these questions to create objectives that answer the question "What steps must be taken to meet the goal?" The SMART standard for objectives will be utilized, which specifies:

Specific: *Identifies specific event or action that will take place.*
Measurable: *Quantifies the amount of change to be achieved.*
Achievable & Ambitious: *Realistic yet challenging.*
Relevant: *Logical and relates to the program's goals.*
Time-Bound: *Specifies time by which objective will be achieved (typically several months to a year).*

Finally, committees would work to identify and articulate tasks related to each objective. Tasks will answer the question "What steps must we take to accomplish the objective?" Tasks will have measurable descriptions and generally a very short time frame. Wherever feasible, tasks will be assigned to an individual or team for completion.

The following example of a completed strategic plan/action plan shows how each of these components fit together:

Goal:
Eliminate information gaps in data that prevent the identification of disparities.
Strategy:
Improve existing surveillance systems to collect data on populations with tobacco-related disparities.
Objective:
By December 2003, complete a statewide epidemiological profile of tobacco use for all rural population groups.
Tasks:
Design a survey for rural populations
Pilot test the survey instrument
Conduct the survey
Analyze the survey data
Report the survey results

Create an Evaluation Plan

Once the Action Plans are complete, established committees would work with agencies and coalitions responsible for implementing them to create an evaluation framework to assess progress towards achieving strategic planning goals. The workgroup is highly aware that performing evaluations on a regular basis allows for the identification and dissemination of assets, challenges, and lessons learned; lessons that allow for quality process improvements to the strategic plan and/or action plan(s) and ultimately successful implementation. As such, effective and planned evaluation is critical to the success of the plan.

Committees would work to incorporate the following topics into each evaluation plan:

- Project description: provide a brief overview of the mission and goals of the strategic plan, noting that the strategies for each goal will be implemented through the accompanying action plan.
- Evaluation purpose and goals: assessing processes/outcomes of action plan implementation and the extent to which they advance the strategic planning goals to which they are related.
- Evaluation design: identify the key processes and outcomes that will be investigated, reported, and assessed.
- Evaluation questions: identify the key process and outcome questions regarding implementation and out comes of the specific strategies developed to reach planning goals.
- Methods: describe methods for data collection, management, and analysis
- Results: describe how results will be used to assess effectiveness of plan implementation activities and the extent to which they support strategic planning goals.
- Conclusions

Committees could then work with the implementation groups to identify standards for an evaluation report for each goal, including timeline (how often the evaluation will take place), responsible party and critical components of the evaluation report such as milestones reached; outcomes achieved, barriers and successes. These periodic reports would assess the extent to which the action plans or other factors have advanced or impeded strategic planning goals and be available to workgroup members, community members, and other interested parties on an ongoing basis.

Create a Marketing Plan

Despite the workgroup and subsequent committee's intent to be inclusive and participatory, there are individuals and groups impacted by the Strategic Plan that have not been at the table during its inception. As a result, a marketing plan should be developed that identifies missing critical players, outlines a plan to educate and inform them about the work completed, and invites them to participate in the critical implementation phase—eliminating disparities in Oregon. As recommended by the CDC in the Pilot Training Program manual, a marketing plan should include the following steps[5]:

- Identify groups critical to the success of the plan. These may include:
  - o Politicians
  - o Community-based Agencies or Board members
  - o Corporate sponsors (health agencies/plans)
  - o Other health-related service organizations
  - o Tobacco prevention coalitions
  - o Tobacco Free Coalition of Oregon (TOFCO)

- Determine the action needed or desired from each identified group or individual.
- Identify benefits for them if they agree to support the plan.
- Identify and consider the barriers to their involvement.
- Create tools and messages that communicate the benefits to participation.
- Determine the marketing approach/tactic appropriate to each group or individual.
- Identify the most effective person/coalition to deliver marketing message.
- Track and utilize feedback from those who receive the marketing message.

CONCLUSION

Oregon's success over the past decade is no surprise: committed professionals are working throughout the state to eliminate the deadly use of tobacco. Despite this success, however, the planning process outlined in this report has identified and highlighted important work facing the tobacco prevention community in Oregon for it has revealed that all Oregonians have not equally benefited from these efforts. The time has come to focus the talents and energy that have brought us this far to bring about parity for all Oregonians. This report is the beginning of the effort. The Tobacco Disparities Project workgroup is ready to join forces with other professionals to complete this critical process and make the vision a reality . . . for everyone.

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3. Wewers ME and others. Misclassification of smoking status among Southeast Asian adult immigrants. American Journal of Respiratory and Critical Care Medicine 1995;152(6 Pt1):1917-21.

4. Blaisdell RK. The health status of the Kanaka Maoli. Asian American and Pacific Islander Journal of Health 1993;1(2):116-60.

5. Centers for Disease Control. Tobacco use among populations: Putting the pieces together to identify and eliminate disparities pilot training program. Atlanta, Georgia: Centers for Disease Control; 2002;manual #3(IV): 6.

Appendix A
WORKGROUP MEMBERSHIP

Community Members

Faye Burch
Consultant
FM Burch Consulting

Sik Yin Chan
Quality Assurance Director
Portland Impact
Board Chair
Asian-Pacific Consortium on Substance Abuse

Shannon Chrisman
Health Educator
Confederated Tribes of Siletz Indians of Oregon

Nelia Collins
Program Coordinator
Asian Family Center

Cathryn Cushing
Consultant
Cathryn Cushing Consulting

Raheve Gray
Health Educator
Multnomah County Health Department

Janet Jones
Coordinator
Umatilla County Coalition Against Tobacco

Sayaka Kanade
Project Specialist
NPAIHB Western Tobacco Prevention Project

Phillip Knowlton
MSM Program Coordinator
Cascade Aids Project

Raleigh Lewis
Affirmative Action Director
Governor's Office - Affirmative Action Office

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Health Promotions Program Manager
Native American Rehabilitation Assoc.

Gloria Muzquiz
Planning Director
Oregon Human Development Corporation

German Nunez
Vice Provost
OHSU Diversity and Multicultural Affairs

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Urban League of Portland

Liling Sherry
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NPAIHB

Judith Van Osdol
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Media Consultant
Tobacco Prevention Program

Luci Longoria
Program Consultant
Tobacco Prevention Program

Gerry Odisio
Mulit-Cultural Program Manager
Tobacco Prevention Program

Kristen Rohde
Research Analyst
Tobacco Prevention Program

Mike Stark
Manager, Program Design and Evaluation Services
Department of Human Services

Facilitators

Carol Gelfer

Sheri Campbell

Appendix B

Agenda
April 24, 2002

Time	Activity	Presenter
12:00	LUNCH	
12:30	Welcome and Introductions	Carol Gelfer and Sheri Campbell
1:00	Overview of CDC Project ▪ Review of TPEP program ▪ Review of current disparities activities in Oregon ▪ Purpose of the Workgroup	Gerry Odisio
1:30	Tobacco in your community ▪ Discussion and brainstorming	Faye Burch
2:00	BREAK (Brownies!!)	
2:15	Roles and Responsibilities of the Workgroup ▪ Overall Role and Function of the Workgroup ▪ Structure of Workgroup ▪ Process Evaluation, Kristen Rohde, Research Analyst, DHS	Carol Gelfer
3:00	Overview of the Strategic Planning Process	Carol Gelfer and Sheri Campbell
3:30	Data Preview/ Discussion	Mike Stark
4:15	Next Steps ▪ Meeting Schedule ▪ Prep for next meeting ▪ Other	Carol Gelfer and Sheri Campbell
4:30	ADJOURN!!!	

Appendix B

Agenda
June 5, 2002

Time	Activity	Presenter
12:00	LUNCH and "Why" Video	
12:15	Introduce new members and welcome	Carol Gelfer
12:20	Workgroup milestones and timeline	Sheri Campbell Carol Gelfer
12:45	Building Consensus	Carol Gelfer
1:00	Data Presentation	Mike Stark
2:15	Break	
2:30	Data Presentation, continued	Mike Stark
3:30	Brainstorm Data Critical Issues	Carol Gelfer
3:45	Next Steps – The Population Assessment ▪ Overview ▪ Process ▪ Workgroup roles	Sheri Campbell
4:30	ADJOURN	

Appendix B

Agenda
July 15, 2002

Time	Activity	Presenter
12:00	LUNCH	
12:10	Update our timeline	Sheri Campbell
12:15	Youth Data Presentation	Kristen Rohde
12:55	1st level Data Prioritization	Carol Gelfer/Workgroup
1:35	Population Assessment Presentations Identification of Critical Issues GLBT Gay Men American Indian Rural Communities OHP/Medicaid AAPI Other?	
2:30	Break	
2:45	Population Assessment presentations, cont.	
3:30	Media Discussion: What Oregonians are Hearing and Seeing via the anti-tobacco paid media campaign	Faye Burch
4:30	ADJOURN	

Appendix B

Agenda
August 21, 2002

Time	Activity	Presenter
12:00	LUNCH	
12:10	Review workgroup purpose/strategic plan	Sheri Campbell
12:40	Population Assessment presentations, (continued) ▪ Native American community ▪ Blue Collar Workers	
1:00	Brainstorm/update/review critical issues from Population Assessment/Data	Carol Gelfer
1:30	S(trengths), W(eaknesses), O(pportunities) and T(hreats) ▪ Presentation of SWOT proposal ▪ Brainstorm critical issues	 Sheri and Carol Workgroup
2:30	Break	
2:55	Prioritizing Critical Issues ▪ Overview of process ▪ Small group discussion ▪ Large group reports ▪ Voting	 Sheri and Carol Sheri, Carol and Faye Workgroup Workgroup
4:45	Next steps and timeline check	Sheri and Carol
5:00	ADJOURN	

Appendix B

Agenda
September 23, 2002

Time	Activity	Presenter
12:00	LUNCH	
12:10	Introductions	All
12:15	Overview of Strategic Plan/Process	Sheri
12:40	Review upcoming meetings and changes	Carol
1:00	Distribute materials from last meeting	Carol
1:15	Critical Issues into Goals • Review final critical issues • Review Goal drafts • Small group discussion (if needed) • Large group reports (if needed)	 Carol Sheri
2:15	Break	
2:30	Creating strategies for each goal • Small group discussion • Large group reports	Sheri
4:45	Meeting review/confirm next steps	Carol
5:00	ADJOURN	

Appendix B

Agenda
November 4, 2002

Time	Activity	Presenter
12:00	LUNCH	
12:10	Introductions	All
12:15	Discuss, adopt strategies	All
12:30	Overview of plan drafts, feedback from group	Sheri
1:30	Brainstorm any recommendations for DHS Action Plan	Carol
2:15	Break	
2:30	Monitoring and evaluating the Plan	
	• On-going roles for workgroup members	Ken
	• Evaluating the plan	Kristen
3:30	Marketing the Plan	Carol
	• December meeting date	
	• December meeting agenda	
	• Invited guests, brainstorm others to invite	
	• Identify speakers for December meeting	
	• Other marketing strategies/plan	Mary B.
4:45	Next steps	
	• Preparation for final meeting	Carol
	• Finalizing the Strategic Plan document	Sheri
5:00	ADJOURN	

Appendix C

Meeting Notes

April 24, 2002

Present: Mary Boehme, DHS; Faye Burch, Pac/West; Sik Yin Chan, Portland Impact; Nelia Collins, Asian Family Center; Janet Jones, Umatilla County Coalition Against Tobacco; Sayaka Kanade, NPAIHB; Luci Longoria, DHS; Kerri Lopez, NARA; Gerry Odisio, DHS; Lorrie Piatt-Montry, APCSA; Kristen Rohde, DHS; Jackie Scott, Urban League; Melissa Shepherd, BRO; Liling Sherry, NPAIHB; Jackie Taylor; Judith Van Osdol; OMAP

Absent: Cathryn Cushing; Ron Hauge, OHDC; Marty Davis, Just Out; Raleigh Lewis, Governors Affirmative Action Office; Maria Underwood, La Clinica del Valle

Facilitators: Carol Gelfer and Sheri Campbell

Overview of project: Carol Gelfer reviewed the differences between Disparities and Diversity (see hand-out) and the goal of the workgroup.

> **Goal:** To conduct a strategic planning process to identify and eliminate disparities in tobacco use in Oregon. Disparities are gaps revealed by a variety of indicators, i.e.: higher prevalence rates, greater exposure to ETS, more aggressive marketing by the tobacco industry. Diversity relates to inclusiveness and assuring that all partners are involved in the decision-making and programmatic process

The work group brainstormed factors that might lead to disparities. Ideas included:

- Age
- Gender
- Ethnicity
- Language
- Education
- Cultural norms
- Geography
- Environment
- Disability
- Sexual orientation
- Occupation
- Chronic disease
- People in recovery
- Mental health issues

Based on these factors related to disparities, the workgroup brainstormed "who is not here" to make the workgroup most effective. Ideas included:

- Tribal member
- Young person (18-24)
- Bartender/wait staff
- Gay man
- Low SES community member
- Senior
- Blue collar worker
- Disability community rep

Overview of CDC Project: Gerry Odesio reviewed the various projects at the State Health Department, Tobacco Prevention and Education Program that are related to the work at of the current workgroup. Please see handouts of Presentation for further information.

Tobacco in your community: Faye Burch facilitated a round table discussion about the personal impacts and motivations of participating in the Workgroup.

Why participate in the strategic planning process?? Ideas included:

- Tobacco is a killer
- Disparities exist in African American communities- want to contribute and gather information on progress made on eliminating disparities

- Make changes in cultures where smoking is so prevalent
- Contribute as individuals both in Oregon and Nationally. Encourage other states to get involved with their tribal communities
- It is a long process. We are doing a good job, yet Asian communities can learn from others and share commonalities.
- Native clients smoke at 2x the rate of overall population. Want to learn to target populations with the highest incidence. Want to learn from research to plan new cessation programs
- Encourage eliminating disparities in rural areas, i.e.: access to training, access to services, and assess to treatment
- Feel a loss and cheated by death of loved ones. Want to eliminate smoking.
- Don't want to avoid places like taverns, bowling alleys and other places that allow smoking. Want to make a difference.

How are individuals in the workgroup and their communities affected by tobacco use? Ideas included:

- Some people feel guilty about smoking, but this differs by cultural groups. At NARA it is part of the norm. 80% of NARA clients smoke.
- Small communities see secondhand smoke as an evil reality. New ordinance protects people more.
- The Asian community has a lot of restaurant workers who smoke even in non-smoking restaurants. People don't believe that smoking is that bad. Where is the proof? Smoking is part of the culture.
- In the rural areas it is more acceptable for people to chew than smoke.

Overview of the Strategic Planning Process: Sheri Campbell and Carol Gelfer gave a presentation overview of the Strategic Planning Process and which components have been outlined by CDC, who is funding this process, by the Department of Human Services TPEP and what is within the purview of workgroup members. Please see handouts for further information.

Workgroup Roles and Responsibilities: Carol Gelfer outlined the roles of the Workgroup and facilitated a discussion about communication and future meetings. Decisions included:

- Please let facilitators know if you can't make a meeting or choose to leave the workgroup. The strategic planning process depends on monthly participation at meetings.
- The group elected not to have a workgroup chair at present, but may re-visit that option if needed.
- The group will use e-mail to communicate with each other and will receive correspondence from Sheri and Carol regarding meetings and updates via e-mail.
- **Meeting Schedule and location—The meetings will be held in the Portland/metro area. The meeting schedule is as follows:**
  - **June 5th 12-4:30 Location to be announced**
  - **July 15th 12-4:30 Location to be announced**
  - **August 21st-12-4:30 Location to be announced**
  - **September 12th- 12-4:30 Location to be announced**

Data Preview/ Discussion: Mike Stark, Manager of Program Design and Evaluation Services, presented the types of data available to the Workgroup to do their planning with. He followed the brief presentation with a discussion about what data Workgroup members would like to have at coming meetings. Data requested included:

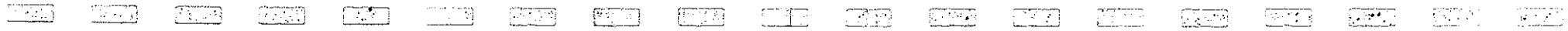
- Chewing tobacco rates-trends in rural areas
- Teenage girls younger than 18—Mike has 8th and 11th grade boys and girls prevalence rates

- Rates for disease by ethnicity
- On-going research information re: GLBT population
- Smoking by ethnicity age group and gender –difficult to obtain because of small numbers
- MDS encouraging cessation by ethnic group
- Trends for quit attempts –post/current/never
- Need subgroup data for API-currently it does not exist. Doesn't look from Data like it is a big problem, but it is.
- Occupational data-not available. Do have income level and exposure to ETS
- Info on barriers to quitting-not available by populations
- Tobacco sales info not that helpful because Oregon does not have a sales tax.
- Ethnic breakdown within low SES community. Who smokes?
- Who calls the Oregon Quitline by race?
- Youth Access by ethnicity—i.e.: family or friends
- Attitudes of adults about youth purchasing tobacco

In the course of brainstorming, several potential recommendations were suggested. These included:

- Don't forget to include other data sources not collected by the state i.e.: NARA, OHSU, etc.
- Look for role the group might play in advocating for change in how data collection is done.
- How one collects data impacts the results, particularly in minority communities—cultural considerations, access to technology for data collection, language barriers.

NEXT MEETING, WEDNESDAY, JUNE 5th, 12-4:30. Location TBD. LUNCH PROVIDED and EXPENSES REIMBURSED. See you there!



Appendix C

Meeting Notes
June 5, 2002

Present: Mary Boehme, DHS; Faye Burch, Pac/West;Sik Yin Chan, Portland Impact; Shannon Chrisman, Siletz Tribe; Nelia Collins, Asian Family Center; Cathryn Cushing; Janet Jones, Umatilla County Coalition Against Tobacco; Sayaka Kanade, NWPAIHB; Luci Longoria, DHS; Kerri Lopez, NARA; Gerry Odisio, DHS; Lorrie Piatt-Montry, APACSA; Gloria Muzquiz, OHDC German Nunez, OHSU; Kristen Rohde, DHS; Jackie Scott, Urban League; Judith Van Osdol, OMAP

Facilitators: Carol Gelfer and Sheri Campbell

Workgroup Milestones and timeline: Sheri Campbell reviewed the newly developed workgroup milestones and timeline charts. These charts will be reviewed and updated as the group moves through the strategic planning process to keep the group on task.

Building Consensus: Carol Gelfer led an interactive exercise pointing out the value of achieving consensus throughout the strategic planning process. The workgroup agreed on a method to reach consensus which they quickly practiced and perfected.
(The method involves holding up 1,2 or 3 fingers to show ones level of acceptance for a certain idea or proposal.)

Data Presentation: Mike Stark, Manager of the Program Design and Evaluation Services, DHS gave a comprehensive Oregon specific data presentation focusing on the following areas: Percentage of adults who smoke cigarettes, percentage who smoke in select subgroups, percentage of adult males who use smokeless tobacco, percentage of adults who smoke by ethnic group and age, percentage of adults who smoke by SES and Race/Ethnicity. Please see handouts of presentation for further information. A similar presentation focusing on youth data will be presented at the next meeting.

Data Critical Issues: Throughout Mike's presentation data critical issues were generated and recorded. (See the data critical issues handout for specific information.)

The Population Assessment: Sheri delivered a presentation on the population assessment which focuses on what is known about a certain population. The assessment, which can take many forms, identifies critical issues for the development of the strategic plan. It is especially important to conduct this type of assessment when there is inadequate quantitative data on a population group. A modified CDC population assessment tool was provided for use by workgroup participants. (See tool for more information on content) Various workgroup members agreed to do "homework" and complete the population assessments before the next meeting. The following communities/individuals will be assessed: Lesbians/Gay men, American Indian, Rural communities, OHP/Medicaid/AAPI, Blue Collar Workers, African Americans. Presentations will be given at the next meeting.

NEXT MEETING: Monday, July 15th, 12-4:30 pm at the American Heart Association, 1425 NE Irving St., Suite 100. See you there!!!

Appendix C

Meeting Notes
July 15th, 2002

Present: Mary Boehme, DHS; Faye Burch, Pac/West ;Sik Yin Chan, Portland Impact; Nelia Collins, Asian Family Center; Cathryn Cushing; Shannon Chrisman, Siletz Tribe; Janet Jones, Umatilla County Coalition Against Tobacco; Sayaka Kanade NWPAIHB; Phillip Knowlton, CAP; Luci Longoria, DHS; Kerri Lopez, NARA; Gerry Odisio, DHS; Lorrie Piatt-Montry, APACSA; Gloria Muzquiz, OHDC; German Nunez, OHSU; Kristen Rohde, Kurt Schweigmann, NARA; DHS; Jackie Scott, Urban League; Judith Van Osdol, OMAP

Facilitators: Carol Gelfer and Sheri Campbell

Update Timeline: Sheri reviewed the timeline chart, making adjustments as necessary. Overall, the project is very much on target with the required tasks.

Youth Data Presentation: Kristen Rohde from DHS presented the second part of the data presentation focusing on youth tobacco use. Most of the data presented was from the Oregon Healthy Teens Survey which is an anonymous, school based survey that provides schools, communities, and our state with yearly data on adolescent health and well being. (This replaces the YRBS and and Oregon Public Schools Drug Use Survey combining them into one research based survey.) Issues covered included percentage of youth who smoke, percentage of males who use smokeless tobacco, age of initiation, youth access by gender, youth access by density. (Data presentation attached) Throughout the presentation, critical issues were generated and recorded.

First Level Data Prioritization: Upon completing the data presentations workgroup members used the "dot method" to begin prioritizing the adult and youth data critical issues. The facilitators will provide the group with the initial results of the prioritization within one week via e-mail.

Population Assessment Presentations: The following workgroup members presented the findings from their population assessments. A written copy was provided to all workgroup members.

- Jackie Scott, African Americans
- Cathryn Cushing, Lesbian Women
- Phillip Knowlton, Gay Men
- Judith Van Osdol, Oregon Health Plan members/low SES
- Lorrie Piatt-Montry, AAPI
- Janet Jones, Rural males (chew tobacco)

During each presentation critical issues were generated. The issues will be e-mailed to all workgroup members before the next meeting.Next meeting the following population assessments will be presented: Native American and Blue Collar Workers.

Media Discussion: What Oregonians are Hearing and Seeing via the anti- tobacco paid media campaign: Faye Burch, contractor with Pac/ West Communications led a presentation focusing on the multi -ethnic media ads currently running in the state. Workgroup members were given the opportunity to ask questions about the campaign and other events that focus on ethnic communities in Oregon.

NEXT MEETING: AUGUST 21st, 2002, 12-5 pm at the American Heart Association, 1425 NE Irving St., Suite 100. See you there!!!!

Appendix C

Meeting Notes

August 21, 2002

Present: Mary Boehme, DHS; Faye Burch, Pac/West ; Nelia Collins, Asian Family Center; Shannon Chrisman, Siletz Tribe; Cathryn Cushing; Raheve Gray, Multnomah Co. Health Dept.; Janet Jones, Umatilla County Coalition Against Tobacco; Sayaka Kanade, NWPAIHB; Phillip Knowlton, CAP; Luci Longoria, DHS; Kerri Lopez, NARA; Gerry Odisio, DHS; Lorrie Piatt-Montry, APACSA; German Nunez, OHSU; Kristen Rohde, DHS; Jackie Scott, Kurt Schweigmann, NARA, Urban League; Judith Van Osdol, OMAP

Facilitators: Carol Gelfer and Sheri Campbell

Review workgroup Purpose/strategic plan: The group reviewed the key principals of the strategic planning process. Questions that were raised last meeting regarding the process for prioritization of critical issues were addressed.

Population Assessments: The remaining population assessment presentations were given:

- Kerri Lopez, Sayaka Kanade- Native American
- Faye Burch, Blue Collar Workers

During each presentation critical issues were generated.

Brainstorm/update/review critical issues: Critical issues from the population assessments, and data presentations were reviewed. Some critical issues had been re-categorized as strategies and moved off the main critical issues list.

SWOT Analysis: The following issues were covered: definition of a SWOT analysis, conducting a SWOT analysis, creation of a SWOT analysis and generation of critical issues.(SWOT analysis attached)

Prioritization of Critical Issues: Twenty Eight critical issues from the population assessments, SWOT analysis and Data presentation were presented to the group for prioritization down to 6 issues . The workgroup formed 2 smaller groups and compared each critical issue against 4 criteria; attention, impact, feasibility and time frame (assessment criteria definitions attached). After much deliberation each group culled the list down to between 8-10 critical issues. The lists from each small group were compared to see which issues appeared on both lists. After much discussion the group decided on 9 issues. The workgroup asked the facilitators to combine two of the issues to further reduce the list and also re-write the issues into goal statements for the next meeting.

Mid-Term Evaluation- Sheri distributed a mid-term evaluation for workgroup members to fill out and return by e-mail.

NEXT MEETING: September 23, 2002, 12-5 pm, American Heart Association. See you there!

Appendix C

Meeting Notes

September 23, 2002

Present: Mary Boehme, DHS; Nelia Collins, Asian Family Center; Cathryn Cushing; Shannon Chrisman, Siletz Tribe; Raheve Gray, Multnomah Co. Health Dept.; Janet Jones, Umatilla County Coalition Against Tobacco; Sayaka Kanade, NWPAIHB; Luci Longoria, DHS; Kerri Lopez, NARA; Gloria Muzquiz, OHDC; Gerry Odisio, DHS; Lorrie Piatt-Montry, OHDC; APACSA; Kristen Rohde, DHS; Jackie Scott, Urban League; Kurt Schweigmann, NARA; Judith Van Osdol, OMAP

Facilitators: Carol Gelfer and Sheri Campbell

Workgroup Introductions

Review upcoming meetings and changes: There will not be a workgroup meeting in October. The next scheduled meeting is November 4th. Gerry Odisio has accepted a position with Multnomah County. This will be her last workgroup meeting.

Review of Critical Issues: The critical issues which were selected as goals from the last meeting were re-worked into goal statements (in between meetings) and distributed to the workgroup. The workgroup members reviewed and discussed each of the 9 goal statements. After much dialogue the group voted to combine some of the goal statements and reduce the number of goals to 6 primary goal statements. (Goal statements attached)

Selecting strategies for goal statements: The workgroup voted to work as one group vs. dividing into small groups to select strategies for each of the 6 goal statements. The workgroup had just enough time to identify strategies for 4 of the goals. Carol, Sheri and Gerry will develop strategies for the remaining 2 goals and will e-mail them to the group for comments prior to the next meeting. (Strategies for goals attached)

NEXTMEETING: Monday, November 4th, 12-5 pm, American Heart Association, 1425 NE Irving St., Suite 100. See you there!

Appendix C

Meeting Notes

November 4, 2002

Present: Mary Boehme, DHS; Cathryn Cushing; Nelia Collins, Asian Family Center; Raheve Gray, Multnomah Co. Health Dept.; Janet Jones, Umatilla County Coalition Against Tobacco; Luci Longoria, DHS; Sharon Lucas, OHDC; Jorge Martinez, OHDC; Gloria Muzquiz, OHDC; German Nunez, OHSU; Ken McGee, DHS; Lorrie Piatt-Montry, APACSA; Kristen Rohde, DHS; Kurt Schweigmann, NARA, Urban League; Judith Van Osdol, OMAP

Facilitators: Carol Gelfer and Sheri Campbell

Discuss and Adopt Strategies: The workgroup approved the final strategies that Carol, Gerry and Sheri developed after the last workgroup meeting. Each of the 6 goal statements now have approved strategies for inclusion in the strategic plan.

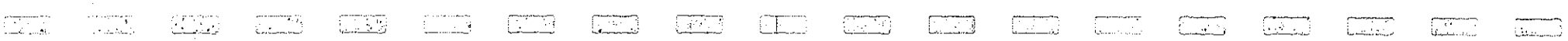
Feedback on strategic plan draft documents: Each workgroup member received a copy of the draft executive summary and strategic plan document via e-mail before this meeting. Workgroup members were first given an opportunity to give feedback prior to this meeting via e-mail and/or offer final suggestions at the meeting. In addition to the written summary, 2 graphs were presented that are being considered for the executive summary. Members gave extensive feedback regarding the graphs, wording, tone and writing style of the document. More time was spent reviewing the executive summary as the timeline for completion is shorter. Sheri introduced Lien Vu who has been hired to work on the graphic design of the document. Lien solicited comments from the group as well.

Monitoring and Evaluating the plan: Kristen Rohde from DHS explained the evaluation component that she is developing to be included in the strategic plan.
Ken McGee, Manager of the DHS, Tobacco Prevention and Education Program discussed on-going roles for workgroup members. He expressed his hope that workgroup members continue to stay involved and evaluate this process and plan although the exact method for that to happen is unknown at this time.

Marketing the Plan: Mary Boehme from DHS gave a brief overview of marketing principles. Various handouts were distributed from the National training in August.

Marketing the plan presentation: A presentation by the workgroup marketing the strategic plan is scheduled for December 12, 2-3 pm., Executives from the Dept. of Health Services.
Plan to attend. The group assigned roles for the presentation and discussed the appropriate content and tone. Cathryn Cushing who is doing the wrap up will e-mail the group a copy of her "speech" before the 12th.

FINAL WORKGROUP MEETING and CELEBRATION December 12, 2002 1-4 pm, American Heart Association, 1425 NE Irving St.



Appendix D

Data Requests from First Disparities Meeting (4/24/02)
Divided into 2 Presentations

Presentation 1

1. Percentage of adults who smoke cigarettes
   - By race/ethnicity
   - By gender
   - By population density
   - By age
   - By SES
   - By Medicaid status
   - For GLBT
   - For disabled
   - For mentally ill

2. Percentage of adult smokers in select subgroups

3. Percentage of adult males who use smokeless tobacco
   - By race/ethnicity
   - By population density
   - By age
   - by SES

4. Percentage of adults who smoke by age and gender
   - for race/ethnicity
   - for SES

5. Percentage of adults who smoke by SES and race/ethnicity

6. Trends in smoking & SLT prevalence
   - By race/ethnicity
   - By gender (smoking only)
   - By age
   - By SES
   - For child-bearing women (smoking only)

7. Tobacco-related disease statistics by race/ethnicity

Behavioral Risk Factor Surveillance System

The Oregon Behavior Risk Factor Surveillance System (BRFSS) is an ongoing random-digit dialed telephone survey of adults concerning health-related behaviors. The BRFSS was developed by the Centers for Disease Control and Prevention (CDC) and is conducted in all states in the U.S. Each year, between 3,000 and 7,000 adult Oregonians are interviewed. In 2001, of those contacted, 56% agreed to complete the interview. The BRFSS includes questions on health behavior risk factors such as seat belt use, diet, weight control, tobacco and alcohol use, physical exercise, preventive health screenings, and use of preventive and other health care services. The data are weighted to represent all adults aged 18 years and older.

The data presented below by race/ethnicity are from a special combined 2000 and 2001 file that includes additional surveys from an oversample of African Americans, American Indians/Alaskan Natives, and Asian/Pacific Islanders. The oversampling was conducted to obtain at least 350 surveys for each racial/ethnic group. The data by race/ethnicity are not weighted because of the smaller number of surveys in each group.

DRAFT - Preliminary Data

Percentage of Adults who Smoke Cigarettes, Oregon 2001

	N	%	95% Confidence Interval
African American*	295	27	21.7 - 31.9
American Indian/Alaskan Native*	358	41	35.9 - 46.2
Asian/Pacific Islander*	478	16	12.2 - 18.7
Hispanic*	1308	17	15.0 - 19.1
Non-Hispanic White*	12226	21	19.7 - 21.2
Female	3653	19.3	17.9 - 20.7
Male	2660	21.9	20.2 - 23.6
< 100 persons/sq. mile	1529	20.6	18.4-22.8
100-499 persons/sq. mile	1508	21.6	19.4-23.8
500-2499 persons/sq. mile	1524	20.2	18.0-22.5
2500+ persons/sq. mile	1577	19.4	17.2-21.6
18-24 year olds	598	30.2	26.1 - 34.3
25-64 year olds	4560	22.1	20.8 - 23.4
65+ year olds	1135	8.4	6.8 - 10.1
Low SES**	1269	36.0	33.0 - 39.0
Not low SES	3291	16.9	15.5 - 18.2
Medicaid***	?	37.0	29.3-44.7
Physically Disability****	463	22.7	18.4-27.0
Mentally Ill****	59	35.4	21.9-49.0
No Disability****	2588	19.3	17.5-21.0
GLBT	?		

*Race/ethnicity estimates based on 2000 and 2001 data combined

** A respondent is categorized as being in the low-SES target group if:
did not graduate from high school or obtain GED,
annual household income is $25,000 or less,
on Medicaid, or
no health insurance.

But, respondent is excluded from group if income is greater than $50,000 or if college graduate.
Analysis limited to 25-64 year olds.

***CAHPS data

****Year 2000 data

Percentage of Adult Smokers in Select Subgroups, Oregon 2001

	% who smoke	% of all smokers	# of persons
African American*	27	2	10,600
American Indian/Alaskan Native*	41	4	21,200
Asian/Pacific Islander*	16	3	15,900
Hispanic*	17	7	37,100
Non-Hispanic White*	21	87	461,100
Female	19.3	48.3	255,990
Male	21.9	51.7	274,010
< 100 persons/sq. mile	20.6	25.3	134,090
100-499 persons/sq. mile	21.6	24.5	129,850
500-2499 persons/sq. mile	20.2	24.9	131,970
2500+ persons/sq. mile	19.4	25.3	134,090
18-24 year olds	30.2	17.3	91,690
25-64 year olds	22.1	75.3	399,090
65+ year olds	8.4	7.4	39,220
Low SES**	36.0	44.5	235,850
Not low SES	16.9	55.5	294,150

*Race/ethnicity estimates based on 2000 and 2001 data combined

** A respondent is categorized as being in the low-SES target group if:
did not graduate from high school or obtain GED,
annual household income is $25,000 or less,
on Medicaid, or
no health insurance.

But, respondent is excluded from group if income is greater than $50,000 or if college graduate.
Analysis limited to 25-64 year olds.

Percentage of Adult Males who Use Smokeless Tobacco, Oregon 2001

	N	%	95% C.I.
African American*	120	1	0 - 2.5
American Indian/Alaskan Native*	155	10	5.5 - 15.2
Asian/Pacific Islander*	216	2	0.1 - 3.7
Hispanic*	595	2	0.6 - 2.7
Non-Hispanic White*	4901	5	4.5 - 5.7
< 100 persons/sq. mile	398	9.8	6.6-13.0
100-499 persons/sq. mile	364	6.8	4.3-9.3
500-2499 persons/sq. mile	378	4.6	2.2-7.0
2500+ persons/sq. mile	411	2.8	1.0-4.7
18-24 year olds	181	9.3	4.6 - 14.0
25-64 year olds	1192	6.4	4.9 - 7.9
65+ year olds	235	1.3	0 - 2.8
Low SES**	296	7.5	4.4 - 10.6
Not low SES	896	6.0	4.3 - 7.7

*Race/ethnicity estimates based on 2000 and 2001 data combined

** A respondent is categorized as being in the low-SES target group if:
did not graduate from high school or obtain GED,
annual household income is $25,000 or less,
on Medicaid, or
no health insurance.

But, respondent is excluded from group if income is greater than $50,000 or if college graduate.
Analysis limited to 25-64 year olds.

Percentage of African Americans who Smoke by Age, 2000-2001

	N	%	95% C.I.
18-24	43	35	20.0-49.7
25-64	216	28	21.8-33.8
65+	35	//	//

Percentage of African Americans who Smoke by Gender, 2000-2001

	N	%	95% C.I.
Male	122	24	16.1-31.4
Female	173	29	22.1-35.7

Percentage of American Indians/Alaskan Natives who Smoke by Age, 2000-2001

	N	%	95% C.I.
18-24	48	33	19.5-47.2
25-64	282	43	37.4-49.1
65+	27	//	//

Percentage of American Indians/Alaskan Natives who Smoke by Gender, Oregon 2000-2001

	N	%	95% C.I.
Male	154	40	32.4-48.1
Female	204	42	34.8-48.5

Percentage of Asian/Pacific Islanders who Smoke by Age, Oregon 2000-2001

	N	%	95% C.I.
18-24	82	23	13.8-32.5
25-64	373	15	10.9-18.1
65+	15	//	//

Percentage of Asian/Pacific Islanders who Smoke by Gender, Oregon 2000-2001

	N	%	95% C.I.
Male	222	19	13.7-24.1
Female	256	13	8.4-16.6

Percentage of Hispanics who Smoke by Age, Oregon 2000-2001

	N	%	95% C.I.
18-24	246	22	16.4-26.7
25-64	1012	16	13.9-18.5
65+	48	13	2.8-22.2

Percentage of Hispanics who Smoke by Gender, Oregon 2000-2001

	N	%	95% C.I.
Male	629	22	18.9-25.4
Female	679	12	9.9-14.9

Percentage of Non-Hispanic Whites who Smoke by Age, Oregon 2000-2001

	N	%	95% C.I.
18-24	987	32	28.7-34.5
25-64	8816	22	21.4-23.1
65+	2366	9	7.8-10.1

Percentage of Non-Hispanic Whites who Smoke by Gender, Oregon 2000-2001

	N	%	95% C.I.
Male	4902	22	20.5-22.8
Female	7267	20	18.7-20.5

Percentage of Adults of Low SES who Smoke by Age and Gender, Oregon 2001

	Male	95% C.I.	Female	95% C.I.
25-64	35.7	31.1 - 40.4	36.2	32.5 - 40.0

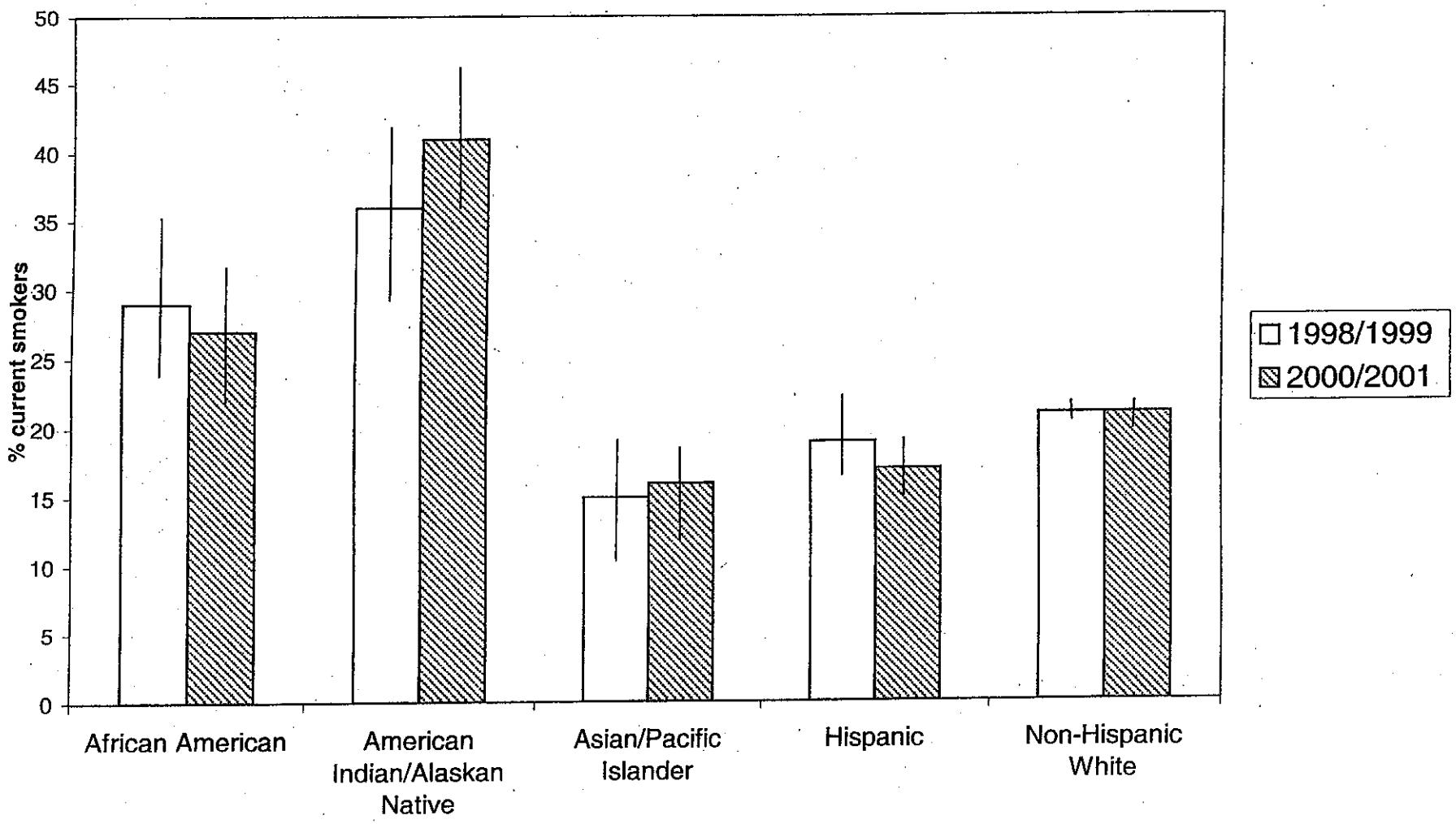
DRAFT - Preliminary Data

Percentage of Adults who Smoke by SES and Race/Ethnicity, Oregon 2000-2001

		N	*%*	*95% C.I.*
Low SES	African American	91	43	32.5-53.2
	American Indian/Alaskan Native	141	51	42.7-59.4
	Asian/Pacific Islander	57	32	19.1-44.0
	Hispanic	687	17	13.8-19.4
	Non-Hispanic White	2077	42	39.4-43.7

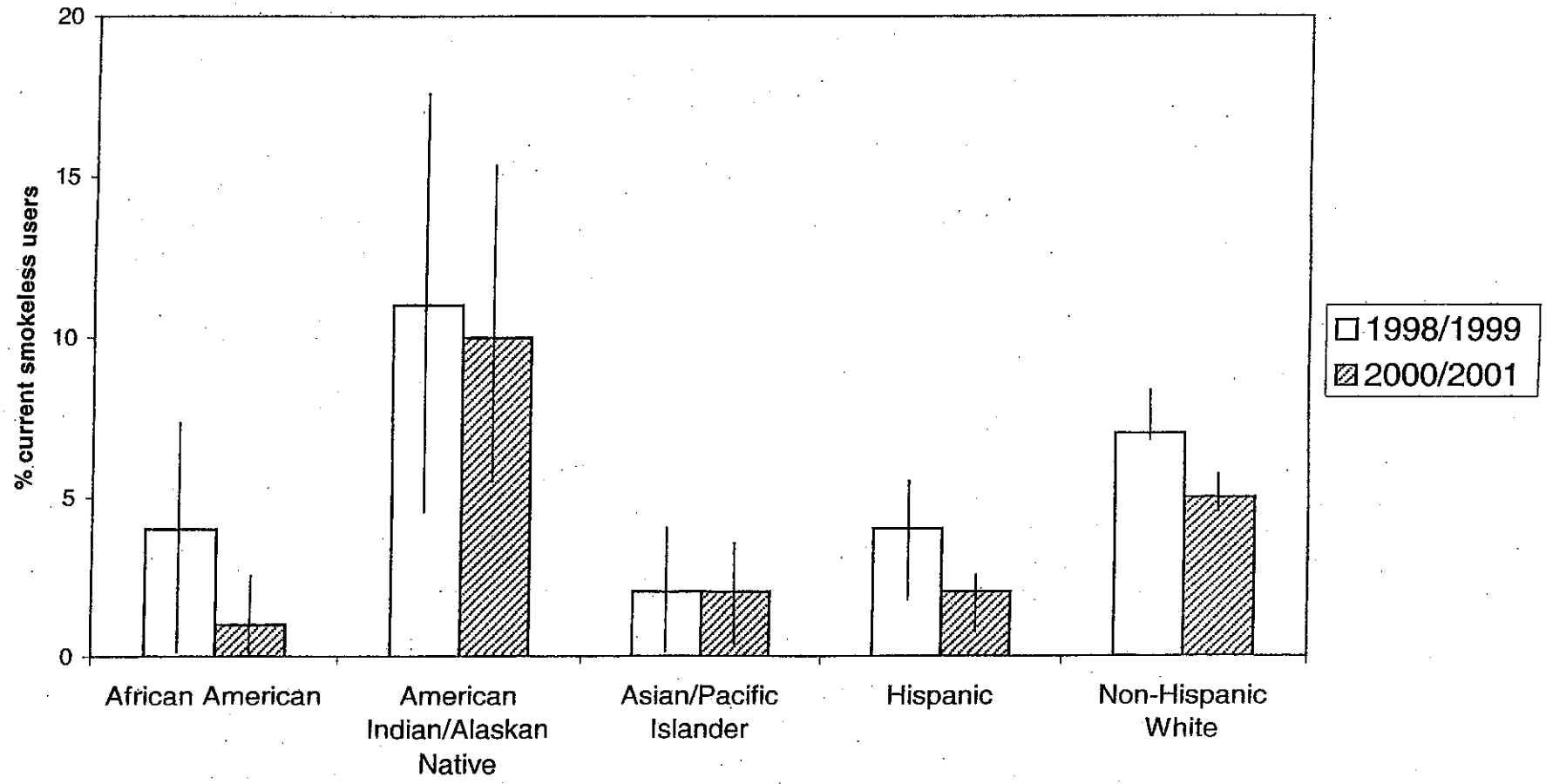
		N	*%*	*95% C.I.*
Not Low SES	African American	125	17	10.2-23.5
	American Indian/Alaskan Native	141	36	27.5-43.5
	Asian/Pacific Islander	312	12	8.0-15.1
	Hispanic	311	15	11.4-19.5
	Non-Hispanic White	6739	16	15.4-17.2

Percentage of Adults who Smoke by Race/Ethnicity and Year, Oregon 1998-2001



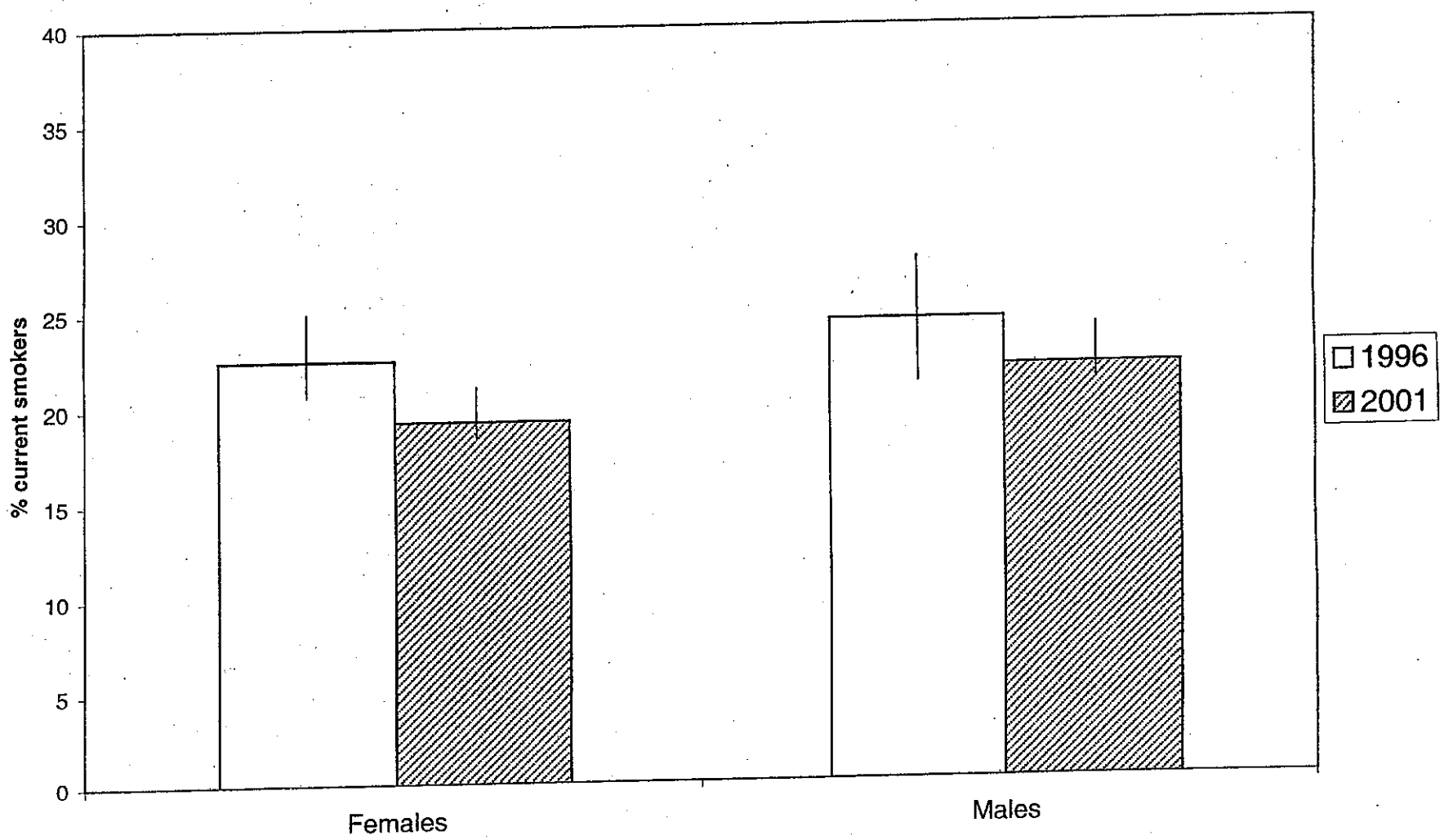
Source: BRFSS
DRAFT - Preliminary Data

Percentage of Adult Males who Use Smokeless Tobacco by Race/Ethnicity and Year, Oregon 1998-2001



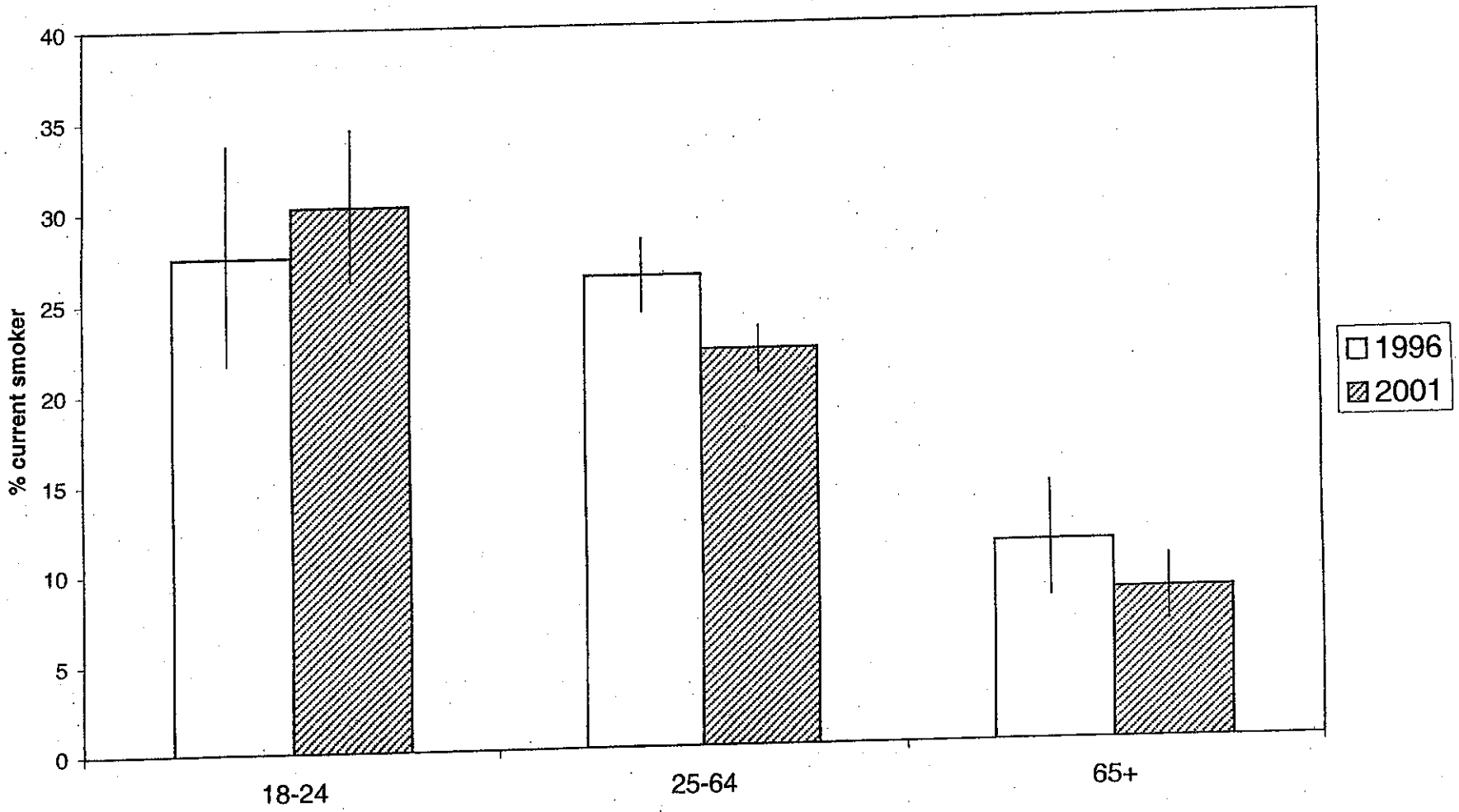
Source: BRFSS
DRAFT - Preliminary Data

Percentage of Adults who Smoke by Gender and Year, Oregon 1996-2001



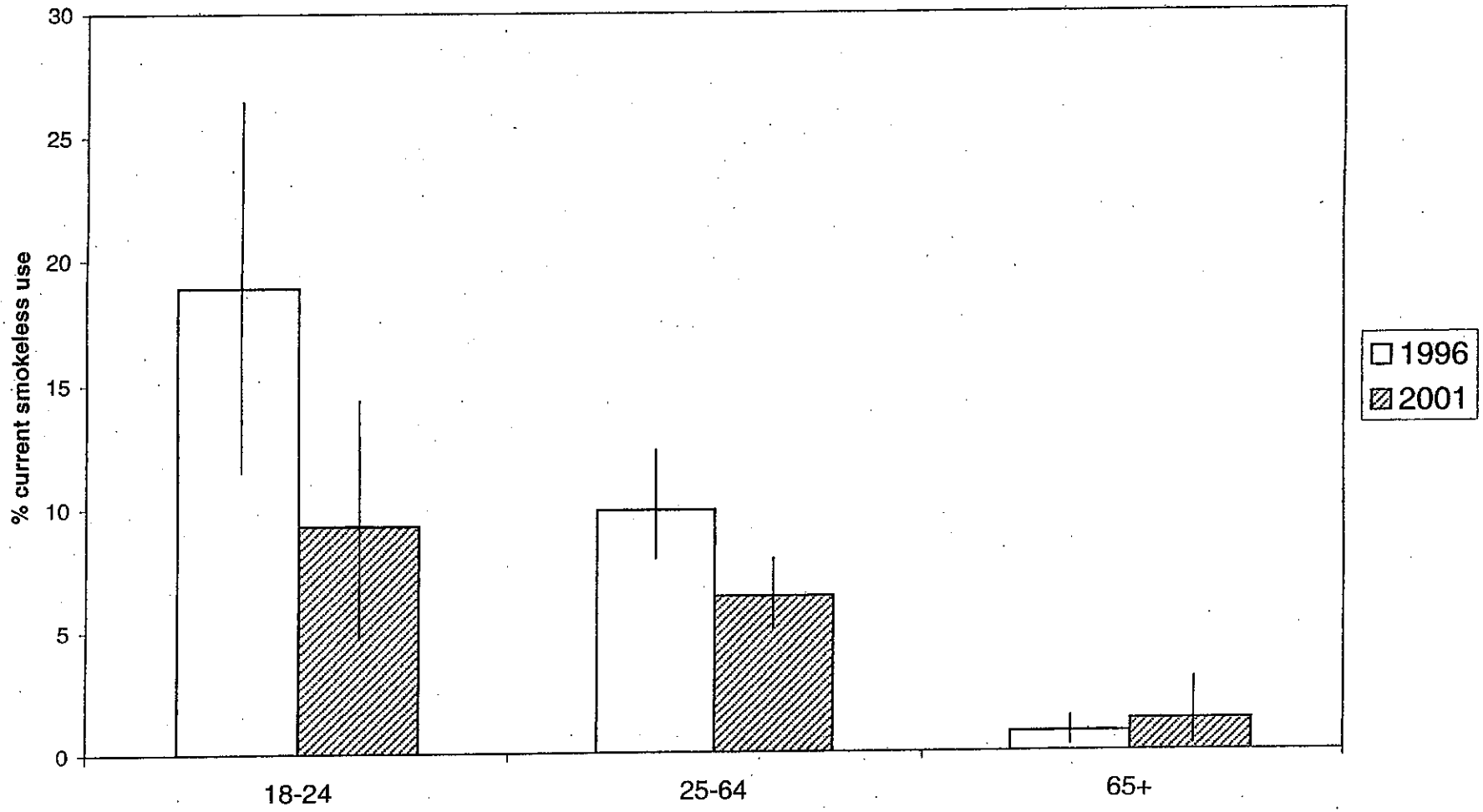
Source: BRFSS
DRAFT - Preliminary Data

Percentage of Adults who Smoke by Age and Year, Oregon 1996-2001



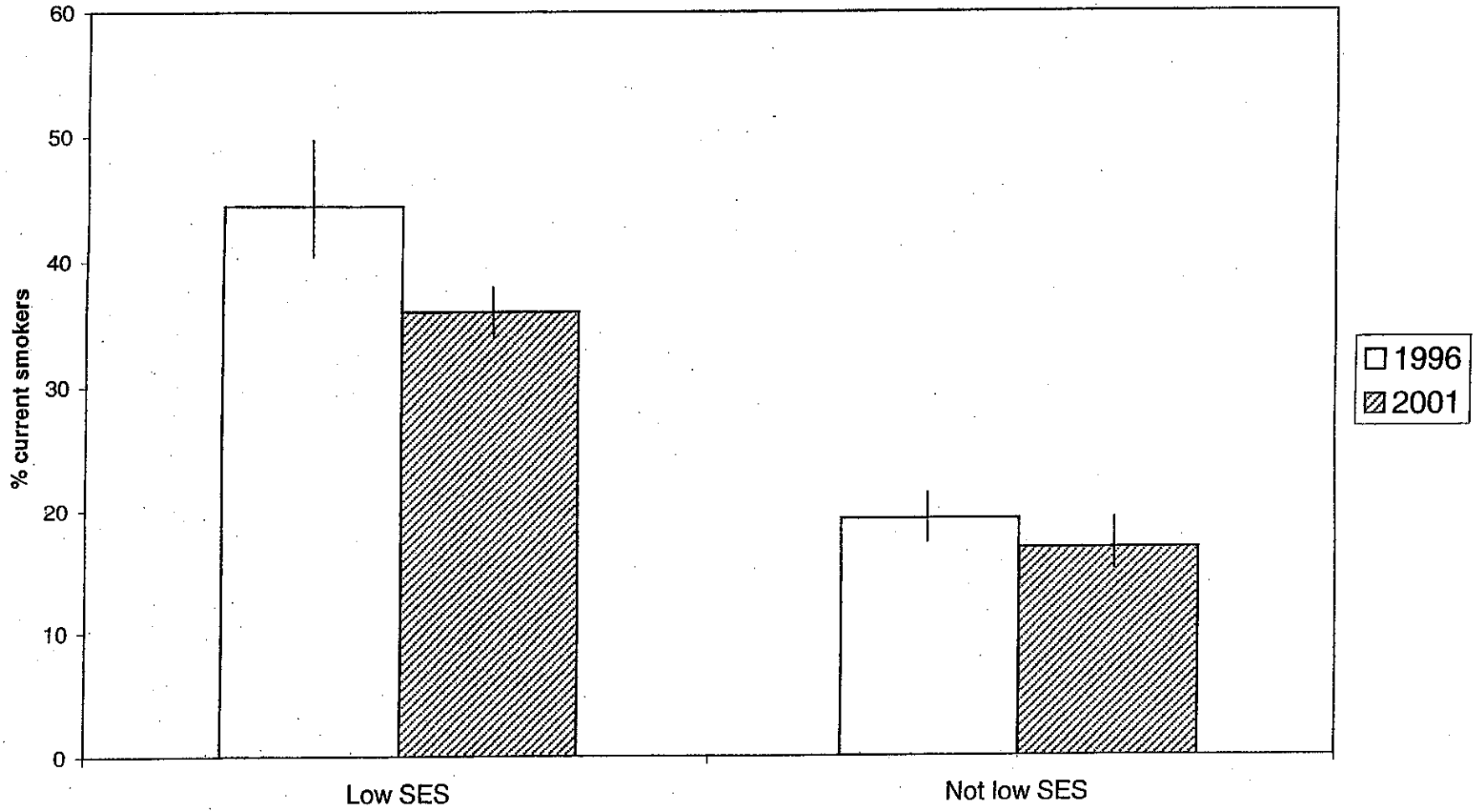
Source: BRFSS
DRAFT - Preliminary Data

Percentage of Adult Males who Use Smokeless Tobacco by Age and Year, Oregon 1996-2001



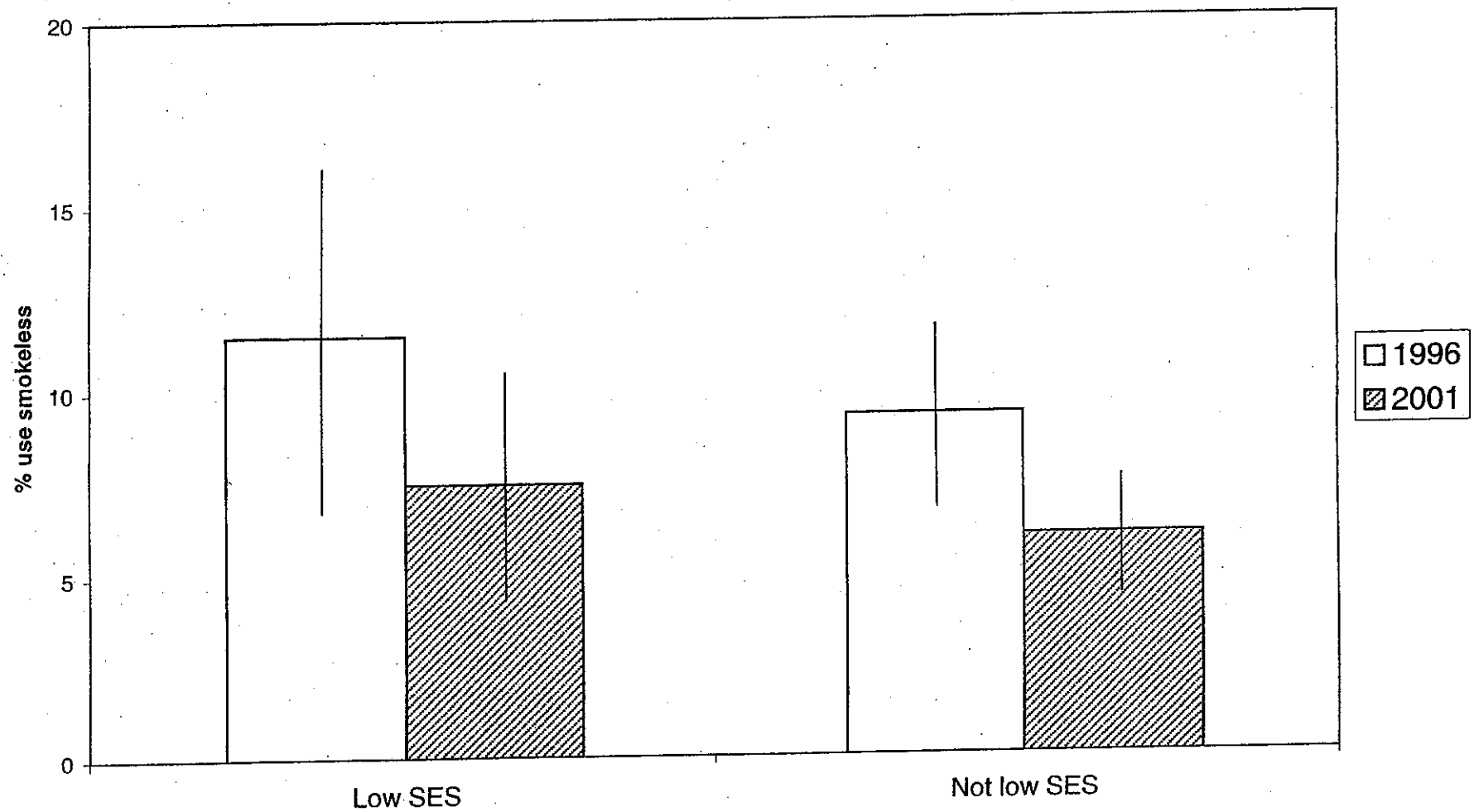
Source: BRFSS
DRAFT - Preliminary Data

Percentage of Adults who Smoke by SES and Year, Oregon 1996-2001



Source: BRFSS
DRAFT - Preliminary Data

Percentage of Adult Males who Use Smokeless Tobacco by SES and Year, Oregon 1996-2001

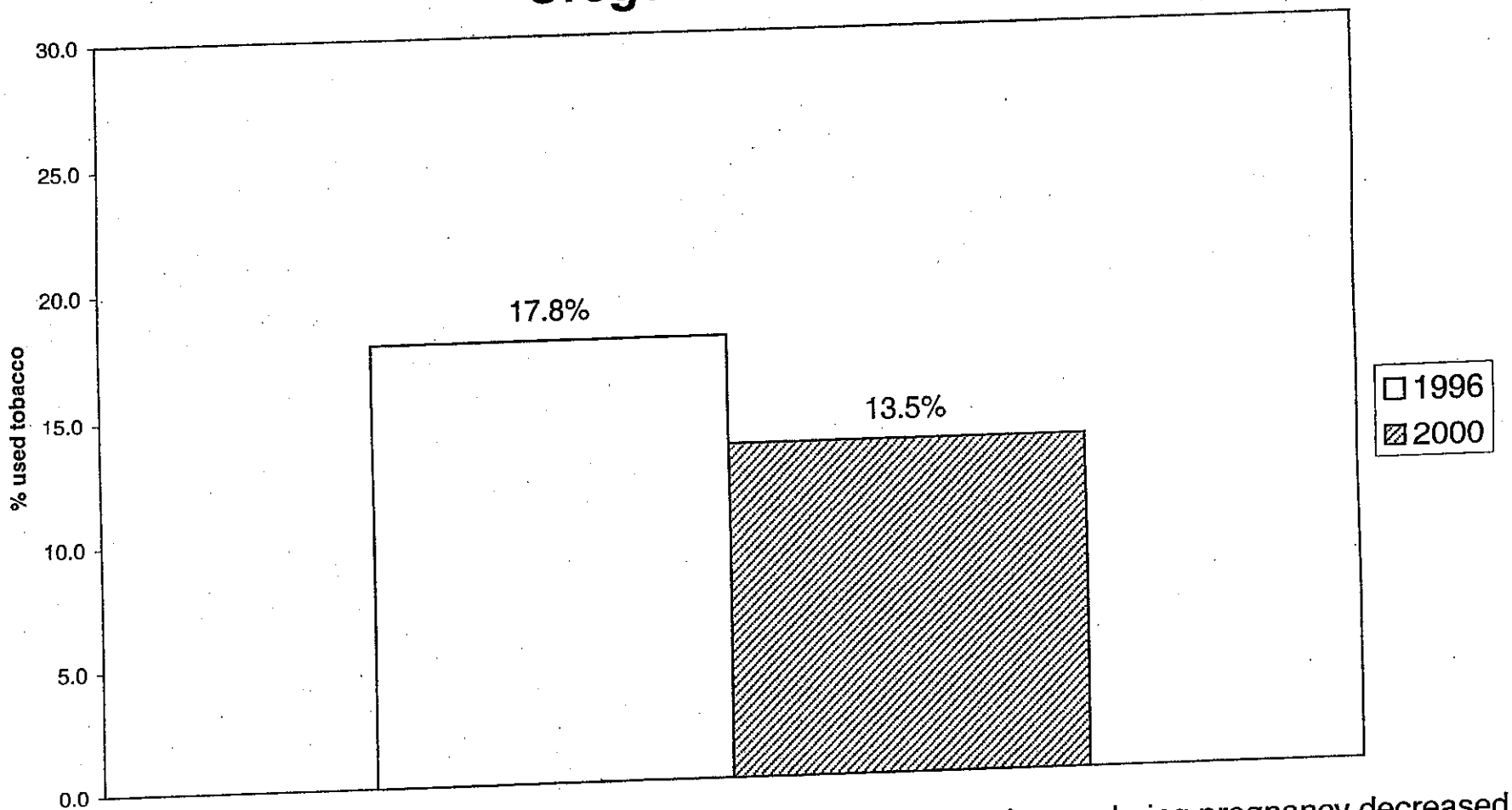


Source: BRFSS
DRAFT - Preliminary Data

Birth Certificate Statistical File

Data from the Birth Certificate Statistical File are coded from birth certificates collected by the State Registrar and represent all births occurring in Oregon and all births occurring out-of-state to Oregon residents. This database includes parental identifying and demographic information, conditions of the newborn, congenital anomalies, medical factors of pregnancy, method of delivery, complications of labor and delivery, smoking, drinking, or illicit drug use during pregnancy, antenatal and intrapartum procedures, and payor source. The birth data analyzed for this report consist of births to Oregon residents and exclude missing and unknown values.

Percentage of Child-Bearing Women who Used Tobacco During Pregnancy by Year, Oregon 1996-2000



From 1996 to 2000, the percentage of child-bearing women who used tobacco during pregnancy decreased 24% (from 17.8% to 13.5%)

Source: Oregon Birth Certificate Statistical File

Death Certificate Statistical File

The Death Certificate Statistical File includes all deaths occurring in Oregon and deaths occurring out-of-state to Oregon residents. Data are obtained from death certificates that are collected by the State Registrar. The data are used to examine trends in mortality and causes of death. Variables in this database include cause of death, decedent's identifying information, date and place of death, occupation of the decedent, whether the death was related to tobacco use, education of decedent, marital status of decedent, and county, place, and date of injury (if applicable). The mortality data analyzed for this report consist of deaths of Oregon residents.

Tobacco-Related Deaths by Race/Ethnicity, Oregon 1999

	Number	% of all deaths
African American	82	23%
American Indian	62	29%
Asian/Pacific Islander	32	12%
Hispanic	45	11%
Non-Hispanic White	6295	23%

Available Data

1. Quit intention and quit behavior
   - By race/ethnicity
   - By gender
   - By population density
   - By age
   - By SES

2. Trends in Ask, Advise, Assist
   - By race/ethnicity
   - By gender
   - By population density
   - By age
   - By SES
   - By Medicaid status

3. Barriers to quitting by race/ethnicity: plan to look at % uninsured, % who have policy that covers cessation assistance, % who think assistance would be somewhat/very helpful

4. Smoking bans in the home
   - By race/ethnicity
   - By gender
   - By population density
   - By age
   - By SES
   - By Medicaid status

5. Adult attitudes about smoking bans by race/ethnicity and rural vs. urban

6. Adult smoking prevalence by population density, age, and sex

7. Calls to Quitline by race/ethnicity

8. Calls to Quitline in response to specific ads by race/ethnicity

9. Calls to Quitline by county

10. Information on tobacco use among persons in various occupations (other studies/reports)

11. Summary information from Pac-West on their GLBT focus groups

12. Internet links to existing data sources

Presentation 2

1. Youth smoking prevalence by gender: plan to present 8th & 11th grade smoking & SLT prevalence
    - by race/ethnicity
    - by gender
    - by population density

2. Youth age of initiation by gender: plan to present 8th & 11th grade smoking initiation
    - by race/ethnicity
    - by gender
    - by population density

3. Youth access to tobacco by race/ethnicity: plan to present where 8th graders got cigarettes
    - by race/ethnicity
    - by gender
    - by population density

4. Adult attitudes about the importance of limiting youth access by race/ethnicity and population density

Oregon Healthy Teens Survey

The Oregon Health Teens Survey (OHT) is an anonymous, school-based survey that provides schools, communities, and our state with yearly data on adolescent health and well-being. The OHT survey replaces the Youth Risk Behavior Survey (YRBS) and the Oregon Public Schools Drug Use Survey combining them into one, research-based survey. The OHT survey collects data on 6th, 8th, and 11th graders from a representative sample of Oregon middle and high schools. In 2001, the OHT survey provided data on over 11,000 8th graders and 7,500 11th graders from 79 high schools and their 91 feeder middle schools, in 33 counties. The modular survey design allows each respondent to take the demographics section and three other randomly assigned sections from the following areas: (1) Alcohol and other drug use, (2) tobacco use and prevention programs, (3) personal safety and violence-related behaviors, (4) diet, exercise and sexual activity, (5) community and family, (6) individual and peer risk and protective factors.

Preliminary Data

Percentage of Youth who Smoke Cigarettes, Oregon 2001

	N	*%*	*95% Confidence Interval*
8th Graders			
African American	103	17.3	3.6-30.9
American Indian/Alaskan Native	122	18.3	12.7-24.0
Asian/Pacific Islander	191	7.3	1.9-12.6
Hispanic	576	10.4	7.6-13.1
Non-Hispanic White	4118	12.3	10.7-14.0
Female	2570	12.1	9.4-14.9
Male	2403	11.9	10.4-13.5
< 100 persons/sq. mile	1489	14.5	12.5-16.4
100-499 persons/sq. mile	1683	11.4	8.9-14.0
500-2499 persons/sq. mile	1009	12.0	10.0-13.9
2500+ persons/sq. mile	720	9.9	8.7-11.1
11th Graders			
African American	45	//	//
American Indian/Alaskan Native	58	35.3	18.9-51.6
Asian/Pacific Islander	135	17.1	9.6-24.7
Hispanic	344	13.8	7.7-19.8
Non-Hispanic White	3156	19.8	16.6-23.0
Female	1801	20.4	16.9-23.9
Male	1756	18.9	16.1-21.7
< 100 persons/sq. mile	1366	23.0	18.9-27.2
100-499 persons/sq. mile	902	18.7	14.9-22.5
500-2499 persons/sq. mile	791	16.8	12.6-20.9
2500+ persons/sq. mile	430	20.3	14.4-26.2

*Percentage of **Males** who Use Smokeless Tobacco, Oregon 2001*

	N	*%*	*95% C.I.*
11th Graders			
African American	30	//	//
American Indian/Alaskan Native	25	//	//
Asian/Pacific Islander	67	9.1	1.3-16.9
Hispanic	159	3.2	//
Non-Hispanic White	1422	9.2	5.6-12.8
< 100 persons/sq. mile	503	14.7	9.6-19.8
100-499 persons/sq. mile	613	10.3	7.5-13.2
500-2499 persons/sq. mile	377	4.2	1.6-6.9
2500+ persons/sq. mile	183	3.4	2.2-4.6

DRAFT - Preliminary Data

Percentage of Adult Smokers in Select Subgroups, Oregon 2001

	% who smoke	% of all smokers	# of persons
African American*	27	2	10,600
American Indian/Alaskan Native*	41	4	21,200
Asian/Pacific Islander*	16	3	15,900
Hispanic*	17	7	37,100
Non-Hispanic White*	21	87	461,100
Female	19.3	48.3	255,990
Male	21.9	51.7	274,010
< 100 persons/sq. mile	20.6	25.3	134,090
100-499 persons/sq. mile	21.6	24.5	129,850
500-2499 persons/sq. mile	20.2	24.9	131,970
2500+ persons/sq. mile	19.4	25.3	134,090
18-24 year olds	30.2	17.3	91,690
25-64 year olds	22.1	75.3	399,090
65+ year olds	8.4	7.4	39,220
Low SES**	36.0	44.5	235,850
Not low SES	16.9	55.5	294,150

*Race/ethnicity estimates based on 2000 and 2001 data combined

** A respondent is categorized as being in the low-SES target group if:
did not graduate from high school or obtain GED,
annual household income is $25,000 or less,
on Medicaid, or
no health insurance.

But, respondent is excluded from group if income is greater than $50,000 or if college graduate.
Analysis limited to 25-64 year olds.

DRAFT - Preliminary Data

Percentage of Adults who Smoke Cigarettes, Oregon 2001

	N	%	95% Confidence Interval
African American*	295	27	21.7 - 31.9
American Indian/Alaskan Native*	358	41	35.9 - 46.2
Asian/Pacific Islander*	478	16	12.2 - 18.7
Hispanic*	1308	17	15.0 - 19.1
Non-Hispanic White*	12226	21	19.7 - 21.2
Female	3653	19.3	17.9 - 20.7
Male	2660	21.9	20.2 - 23.6
< 100 persons/sq. mile	1529	20.6	18.4-22.8
100-499 persons/sq. mile	1508	21.6	19.4-23.8
500-2499 persons/sq. mile	1524	20.2	18.0-22.5
2500+ persons/sq. mile	1577	19.4	17.2-21.6
18-24 year olds	598	30.2	26.1 - 34.3
25-64 year olds	4560	22.1	20.8 - 23.4
65+ year olds	1135	8.4	6.8 - 10.1
Low SES**	1269	36.0	33.0 - 39.0
Not low SES	3291	16.9	15.5 - 18.2
Medicaid***	?	37.0	29.3-44.7
Physically Disability****	463	22.7	18.4-27.0
Mentally Ill****	59	35.4	21.9-49.0
No Disability****	2588	19.3	17.5-21.0
GLBT	?		

*Race/ethnicity estimates based on 2000 and 2001 data combined

** A respondent is categorized as being in the low-SES target group if:
did not graduate from high school or obtain GED,
annual household income is $25,000 or less,
on Medicaid, or
no health insurance.
But, respondent is excluded from group if income is greater than $50,000 or if college graduate.
Analysis limited to 25-64 year olds.

***CAHPS data

****Year 2000 data

Preliminary Data

Age of Smoking Initiation, Oregon 2001
How old were you when you first smoked a whole cigarette?
(Amongst all respondents who have ever smoked a cigarette)

	N	*% 12 years or younger*	*95% C.I.*
11th Graders			
African American	18	//	//
American Indian/Alaskan Native	34	//	//
Asian/Pacific Islander	60	34.5	20.8-48.2
Hispanic	164	48.5	32.9-64.1
Non-Hispanic White	1425	42.9	40.1-45.8
Female	845	43.4	38.4-48.5
Male	785	46.6	43.1-50.1
< 100 persons/sq. mile	594	51.5	45.1-57.9
100-499 persons/sq. mile	617	42.0	36.4-47.5
500-2499 persons/sq. mile	328	39.9	36.8-42.9
2500+ persons/sq. mile	174	44.5	37.2-51.9

Age of Smoking Initiation, Oregon 2001
How old were you when you first smoked a whole cigarette?
(Amongst Current Smokers Only)

	N	*% 12 years or younger*	*95% C.I.*
11th Graders			
Female	366	50.9	42.4-59.4
Male	324	43.3	35.3-51.2
< 100 persons/sq. mile	267	59.5	50.9-68.0
100-499 persons/sq. mile	245	43.2	32.8-53.5
500-2499 persons/sq. mile	135	40.2	36.2-44.2
2500+ persons/sq. mile	71	41.2	35.4-47.0

Youth Access to Tobacco by Gender, Oregon 2001
During the past 30 days, how many times did you get tobacco from each of the following?

	% 1+ times Male	% 1+ times Female
(Amongst current 8th grade smokers)*		
convenience store	26.8	22.1
drug store	18.3	4.8
grocery store	25.4	18.3
gas station	30.7	23.5
friends under 18	75.3	85.1
friends 18 or older	68.5	80.6
from home w/o permission	51.4	38.5
parent	29.3	29.1
sibling	28.2	31.7
people selling on street	24.3	14.7
vending machine	21.1	4.9
internet	8.6	1.9
(Amongst current 11th grade smokers)**		
convenience store	40.9	41.9
drug store	4.3	4.0
grocery store	32.2	25.2
gas station	51.7	46.5
friends under 18	62.5	64.5
friends 18 or older	84.2	85.3
from home w/o permission	16.2	5.9
parent	15.4	22.5
sibling	16.2	31.4
people selling on street	6.0	2.0
vending machine	4.2	1.0
internet	1.7	0.0

* The number of respondents ranged between 80 and 84 for males and between 111 and 116 for females

** The number of respondents ranged between 120 and 133 for males and between 120 and 131 for females

Preliminary Data

Youth Access to Tobacco by Density, Oregon 2001
During the past 30 days, how many times did you get tobacco from each of the following?

	% 1+ times Density 0-499 persons/sq. mile	% 1+ times Density 500+ persons/sq. mile
(Amongst current 8th grade smokers)*		
convenience store	18.8	28.3
drug store	9.0	13.3
grocery store	18.8	28.3
gas station	21.9	33.3
friends under 18	77.7	78.7
friends 18 or older	77.2	73.8
from home w/o permission	46.2	37.7
parent	29.8	26.7
sibling	26.5	34.4
people selling on street	12.0	18.3
vending machine	12.0	13.1
internet	3.0	8.3
(Amongst current 11th grade smokers)**		
convenience store	47.4	34.7
drug store	3.9	4.3
grocery store	31.9	26.0
gas station	48.3	47.9
friends under 18	62.3	69.0
friends 18 or older	86.0	81.1
from home w/o permission	11.8	11.1
parent	18.1	18.3
sibling	26.1	15.3
people selling on street	2.6	5.5
vending machine	3.3	2.7
internet	1.3	0.0

* The number of respondents ranged between 128 and 131 for low density and between 58 and 63 for high density

** The number of respondents ranged between 178 and 194 for low density and between 71 and 78 for high density

Behavioral Risk Factor Surveillance System

The Oregon Behavior Risk Factor Surveillance System (BRFSS) is an ongoing random-digit dialed telephone survey of adults concerning health-related behaviors. The BRFSS was developed by the Centers for Disease Control and Prevention (CDC) and is conducted in all states in the U.S. Each year, between 3,000 and 7,000 adult Oregonians are interviewed. In 2001, of those contacted, 56% agreed to complete the interview. The BRFSS includes questions on health behavior risk factors such as seat belt use, diet, weight control, tobacco and alcohol use, physical exercise, preventive health screenings, and use of preventive and other health care services. The data are weighted to represent all adults aged 18 years and older.

The data presented below by race/ethnicity are from a special combined 2000 and 2001 file that includes additional surveys from an oversample of African Americans, American Indians/Alaskan Natives, and Asian/Pacific Islanders. The oversampling was conducted to obtain at least 350 surveys for each racial/ethnic group. The data by race/ethnicity are not weighted because of the smaller number of surveys in each group.

Percentage of Adults who Say it is Important for Communities to Keep Stores from Selling Tobacco to Minors, Oregon 2001

	N	*% Important*	*95% C.I.*
African American*	81	95.1	90.2-99.9
American Indian/Alaskan Native*	130	95.4	91.7-99.0
Asian/Pacific Islander*	142	95.1	91.5-98.7
Hispanic*	498	95.8	94.0-97.6
Non-Hispanic White*	6813	96.8	96.4-97.2
Female	1201	97.7	96.8-98.7
Male	895	97.0	95.7-98.2
< 100 persons/sq. mile	519	96.5	94.7-98.4
100-499 persons/sq. mile	496	98.5	97.5-99.6
500-2499 persons/sq. mile	498	96.7	95.0-98.3
2500+ persons/sq. mile	531	98.1	96.7-99.4

** Race/ethnicity estimates based on 2000 and 2001 data combined

Appendix E

Issues from Data Presentation

By population group

Note:

- Items that were essentially the same were combined for purposes of clarity
- Critical issues with an asterisk (*) were received from workgroup members after the conclusion of the last meeting
- Group breakdowns were taken from the critical issues themselves or from the brainstorming session in meeting one to identify groups that likely experience a disparity.

Race/Ethnicity

- We need to collect enough data each year to get reliable ethnic data.
- Tobacco use may have an impact on long-term survival of ethnic/racial populations, such as Native American tribes with few members.
- Interaction of socio-economic status with ethnicity on smoking rates differs among different ethnic populations.
- Death certificates are not accurate data sources due to their unreliable reporting of ethnic and racial status*

African Americans

- African Americans have a disparity in tobacco use, with significantly higher smoking prevalence than among whites.
- We need different (or additional) data collection methods to ensure adequate numbers of survey respondents among African Americans.
- In the African American population, smoking is more prevalent among those with lower socio-economic status.

Native Americans

- Native Americans have an obvious disparity in tobacco use, with significantly higher smoking prevalence than among other population groups.
- Native American males have a disparity in smokeless tobacco use, with significantly higher prevalence than among other population groups.
- Behavioral Risk Factor Surveillance System (BRFSS) does not distinguish between ceremonial/traditional use of tobacco and habitual smoking of commercial tobacco.
- Among Native Americans, smoking does not appear to be related to socio-economic status.

Asian- Pacific Islanders

- The "lumping together" of all Asian-Pacific Islander populations does not allow assessment of smoking prevalence among specific population/language groups. High smoking rates among some groups may be masked by low rates in others.
- There is a need to find a way to collect tobacco-use data on specific API populations.
- In the API population, smoking is more prevalent among those with lower socio-economic status.

Hispanic Community

- Hispanic males show a disparity in tobacco use, with smoking prevalence higher than non-Hispanic whites.
- Hispanics maintain a healthier life before they acculturate. We need to know what works.

Sexual Orientation

- There is a lack of Oregon-specific tobacco use data for GLBT populations. Existing surveys such as BRFSS and Healthy Teens should include a question on sexual orientation.
- Existing data from special studies indicate that smoking prevalence is higher among gay men and lesbians than the overall population.
- Despite a lack of local data, there is enough evidence that a tobacco-use disparity exists among GLBTs for us to take action.

Age

- Disparities exist in the 18-24 population group, with 18-24 year olds having a higher smoking rate than other age groups.

Language

- Existing data collection methods do not adequately reach non-English, non-Spanish speaking Oregonians.

Geography

- Males, and especially younger males, in rural communities have a higher rate of smokeless tobacco use.

Environment

- Existing data collection methods do not adequately reach the homeless and others who do not have phones.
- Existing data collection methods do not reach institutionalized persons, and may lead to an undercount of those with disabilities or chronic diseases, the mentally ill and people in recovery facilities.

Occupation

- Second hand smoke from the workplace is not likely to be reported on death certificates as a cause of death*

Income

- Low SES smokers are as motivated to quit as non-low SES groups.
- There is a lack of data from homeless/low SES individuals and population groups

Other

- Agencies within identified communities may be able to assist in data collection in order to increase and collection of response rates and collection of better data within those communities.
- Interventions should not be evaluated by the criteria of getting "the biggest bang for the buck", but rather targeted to communities with the highest smoking rates and identifiable avenues for implementing effective strategies.
- Provide technical assistance to groups within targeted communities that want to conduct surveys to assess smoking rates.

Appendix F

Population Assessment Tool, Part I

1. Is the population a "community"(in that it shares its own history, context and culture), a subpopulation of a larger group (e.g., Puerto Rican women) or a "stratum" (e.g., low SES or rural)? If it is a "stratum", which communities can be used to reach them? If it is a subpopulation, what makes it unique?

2. What is the geographic distribution of the population?

3. What are ways that members of the population relate to one another? (e.g. language, religion, occupation, media, social life)

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?

6. Do methods exist to track and/or collect additional information on communication issues?

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?

10. What barriers exist in reaching this specific population?

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?

Appendix F

Population Assessment Tool, Part 2

Extent of involvement in decision-making/planning by representatives of the population

State Level

Not involved	1	2	3	4	5	Very involved	Don't know

Local Level

Not involved	1	2	3	4	5	Very involved	Don't know

Comments:

Extent of support by key opinion leaders for tobacco prevention and control issues

None	1	2	3	4	5	Excellent	Don't know

Comments:

Extent of the specific population's involvement in policy/regulatory activities

Not involved	1	2	3	4	5	Very involved	Don't know

Comments:

Extent of existing infrastructure for addressing tobacco prevention and control issues in the specific population (e.g., staff, financial and communication resources, training, leadership development, research/researchers, professional networks)

No infrastructure	1	2	3	4	5	Well-established infrastructure	Don't know

Comments:

Extent that existing population-specific community-based organizations, coalitions, and networks link to one another to address tobacco prevention and control issues

No linkages	1	2	3	4	5	Strong linkages	Don't know

Comments:

Extent that the members of the specific population participate in trainings designed to build capacity on tobacco prevention and control issues

No participation	1	2	3	4	5	High participation	Don't know

Comments:

Advocacy/policy	1	2	3	4	5	Not available	Don't know
Media advocacy	1	2	3	4	5	Not available	Don't know
Leadership development	1	2	3	4	5	Not available	Don't know
Tobacco 101	1	2	3	4	5	Not available	Don't know
Grant writing	1	2	3	4	5	Not available	Don't know
Coalition building/	1	2	3	4	5	Not available	Don't know
Program planning/ evaluation	1	2	3	4	5	Not available	Don't know
Other:	1	2	3	4	5	Not available	Don't know

Comments:

Extent that educational programs and media materials reflect the culture, ethnic background, and language of the specific population

Not at all	1	2	3	4	5	Excellent	Don't know

Comments:

Appendix G

Population Assessment, Part I

Asian Communities

1. Is the population a "community"(in that it shares its own history, context and culture), a subpopulation of a larger group (e.g., Puerto Rican women) or a "stratum" (e.g., low SES or rural)? If it is a "stratum", which communities can be used to reach them? If it is a subpopulation, what makes it unique?

Chinese, Vietnamese, Hmong

2. What is the geographic distribution of the population?

Chinese-	***Vietnamese***	***Hmong***
Multnomah-7,785	*Multnomah- 11,102*	*The majority reside in Mult, WA*
Clackamas2,032	*Washington-4,831*	*and Clackamas Cos.*
Washington-5,668	*Clackamas- 4,831*	
Lane 1,633	*Marion- 872*	
Benton-961		

3. What are ways that members of the population relate to one another? (e.g. language, religion, occupation, media, social life)

Chinese-Same dialect(4 dialects in Chinese), Chinese New Year
Vietnamese- Language and Religion
Hmong- Language and cultural affair

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)

Chinese- Community organizations/leaders, Chinese newspapers
Vietnamese- Temples, churches,New Years Events and other holidays
Hmong- Community leaders, churches and organizations

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?

Chinese- Older Chinese men do not want to listen to a younger, female health educator about the health risks of smoking. An older outreach worker would be more effective
Vietnamese- Most Vietnamese are not fluent in English. Having a knowledgeable interpreter in tobacco issues will help this barrier
Hmong- Most of the population does not speak English. The majority of the older populations do not have high school diplomas.

6. Do methods exist to track and/or collect additional information on communication issues?

Chinese, Vietnamese and Hmong- NO

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)

Chinese- The smokers are mostly men. However, smokoing among youth had been increasing, especially among young women.
Vietnamese- Smoking is accepted in the community. Cigarettes are given as gifts and used in social gatherings. It is part of the culture. Many Vietnamese smoke at a young age.
Hmong- It is seen as unhealthy for one's body but culturally accepted. Cigarettes are used customarily in weddings and funerals. Most Hmong do not know the specific risks of smoking.

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?

Chinese, Vietnamese, Hmong- NO

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?

The Hmong is a small close knit community. Everyone knows everyone else.

Appendix G

Population Assessment, Part I
Asian Communities

10. What barriers exist in reaching this specific population?
Chinese- Most Chinese Families are too busy with their business to get involved with tobacco prevention.Language is a barrier because of the 4 dialects. Older people are not fluent in English.
Vietnamese- language
Hmong- Language and education levels

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?
Chinese--Yes. The tobacco industry is sponsoring events in China such as Tennis Tournaments with Michael Chan. The Virginia Slims "find Your own voice" features a Chinese woman in her traditional clothing. The ads promote smoking as a way of gaining social acceptance.

Vietnamese- Yes. The industry is sponsoring events such as music concerts and giving out free bags, hats and t-shirts. In 1995 RJ Reynolds added a facility in Vietnam. Smoking among young women is on the rise due to the Virginia Slims " find your Own voice" Campaign. The ads clearly target ethnic girls who are seeking their identities and social and cultural acceptance.

Hmong- Yes. Smoking is on the rise due to the "Find Your Own Voice" campaign. The ads promote smoking as a way of gaining cultural acceptance. Hmong youths feel Americanized.

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?
Yes. The Tobacco Prevention and Education Program(TPEP) at Asian Family Center is focused on educating and raising awareness about tobacco uses and the dangers of smoking within the API community in Oregon. TPEP has also contracted with the Asian Family Center to develop an API Tobacco Education network in Oregon.

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?
Yes, the Oregon's smokefree workplace law, however there is no culturally specific cessation program for the Vietnamese Community

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?
Hopefully the API tobacco education network will be able to help evaluate Oregon's API existing ads.

Appendix G
Population Assessment, Part 2
Asian Communities

Key for answers to following information:
H: Hmong community V: Vietnamese community C: Chinese Community

Extent of involvement in decision-making/planning by representatives of the population

State Level

Not involved	1 H, V	2	3 C	4	5	Very involved	Don't know

Local Level

Not involved	1 H, V	2	3 C	4	5	Very involved	Don't know

Extent of support by key opinion leaders for tobacco prevention and control issues

None	1 C, V	2	3 H	4	5	Excellent	Don'tknow

Extent of the specific population□s involvement in policy/regulatory activities

Not involved	1 C,V,H	2	3	4	5	Very involved	Don'tknow

Extent of existing infrastructure for addressing tobacco prevention and control issues in the specific population

No infrastructure	1 C, H	2	3	4	5	Well-established infrastructure	Don'tknow

Extent that existing population-specific community-based organizations, coalitions, and networks link to one another to address tobacco prevention and control issues

No linkages	1 C,V,H	2	3	4	5	Strong linkages	Don'tknow

Extent that the members of the specific population participate in trainings designed to build capacity on tobacco prevention and control issues

No participation	1 C,V,H	2	3	4	5	High participation	Don'tknow
Advocacy/policy	1 C,V,H	2	3	4	5	Not available	Don'tknow
Media advocacy	1 C,V,H	2	3	4	5	Not available	Don'tknow
Leadership development	1 V,H	2 C	3	4	5	Not available	Don'tknow
Tobacco 101	1 C,V,H	2	3	4	5	Not available	Don'tknow
Grant writing	1 C,V,H	2	3	4	5	Not available	Don'tknow
Coalition building/	1 C,V,H	2	3	4	5	Not available	Don'tknow
Program planning/ evaluation	1 C,V,H	2	3	4	5	Not available	Don'tknow

Extent that educational programs and media materials reflect the culture, ethnic background, and language of the specific population

Not at all	1 C,H	2	3	4	5	Excellent	Don'tknow

Appendix G

Population Assessment, Part I
Blue Collar Workers

1. Is the population a "community"?
Blue Collar – skilled Laborers -- Union Workers

2. What is the geographic distribution of the population?
Statewide

3. What are ways that members of the population relate to one another?
As little as possible – works divides them -over a beer- at a safety meeting – Union Picnic –fishing-hunting sports

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)
Projects and work availability – status of the economy

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?
Geographic areas of the work spread out over miles – noise- heavy machinery- individual work discipline- Electricians- HVAC- concrete Pourers talk to each other primarily – but in general men don't talk much to one another.

6. Do methods exist to track and/or collect additional information on communication issues?
Newsletters suggestions team meetings safety meetings and payroll check inserts

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)
Large percentage of them smoke and have heavy stress factors- due to schedule dangers and a lot of physical activity work is very time sensitive and schedule delays cost

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?
Yes, # 6 surveys and conversations interviews

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?
Some but very limited information with the unions- smoking in many places is hazardous

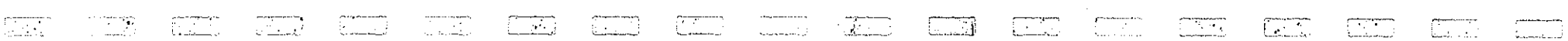
10. What barriers exist in reaching this specific population?
Geographic work areas and Machoism

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?
Not aware of any

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?
None

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population? ***Not that I am aware of***

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)? ***Available***



Appendix G

Population Assessment, Part I
Gay male community

1. Is the population a "community"(in that it shares its own history, context and culture), a subpopulation of a larger group (e.g., Puerto Rican women) or a "stratum" (e.g., low SES or rural)?
Yes, it is a community of its own

2. What is the geographic distribution of the population?
Mostly concentrated in the Metro Multnomah County, Esp. Portland

3. What are ways that members of the population relate to one another?
Social life, community and social norms and subsets of the larger community

4. What entities influence the population?
Media, bars, popular culture and each other

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?
Yes, internalized homophobia, externalized homophobia, and distrust and fatigue of public health interventions

6. Do methods exist to track and/or collect additional information on communication issues?
None that I'm aware of

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)
Tobacco use is extremely common and anti tobacco persons are seen as uncool.

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?
None that I'm aware of

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?
Easily united political movement and outspoken community leaders

10. What barriers exist in reaching this specific population?
See Question #5

11. Is there evidence that the tobacco industry is targeting this specific population?
Yes, bars, magazines, free cigarettes, infiltration of community spaces

12. Are there community/population-based interventions that directly reach the specific population?
Yes, mostly HIV, STD prevention efforts-outreach and classes/workshops

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?
No

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?
No

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?
Not familiar enough to answer this question.

Appendix G

Population Assessment, Part I
Lesbian, Gay, Bisexual and Transgender Communities

1. Is the population a "community"?
The LGBT population is a community sharing history, context and culture and is composed of several subpopulations, each with individual perspectives on this shared history. The subpopulations are varied enough to warrant separate research, interventions and programs.

2. What is the geographic distribution of the population?
The LGBT population is heavily concentrated in Multnomah County, however, census data indicates that LGBT couples now live in every county in the state.

3. What are ways that members of the population relate to one another?
LGBT members relate to each other through group activities and functions, political involvement and LGBT specific publications.

4. What entities influence the population?
Political and community based organizations have the most influence.

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?
Barriers include: fear by the straight population of LGBT's, unwillingness to acknowledge our existence as a cultural entity, the difficulty we have even identifying the population, lack of LGBT specific publications, lack of LGBT specific broadcast media.

6. Do methods exist to track and/or collect additional information on communication issues?
The LGBT Community Center in Orange County had been conducting focus groups about LGBT tobacco issues – the data has not yet been released. PacWest Communications just conducted two focus groups, one for gay smokers, the other for lesbian smokers primarily to determine the best ways to reach the population with media messages and which messages are most appropriate.

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)
In interviews with 20 key community leaders in Portland, OR, 100% believe tobacco is a problem for the LGBT population. This includes smokers and non-smokers. 100% of those interviewed believe that one reason for the high rate of tobacco use in the LGBT population is the bar culture. Bars, with the attendant drinking and smoking, are one of the first places young LGBT people go to seek acceptance and inclusion. Although all recognize tobacco use as problematic, most feel that other issues such as safety, fighting for basic human rights and battling HIV/AIDS are more important. In one study of lesbians, it was found that the knowledge of the dangers of tobacco use was higher than in the general population of women, even though lesbians smoke at a much higher rate. Community leaders believe that the high prevalence rate is due in large part to the stress of oppression and of trying to function in the straight world.

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?
Methods exist, but funding is needed to conduct them! Surveys are being conducted on a very limited basis nationwide. In Oregon, there are no surveys being conducted other than the ones mentioned. The CDC sponsored focus groups out of Orange County probably ask questions about norms and attitudes, but I can't say for certain, not having seen the instrument.

9. What assets does the population have that supports tobacco prevention/control efforts?
A history of community activism, active social and political organizations and a well read community newspaper.

10. What barriers exist in reaching this specific population?
See question #5.

Appendix G

Population Assessment, Part I
Lesbian, Gay, Bisexual and Transgender Communities

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?

Yes. Tobacco companies are conducting very gay-specific giveaways in gay bars and covering our national magazines in advertisements. Plus, many ads for the general population are non-gender specific, homo-erotic and have cross-over appeal. In fact, so much so, that one community leader speculated that the creators of the ads must be gay themselves.

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?

Tobacco control interventions? None in Oregon, yet.

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?

Not that they have told me!

14. Are there policies in place (public and voluntary) that impact the specific population?

On the positive side, the work already done in Oregon in CIA does affect everyone positively. In my interviews, 100% remember one or more of the state media program's anti-ads and, if voters approve the new 60 cent raise in excise tax, many LGBT folks will quit.

On the negative – the state law exempts bars. Creating smokefree bars would probably have the greatest impact on the LGBT population.

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?

Beginning July 1, the state will ask a question about sexual orientation on the BRFSS. If all goes well, we should have some information about the population by November or December. We will also have a tool in place to measure effectiveness of all efforts.

Appendix G

Population Assessment, part 2
Lesbian, Gay, Transgender, Bisexual

Extent of involvement in decision-making/planning by representatives of the population

State Level

Not involved 1 [2] 3 4 5 Very involved Don't know

Local Level

Not involved 1 [2] 3 4 5 Very involved Don't know

Extent of support by key opinion leaders for tobacco prevention and control issues

None 1 2 3 4 5 [Excellent] Don't know

Extent of the specific population's involvement in policy/regulatory activities

Not involved 1 2 3 4 5 [Very involved] Don't know

Extent of existing infrastructure for addressing tobacco prevention and control issues in the specific population

No infrastructure [1] 2 3 4 5 Well-established infrastructure Don't know

Are there other health issue infrastructures that could provide channels for addressing tobacco-related disparities (e.g., diabetes, cardiovascular health, maternal and child.) health)? Perhaps HIV/AIDS – but that population is changing radically. Some women's health organizations are beginning to reach out to lesbians.

Extent that existing population-specific community-based organizations, coalitions, and networks link to one another to address tobacco prevention and control issues

[No linkages] 1 2 3 4 5 Strong linkages Don't know

Extent that the members of the specific population participate in trainings designed to build capacity on tobacco prevention and control issues

[No participation] 1 2 3 4 5 High participation Don't know

Comments:

We have not been invited to the table yet. In Oregon. Except for me

Advocacy/policy	1	2	3	4	5	N/A	Don't know
Media advocacy	1	2	3	4	5	N/A	Don't know
Leadership development	1	2	3	4	5	N/A	Don't know
Tobacco 101	1	2	3	4	5	N/A	Don't know
Grant writing	1	2	3	4	5	N/A	Don't know
Coalition building/ Community mobilization	1	2	3	4	5	N/A	Don't know
Program planning/ evaluation	1	2	3	4	5	N/A	Don't know
Other:	1	2	3	4	5	N/A	Don't know

Is there any assessment of the training needs of specific population groups?

The assessment is easy- since there is no infrastructure yet, and nothing has been done (in Oregon) all training is needed.

Extent that educational programs and media materials reflect the culture, ethnic background, and language of the specific population

[Not at all] 1 2 3 4 5 Excellent Don't know

Appendix G

Population Assessment, Part I
Oregon Health Plan Recipients

1. Is the population a "community"

All categories of low-income Oregonians, not a community, but some subgroups exist such as disabled community, various cultural/language groups, etc. A stratum of low SES. All communities can be used to reach this group except there is not a high advocacy presence in OHP within the of the gay/lesbian community.

2. What is the geographic distribution of the population?

Statewide distribution; some cultural subgroups are clustered in certain areas. See OHP demographic program data with county population numbers on our website under demographics (www.omap.hr.state.or.us). Also see OHP managed care Fully Capitated Health Plan (FCHP) enrollment data by county on the OMAP website. Some rural/urban differences. Disabled population tends to be more in urban areas where services are more available.

3. What are ways that members of the population relate to one another? (e.g. language, religion, occupation, media, social life)

We're not aware that this population relates to one another. Possibly through social life, geographically/income level (e.g. housing areas for low SES), common needs (medical/dental, use of Federally Qualified Health Centers), media TV, or various subgroups such as the disabled. Can reach them through support services, boys/girls clubs, schools, churches, refugee centers, and other places they frequent.

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)

Same as the general population. Community hierarchy.

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?

You need a cultural anthropologist for this assessment—there is a culture of poverty. Tobacco use may not be their top priority and long-term health effect may not be effective; education/literacy, cultures & "cultural" messages, language, mobility/disabilities. This may be one of the few pleasures they have and it is also tied to social interaction & a communication vehicle as part of the larger context. Need to understand the cultural impact of tobacco use for intercommunication. Need to approach why they use it within their community.

6. Do methods exist to track and/or collect additional information on communication issues?

Yes: 1. Talking circles
2. In-depth qualitative assessments—doing some ethnographic work
3. Harder to track due to constant changes

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)

See 5. Only pleasure they have; tobacco use surrounds them in their environment; smoking breaks are a survival mechanism; knowledge and attitude about tobacco use; behavior change is harder; appetite suppressant; already marginalized their personal experience. Higher per capita use of tobacco products among almost every subgroup of Medicaid clients than in the general public.

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?

See #6. In-depth qualitative levels.

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?

OHP benefit package—tobacco cessation is a covered benefit and access to health providers when on OHP. Lack of income. Interpersonal communication could impact positively.

Appendix G

Population Assessment, Part I
Oregon Health Plan Recipients

10. What barriers exist in reaching this specific population?
See #5.

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?
Yes. Billboard purchase locations; market strategies to focus activities in bars and at car racing events. Selective mediums and time slots based on this population. Media over exposure; product placement in TV and movies; increase in actors smoking since 1970. Low SES more vulnerable. Passive consumption.

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?
*Intervention efforts through public health offices. Also through OHP managed care plans and Project: **PREVENTION!** program (PP), and the Oregon Quit Line.*

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?
?

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?
Tobacco tax; OHP benefit coverage of tobacco cessation; OHP mandatory participation in PP.

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?
PP performance measures: CAHPS survey, encounter data/FFS claims using 305.1 diagnosis code; EQRO focus studies; Oregon Quit Line reports; OHP managed care plan quality reviews by OMAP.

Appendix G

Population Assessment, Part 2
Oregon Health Plan Recipients

Extent of involvement in decision-making/planning by representatives of the OHP/Medicaid population

State Level

Not involved [1] 2 3 4 5 Very involved Don't know

Local Level

Not involved [1 2] 3 4 5 Very involved Don't know

Extent of support by key opinion leaders for tobacco prevention and control issues

None [1] 2 3 4 5 Excellent Don't know

Extent of the specific population's involvement in policy/regulatory activities

Not involved [1] 2 3 4 5 Very involved Don't know

Extent of existing infrastructure for addressing tobacco prevention and control issues in the specific population

No infrastructure 1 2 3 [4] 5 Well-established infrastructure Don't know

Are there other health issue infrastructures that could provide channels for addressing tobacco-related disparities (e.g., diabetes, cardiovascular health, maternal and child.) health)?

Yes, MCH, diabetes, asthma and CHF disease management

Extent that existing population-specific community-based organizations, coalitions, and networks link to one another to address tobacco prevention and control issues

No linkages 1 2 3 4 5 Strong linkages Don't know

Comments: Community-based OHP managed care plans

Extent that the members of the specific population participate in trainings designed to build capacity on tobacco prevention and control issues

No participation	[1]	2	3	4	5	High participation	Don't know
Advocacy/policy	[1]	2	3	4	5	Not available	Don't know
Media advocacy	[1]	2	3	4	5	Not available	Don't know
Leadership development	[1]	2	3	4	5	Not available	Don't know
Tobacco 101	[1]	2	3	4	5	Not available	Don't know
Grant writing	[1]	2	3	4	5	Not available	Don't know
Coalition building/ Community mobilization	[1]	2	3	4	5	Not available	Don't know
Program planning/ evaluation	[1]	2	3	4	5	Not available	Don't know
Other:	[1]	2	3	4	5	Not available	Don't know

Comments: Not to our knowledge

Extent that educational programs and media materials reflect the culture, ethnic background, and language of the specific population

Not at all 1 2 3 4 5 Excellent Don't know

Comments: At times literacy has been considered

Appendix G

Population Assessment, Part I
Umatilla County Males

1. Is the population a "community"(in that it shares its own history, context and culture), a subpopulation of a larger group (e.g., Puerto Rican women) or a "stratum" (e.g., low SES or rural)? If it is a "stratum", which communities can be used to reach them? If it is a subpopulation, what makes it unique?
Umatilla County Males, mostly white, mixed income. Rural Farming, ranching, manufacturing,

2. What is the geographic distribution of the population?
Eastern Oregon Rural (Umatilla County, Pendleton)

3. What are ways that members of the population relate to one another? (e.g. language, religion, occupation, media, social life)
At work, at rodeo's, farm meetings, bars/taverns, sporting events, hunting snowmobiling, four wheeling.

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)
Peer pressure in ranching & farm work. Family role models, friends, sports & rodeo figures. Round-Up & associated promotions such as free chew sample booths.

5. Are there barriers to communication that will make addressing the tobacco-related disparity within this population difficult? If so, what are they?
- *Corporate sponsorship of rodeo events (bull riding)*
- *Free sample booths around Round-Up*
- *The population is self reliant, often self employed or under insured and will not see a health care provider unless they have an illness.*

6. Do methods exist to track and/or collect additional information on communication issues?
There are no dollars for extensive surveying, but more needs to be done.

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)
Women see it as unhelathy & nasty/gross (i.e. negative.) Men see it as desirable, positive, macho, harmless. (This is starting to change) Most men grew up around the product being used. Knowledge is there, but it doesn't affect them personally until they have for instance a mouth lesion, or know of someone with mouth or other chewing related cancer.

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?
Local tobacco prevention coalition if time & money permits. State, if funding available, and they target chewing tobacco use.

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?
Local tobacco prevention coalition. Local media supportive of our efforts. Health care providers, dentists, physicians, presentations to schools & community groups. Quit Line

10. What barriers exist in reaching this specific population?
Getting access to them at work, and during their free time. Persuading them the health and addiction concerns are valid.

Appendix G

Population Assessment, Part I
Umatilla County Males

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?

Yes: sports, magazine & retailer ads and promotions. Sample booths, sponsorship of rodeo events. (Unrelated to chew, but Phillip Morris gave 10,000 to local domestic violence prevention organization.)

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?

Local tobacco prevention coalition provides educational materials, links to cessation resources to health care professionals, schools, and businesses.

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?

No, it focuses primarily on smoking. We need more emphasis in rural areas on helping people quit using chew/dip (the x-chew challenge for schools is great.)

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?

Hard to enforce no tobacco policy for chewing. Need more media & educational resources, more assistance for no or under-insured.

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?

Local tobacco prevention coalition & partners.

Appendix G

Population Assessment, Part 2
Umatilla County Males

Extent of involvement in decision-making/planning by representatives of the population

State Level

Not involved 1 [2] 3 4 5 Very involved Don't know

Local Level

Not involved 1 2 [3] 4 5 Very involved Don't know

Extent of support by key opinion leaders for tobacco prevention and control issues

None 1 2 3 [4] 5 Excellent Don't know

Extent of the specific population's involvement in policy/regulatory activities

Not involved 1 [2] 3 4 5 Very involved Don't know

Extent of existing infrastructure for addressing tobacco prevention and control issues in the specific population

No infrastructure 1 2 3 [4] 5 Well-established infrastructure Don't know

Are there other health issue infrastructures that could provide channels for addressing tobacco-related disparities (e.g., diabetes, cardiovascular health, maternal and child.) health)?

We have two hospitals in the county, along with Yellowhawk clinic at the Confederated Tribes of the Umatilla Indian Reservation. Our local tobacco prevention program has worked extensively with these three organizations, but a lot of the effort has been on stop smoking as opposed to stop using chewing tobacco.

Extent that existing population-specific community-based organizations, coalitions, and networks link to one another to address tobacco prevention and control issues

No linkages 1 2 3 4 [5] Strong linkages Don't know

Extent that the members of the specific population participate in trainings designed to build capacity on tobacco prevention and control issues

No participation	[1]	2	3	4	5	High partiipation	Don't know
Advocacy/policy	[1]	2	3	4	5	Not available	Don't know
Media advocacy	[1]	2	3	4	5	Not available	Don't know
Leadership development	[1]	2	3	4	5	Not available	Don't know
Tobacco 101	[1]	2	3	4	5	Not available	Don't know
Grant writing	[1]	2	3	4	5	Not available	Don't know
Coalition building/	[1]	2	3	4	5	Not available	Don't know
Program planning/	[1]	2	3	4	5	Not available	Don't know

Comments: *There currently is very little involvement of chewers or ex-chewers in our tobacco prevention efforts in Umatilla County. We've done trainings and provided materials to health care providers, various agencies, and school groups in the county.*

Is there any assessment of the training needs of specific population groups?

Not that we're aware of.

Extent that educational programs and media materials reflect the culture, ethnic background, and language of the specific population

Not at all 1 2 [3] 4 5 Excellent Don't know

Comments: We need more spit tobacco resources & media coverage. Quit line promotional material should address spit tobacco in a more visual way. It would be helpful to have a Umatilla County resident (or someone from a rural area) tell how he was able to quit, and then use that in promotional material.

Appendix G

Population Assessment, Part I
African-American Community

1. Is the population a "community"(in that it shares its own history, context and culture), a subpopulation of a larger group (e.g., Puerto Rican women) or a "stratum" (e.g., low SES or rural)? If it is a "stratum", which communities can be used to reach them? If it is a subpopulation, what makes it unique?

This community is difficult to classify into one of the listed categories because true enough it is a community but it would be wrong to overlook the strong "stratum" elements of this group because as shown by numerous studies here in Oregon and across the U.S. African-Americans make up a huge percentage of the low SES group as well.

2. What is the geographic distribution of the population?

There are few ways for the average person to say what the exact distribution of any population might be, however, it is not difficult to see that African-Americans occupy inner-cities all over the U.S. in other words, if you are in the suburbs of a state looking for African-American's to survey you won't find many, this fact bodes the same for Oregon, where Portland, Oregon's largest populated city is home to most of the African-American population.

****Note****

However, this last fact is changing, due to the increasing popularity of NE Portland, gentrification is in full swing. I personally have listened to countless stories of how homes are being bought out from under the African-American homeowners or how they are being offered larger homes at lower rates in other neighborhoods. I listened to a 68 year-old Portland native explain how her taxes were going up so high that she had little choice but to leave the home she had known all of her life. Her large home will soon become a two apartment unit. The general response to this is, that's how the system works, "We live in the ghetto's until "they" come along and fix it up so that it is considered too good for us or at least too expensive and so we get forced out into the next nearest ghetto. And then we wait in our new home for it to happen again, and we will just keep moving from ghetto to ghetto until there are no more ghetto's, maybe then we can just go back to our real home."

3. What are ways that members of the population relate to one another? (e.g. language, religion, occupation, media, social life)

African-Americans relate to each other through ways that are similar to the rest of the world population, language, occupation, social life, and entertainment. To truly focus on our purpose which is decreasing disparities particularly in the field of health and tobacco prevention we need to look closely at what is the "primary" way in which African-Americans relate to each other, this will lead you directly to the faith communities. Not only is it a place for education, after-school activities, socializing, health promotion, a helping hand, counseling, and worship, according to one sister "Church, has been the place where African-Americans seek the strength to deal with things that no people should ever have to deal with."

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)

Churches, faith communities, preachers, brothers, and sisters, this is the entity that holds the most influence, "The church is the soul of our community, and I believe that it is the heartbeat of all African-American neighborhoods.

Appendix G

Population Assessment, Part I
African-American Community

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?

- *Cultural competency – the ability to address population sans biases and stereotypes.*
- *Lack of data – Not enough research to identify specific needs to devise appropriate approaches, e.g. culturally competent cessation for youth, gender specific, menthol cigarettes and mortality rates. Etc.*
- *Mainstream institution vs. community based organization.*

Personal Look: *there are barriers... It is the simple lack of trust the African-American's have for their government and those that run it, it is the fear that all good intentions hide an evil one. This has been what I have found to be the greatest barrier to communication, when I started my work in tobacco I called many churches requesting to meet with them and many said no simply because they originally thought that I sounded like a white person on the phone, or because I said that I was with the County. After finally getting to meet face to face with a few church leaders I started to receive calls requesting my presence at other local churches, when I asked what changed their minds, many remarked "I am so sorry, but I thought you were white."*

Note

This is not to say that whites can not successfully run programs for African-Americans, it is to say that when they do they must be:

1. *Genuinely empathic to those they seek to help*
2. *Non-judgmental of the people they meet*
3. *Sincere about solving the problem*

(The basic rules of all public help work.)

There is another way to cross that barrier and that is through collaborations with existing organizations that have already gained the trust of the community that it serves.

6. Do methods exist to track and/or collect additional information on communication issues?

Many whom I posed this question to had but one reply: "Shouldn't you folks know?"

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)

A. It is believed that tobacco is turning into a very serious concern for African-Americans.
B. African-American women smoke more than men, (females are also featured in more tobacco ads than males)
C. Almost half 50% of the African-American's living in the low SES smoke compared to less than 17% when living above this level. (a major problem due to the fact that the majority of the population lives in the low SES category).
D. Smoking is used as a symbol that an African-American has assimilated into the American culture which for many is a life goal, "You've come a long way baby...
E. Studies link stress to smoking because most African-Americans say smoking relaxes them and relieves stress, just for the record the number one cause of stress for most African-Americans...Racism, not only does this daily dose of hate increase a smokers usage, but it raises the blood pressure as well, not a good combination for a smoker.

123 adults surveyed – more needs to be done to reduce the amount of tobacco advertising in the African American community
117/95% Yes 6/5% No

123 adults surveyed - Tobacco use is a serious problem
101/82% Yes 22/17% No

Appendix G

Population Assessment, Part I
African-American Community

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?
Not enough research available on African American smoking patterns for: adults and youth, gender specific, or marijuana and tobacco use, e.g. blunts, swishers.

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?
Lack of funding to facilitate development of capacity and infrastructure in areas such as training and technical assistance.

10. What barriers exist in reaching this specific population?
Severely lacking in community based resources that reach the economically challenged.

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?
124 adults surveyed – tobacco companies deliberately advertise and promote cigarettes to encourage African Americans to smoke
100/81% Yes 24/19% No

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?
123 adults surveyed – Awareness of classes support groups, resources to help people in the African American community to stop smoking.
15/12% Yes 108/88% No

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?
No, the general consensus of the interviewed population was that they are not aware of any form of anti-tobacco campaign aimed at African-Americans.
Many have seen the humorous ads featuring the cancer stricken Marlboro Man but African-Americans generally do not smoke this brand preferring Kools or Newports both of which sport no form of anti-smoking advertising or promotion.

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?
If these exist the general population surveyed (African-Americans in the NE Portland area) are unaware of it.

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?
Tobacco control programs should be linked to community development and economic development programs.

Provide funding to develop an initiative that explores the link between tobacco and asthmas in children.

The community is ready are we...?

Appendix G

Population Assessment, Part I
Native American Community

1. Is the population a "community"(in that it shares its own history, context and culture), a subpopulation of a larger group (e.g., Puerto Rican women) or a "stratum" (e.g., low SES or rural)? If it is a "stratum", which communities can be used to reach them? If it is a subpopulation, what makes it unique?

American Indian/Alaska Native are a recognized community by political designation of the United Stated Government. American Indian/Alaska Native population can be thought of as a "community" in terms of addressing tobacco issues. It should be acknowledged that within this larger population, there are two 'sub-populations,' the tribes and the urban Indians, which have varied needs and requires a different political approach. There are 9 federally recognized tribes in Oregon, but many enrolled members do not live on the reservation and live across the state and country. For AI/AN that live in Oregon, mainly in cities ('urban Indians'), they may represent any of the 550+ federally recognized tribes, may come from a terminated tribes, state recognized tribes, IHS tribe, and may be a community in that they self-identify as AI/AN but have great differences in terms of sense of history, context, and culture.

2. What is the geographic distribution of the population?

There are 9 Oregon tribes (map included). Urban Indians live mostly in Portland, Medford, Ashland, Grants Pass, and Brookings. Last year NARA served 250 of the 550 federally recognized tribes. The Indian population is 40,000 with 22,000 living in Urban Areas.

3. What are ways that members of the population relate to one another? (e.g. language, religion, occupation, media, social life)

Members of the population relate to one another socially, culturally, and politically. AI/AN identify themselves with their tribe, their family, and whether or not they were raised on a reservation. They relate through tradition and cultural values, such as reverence for elders and belief in youth, and through social events such as powwows and traditional events.

4. What entities influence the population? (e.g. places of worship, political leaders, community based organizations, media, the workplace)

(Not in any particular order)

- *Political leaders*
- *Family*
- *Native media such as newsletters*
- *Tribal Boards*
- *Workplace*
- *Community groups*
- *Tribal council*
- *Health care (such as; access too and availability)*
- *Religion/Spirituality*

5. Are there barriers to communication that will make addressing the tobacco related disparity within this population difficult? If so, what are they?

While there are media avenues including tribal newsletters and health organizations including NARA and NPAIHB, communication must be highly targeted. Information must be distributed through the 9 tribes individually and urban Indians must also be targeted. More importantly, however, there is lack of trust. AI/AN communities have such a long history of oppression and treaties and broken promises with the U.S. federal government, that it is necessary to account for the time and effort it takes to gain some trust from the community. Another barrier to communication stems from their reverence for elders, an important native cultural value. It may be considered impolite to tell elders not to smoke while youth look up to them.

6. Do methods exist to track and/or collect additional information on communication issues?

We are unaware of the methods that track and/or collect information on communication issues. The majority of Native people are oral, interactive learners when asked to participate.

Appendix G

Population Assessment, Part I
Native American Community

7. What is known about the social norms, knowledge and attitudes of the population regarding tobacco use? (e.g., positive/negative, men/women)

Tobacco is still a norm, much more so than in the mainstream population. Because of competing health issues and other addictions, tobacco is seen as the lesser evil. There is a level of denial not only that one is addicted but that tobacco abuse itself can become an addiction. Some women claim to smoke because they want small babies. Tobacco is used as a stress reducer and to reduce stress. Tobacco in our communities is also given to youth by friends, older family members and parents.

** Tobacco In Portland Indians (TIPI) Survey results available for NARA service area. According to the Oregon Tobacco Facts 2000, AI/AN lead all racial/ethnic categories for tobacco prevalence in youth, women, pregnant women and men..*

8. Do methods exist to track and/or collect additional information on tobacco-related norms and attitudes?

There are surveys utilized by tribes, NPAIHB, NARA, and Oregon DHS such as ATS, BRFSS, TIPI, YTS, and the CDC health risk assessment (pilot project from 4 years ago).

9. What assets does the population have that supports tobacco prevention and control efforts (e.g. effective community communication channels, active community-based organizations, etc.)?

Assets include the various organizations that address tobacco prevention in AI/AN populations. This includes the state program, NARA, NPAIHB, Portland Area IHS, and tribal programs. NARA addresses urban Indian issues and NPAIHB addresses NW regional issues. While they may be lacking in resources, all 9 of the federally recognized tribes, NARA, and NPAIHB have some form of funding to specifically address tobacco prevention and control within their identified populations.

Oregon tribes also have a working relationship with Oregon State DHS, a pioneer itself in tobacco prevention and control. While there is still much room for more communication and collaboration, compared to other tribes and their respective states, Oregon is progressive in their approach.

Furthermore, there are many dedicated people working with native communities in the area of tobacco. Two of which are Kerri Lopez of NARA and Liling Sherry of NPAIHB, both widely recognized as leaders in this field.

10. What barriers exist in reaching this specific population?

Tobacco is not a priority in our Native communities. While Oregon has a working relationship with the tribes, there is a historical relationship between tribal governments and the federal government that represents centuries of oppression. This refers back to the issue with trust and barriers to communication. It is also in some ways a tangible practice of tribal sovereignty in tobacco laws in the face of opposition making education for tribal governing bodies so important to community mobilization.

Native communities are also faced with poverty and often of low SES status. This, of course, adds to the stress factor for individuals, as well as adding one more issue to the already great number of competing issues. Native communities experience an extremely high prevalence of various other health problems.

While there may be health promotion efforts at the tribal, state, and regional levels, there is a lack of resources for cessation. It is hard to reach a population when we can only offer education without treatment.

Appendix G

Population Assessment, Part I
Native American Community

11. Is there evidence that the tobacco industry is targeting this specific population? If so, what is it and how is it done?

Industry, including chew brands, targets AI/AN in the form of event promotion with giveaways at rodeos, powwows, and traditional ceremonies (Marlboro made donations during Sundance). With brands such as American Spirit, the tobacco industry tries to associate their product with the natural, traditional use of tobacco that is important to many native cultures. Tobacco products are currently being made and marketed by AI/AN tribal businesses. Not only is tobacco industry targeting the AI/AN they are exploiting its culture and traditional uses of tobacco.

12. Are there community/population-based interventions that directly reach the specific population? What type of intervention? What is the amount and source of funding?

- *Tribes have their own health programs that address health issues such as diabetes, cancer, and alcoholism within their community. They may also have community groups including elder and youth that can be vehicles of health promotion.*
- *NARA has a tobacco program, an urban clinic, and various health programs including WIC, women's' health, parenting, and diabetes.*
- *NPAIHB's Western Tobacco Prevention Project is funded by CDC to provide technical assistance in the area of tobacco prevention for the NW tribes. NPAIHB also has various other health promotion projects and an Epidemiology Center.*

13. Does the State media plan address the identified tobacco-related disparity with efforts focused on the specific population?

It is unclear to us how AI/AN populations are represented in the state media plan.
There are some pamphlets distributed free of charge through OTEC that are native specific. The resource that seems most useful for Oregon tribes is the "It's Your Life – It's Our Future: Stop Smoking Guide." The state does offer some AI/AN specific materials but is lacking anything on Secondhand smoke. There have been no new AI/AN specific tobacco materials developed in the last 5 – 10 years.

14. Are there policies in place (public and voluntary) that impact the specific population (e.g. Clean indoor air, excise tax, insurance coverage for treatment and cessation, access to cessation resources, CDC school health guidelines)?

Each tribe develops its own policies. All Oregon tribes have a resolution or some form of approved policy that prohibits smoking in all government offices. Some tribes have policies that involve youth including selling to minors and use by youth. However, many of these tribes do not have a follow-up program to ensure implementation and to provide education to community members and officials. Off of the reservations, all mainstream policies in Portland and other areas apply for urban Indians.

15. What mechanisms are in place to evaluate the effectiveness of programmatic, policy and media efforts addressing the identified disparity?

Tribal programs, NARA, NPAIHB have their own mechanisms to evaluate internal activities including trainings, overall tobacco program, staff evaluation, progress reports to state and other funding organizations. However, we do not know of mechanisms that evaluate state programs in relation to AI/AN tobacco efforts other than the methods listed in #8 to gather tobacco related information.

Appendix G

Population Assessment, Part I
Native American Community

Traditional Tobacco Use:
Though this is not a part of all tribal cultures, for many American Indians, tobacco is a sacred plant. However, as a result of industry marketing and accessibility, commercial tobacco is often substituted for the traditional tobacco plant in ceremonies. This tie to traditional tobacco can be interpreted as a barrier because the mainstream message that "tobacco kills" is rendered ineffective in many native populations. Also, it can be interpreted that because their relationship to tobacco is cultural, it is valid and culturally insensitive to suggest otherwise. However, traditional tobacco plants have no connection to the commercial tobacco products, and traditional tobacco use does not always entail smoking or burning; it is often given as a gift and is used for medicinal purposes. Distinguishing traditional tobacco from the manufactured product in composition and in use is more culturally appropriate and can be 'an asset' to commercial tobacco prevention and control.

Tribal Infrastructure:
A unique asset specific to the Oregon tribal community is that each of the tribes has an identifiable infrastructure that ultimately has the capacity to address tobacco issues individually. This infrastructure includes the governing body of the tribal council, Tribal Health Director or equivalent, a health department or equivalent, defined mechanisms to pass policies and resolutions, enrollment network, communication routes including a tribal newsletter, community groups including youth and elder groups, and other health programs with which to collaborate.

While the asset of the tribal infrastructure is real, ultimately it is the staff that heads these programs and coordinates community efforts. The turnover in staff is such that it is hard to establish programs and gain the trust necessary to encourage change. Also, tribes must be addressed individually to honor tribal sovereignty as well as their cultural and historical differences. Though they each have their own infrastructure, it still means 9 different programs. Urban Indians must also be addressed as a separate sub-population.

Appendix H

Population Assessment Issues

- OHP members don't know about available insurance coverage for smoking cessation
- African Americans don't know about cessation resources available to them
- There is no anti-tobacco media targeted specifically to rural areas
- There is a need for anti-chew ads in rural communities (again)
- We need to ensure that counter advertising is effective/appropriate for diverse communities (example: Marlboro Cowboy image not appropriate in AA community)
- There is a problem with health message fatigue in the GLBT community
- We need to reevaluate the overall policy direction for the media program
- Advertising on quit line should be in languages other than just Spanish and English
- Advertising is not being placed in available Native American publications
- There is a lack of trust of the public health messenger in the GLBT community
- There is a lack of trust of government and whites in the African American Community
- There is a lack of adequate funding for the African American Community
- Diverse communities want to hear from "own kind"(AA, rural, APACSA, Native American)
- No state funding is currently allocated for the GLBT community
- Tobacco industry targets the African American, NA, GLBT, API and Hispanic communities
- There is no backlash to tobacco advertising in gay bars
- Rural population is less likely to be insured
- Rural men see smoking as macho and harmless
- Workplace smoking policy is driving some to smoke rather than chew
- Chew is culturally acceptable in rural areas
- Stress leads to chewing tobacco
- Culture of poverty—cessation is not a top priority in OHP community
- High incidence of depression –tobacco is one of the few pleasures low SES folks have
- Social use of tobacco is high in the low SES community
- Low SES population changes constantly with the exception of the disabled
- OHP population wants to quit as much as anyone else
- Persons from low SES groups are as motivated to quit as other groups
- There are two distinct communities-immigrant and refugee in the API community
- Politics is very important. Subgroups do not typically mix socially in the API community
- Cigarettes are used to show appreciation and as a status symbol within some API groups.
- Experience in Asian homeland relates to behavior now
- High representation of API in low SES community
- Hispanics maintain a healthier lifestyle before they acculturate.
- Agencies within identified communities may be able to assist with data collection in order to increase the response rates and collect better data within those communities. Agencies offering to assist should be provided technical assistance to do so.
- Native Americans are the only minority with a political identity
- Individuals relate by tribe first, then family, then reservation (communication patterns)
- The best means to communicate are via tribal boards, health care facilities (urban and rural) and tribal newsletters. Other arenas include pow wows, sundances and traditional activities.
- Barriers to communication with Native Americans include oppression, low SES status, broken promises, and difficulty in telling elders not to smoke.

- Traditions are oral—people learn by example
- Tobacco is a norm in Indian Country. Spit and smoking rates are high.
- Cessation is not a priority in Indian Country. Tobacco is seen as a lesser evil. It is used to reduce stress and have smaller babies.
- Thus far tobacco advertising on reservations has been limited. There is a fear it will soon become more prevalent.
- Tribes have their own health programs. This includes WIC, diabetes education, and children's programs. The NWPAIHB runs programs as well.
- The state media program has not developed new ads for the Native American population. The materials are dated.
- Non smoking messages are confusing because of Native Americans traditional use of tobacco
- It's a norm in Indian Country for parents and relatives to give cigarettes to kids.
- NWPAIHB has done surveillance re: tobacco use along with DHS, CDC, and Legacy. NARA and the State Health Department in WA are collaborating on an adult urban survey to compare urban and rural tobacco use.
- Sovereignty is always an issue when dealing tribe to tribe.
- The Blue Collar industry is male dominated. Communication is limited. Many folks talk one on one over a beer, at a union picnic, or at sporting events.
- The Blue Collar industry is heavily affected by the economy because jobs are funded by government contracts.
- People who work in Blue Collar jobs generally communicate via newsletters, suggestion boxes, team meetings, and payroll inserts.
- Smoking is a norm in these highly stressful jobs. Jobs are sometimes solitary (like truck drivers) which encourages smoking without restrictions.
- State media plan does not specifically target blue collar workers
- Many Blue Collar workers do have access to cessation services through their insurance providers

Appendix I

SWOT Analysis

STRENGTHS

1. Capacity and infrastructure for data collection and analysis.
2. Comprehensive TPEP program with defined program goals and objectives
3. Four year history of funding disparate populations
4. History of success in reducing tobacco use for all Oregonians
5. Oregon is the only state that provides coverage for all proven treatments recommended by the Public Health Service (PHS) Clinical Practice Guideline for smoking cessation
6. Oregon has more data on the OHP population than any other state
7. TPEP has competent and committed staff

WEAKNESSES

1. Limited resources including funding. Funded at 44% of CDC recommended funding level.
2. Working from a historical lack of trust of the former OHD and other governmental agencies on the part of various population groups.
3. There is a lack of best practices for disparate populations.
4. The DHS is in a period of transition because of a re-organization with the potential loss of visibility for public health issues.
5. Program is Portland based which leads to issues with communication and less attention being paid to people and programs outside this area.
6. Diverse populations are metro based, so more programming occurs in the metro areas

OPPORTUNITIES

1. Strong ongoing and new partners who can engage in advocacy for program efforts.
2. External funding opportunity by Legacy Foundation and technical assistance through the National networks.
3. New Governor and new legislative session provide opportunity to identify new champions.
4. Collaboration with other states and national partners who are working to reduce tobacco disparities.

THREATS

1. Additional revenue for the tobacco control programs unlikely due to Oregon's current budget crisis and budget difficulties from within federal funding agencies like the CDC.
2. Recurring legislative threats to re-direct tobacco program funding.
3. There is increased financial and political stress on partner agencies such as the health voluntaries and community-based organizations.
4. The tobacco industry continues to be a strong adversary, marketing its product to disparate populations and countering efforts to reduce tobacco use in Oregon through political and other means.
5. Both DHS and larger politics make it difficult to target politically controversial groups. Support and money don't necessarily go to the most effective group to implement strategies.