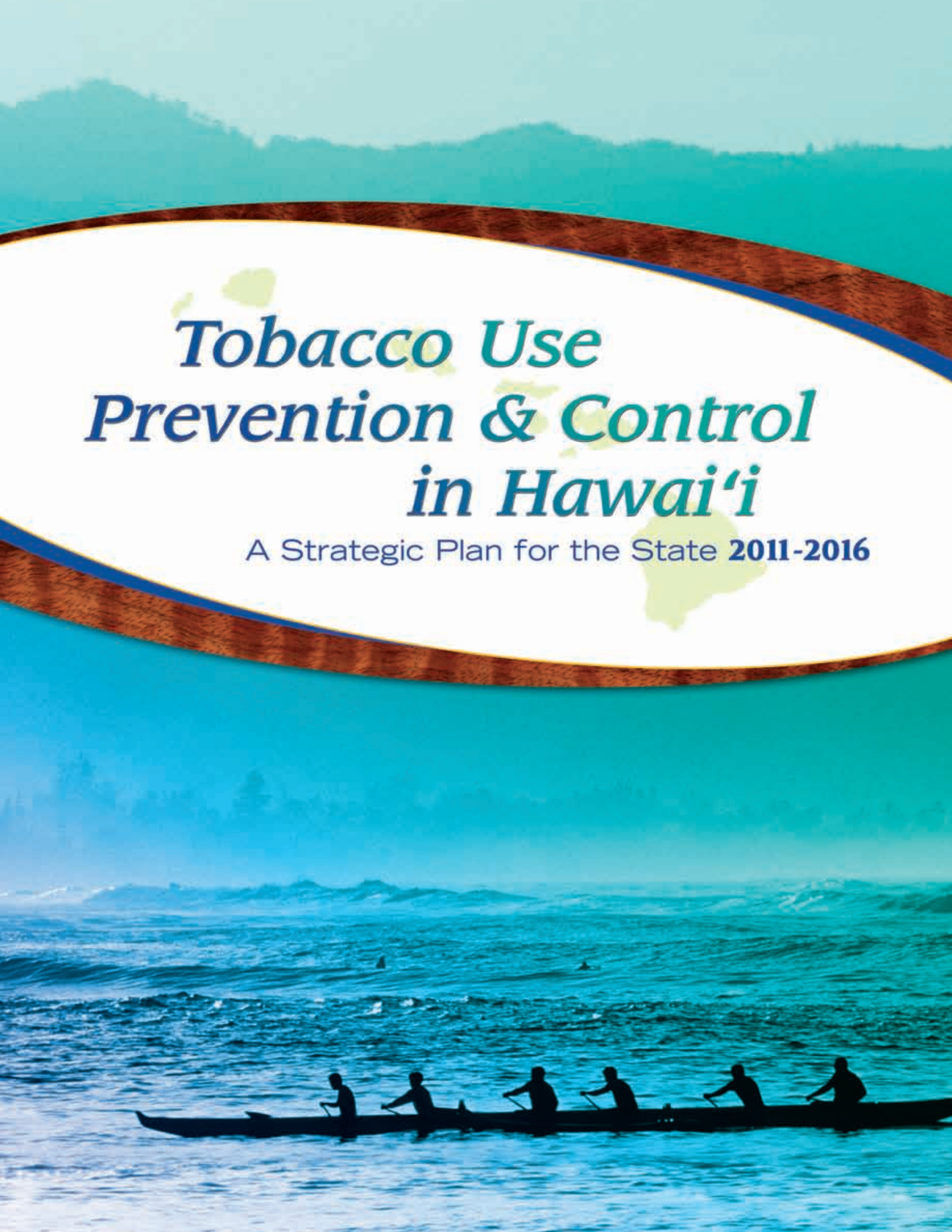
Tobacco Use Prevention & Control in Hawai'i

A Strategic Plan for the State **2011-2016**



The Hawai'i State Department of Health, the Tobacco Prevention and Control Trust Fund Advisory Board and the Coalition for a Tobacco-Free Hawai'i are pleased to present the 2011-2016 Strategic Plan for Tobacco Prevention and Control in Hawai'i. The Plan is intended to serve as the principal guide in the fight to reduce the health and economic burden of tobacco use in Hawai'i over the next five years. The Plan identifies and defines priority strategies, recommended community activities and targeted outputs, and provides key outcome indicators to measure progress.

The Plan was developed through an intensive community process that produced valuable information from public, private and community groups as well as individuals from across the state. Input was generated from numerous sources, including key informant interviews; a series of six community town hall meetings held across the state; a youth summit; and an electronic survey. The process culminated in a summit, held in September 2010, at which 100 stakeholders met to develop guiding principles and priorities. Further review and refinement were provided from both a steering committee and the Tobacco Prevention and Control Trust Fund Advisory Board.

The Plan is designed to provide organizations, communities and individual advocates with a blueprint to help focus and guide their resources around a common agenda and an evidence-based set of strategies that can be tracked over time. This plan is intended to be inclusive of the varied and diverse voices of our community. The components of this plan closely follow the best practices for comprehensive tobacco control programs recommended by the Centers for Disease Control and Prevention (CDC).

The Hawai'i Strategic Plan for Tobacco Prevention and Control reflects the diligent work of more than 200 individuals and organizations statewide. We hope that you will use this as an essential tool for planning, implementing and annually measuring progress toward common goals to reduce tobacco use in Hawai'i over the next five years.

Aloha,

Elizabeth Tam, MD
Chair
Hawai'i Tobacco Prevention and Control Trust Fund Advisory Board

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Since the previous Tobacco Use Prevention and Control in Hawai'i Five-year Strategic Plan (2005-2010), there have been significant gains in tobacco prevention and control in Hawai'i. Our adult and youth tobacco prevalence rates have dramatically decreased. We were the 14th state to pass comprehensive smoke-free legislation to protect workers and the public in the workplace. Hawaii's cigarette excise tax is currently the fourth highest in the nation. The Hawaii Tobacco Quitline was initiated and has provided assistance to more than 21,000 callers.

Yet there is still much work to be done. Tobacco use remains the leading cause of preventable death and disease in Hawai'i, claiming 1,100 lives each year and creating $336 million in annual health care costs directly attributed to smoking[1]. An estimated 145,700 adults in the state report being current smokers[2] and approximately 18,000 public high school youth report smoking cigarettes[3]. In addition, some populations are particularly at risk. People with low household incomes and/or education, the unemployed, the unmarried and young adults persistently have the highest smoking rates in the state. Native Hawaiians consistently have a higher smoking rate of any ethnic group in Hawai'i followed by Filipino adult males.[2]

An ongoing, comprehensive and strategic approach to tobacco-free living is crucial. To create a Hawai'i where no one uses tobacco and we are all free from secondhand smoke exposure, community members came together to provide input, plan, implement, assess and evaluate the vision and work for a tobacco-free Hawai'i. Diverse stakeholders from state and local government, community-based agencies and individuals participated in an extensive process in 2010 which culminated in this plan and its recommendations for the next five years.

Summary of the Plan

The five-year strategic plan (2011-2016) is intended to serve as the principal guide for promoting tobacco-free living in Hawai'i through the year 2016. It serves as a framework for programmatic direction and evaluation of efforts. The plan is an update to the previous strategic plan (2005-2010) and sets new goals and direction through 2016. The plan fulfills a strategic planning directive from the Centers for Disease Control and Prevention (CDC) and a statutory requirement of the Tobacco Prevention and Control Trust Fund Advisory Board.

The plan represents the work of experts, public health officials, nonprofit agencies and community representatives and was developed with active and diverse community participation. Its goals and recommendations were developed using the latest evidence-based research and data.

VISION, GOALS AND GUIDING PRINCIPLES

Vision

A Hawai'i free from tobacco use, nicotine addiction and exposure to secondhand smoke.

Goals

The tobacco prevention and control community of Hawai'i has adopted the following broad framework and goals based on national and international best practices.

Hawai'i will continue to focus on CDC's four goal areas for comprehensive tobacco control programs:

1) preventing initiation of tobacco use among youth and young adults;
2) promoting quitting among adults and youth;
3) eliminating exposure to secondhand smoke; and
4) identifying and eliminating tobacco-related disparities among population groups.

Hawai'i will utilize CDC's integrated framework from Best Practices for Comprehensive Tobacco Control Programs (October 2007) as the programmatic structure for implementing interventions.

- Statewide and Community Interventions
- Health Communication Interventions
- Cessation Interventions
- Surveillance and Evaluation
- Administration and Management

The Hawai'i Strategic Plan is in alignment with the US Department of Health and Human Services' Healthy People 2020 which has identified effective strategies to end the tobacco use epidemic:

- Fully funding tobacco control programs
- Increasing the price of tobacco products
- Enacting comprehensive smoke-free policies
- Controlling access to tobacco products
- Reducing tobacco advertising and promotion
- Implementing anti-tobacco media campaigns
- Encouraging and assisting tobacco users to quit

Guiding Principles

The tobacco prevention and control community in Hawai'i adopted the following principles in 2006 to guide its efforts. These principles remain significant and will carry the community forward for the next five years. They reflect the underlying philosophy against which strategies, programs and investments in tobacco prevention and control will be judged.

- The tobacco prevention and control plan for Hawai'i will be based upon the comprehensive approach defined by CDC in its *Best Practices for Comprehensive Tobacco Control Programs* (October 2007).
- Communities and populations served by the tobacco prevention and control system will be joint owners of that system, empowered in planning, decision making, implementation and evaluation to the maximum feasible extent.
- Effective tobacco prevention and control will require a long-term, sustained effort.
- Tobacco prevention and control programs carried out on a statewide basis must reach all segments of the population.
- Specific strategies will be identified for reducing tobacco-related disparities among priority groups and communities in Hawai'i.
- All islands will have opportunities to develop and implement their own ideas for what works best in their communities.

- Tobacco users are people with a serious addiction who need help and who must be treated with respect. They should be consulted in the planning and evaluation of prevention and control programs whenever possible.
- Tobacco prevention and control efforts must be able to compete with the aggressive and well-funded efforts of the tobacco industry, which is continually looking to addict new customers Hawaii's residents have a right to know the full impact of tobacco use on their communities and the economy, what is being done to reduce tobacco use and what is hindering progress in tobacco control.
- Hawaii's tobacco prevention and control efforts will be supportive of, coordinated with and informed by national and international best practices whenever feasible and appropriate.
- Tobacco prevention and control strategies will be evidence-based. Emerging strategies using new, innovative and promising practices are encouraged with ongoing evaluation of these efforts.
- Progress toward the plan's priorities will be regularly monitored and assessed in a public and transparent manner.
- Timely refinements to the plan will be made based on assessments, evaluation and research in a public and transparent manner.
- Tobacco prevention and control should be part of and consistent with a broader approach to encouraging healthy lifestyles and addressing health disparities.
- Meeting Hawaii's tobacco prevention and control goals will require identifying and tapping new and sustainable resources outside of the funds from the tobacco Master Settlement Agreement (MSA).

BURDEN OF TOBACCO

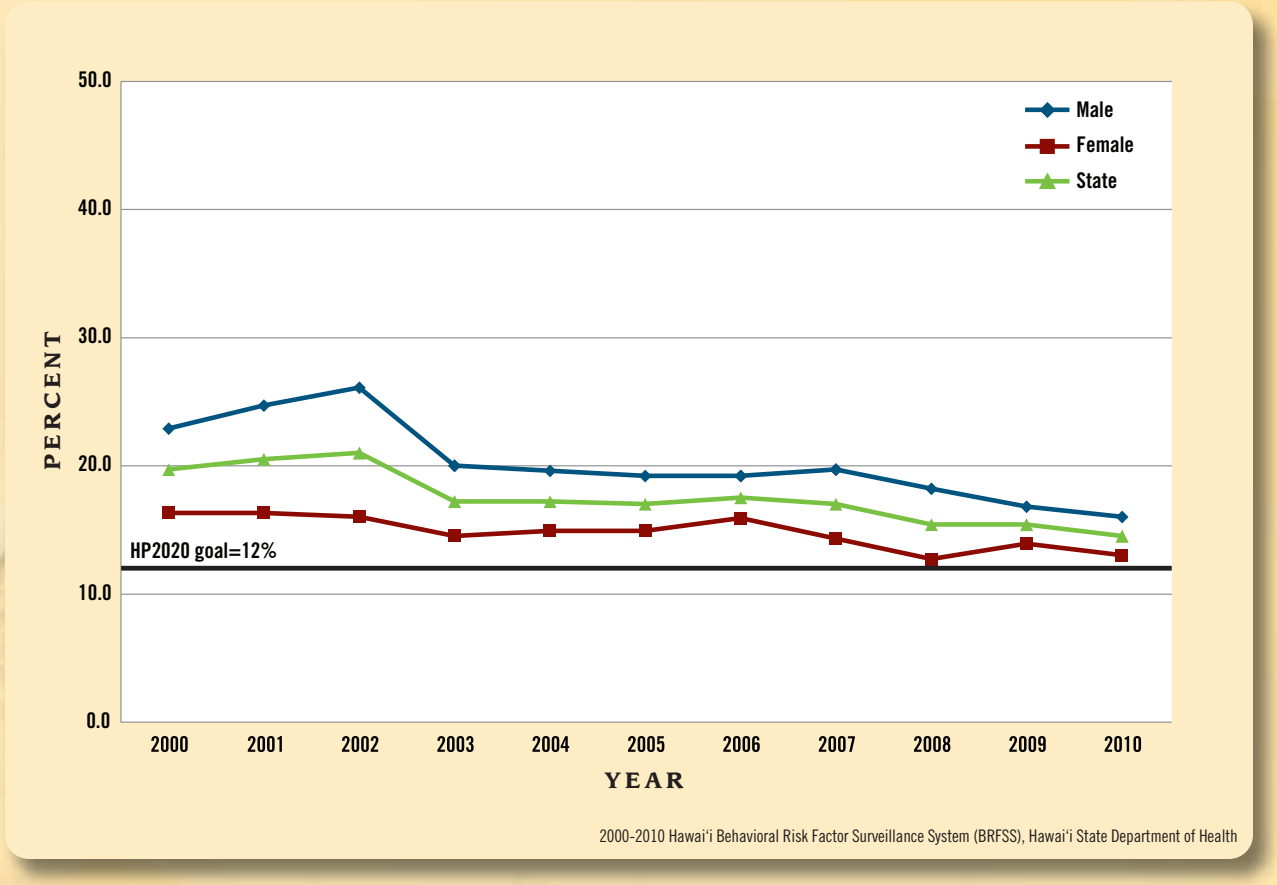
- Tobacco use is the single most preventable cause of death and disease in the United States and in Hawai'i.[4]
- Smoking harms nearly every organ in the body.[5]
- Half of all long-term smokers die prematurely from tobacco-related diseases.[5]
- All tobacco products, including smokeless products and cigars, cause cancer.[5]
- All forms of tobacco are addictive.[5]
- Secondhand smoke causes premature death and disease in children and adults who do not smoke.[6]
- There is no risk-free exposure to secondhand smoke.[6]
- Roughly 1,100 deaths each year in Hawai'i are attributable to smoking and 150 deaths are attributable to secondhand smoke.[1]
- Smoking-related costs in Hawai'i are separately estimated at:[1]
  - $336 million in health care costs
  - $320 million lost productivity costs
  - $117 million of all Medicaid expenditures
  - $624 per household tax burden

What are the most important tobacco control accomplishments in Hawai'i over the past five years?

- The smoke-free workplaces law
- Significant increases in cigarette tax
- Some of the tobacco settlement funds were preserved for the purpose of tobacco prevention and control.
- Starting and sustaining the Quitline; making it available to everyone
- County legislation on Big Island for smoke-free parks, beaches and cars with children
- Inroads made into voluntary policies for multi-unit residential homes

"Tobacco use is the single most preventable cause of death and disease in the United States and in Hawai'i."

Figure 1. **Prevalence of Current Smoking Among Adults by Gender, 2000-2010, State of Hawai'i BRFSS**



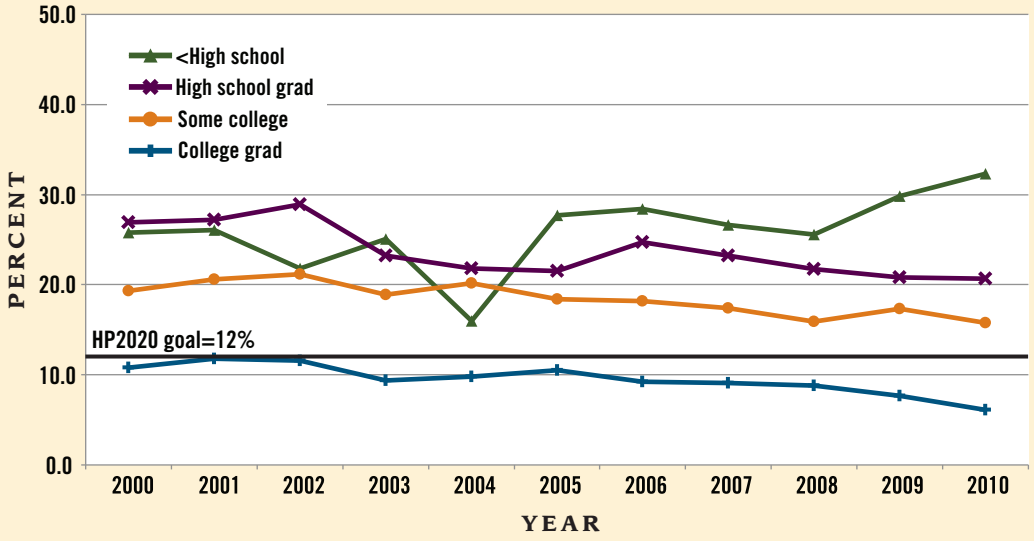
Based on the 2010 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS), there are an estimated 145,700 current adult smokers in Hawai'i, or 14.5% of the population, which is a statistically significant decline since 2002. Men continue to smoke at higher rates (16%) than women (13%).[2] In 2010, Hawai'i had the eighth lowest smoking rate in the country, according to CDC.[7]

Despite the significant gains in the last decade and an overall decline in tobacco use, certain communities and groups still have disproportionate rates of tobacco use.

Socioeconomic Disparities

The highest smoking rates in Hawai'i are among those smokers with lower educational levels. In 2010, 32.3% of residents with less than a high school education smoke.

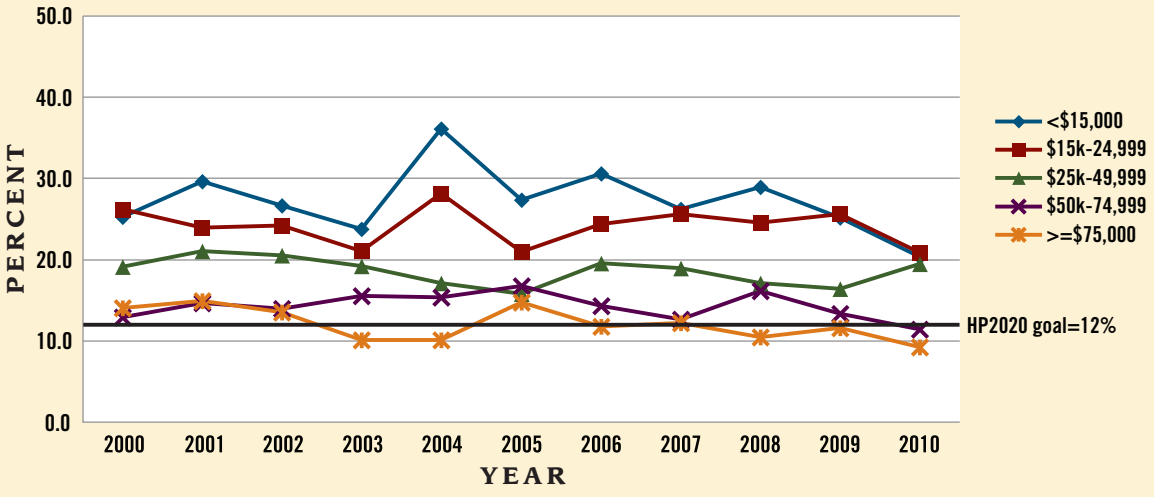
Figure 2. **Prevalence of Current Smoking by Educational level, 2000-2010, State of Hawai'i BRFSS**



2000-2010 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS), Hawai'i State Department of Health

The pattern of higher smoking rates among those with the lowest annual household incomes (less than $25,000 per year) in Hawai'i has persisted over ten years. This is consistent with the U.S. national pattern whereby tobacco use is more prevalent in low-income populations compared with high-income demographic groups.[7]

Figure 3. **Prevalence of Current Smoking by Income, 2000-2010, State of Hawai'i BRFSS**

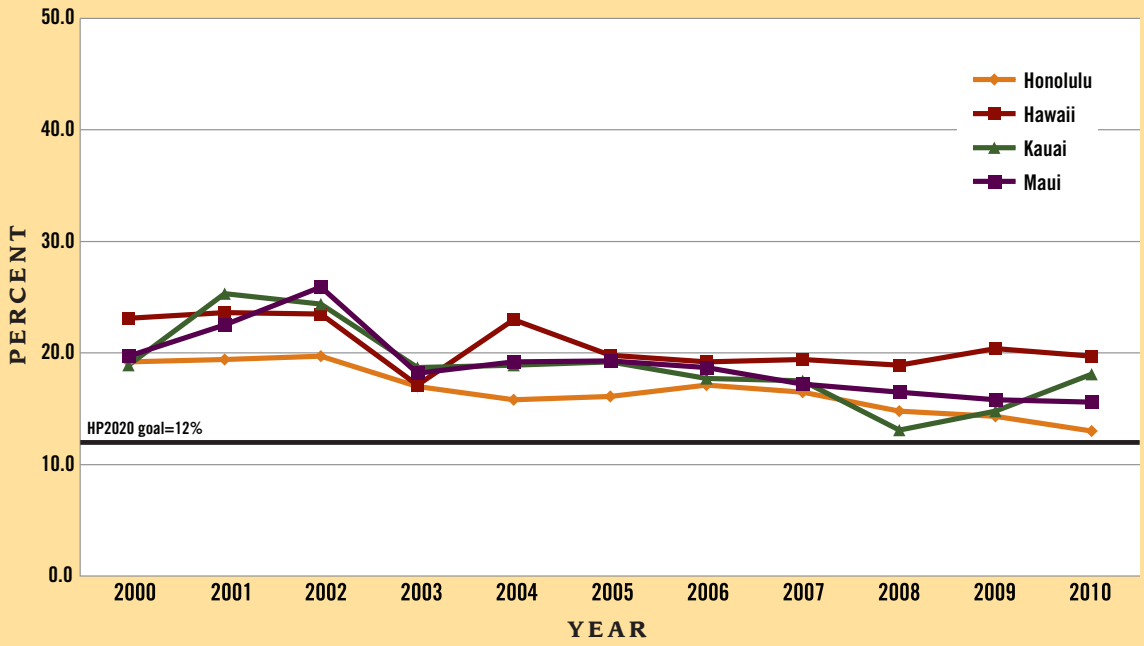


2000-2010 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS), Hawai'i State Department of Health

Geographic Disparities

There continue to be smoking rate differences based on geographic region. In 2010, the smoking prevalence rates for the counties in Hawai'i were: Honolulu County (13.6%), Hawai'i County (19.7%), Kauai County (18.1%), and Maui County (15.6%).

Figure 4. **Prevalence of Current Smoking by County, 2000-2010 State of Hawai'i, BRFSS**

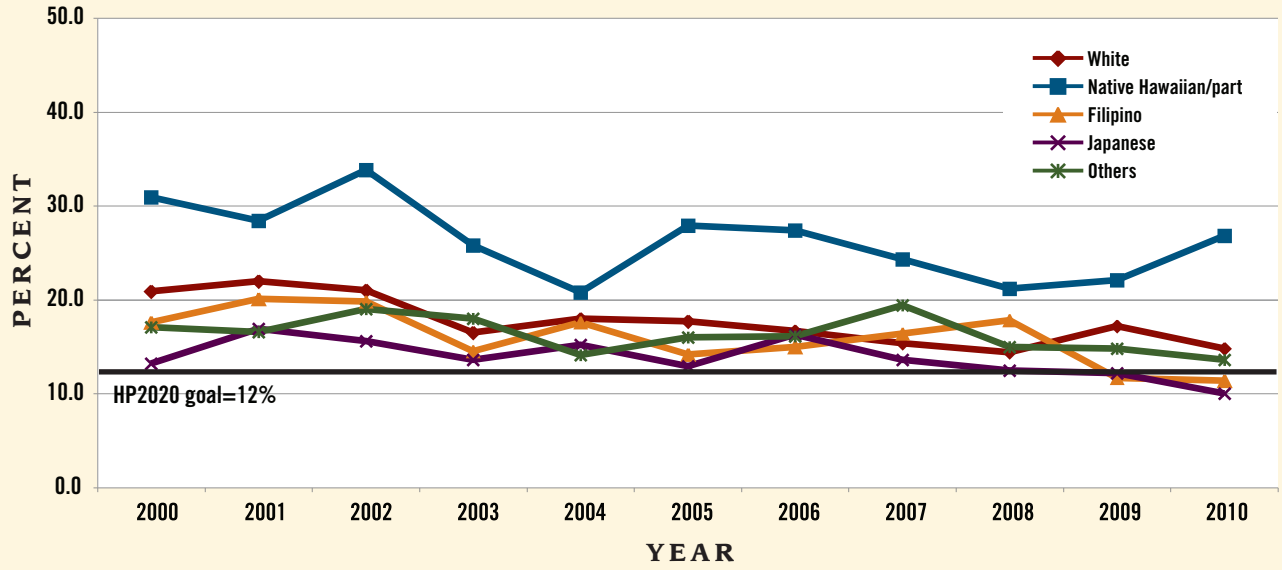


2000-2010 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS), Hawai'i State Department of Health

Ethnic Disparities

Native Hawaiians and part-Hawaiians are more likely to smoke than any other ethnic group in Hawai'i, with a smoking prevalence of 26.8%. In the general population, about one in seven adults smokes cigarettes; yet, among Native Hawaiians, more than one in five smoke. Native Hawaiian women are as likely to smoke as their male counterparts.

Figure 5. **Prevalence of Current Smoking by Ethnicity, 2000-2010 State of Hawai'i, BRFSS**



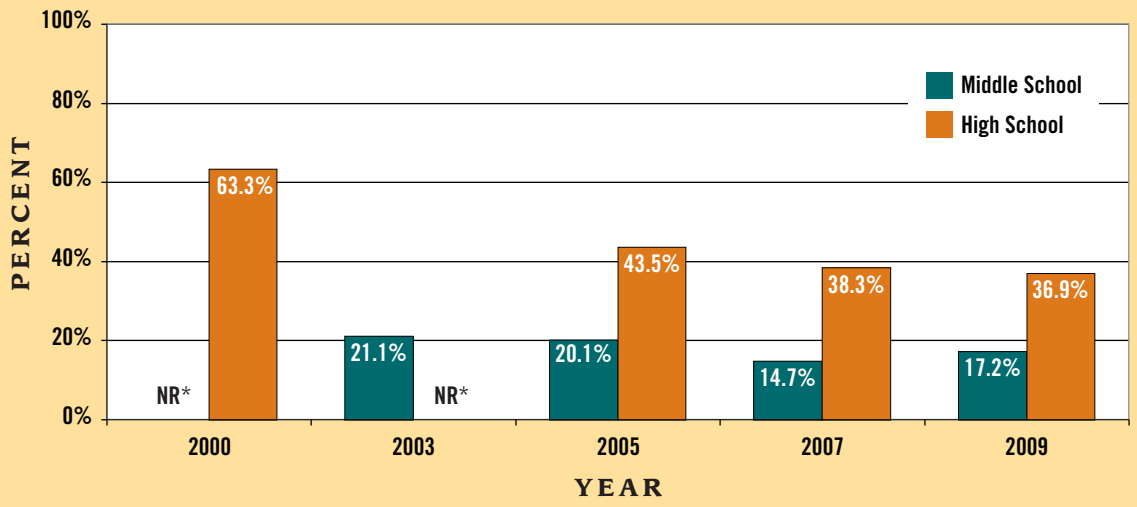
2000-2010 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS), Hawai'i State Department of Health

Youth Cigarette Smoking

Data from the 2000 Hawai'i Youth Tobacco Survey revealed that almost two-thirds of public high school students, or 63.3%, reported they had tried smoking cigarettes. However, by 2009, this number decreased dramatically to slightly more than one-third, or 36.9%, who had ever tried a cigarette, even one or two puffs.

In 2000, almost one-quarter of high school students, or 24.5%, were current smokers. By 2009, that number dropped by more than half to 11.4%. The downward trend was mirrored among middle school students as well, from 5.3 % in 2003 to 4.5% in 2009.

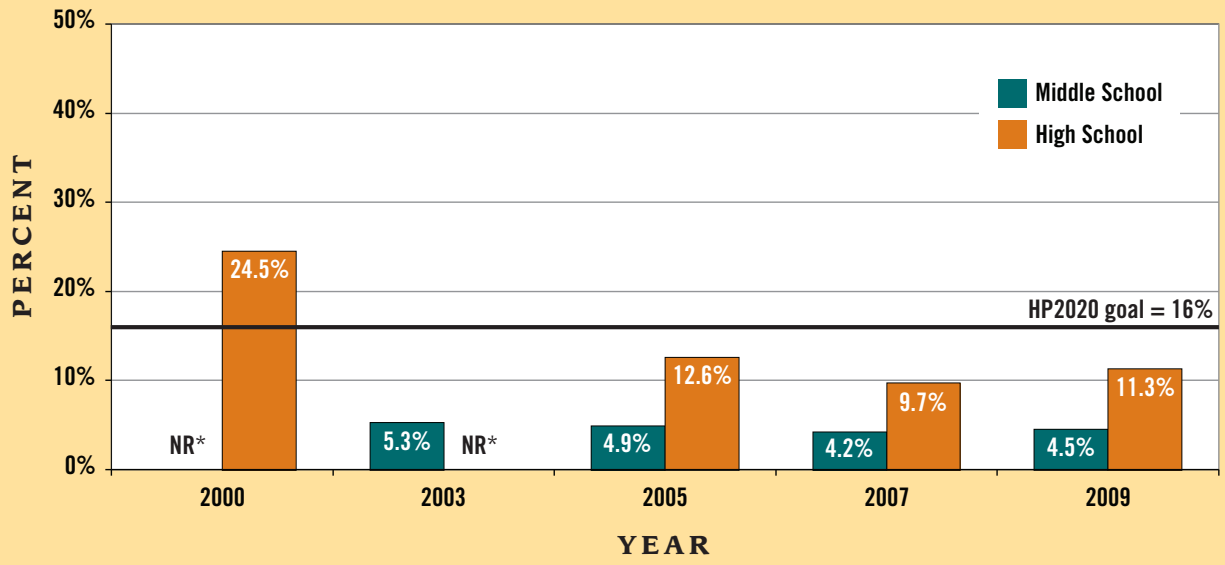
Figure 6. **Public Middle and High School Students Who Ever Tried Smoking, YTS 2000-2009**



2000-2009 Hawai'i Youth Tobacco Survey (YTS). Hawai'i State Department of Health

* **NR** (Not Reportable): 2000 MS and 2003 HS data were not reportable due to insufficient participation

Figure 7. **Public Middle and High School Students Who Smoked in the Last Month, YTS 2000-2009**



2000-2009 Hawai'i Youth Tobacco Survey (YTS). Hawai'i State Department of Health

* **NR** (Not Reportable): 2000 MS and 2003 HS data were not reportable due to insufficient participation

SOCIAL DETERMINANTS OF HEALTH

Tobacco use, like other risk factors for poor health and chronic diseases, is impacted by the social determinants of health. The social determinants of health have been defined as "the non-medical and non-behavioral precursors of health and illness."[8]

They are the conditions in which people are born, grow, live, work and age and include a person's ability to access health systems. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are major contributors to the development and persistence of health inequities - the unfair and avoidable differences in health status. Ultimately, creating environments and communities that actively support tobacco-free norms and provide the opportunities for all to remain free from tobacco's harmful effects will require a frank examination of the social determinants of health. Eleven key social determinants of health have been identified: aboriginal status; early life; education; employment and working conditions; food security; health care services; housing; income and its distribution; the social safety net; social exclusion; and unemployment and employment security.[8]

The Social Determinants of Tobacco Use[11]

Population health outcomes related to tobacco use depend on improving many of the fundamental social determinants of health, including:

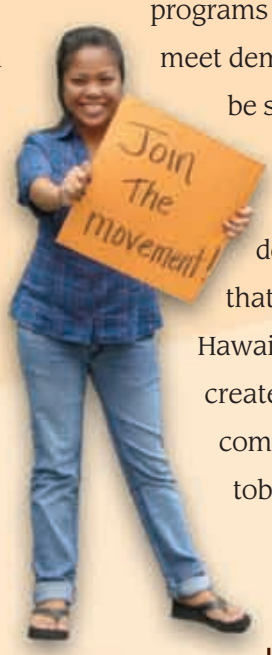
1) educational opportunities;
2) low income/poverty;
3) limited access to health services and supports, including insurance;
4) gender and gender identity;
5) sexual orientation;
6) racism and historical targeting;
7) culture and language;
8) physical environments, such as community, housing and work environments; and
9) limited social supports and social stressors.

Figure 8. **Socio-Economic Status (SES) and Smoking**

These social determinants of health can impact smoking in many ways. It is known that disparities persist in smoking rates in Hawai'i and across the nation, with people of low household incomes and low educational levels more likely to smoke than those with more resources, i.e. higher household incomes, education and better jobs. Poverty and chronic stress can limit people's ability to make healthy choices or change behavior. Understanding and addressing the nuances of how social determinants and social factors (as well as stigma) lead to the creation and persistence of tobacco use disparities must be part of the focus for tobacco prevention and control in the next five years.

TOBACCO PREVENTION AND CONTROL LANDSCAPE

Tobacco prevention and control in Hawai'i and the United States looks dramatically different now than it did during the development of the state's 2005-2010 strategic plan. Statewide, several positive changes have taken place, such as the enactment of a comprehensive smoke-free workplace law; an increase in the number of smoke-free areas; implementation of the Hawaii Tobacco Quitline; and an increase in the cost of tobacco, most notably cigarettes. On the other hand, there has been a reduction in dedicated funding for tobacco prevention and control. Still, successful comprehensive programs and services continue to keep children from initiating tobacco use and help those who smoke or use tobacco products to quit.



In addition to strong state policies, the passage of three federal laws related to tobacco control has presented new opportunities to reduce tobacco use. Those measures include a $1.00 increase in the federal excise tax, as well as passage of the Family Smoking Prevention and Tobacco Control Act and the Patient Protection and Affordable Care Act. Existing laws at all levels (county, state and federal) require constant attention. At the county and state level, legislation must be protected and improved; and at the federal level, implementation and impact must be monitored to align with reducing tobacco use in Hawai'i.

A constant issue is funding for tobacco prevention and control efforts. As policies change to drive more people to address their tobacco dependence, treatment programs must have the resources and capacity to meet demand. Additionally, advocacy efforts must be supported to maintain strong and protective laws and to address the emerging efforts of the tobacco industry, which continues to develop new products and promote legislation that encourage tobacco use and addictions. Hawai'i must take advantage of new opportunities created by federal legislation that encourage community-level policy-making to counter the tobacco industry.

Comprehensive Smoke-Free Workplaces Law and Increased Smoke-Free Areas

In 2006, Hawai'i passed its Smoke-Free Workplaces Law (§328J, HRS), which protects children, families and workers from secondhand smoke exposure in enclosed and partially enclosed areas open to the public. Since its passage, there have been numerous efforts to weaken the law through exemptions. Thus far, all efforts to weaken the law have failed. Fortunately, the law has remained intact and strong and continues to be a critical component in efforts to create a tobacco-free culture in Hawai'i.

In late 2010, Governor Linda Lingle signed the administrative rules that provide the state department of health with the authority to oversee implementation of the 2006 smoke-free law. These rules provide that the health director can designate inspectors. Since 2006, the Hawai'i State Department of Health (DOH) has monitored compliance with the Smoke-Free Workplaces Law, but did not have the authority to issue citations. When the DOH received complaints, certified letters were sent to the business owners indicating the alleged violation and providing helpful information on how to comply with the Smoke-Free Workplaces Law.

Policy changes that reduce exposure to secondhand smoke are a critical piece of effective tobacco control. Even though more than 90% of Hawaii's public high school students think that secondhand smoke is harmful, 46% of those who have never smoked and 84% of current smokers report being exposed to tobacco smoke in a room in the last week. Twenty-five percent of high school students in Hawai'i, who never smoked, and 73% of current smokers were exposed to second-hand smoke in an automobile.[3]

In addition to strong state laws aimed at limiting exposure to secondhand smoke, the Hawai'i County Council passed legislation to prohibit smoking or use of any tobacco products at county parks and recreational facilities (which includes beaches) in 2008 (§14-21(b) Hawai'i County Code) and in 2010, passed legislation prohibiting smoking in a motor vehicle whenever occupied by a person less than eighteen years of age (§14-21(a)(12) Hawai'i County Code).

TOBACCO PREVENTION AND CONTROL LANDSCAPE

Tobacco Taxes

Hawai'i has continued to raise the cost of tobacco products through increases in taxes. The cigarette tax increased to 15 cents per stick ($3 per pack) on July 1, 2010, and increases again to 16 cents per stick ($3.20 per pack) on July 1, 2011. Hawai'i is now one of five states with taxes of $3 or more and currently ranks fourth highest in the country regarding cigarette taxes.

Taxes on other tobacco products (OTP) have been modified as well. Part of this modification includes new categories of OTP: little cigars, large cigars, and tobacco products, which include snuff, chew, snus, and all other forms of tobacco. Little cigars are defined as rolls for smoking made of tobacco that weighs no more than four pounds per thousand; large cigars are those that exceed four pounds per thousand. OTP are tobacco products that are neither cigarettes nor little or large cigars. Little cigars are now taxed as cigarettes at 15 cents per stick starting on July 1, 2010, and will increase to 16 cents per stick on July 1, 2011. Large cigars are taxed at 50% of the wholesale price. All other tobacco products are taxed at 70% of the wholesale price.

Tax revenue from the sale of tobacco has steadily increased despite decreases in smoking rates.

What will be the most important challenges facing Hawai'i in tobacco control over the next five years?

- The influence of the tobacco industry
- In the face of the recession, people may turn to smoking more
- Cheap and illegal or free sources of cigarettes; circumventing the taxes; industry subsidizing of cigarettes
- General public thinks the tobacco epidemic is solved in part because of our success
- Maintaining an ongoing source of funding to support community tobacco control initiatives

Figure 9. **Reduction in Smoking 1997-2010**

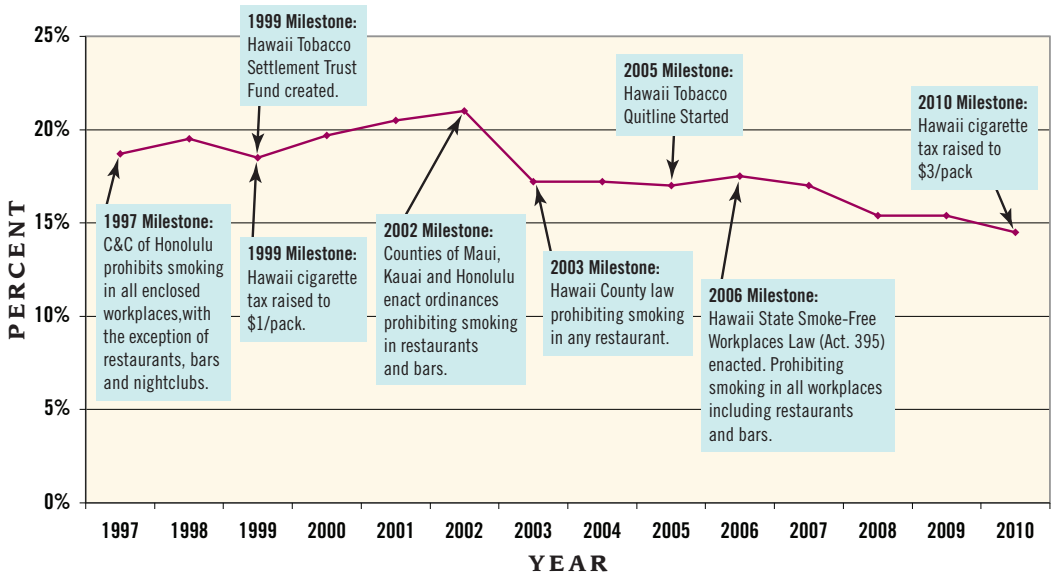
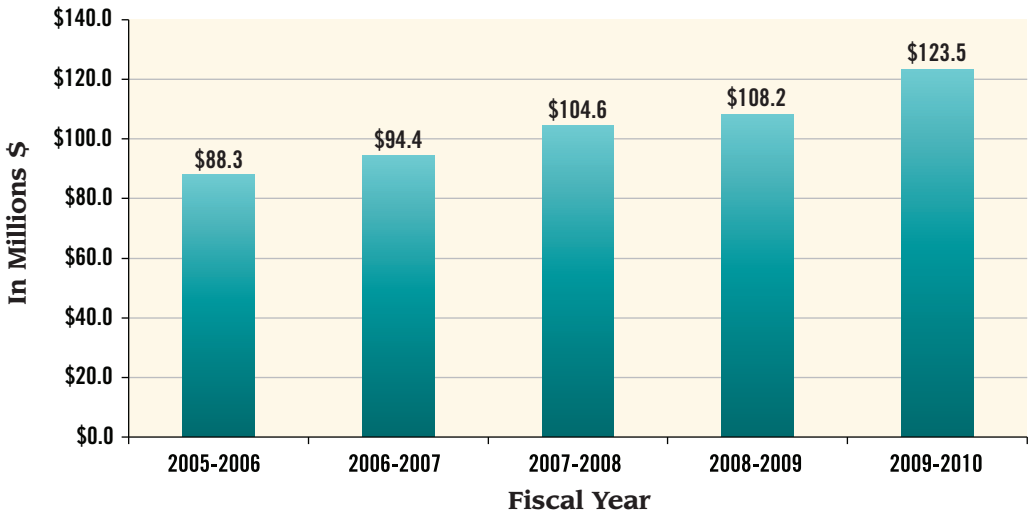


Figure 10. **Total Tobacco Tax and Licenses Collections**



Data compiled from annual reports from the Hawai'i State Department of Taxation. Available at: http://www6.hawaii.gov/tax/a5_3txcolrptarchive.htm

PARTNER AGENCIES AND PROGRAMS

In addition to the strong state policies in place, successful programs continue to provide services to Hawaii's communities. There are many agencies and organizations in Hawai'i that participate in the broad-based efforts against tobacco addiction. Key stakeholders and efforts include:

Hawai'i State Department of Health

The Hawai'i State Department of Health (DOH) contributes to tobacco prevention and control via several efforts: the Tobacco Prevention and Education Program (TPEP), Tobacco Settlement Project / Healthy Hawai'i Initiative (TSP/HHI) and the Alcohol and Drug Abuse Division (ADAD).

TPEP is the official state government program addressing tobacco control in Hawai'i. It has been funded by CDC since 1994 through the comprehensive National Tobacco Control Program. TPEP focuses on the four major CDC program goals and provides the infrastructure for the state's strategic efforts. Among its work, TPEP fosters collaboration among the state and local tobacco control community through the provision of funding that supports local coalition work to strengthen community capacity to address tobacco use. TPEP also provides program oversight, technical assistance, education and training.

The Tobacco Settlement Special Fund (TSSF) is administered by the DOH, and more specifically, the reporting, departmental implementation and coordination of the requirements for §328L-2, 4, 5 and 6, HRS, is managed by the HHI. As of fiscal year (FY) 2010 the DOH portion of the TSSF was reduced from 25% to 15%. Furthermore, from FY2010 all general funded positions and operating expenses in the Chronic Disease Management Control Branch (CDMCB) were transferred from general funds to the TSSF. CDMCB was administratively combined with TSP/HHI. With this transfer, no general funds in the state are used for programs in the DOH for the prevention, control and management of chronic diseases. More specifically, the program areas cover, nutrition, physical activity, obesity prevention, tobacco, asthma, cancer, diabetes, and heart disease and stroke. The DOH now funds 38 FTE (full-time equivalent) positions with the DOH 15% net portion of the TSSF.

The DOH established the HHI pursuant to §328L-4, HRS, for health promotion and disease prevention programs to prevent and reduce the personal and societal burden of chronic diseases, such as diabetes, heart disease, and cancer. The TSSF in the DOH is used specifically for tobacco prevention and control activities through TPEP and ADAD.

ADAD conducts surveillance and enforcement of the youth tobacco access laws. At 11.2%, the Hawai'i retail violations rate (RVR) was among

43 of the 50 states and the District of Columbia that achieved and RVR rate below 15.0%. (States must maintain an RVR rate below 20% to comply with Synar Amendment requirements to decrease youth access to tobacco.)

Community Programs Preventing Youth Tobacco Use and Helping Smokers Quit

In 2006, three-year grants were offered for tobacco prevention and cessation. In 2007, a series of grants to support new innovations were offered, followed in 2009, by a three-year cycle of community grants. In 2011, a new two-year cycle of community grants will focus on tobacco cessation.

Between 2001 and 2009, more than $23 million in community grants was awarded to programs working to reduce tobacco use through tobacco treatment or youth prevention. In addition, the trust fund has supported the state's quitline, adult and youth advocacy efforts, and a statewide media campaign created to encourage people to quit and make their environments smoke-free.

Summary List of Organizations Funded by the Tobacco Prevention & Control Trust Fund Through the Community Grants Program (2000-2009)

Aloha Pride Center (formerly called The Center)
Alu Like
American Cancer Society
American Lung Association
Boys & Girls Club of Hawai'i
Boys & Girls Club of Maui, Inc.
Boys & Girls Club of the Big Island
Castle Medical Center
Child & Family Service (CFS)
Coalition for a Drug Free Hawai'i
Community Clinic of Maui, Inc.
Hawai'i COPD Coalition
Friends for Fitness
Friends of Operation Manong
Friends of the Future
Grassroots Community Development Center
Hale Kipa Inc.
Hale Opio
Hawai'i State Primary Care Association
Hawai'i Youth Services Network
Healthy Mothers Healthy Babies Coalition of Hawai'i
Ho'ola Lahui Hawai'i
Hui Malama Learning Center
Hui Malāma Ola Nā 'Ōiwi
Kaala Farms
Kalihi-Palama Health Center
Kaua'i Economic Opportunity, Inc.
Kaua'i Rural Health Association
Kokua Kalihi Valley Comprehensive Family Services
Konawaena High School
Maui Economic Opportunity, Inc.
Maui Youth & Family Services
Na Lei Wili Area Health Education Center
Paia Youth Council Inc.
Palama Settlement
Papa Ola Lokahi
Parents & Children Together (PACT)
The Path Clinic
The Hawai'i Academy of Family Physicians Foundation
The Queen's Medical Center
The Salvation Army
The Salvation Army – Family Intervention Services
University of Hawai'i – Office of Research Services
University of Hawai'i at Hilo
Wai'anae Coast Community Mental Health Center, Inc.
Wai'anae District Comprehensive Health & Hospital Board, Inc.
Waipahu High School
West Hawai'i Community Health Center
West Hawai'i Tobacco-Free Coalition
Wilcox Health Foundation

Prepared by the Department of Health in January 2011.

Hawaii Tobacco Quitline

The Hawaii Tobacco Quitline has provided tobacco users with assistance to quit since 2005. Since its inception, the Hawaii Tobacco Quitline has received more than 21,000 calls from tobacco users, family and friends of tobacco users, and health care providers. In 2010, 1.43% of current smokers called the Hawaii Tobacco Quitline — a success compared to the average U.S. quitline reach of 1%. In 2005, participants in the free intensive counseling program with nicotine replacement therapy achieved a 30% abstinence rate (reporting no tobacco use in the last 30 days at the time of follow-up), which demonstrates the success of the Hawaii Tobacco Quitline program.

In 2009, the Hawai'i Tobacco Prevention and Control Trust Fund partnered with the University of California, San Diego, which received a grant from CDC to provide free in-language counseling services and nicotine replacement therapy to Hawai'i tobacco users who speak Cantonese, Mandarin, Korean and Vietnamese.

REAL: Hawaii's Youth Movement Exposing the Tobacco Industry

REAL has multiplied its membership to more than 4,000 young people across Hawai'i speaking out against the tobacco industry and advocating for issues that seek to reduce the industry's influence over youth. In 2006, REAL was instrumental in leading actions at the state capitol that motivated Governor Lingle to sign the Smoke-Free Workplaces Law. REAL reaches out to youth and young adults through countermarketing campaigns such as "Share the Love," which was developed to play off an American Spirit coupon giveaway. Instead of "sharing the love" by giving someone a coupon for free cigarettes, REAL sought to "share the love" by educating the community about the tobacco industry and providing support for those trying to quit.

The Coalition for a Tobacco-Free Hawai'i

The Coalition for a Tobacco-Free Hawai'i is a 501(c)(3) nonprofit with a mission to build, sustain and support a statewide coalition to create a tobacco-free Hawai'i. A major focus of the Coalition is influencing policy and system change at state, local, and institutional levels. With major funding provided by the Hawai'i State Department of Health and the Tobacco Prevention and Control Trust Fund, the Coalition staffs local tobacco-free coalitions on all major islands.

The Coalition continues to be Hawaii's only nonprofit organization whose sole mission is to reduce tobacco use. In 2006, the Coalition led the comprehensive statewide campaign to pass the Smoke-Free Workplaces Law, and in 2010, successfully defended against possible funding cuts to tobacco prevention and control. The Coalition

continues its efforts to increase smoke-free areas through its Smoke-Free Homes initiative, which offers online resources for owners and managers of multi-dwelling units impacted by secondhand smoke. The Coalition also provides support to worksites that want to include tobacco cessation as part of their worksite wellness plans. In large part, the Coalition draws together tobacco control advocates to address policy changes that will reduce exposure to secondhand smoke and access to tobacco, and increase accessibility and availability of tobacco treatment to those who wish to quit.

Additional Stakeholder Agencies and Organizations

There are many large and small agencies and organizations that play an important role in tobacco prevention and control in Hawai'i. All participants who helped develop this plan are listed in Appendix C.

Integration with other Chronic Disease and Public Health Efforts

Tobacco control in Hawai'i will strive to integrate its efforts with other chronic disease programs to address diseases that are caused or worsened by tobacco use, including numerous cancers, heart disease and stroke, and chronic lung and respiratory diseases, among others. Addressing tobacco control in the broader context is beneficial for three reasons. First, it is critical that interventions are implemented to alleviate the existing burden of disease caused by tobacco. Second, incorporating tobacco prevention and cessation messages into broader public health activities assures wider dissemination of tobacco control strategies. Finally, tobacco use in conjunction with specific diseases, co-morbidities and risk factors such as sedentary lifestyle, poor diet and/or existing chronic disease (diabetes, heart disease, lung disease) poses a greater combined risk than the sum of each individual degree of risk. Integration in these areas has the potential to synergistically move the state to reach desired outcomes. Integration is also an opportunity to begin to address health disparities and health inequities through understanding the social determinants of health across all chronic disease programs.

PRIORITY STRATEGIES

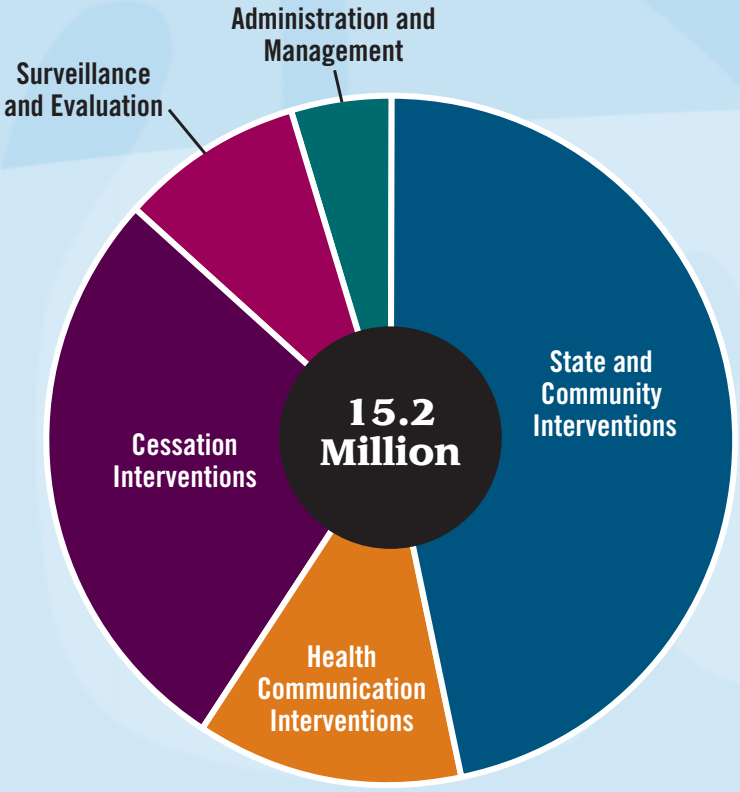
The 2011-2016 Hawai'i Strategic Plan addresses four priority goal areas. CDC, through its National Tobacco Control Program (NTCP), established these four priority goal areas to address the larger goal of reducing tobacco-related disease and preventable death. This section describes the rationale upon which tobacco prevention and control is based in each priority goal area.

1. *Preventing the initiation of tobacco use among young people*
2. *Promoting quitting among adults and young people*
3. *Eliminating exposure to secondhand smoke*
4. *Identifying and eliminating tobacco-related disparities among population groups*

In addition, CDC also issues recommendations on how to achieve these goals. In its *Best Practices for Comprehensive Tobacco Control Programs*, which was revised in 2007, CDC describes an integrated programmatic structure for implementing interventions proven to be effective. Based on the evidence of documented scientific literature, the most effective population-based approaches have been defined within the following overarching components:

1. **State and Community Interventions**
   (Multiple societal resources working together have the greatest long-term population impact.)
2. **Health Communication Interventions**
   (Strategic, culturally appropriate, high-impact and adequately funded media campaigns and messages prevent tobacco use initiation, promote cessation and shape societal norms.)
3. **Cessation Interventions**
   (Policy, system and population-based interventions to increase cessation are effective and have the potential to reach large numbers of tobacco users.)
4. **Surveillance and Evaluation**
   (Publicly-financed programs should be accountable and demonstrate effectiveness.)
5. **Administration and Management**
   (Complex, integrated programs require experienced staff to provide fiscal management, accountability and coordination.)

In "*Best Practices*," CDC also recommends ideal state spending levels for each component to reduce tobacco use. It is recommended that Hawai'i spend $15.2 million annually for its state tobacco control programs.



CDC allocates this $15.2 million as follows:

$7.1 million in State and Community Interventions;
$1.9 million in Health Communication Interventions;
$4.2 million in Cessation Interventions;
$1.3 million in Surveillance and Evaluation; and
$0.7 million in Administration and Management

"The Hawaii Tobacco Quitline, launched in 2005, offers free local and confidential support for anyone who is ready to quit tobacco in Hawai'i."

The ***Logic Models*** on the following pages are patterned after the CDC template for the four goal areas. Logic models are graphic depictions of the presumed causal pathways that connect program inputs, activities, outputs, and outcomes. These specifically identify tobacco control priority strategies, activities, outputs, short-, intermediate-, and long- term outcomes.

The ***Activities and Outputs*** (also in the four goal areas) list the identified priority strategies and offer broad recommendations for community activities and measurable target outputs.

Prevention

Preventing and eliminating tobacco use among young people are the standards for success in changing the social environment and creating a statewide norm where tobacco use becomes an unacceptable behavior. The theoretical model associated with preventing young people from starting to use tobacco begins with increasing their knowledge of the dangers of tobacco use, changing their attitudes toward tobacco use, and increasing public support for the policies that reduce the likelihood that young people will use tobacco.[12]

The current smoking prevalence rate among public high school students in Hawai'i dropped from 24.5% in 2000 to 9.7% in 2007 and now sits at 11.3%. For middle school students, current smoking went from 12.9% in 2000 to 4.2% in 2007 and is now at 4.5%.[3]

Interventions to prevent tobacco-use initiation and encourage cessation among young people need to support tobacco-free norms. Community programs and school-based policies and interventions should be a part of a comprehensive effort. In addition, it is important to increase the price of tobacco products and sustain anti-tobacco media campaigns[13]. Reducing illegal tobacco sales to minors and countering pro-tobacco marketing are being addressed by focusing efforts on tobacco advertising and promotional practices in retail outlets in Hawai'i.

Engagement of youth in tobacco control efforts has evolved in Hawai'i as well as in the nation. Strategies for influencing youth have changed over the years from the assumption that young people simply needed access to the right information to reject tobacco to the recognition that youth's choices are more influenced by their social environments (peers, family and media).[14] Youth engagement is now a common practice in coordinated tobacco control policy strategies, and young people are now considered part of the solution instead of part of the problem.[15]

To reap the largest gains in changing social norms around tobacco use, programs that engage youth should focus on transforming community environments to make it easy and acceptable for young people to reject tobacco use.[11] Young people can enhance policy-driven goals by participating in policy and media advocacy, forming community linkages and fighting pro-tobacco influences.[15]

For example, REAL: Hawaii's Youth Movement Exposing the Tobacco Industry, established in 2000, exists as an empowered youth movement whose aim is to raise awareness of and educate youth about the manipulative strategies used by the tobacco industry to addict young people.

Goal: Prevent the initiation of tobacco use among all of Hawaii's people

Priority Strategy	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
A. Provide evidence-based prevention programs for young people through school and community-based programs.	School and community-based prevention programs	Completed activities to increase use of anti-tobacco curricula in all schools and community settings	1. Increased anti-tobacco programs in schools and communities	6. Reduced susceptibility to experimentation with tobacco products	8. Reduced initiation of tobacco use by young people 9. Reduced tobacco use prevalence among young people
B. Educate youth and young adults, families and communities about tobacco hazards, marketing efforts by the tobacco industry and benefits of a tobacco-free lifestyle.	Counter-marketing activities	Completed activities to reduce and counteract pro-tobacco messages	2. Increased knowledge of, improved attitudes toward and increased support for policies that reduce youth linitiation		
C. Increase capacity in local youth and priority populations to create peer-to-peer messages that counter tobacco industry influences.	Capacity building among youth and priority populations	Completed activities to deliver anti-tobacco and pro-health messages from youth and priority populations			
D. Maintain surveillance systems to monitor and respond to youth tobacco use trends, including other tobacco products and use of emerging products as well as attitudes.	Surveillance systems	Completed activities which incorporate public and private schools in surveillance systems data collection			
E. Promote policy change to reduce accessibility of tobacco and non-FDA-approved nicotine products.	• Policy and regulatory actions • Community mobilization	• Completed activities to increase cigarette excise tax • Completed activities to increase restrictions on tobacco sales to minors and to enforce those restrictions	3. Reduced tobacco industry influences 4. Increased restriction and enforcement of restrictions on tobacco sales to minors 5. Increased price of tobacco products	7. Decreased access to tobacco products	

Goal: **Prevent the initiation of tobacco use among all of Hawaii's people**

Priority Strategy	Recommended Community Activities	Possible Outputs
A. Provide evidence-based prevention programs for young people through school and community-based programs.	• Provide evidence-based, tobacco-use prevention programs in DOE schools that meet DOE health standards (State and Community Interventions) • Provide evidence-based, tobacco-use prevention programs in after-school and community-based programs (State and Community Interventions) • Expand evidence-based, tobacco-use prevention programs in private schools (State and Community Interventions)	• At least one teacher training provided per year on delivery of curriculum- based tobacco education that involves parents/families • Programs offered in after-school or community-based program in at least 3 at-risk communities on Oahu and at least 1 on each neighbor island; these programs have components to involve parents/families • At least one teacher training provided per year on delivery of curriculum-based tobacco education that involves parents/families
B. Educate youth and young adults, families and communities about tobacco hazards, marketing efforts by the tobacco industry and benefits of a tobacco-free lifestyle.	• Produce and disseminate counter-marketing campaigns to at-risk families and communities (Health Communication Interventions) • Produce and disseminate statewide counter-marketing campaigns to the public, including youth and young adults (Health Communication Interventions)	• Materials for at-risk families and communities developed by July 2011 • At least 1 statewide counter-marketing campaign produced/sustained and disseminated statewide each year targeted to youth and 1 targeted to young adults
C. Increase capacity in local youth and priority populations to create peer-to-peer messages that counter tobacco industry influences.	• Establish youth-developed counter-marketing campaigns for youth and young adults. (Health Communication Interventions) • Link school-based programs to youth development programs and community events that support anti-tobacco campaigns (Health Communication Interventions) • Maintain and expand a statewide youth movement through annual paid counter-marketing and mass media education campaigns (Administration and Management)	• At least 1 statewide counter-marketing campaign produced/sustained and disseminated statewide each year targeted to and developed by youth and 1 targeted to and developed by young adults • At least 3 community grants that support youth development and empowerment and programs for message development and dissemination should be issued • A biennial youth summit will be conducted to provide training and build capacity to counter tobacco industry influence
D. Maintain surveillance systems to monitor and respond to youth tobacco use trends, including other tobacco products and use of emerging products as well as attitudes.	• Maintain and sustain the Hawai'i Youth Tobacco Survey and support the Youth Risk Behavior Survey (Surveillance and Evaluation) • Incorporate public and private schools in surveillance systems data collection (Surveillance and Evaluation	• At least biennially conduct HYTS and YRBS at county level on alternate surveillance cycles • Surveillance reports will integrate data from both Hawai'i public and private schools
E. Promote policy change to reduce accessibility of tobacco and non-FDA-approved nicotine products.	• Ensure funding to community-based organizations, community coalitions and youth-based organizations to advance policy and social norm change to reduce tobacco accessibility (Administration and Management) • Increase the state excise tax on cigarettes, other tobacco products in substantial increments rather than gradual increases over time (State and Community Interventions) • Increase limitations of advertising of tobacco products in retail outlets (State and Community Interventions) • Create policies that are compliant with or enhance FDA regulations on tobacco-product placement (State and Community Interventions) • Limit tobacco permits granted (State and Community Interventions) • Monitor compliance with tobacco control policies (State and Community Interventions)	• Increased level of community activism to support policy changes • State excise tax on all cigarettes increased (100%) over the 2010 amount • Amount of state excise tax on other tobacco products increased by 100% over the 2010 amount • Portion of tax earmarked for tobacco prevention and control activities • New policies limiting tobacco advertising enacted • New policies enacted to bring Hawai'i closer to compliance with FDA • New policy changes to limit location and/or number of permits granted • Ban tobacco sales in pharmacies • Number of compliance assessments conducted (at least) annually

Cessation

Tobacco dependence is a chronic disease that often requires repeated interventions and multiple quit attempts. Of the 14.5% of Hawaii's population that are current smokers, 60% of these smokers reported that they had stopped smoking for one day or longer while trying to quit smoking.[2]

Interventions that increase the success of quitting attempts can decrease premature mortality and tobacco-related health care costs in the short-term.[16,17] The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, cites that tobacco dependence treatments, such as counseling and the use of pharmacotherapy, are effective across a broad range of populations. Tobacco use screening together with brief interventions by clinicians is a top-ranked clinical preventive service in terms of health impact, effectiveness and cost-savings.[19]

Quitlines are also among the most cost-effective clinical preventive services and can reach large numbers of smokers through promotion and clinical referral.[19,20] The Hawaii Tobacco Quitline, launched in 2005, offers free local and confidential support for anyone who is ready to quit tobacco in Hawai'i. Pharmacotherapy is also currently provided without cost to the caller. The Asian Smokers' Quitlines provide in-language counseling services to Hawai'i tobacco users who speak Korean, Cantonese, Mandarin or Vietnamese.

Since 2002, Hawai'i has offered training and technical assistance in Basic Tobacco Intervention Skills Certification to more than 1,500 participants. Experts have also been brought to Hawai'i to provide advanced Tobacco Treatment Specialist training to increase the skills and abilities of cessation service providers from health centers and organizations.

There are more than 30 community- and hospital-based tobacco cessation service providers currently providing tobacco dependence treatment services across the state. To reach disparate populations, community health centers provide a variety of comprehensive tobacco treatment programs that include culturally appropriate interventions for their clients. These interventions include group support, individual cessation counseling, integrated clinical services with medical evaluation and pharmacologic intervention, peer educated/trained support, traditional ethnic-specific healing and multi-language materials.

Goal: Promote quitting tobacco and tobacco products among young people and adults.

Priority Strategy	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
A. Expand access to and use of evidence-based interventions for cessation, such as the Quitline, especially for priority groups and communities.	Provide evidence-based cessation programs	Cessation Quitline and other evidence-based services are operational	1. Establishment of or increased use of cessation services	6. Increased number of quit attempts 7. Increased number of quit attempts using proven cessation methods	9. Increased cessation among adults and young people 10. Reduced tobacco-use prevalence and consumption 11. Reduced tobacco-related morbidity and disparity
B. Promote quitting and cessation products and services through health communications activities.	Cessation marketing activities	Completed activities to disseminate information about cessation.	2. Increased awareness, knowledge, intention to quit and support for policies that support cessation		
C. Build capacity of cessation providers and their organizations.	Capacity-building activities	Completed activities to work with health care systems to institutionalize PHS-recommended cessation interventions	3. Increase in the number of health care providers and health care systems following PHS guidelines		
D. Promote insurance coverage for evidence-based interventions for cessation	• Community Mobilization • Policy and regulatory action	Completed activities to increase insurance coverage for cessation interventions	4. Increased insurance coverage for cessation services		
E. Increase tobacco taxes	• Community Mobilization • Policy and regulatory action	Completed activities to increase tobacco excise tax	5. Increased taxes of tobacco products	8. Increased price for tobacco products	

"Tobacco dependence is a chronic disease that often requires repeated interventions and multiple quit attempts."

Goal: Promote quitting tobacco and tobacco products among young people and adults.

Priority Strategy	Recommended Community Activities	Target Outputs
A. Expand access to and use of evidence-based interventions for cessation, such as the Quitline, especially for priority groups and communities.	• Maintain comprehensive inventory of all cessation services (Administration and Management) • Provide education and technical assistance to health care providers and health care systems regarding the Public Health Service Guidelines (5A's) (Cessation Interventions) • Expand use of Quitline, referrals to Quitline, and referrals from QuitLine (Cessation Interventions) • Provide technical assistance to workplaces to change policies or incorporate programs that increase cessation (Cessation Interventions, State and Community Interventions) • Remove policy barriers to providing cessation services to youth without parental consent (State and Community Interventions) • Provide community-based cessation services to priority populations, including youth (Cessation Interventions, State and Community Interventions)	• A comprehensive list of cessation providers is produced and disseminated at least once a year • At least 200 health care providers trained each year in Public Health Service Guidelines • Quitline is operational and receives calls from at least 6% of current cigarette smokers by 2016 • At least 5 new workplaces adopt policies that increase coverage for cessation services or add an in-house cessation program or contract with the Quitline each year • At least 1 program that provides cessation services for youth is available on each island by 2016 • At least 1 cessation program that offers community-based cessation services to communities with priority populations annually
B. Promote quitting and cessation products and services through health communications activities.	• Sustain cessation mass communications that help people become non-tobacco users and access cessation services (Health Communication Interventions) • Develop tobacco cessation-related health education materials for priority populations (Health Communication Interventions)	• At least one cessation campaign that reaches 75% of target population is conducted annually. • At least 3 health education products that promote cessation or cessation services for identified priority populations are developed yearly
C. Build capacity of cessation providers and their organizations.	• Increase the number of people trained in Public Health Service Guidelines, including people from and serving priority populations (including youth) (Cessation Interventions, State and Community Interventions) • Provide or expand continuing education and technical assistance (e.g., on clinical consultation, problem-solving, motivation interviewing, marketing of services) to support tobacco control community in promoting cessation (Cessation Interventions, State and Community Interventions) • Develop credentialing for Tobacco Treatment Specialists (Cessation Interventions)	• A Training center for continuing education of tobacco treatment providers is created in Hawai'i by 2016 • Standards for Tobacco Treatment Specialists are developed and enforced by 2016
D. Promote insurance coverage for evidence-based interventions for cessation	• Provide training and technical assistance to insurers, employers, unions and policymakers about the benefits of providing insurance coverage for proven cessation products and services (Cessation Interventions, State and Community Interventions)	• At least 2 trainings for insurers, employers, unions and policymakers are provided, which increases knowledge about the importance and the technical knowledge of increasing insurance coverage
E. Increase tobacco taxes	• Increase tobacco taxes. (State and Community Interventions)	• Tobacco taxes are increased by at least 100% of their 2011 amount by 2016

Secondhand Smoke

Secondhand smoke is a mixture of sidestream smoke and exhaled smoke in the air. Secondhand smoke has been shown to cause heart disease, cancer, respiratory problems, eye and nasal irritation. It is classified as a Group A carcinogen (cancer-causing agent) under the Environmental Protection Agency's (EPA) carcinogenic assessment guidelines. Secondhand smoke contains over 4,000 compounds, more than 40 carcinogens and other irritants and toxins.[21]

The Health Consequences of Involuntary Smoke: Report of the Surgeon General (2006) concluded there is no safe level of secondhand smoke and the only way to provide protection against secondhand smoke is to eliminate it. Smoke-free laws are tools intended to protect public health based on clear scientific evidence about the hazards of exposure to secondhand tobacco smoke.[6]

In 2006, Hawai'i became the 14th state to enact legislation creating smokefree worksites, including bars, restaurants and nightclubs. The law also restricts smoking within twenty feet of entrances, windows and ventilation systems of enclosed places.

In addition, local efforts at the county level expand protection from secondhand smoke. Hawai'i County successfully passed an ordinance in 2008 banning smoking in all county beaches, parks and recreation areas on its island. In 2010, the Hawai'i County Council enacted legislation prohibiting smoking in motor vehicles when a minor is present. Other counties in the state are exploring similar legislation.

Requests for protection by residents in multi-unit housing have generated increased discussion and the evolution of voluntary policies. Serious consideration is being given to restricting secondhand smoke in public housing.

Goal: **Eliminate nonsmokers' exposure to secondhand smoke**

Priority Strategy	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
A. Increase knowledge of the risks and dangers of secondhand smoke through educational campaigns.	Counter-marketing and educational activities	Completed activities to disseminate information about secondhand smoke and tobacco-free policies	1. Increased knowledge of, improved attitudes toward and increased support for the creative and active enforcement of tobacco-free policies	4. Compliance with tobacco-free policies	5. Reduce exposure to secondhand smoke 6. Reduced tobacco consumption
B. Expand policies to prohibit and restrict exposure to secondhand smoke and promote active enforcement of these policies.	• Community Mobilization • Policy and regulatory actions	Completed activities to enhance and enforce tobacco-free policies	2. Creation of tobacco-free policies 3. Enforcement of tobacco-free policies		

Goal: **Eliminate nonsmokers' exposure to secondhand smoke**

Priority Strategy	Recommended Community Activities	Target Outputs
A. Increase knowledge of the risks and dangers of secondhand smoke through educational campaigns.	• Create and disseminate mass communication messages that educate the public on dangers to children of secondhand smoke exposure in homes and cars (Health Communications Interventions). • Create and disseminate secondhand smoke messages through chronic disease programs and organizations (e.g., cardiovascular disease, asthma, diabetes and chronic obstructive pulmonary disease) (Health Communications Interventions). • Create and disseminate messages about the risks of secondhand smoke to pregnant women (Health Communications Interventions). • Create and disseminate tools for health care providers to use to educate patients and families about dangers of secondhand smoke (State and Community Interventions)	• A minimum of 1 statewide mass communications campaign produced each year targeting parents, adults and child-care providers • At least 3 educational materials that link smoking and/or secondhand smoke and chronic disease targeting persons with a chronic disease are created and disseminated statewide by 2016 • A minimum of 2 educational messages targeting pregnant women and/or women of childbearing age created and disseminated by 2016 • A minimum of 2 educational tools targeted to health care providers to be created and disseminated by 2016
B. Expand policies to prohibit and restrict exposure to secondhand smoke and promote active enforcement of these policies.	• Conduct educational campaign to increase public support for tobacco-free policies in public places (e.g., beaches, playgrounds, public parks, bus transit stops and/or parking lots), homes and vehicles (State and Community Interventions) • Support the passage of new and protection of existing tobacco-free policies (public places, homes, educational systems and vehicles) (State and Community Interventions) • Promote compliance with tobacco-free public policies. (State and Community Interventions) • Educate enforcement personnel in all counties (State and Community Interventions)	• A minimum of 2 educational statewide campaigns, 1 island/county-specific campaign will be conducted each year to increase support for expanding protections in public places by 2016 • A minimum of 3 new statewide, county or UH system policies that increase protections against exposure to secondhand smoke and 3 new actions taken to protect existing policies by 2016 • A minimum of 1 activity each year will be conducted to promote compliance with existing tobacco-free policies • A minimum of 4 educational activities will be conducted (statewide or county specific) to educate enforcement personnel by 2016

"The Health Consequences of Involuntary Smoke: Report of the Surgeon General (2006) concluded there is no safe level of secondhand smoke and the only way to provide protection against secondhand smoke is to eliminate it. Smoke-free laws are tools intended to protect public health based on clear scientific evidence about the hazards of exposure to secondhand tobacco smoke."[6]

Tobacco-Related Disparities

Despite the significant gains in Hawai'i, there are some populations that experience a disproportionate health and economic burden from tobacco use. A focus on eliminating such tobacco-related disparities is necessary.

Tobacco-related disparities were defined at the National Conference on Tobacco and Health Disparities, held in 2002, as "differences in patterns, prevention and treatment of tobacco use; differences in risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in capacity and infrastructures, access to resources and secondhand smoke exposure."[22]

Based on tobacco-use prevalence from the 2010 Hawai'i BRFSS, those populations with the highest smoking rates in Hawai'i are people with less than a high school education (32.3%), Native Hawaiians of both sexes, (27%), young adults ages 25-34 years old (24.3%) and those with low household incomes (20%).[2] National data indicate that people with mental illnesses smoke at rates almost twice as high as the general population, and nearly half the cigarettes smoked in the United States (44-46 percent) are consumed by people with co-occurring psychiatric or addictive disorders.[23,24,25]

Even though low socioeconomic status is a powerful determinant of smoking behavior,[9,26] no single factor determines patterns of cigarette smoking and other tobacco use among vulnerable populations; rather these are the result of complex interactions of multiple factors (e.g., socioeconomic status, cultural characteristics, acculturation, stress, biologic elements, targeted advertising, price of tobacco products, and varying capacities of communities to mount effective tobacco control initiatives).[27,28] Enhanced efforts utilizing innovative methods are needed to gather more information to increase understanding of these multiple factors and the social determinants of tobacco use among groups disproportionately affected.[28]

Fundamental to addressing the disproportionate share of the tobacco burden is the belief that "priority populations" need to be considered a real priority, defined not only by the severity of the groups' needs but by their involvement in shaping the tobacco control programs and policies that affect them. Communities must be empowered to plan, make decisions and act for themselves whenever possible. Community-based approaches should permeate strategies in all the four priority goal areas, with communities able to define themselves according to ethnicity, identity, geography, social economic status and/or any other characteristic that gives people a sense of cohesion.

State capacity and infrastructure, including clear leadership and dedicated resources, are essential to the development and implementation of a strong strategic plan that includes the enhanced identification of tobacco-related disparities and their eventual elimination.

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

Priority Strategy	Activities	Outputs	Short Term Outcomes	Intermediate Outcomes	Long Term Outcomes
A. Expand surveillance mechanisms to assess factors that affect tobacco-related disparities, including community-based data collection.	• Relevant data sources reviewed to identify tobacco-related disparity issues, population groups and communities • Social determinants of health indicators included in surveillance methodology • Additional data methodologies employed to fill gaps in knowledge	• Evidence from existing tobacco surveillance data that disparities are apparent among population groups and communities • Evidence that social determinants of health indicators have been incorporated • Completed surveys, focus groups or other methods that provide new information	1. Increased data and information collected	3. Data used to develop innovative and culturally appropriate interventions 4. Appropriate and effective interventions developed	5. Decreased tobacco-related health disparities 6. Decreased tobacco-related morbidity and mortality
B. Develop community-based capacity, including leadership development and participatory approaches to address tobacco-related disparities.	Capacity building with population groups and communities	Completed training and technical assistance activities	2. Increased capacity and infrastructure developed with population groups and communities		

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

Priority Strategy	Recommended Community Activities	Possible Outputs
A. Expand surveillance mechanisms to assess factors that affect tobacco disparities, including community-based data collection.	• Assess existing tobacco surveillance data to identify populations that experience disproportionate health and economic burdens from tobacco use (Surveillance and Evaluation) • Improve existing surveillance systems to collect additional data on tobacco disparities and the social determinants of health (Surveillance and Evaluation) • Develop new community-based data collection methods and approaches to assess tobacco use where gaps in knowledge exist (Surveillance and Evaluation)	• A Define cost and other requirements for additional data collection on existing surveys and new data sources • Utilize existing data sources and develop new methods, approaches and sources of surveillance and community-based data on tobacco disparities • Create and test innovative (quantitative and qualitative) data collection methods to fill gaps in knowledge • Implement, evaluate and share methods and new information to produce a Hawai'i Tobacco Disparities Report on existing and new data sources and knowledge • Distribute Report to key tobacco stakeholders, especially priority groups and communities
B. Develop community-based capacity, including leadership development and participatory approaches to address tobacco-related disparities.	• Provide culturally competent training and technical assistance for all stakeholders and partners to effectively address issues of tobacco use within priority groups and communities (State and Community Interventions) • Develop culturally appropriate health communications products that support community-level interventions (Health Communications Interventions)	• Use the Tobacco Disparities Report as a tool to engage community leaders and priority groups and communities • Educate leaders and individuals in priority populations • Provide training and technical assistance to priority populations and communities for developing plans • Provide training and technical assistance to priority populations and communities for implementing plans • Collaborate on creating culturally appropriate informational materials about tobacco control strategies • Work with media contractors to ensure cultural proficiency and involvement with priority populations • Use and test alternative communications strategies to more effectively reach and involve priority populations
C. Increase participation and engagement of at-risk populations in tobacco prevention and control activities.	• Demonstrate increased collaborative efforts between tobacco control advocates and priority populations (State and Community Interventions) • Engage priority groups and communities in compiling a Tobacco Disparities Strategic Plan (State and Community Interventions)	• Compile and maintain an inventory of organizations working in and for various communities • Maintain community coalitions and expand participation in coalitions by priority populations • Ensure that priority groups and communities come together to produce a Tobacco Disparities Strategic Plan
D. Ensure adequate funding for tobacco-related disparities.	• Fund priority groups and communities and/or the organizations that serve them to develop and implement appropriate and effective interventions to address tobacco-related disparities (Administration and Management)	• Ensure funding formulas for priority groups and communities and/or organizations that serve them to develop and implement appropriate and effective interventions to address tobacco-related disparities • Provide outcome and performance-based funding for groups and organizations that demonstrate a commitment to tobacco prevention and positive change

Outcome Indicators and Benchmarks

Evaluation and reporting are the principal means of holding the tobacco control movement in Hawai'i accountable for execution of this Plan. This section identifies key measures for tracking progress on the Plan's goals and assessing the effectiveness of its priority strategies.

Each strategy and outcome has one or more outcome indicators that define if an outcome can be denoted as achieved. The list of indicators was selected from a larger list of 120 indicators recommended by CDC as well as additional indicators suggested by participants in the planning process. The selected indicators used in this plan were selected for the following reasons:

- They provide the basis for evaluating overall progress in tobacco prevention and control as well as progress in specific goal areas and priority strategies. Indicators were selected that speak directly to the goals and strategies outlined in this Plan.
- The indicators speak to the activities and strategies recommended by community members. If an indicator was not relevant to the strategies recommended by the community, it was not chosen for the list of outcome indicators in this plan.
- Data for these indicators were available or could be collected on a regular basis (more frequently than every five years). In some cases, an indicator was deemed so important that it was included even if data were currently unavailable, with the implication that we should begin collecting the data required.
- These indicators allowed for benchmarking against historical data, the national average, the performance of other states or some other meaningful basis of comparison. Again, in some cases, an indicator was so important that it was recommended even if existing benchmarks were lacking.

In addition to listing key indicators, the tables below define the current baseline (from the most recently available data) and benchmarks for the year 2016. Goals were established using the following rationale provided by experts in evaluation and monitoring:

For indicators that had baseline data, current data and were trending in a positive direction, 2016 benchmarks were set by determining the rate of change between the baseline and current data and anticipating similar rate of change for the next five years. For example, the 2005 smoking prevalence rate was 17.0% while the prevalence rate in 2010 was 14.5%. The rate of change between the two prevalence rates is .175. If we expect similar change over the next five years, then the rate in 2016 is expected to be 12%. This follows guidelines used to determine the benchmarks for Healthy People 2020, the national objectives for health in the United States.

These "rules of thumb" were adjusted for specific indicators based upon input from experts in evaluation and monitoring as well as the input of practitioners with knowledge of unique conditions that might affect 2016

EVALUATING THE PLAN

outcomes. While they do not offer a perfect methodology, they do provide a reasonable rationale for setting goals for Hawai'i over the next five years. It's important to remember that the benchmarks chosen are a reflection of the health data that are currently available in Hawai'i. The data and measurements listed are for evaluation purposes only and not absolute.

In some cases, data were not available or collected for a recommended indicator. For these measures, the key outcome by 2016 is establishing a data collection and/or reporting system.

This Plan is intended to be a living document that is regularly revisited and revised to reflect changes in needs, opportunities, and the landscape of resources available in tobacco prevention and control. The Plan will be reviewed at least once a year and revised to adjust to changing data along with economic, political and social realities as well as special opportunities that may arise.

An external evaluator will be contracted to develop a written evaluation plan, which will include a system to evaluate the strategic planning process and to monitor the implementation of the plan and its progress toward meeting measurable goals and objectives.

The evaluator will participate with a Strategic Plan Evaluation Committee to provide guidance in summative and formative evaluation; technical assistance and consultation on evaluation of strategies; designing a system to examine the effectiveness of the Plan; designing a standardized reporting form for annual assessment of the Plan's goals, priority strategies and outcomes; and in fostering statewide coordinated efforts and accountability to the public.

If you could change three things about the overall tobacco prevention and control efforts in Hawai'i currently what would they be?

- More evaluation so that the efforts that are made can be assessed and shown to be effective and warrant continued presence
- Always more room for collaboration at community levels
- Leadership that is highly supportive of tobacco prevention and control
- More funding, but targeted to proven cessation and prevention programs

PREVENTION

OUTCOMES	MEASURE/INDICATOR	BASELINE	CURRENT	2016 TARGET
1. Increased anti-tobacco programs in schools and communities	Proportion of students who participate in tobacco-use prevention activities KOI 1.7.8	MS: 14.0% HS: 15.3% *2005 YTS*	MS: 20.5% HS: 14.1% *2009 YTS*	**MS: 27%** **HS: 15.3%***
	Level of reported exposure to school-based tobacco-use prevention curricula that meet CDC guidelines KOI 1.7.9	MS: 71.9% HS: 56.6% *2005 YTS*	MS: 62.1% HS: 47.8% *2009 YTS*	**MS: 71.9%*** **HS: 56.6%***
2. Increased knowledge of, improved attitudes toward and increased support for policies that reduce youth initiation	Level of confirmed awareness of anti-tobacco media messages KOI 1.6.1	MS: 63.6% HS: 75.3% *2005 YTS*	MS: 58.3% HS: 78.2% *2009 YTS*	**MS: 63.6%*** **HS: 81.1%**
	Proportion of young people who think that the cigarette companies try to get young people to smoke KOI 1.6.8	Not Available	Not Available	**TBD**
3. Reduced tobacco industry influences	Proportion of jurisdictions with policies that regulate the extent and type of retail tobacco advertising and promotions KOI 1.9.2	Not Available	Not Available	**TBD**
4. Increased restriction and enforcement of restrictions on tobacco sales to minors	Proportion of jurisdiction with policies that require retail licenses to sell tobacco products KOI 1.8.2	Not Available	Not Available	**TBD**
	Proportion of retailers that are in compliance	94.4% *2005 Synar*	93.8% *2010 Synar*	**94.4%***
5. Increased price of tobacco products	Amount of tobacco product excise tax KOI 1.12.1	$1.40	$3.00	**$6.00**
6. Reduced susceptibility to experimentation with tobacco products	Proportion of young people who think that smoking is cool and helps them fit in KOI 1.10.1	MS: 13.3% HS: 15.1% *2005 YTS*	MS: 9.5% HS: 11.4% *2009 YTS*	**MS: 5.7%** **HS: 7.7%**
	Proportion of young people who report that their parents have discussed not smoking with them KOI 1.10.3	MS: 75.8% HS: 67.0% *2005 YTS*	MS: 66.0% HS: 61.0% *2009 YTS*	**MS: 75.8%*** **HS: 65.0%***
7. Decreased access to tobacco products	Proportion of young people reporting that they have been sold tobacco products by a retailer KOI 1.11.2	MS: 6.1% HS: 10.1% *2005 YTS*	MS: 1.3% HS: 5.7% *2009 YTS*	**MS: 0%** **HS: 1.3%**
	Proportion of young people reporting that they have received tobacco products from a social source KOI 1.11.4			
	Gave someone money to buy them:	MS: 20.5% HS: 26.7%	MS: 21.0% HS: 29.01%	**MS: 20.5%** **HS: 26.7%***
	Borrowed from someone:	MS: 23.4% HS: 28.3%	MS: 27.0% HS: 28.5%	**MS: 23.4%** **HS: 28.3%***
	Given by someone under 18:	MS: 6.0% HS: 11.2%	MS: 8.7% HS: 17.0%	**MS: 6.0%*** **HS: 11.2%**
	Taken from store/family member:	MS: 19.0% HS: 9.2% *2005 YTS*	MS: 20.2% HS: 4.9% *2009 YTS*	**MS: 19.0%** **HS: 0.6%**
	Level of support for policies and enforcement of policies to decrease young people's access to tobacco KOI 1.6.4	Not Available	Not Available	**TBD**
8. Reduced initiation of tobacco use by young people	Proportion of young people who report never having tried a cigarette KOI 1.13.2	MS: 79.9% HS: 56.5% *2005 YTS*	MS: 82.8% HS: 63.9% *2009 YTS*	**MS: 85.7%** **HS: 71.3%**
9. Reduced tobacco use prevalence among young people	**Prevalence of tobacco use among young people 1.14.1 (current cigarette use)**	**MS: 79.9%** **HS: 56.5%**	**MS: 82.8%** **HS: 63.9%**	**MS: 85.7%** **HS: 71.3%**
	(current any tobacco use)	**MS: 79.9%** **HS: 56.5%** ***2005 YTS***	**MS: 82.8%** **HS: 63.9%** ***2009 YTS***	**MS: 85.7%** **HS: 71.3%**

MS: Middle School **HS:** High School **YTS:** Youth Tobacco Survey

Target setting methods derived from examples in Healthy People 2020: Tobacco use. Available at: http://www.ct.gov/sustinet/lib/sustinet/taskforces/tobaccotaskforce/07012010report/attachment_5.pdf
Formula for target setting: Indicates trend from 2005 to 2010 was in wrong direction, therefore target represents maintaining most favorable rate.

CESSATION

OUTCOMES	MEASURE/INDICATOR	BASELINE	CURRENT	2016 TARGET
1. Establishment of or increased use of cessation services	Number of callers to telephone quitlines KOI 3.7.1	Not Available	1.4% of current cigarette smokers[i]	6% of current cigarette smokers (2015 target)[i]
	Proportion of smokers who have used group cessation or community-based cessation programs KOI 3.7.4	Not Available	Not Available	TBD
	Proportion of worksites, schools or community-based organizations with a cessation program KOI 3.7.6	Not Available	Not Available	TBD
2. Increased awareness, knowledge, intention to quit and support for policies that support cessation	Level of confirmed awareness of media campaign messages on the dangers of smoking and the benefits of cessation KOI 3.8.1	Not Available	Not Available	TBD
	Proportion of smokers who intend to quit in the next 6 months KOI 3.8.3	59% 2006 ATS	Not Available	TBD
3. Increase in the number of health care providers and health care systems following PHS guidelines	Proportion of health care providers and health care systems that have fully implemented the Public Health Service (PHS) guidelines KOI 3.9.1	Not Available	Not Available	TBD
	Proportion of smokers (including priority populations) who have been advised to quit smoking by a health care professional on three or more visits KOI 3.9.3	34.5% 2005 BRFSS	24.9% 2009 BRFSS	34.5%*
	Proportion of pregnant women who report that a health care professional advised them to quit smoking during a prenatal visit KOI 3.9.7	Not Available	45.6% 2009 PRAMS	TBD
4. Increased insurance coverage for cessation service	Proportion of insurance purchasers and payers that reimburse for tobacco cessation services KOI 3.10.1	Not Available	Not Available	TBD
5. Increased number of quit attempts	Proportion of adult smokers who have made a recent quit attempt KOI 3.11.1	63.2% 2005 BRFSS	60.1% 2010 BRFSS	63.2%*
6. Increased number of quit attempts using proven cessation methods	Proportion of adult and youth (HS) smokers who have made a quit attempt using proven cessation methods KOI 3.11.3	17.3% Used Medication 3.2% Used counseling or classes 2006 ATS	Not Available	TBD
		HS 14.5 2005 YTS	HS 12.1% 2009 YTS	-
7. Increased price of tobacco products	Amount of tobacco product excise tax KOI 3.12.1	$1.40	$3.00	$6.00
8. Increased cessation among adults and young people	Proportion of smokers (including priority populations) who have sustained abstinence from tobacco use (6 months or longer) KOI 3.13.1	91.2% 2005 BRFSS	96.1% 2005 BRFSS	100%
9. Reduced tobacco-use prevalence and consumption	Smoking prevalence KOI 3.14.1	17.0 2005 BRFSS	14.5% 2010 BRFSS	12%
	Prevalence of tobacco use during last trimester pregnancy KOI 3.14.2	8.4% *2005 PRAMS*	9.7% *2009 PRAMS*	8.4%*
10. Decreased tobacco-related health disparities	Reduced smoking prevalence among specific ethnic groups, those with low household incomes and/or low educational levels, and other priority groups (e.g. postpartum) and communities ***(see Disparities Logic Model)***			
11. Decreased tobacco-related morbidity and mortality	Long-term objective included here but not measurable in the five-year strategic plan			

SECONDHAND SMOKE

OUTCOMES	MEASURE/INDICATOR	BASELINE	CURRENT	2016 TARGET
1. Increased knowledge of, improved attitudes toward and increased support for the creation and active enforcement of tobacco-free policies	Attitudes of smokers and nonsmokers about the acceptability of exposing others to secondhand smoke KOI 2.3.3	93% 2006 ATS	Not Available	TBD
	Proportion of the population that thinks SHS is somewhat or very harmful to: Infants Children Pregnant Women Teenagers Adults Senior Citizens	Not Available	Not Available	TBD
2. Creation of tobacco-free policies	Proportion of colleges and private schools reporting the implementation of 100% tobacco-free policies KOI 2.4.5	Not Available	Not Available	TBD
3. Enforcement of tobacco-free policies	Number of warnings, citations and fines issued for infractions of tobacco-free public policies KOI 2.5.3	Not Available	Not Available	TBD
4. Compliance with tobacco-free policies	Perceived compliance with tobacco-free policies in workplaces KOI 2.6.1	Not Available	Not Available	TBD
	Perceived compliance with tobacco-free policies in indoor and outdoor public places KOI 2.6.2	Not Available	Not Available	TBD
	Perceived compliance with voluntary tobacco-free home or vehicle policies KOI 2.6.4	Not Available	Not Available	TBD
5. Reduce exposure to secondhand smoke	Proportion of youth reporting exposure to secondhand smoke at home in the past week KOI 2.7.3	MS: 25.6% HS: 28.3% 2005 YTS	MS: 27.4% HS: Not available 2009 YTS	MS: 25.6%* HS: 28.3%*
	Proportion of youth reporting exposure to secondhand smoke in vehicles in the past week KOI 2.7.3	MS: 31.1% HS: 34.8% 2005 YTS	MS: 23.1% HS: 24.9% 2009 YTS	MS: 15.1% HS: 14.4%
	Proportion of nonsmokers reporting overall exposure to secondhand smoke KOI 2.7.5	Not Available	Not Available	TBD
	Proportion of Adults reporting exposure to secondhand smoke at homes or vehicles	**Not Available**	**Homes: 11.3% Vehicles:13.1% 2010 BRFSS**	TBD

Target setting methods derived from examples in Healthy People 2020: Tobacco use. Available at: http://www.ct.gov/sustinet/lib/sustinet/taskforces/tobaccotaskforce/07012010report/attachment_5.pdf
Formula for target setting: Indicates trend from 2005 to 2010 was in wrong direction, therefore target represents maintaining most favorable rate.

[i] The Hawaii Tobacco Quitline call volume is derived by using the North American Quitline Consortium's standard promotional reach rate. Current call rates derived from the Hawaii Tobacco Quitline Aggregate Experience Survey and Quitline Utilization Report Fiscal Year 2010

DISPARITIES

OUTCOMES	MEASURE/INDICATOR	BASELINE	CURRENT	2016 TARGET
1. Increased data and information collected	Number of new data indicators on the social determinants of health added to existing surveillance systems that further identify populations experiencing disproportionate health/economic burdens from tobacco use (e.g. social context, reactions to race, occupation, poverty)	0 *2005 BRFSS*	14 *2010 BRFSS*	**24**
	Number of innovative methodologies employed to gather data on tobacco-related disparities	Not Available	Not Available	**5**
2. Increased capacity and infrastructure developed with priority groups and communities	Number of culturally appropriate health communications products	Not Available	Not Available	**5**
	Number of alternative communication strategies used to reach and involve priority populations	Not Available	Not Available	**5**
3. Data used to develop innovative and culturally appropriate interventions	Number of interventions and/or products for priority groups and communities developed	Not Available	Not Available	**5**
4. Appropriate effective interventions developed	Number of community competent and culturally appropriate interventions developed as part of community and leadership capacity building	Not Available	Not Available	**5**
5. Decreased tobacco-related health disparities	Reduced smoking prevalence among priority population groups and communities:			**12%** **TBD**
	Native Hawaiians	27.9%	26.8%	
	Filipino Males	18.5%	16.5%	
	Low Household Income (less than $15,000/year)	27.3%	20.3%	
	Less than High School Education	27.7%	32.3%	
	Young Adults (18-24 years)	18.9% 2005 BRFSS	12.3% 2010 BRFSS	
	Post-Partum	14.06% 2005 PRAMS	13.4% 2009 PRAMS	
6. Decreased tobacco-related morbidity and mortality	**Note – Long term objective included here but not measureable in the five-year strategic plan**			

Target setting methods derived from examples in Healthy People 2020: Tobacco use. Available at: http://www.ct.gov/sustinet/lib/sustinet/taskforces/tobaccotaskforce/07012010report/attachment_5.pdf
Formula for target setting: Indicates trend from 2005 to 2010 was in wrong direction, therefore target represents maintaining most favorable rate.

Opportunities

Recent federal legislation presents unique opportunities and possible challenges for tobacco prevention and control. In June 2009, President Obama signed the Family Smoking Prevention and Tobacco Control Act. This law allows the U.S. Food and Drug Administration (FDA) to regulate the manufacture, marketing and sale of tobacco products. The FDA must implement stringent rules that regulate the labeling of tobacco products, including cigarettes, free gifts with proofs of purchase and free samples of cigarettes.

The Family Smoking Prevention and Tobacco Control Act provides for state and local authority to adopt rules regarding the sale, distribution, advertising, and promotion or use of tobacco products. The act also amends the Federal Cigarette Labeling and Advertising Act to provide local government the authority to also regulate the time, manner, and place of the advertising or promotion of cigarettes.

The state can significantly reduce tobacco use by exploring ways to regulate advertising and promotion of tobacco products. In doing so, efforts should be comprehensive and seek to address cigarettes and other tobacco products together.

Provisions of the Family Smoking Prevention and Tobacco Control Act continue to be implemented. Local efforts can focus on providing state-specific responses to requests for comment by FDA on proposed rules, labels and related issues (menthol, flavored tobacco products, etc.). Hawai'i is uniquely positioned to respond to requests for comments on the impact of the law on Native Hawaiians, other Pacific Islanders and Asian American populations.

The Patient Protection and Affordable Care Act, signed into law in 2010, is also an important component to tobacco control. This law increases Medicaid access to tobacco cessation prescriptions and over-the-counter medications and also mandates comprehensive coverage of tobacco cessation services for pregnant woman covered by Medicaid.

As the Patient Protection and Affordable Care Act is being challenged in the courts and congressional attempts to amend the law continue, it is crucial that tobacco control advocates monitor the law's implementation and stay informed. Similarly, advocates must be vigilant that administrative rules provide for accessible coverage of comprehensive tobacco dependence treatments recommended by the U.S. Public Health Service, including group and individual counseling and FDA-approved pharmacotherapies. Additional concerns are the cost of the treatment (counseling and pharmacotherapy), increasing the number of quit attempts covered per year and not setting lifetime limits on quit attempts covered.

While many provisions of the Patient Protection and Affordable Care Act won't be fully realized until 2014, Hawai'i can move in advance to provide comprehensive insurance coverage for tobacco dependence treatment. Local efforts may include monitoring legislation that look to extend Hawaii's Pre-Paid Healthcare Act.

OPPORTUNITIES AND CHALLENGES

Challenges

Funding for Tobacco Prevention and Control

Funding for tobacco prevention and control in Hawai'i is predominantly derived from the tobacco Master Settlement Agreement (MSA) and support from CDC. Currently, Hawai'i state taxes on tobacco products do not directly fund tobacco prevention and control.

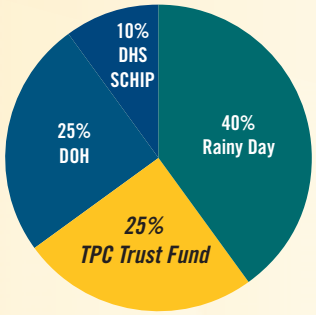
The MSA is the result of a 1999 settlement between 46 states, including Hawai'i, and the major tobacco companies. The settlement resolved a lawsuit brought by the states' attorneys general against the major tobacco companies to recover tobacco-related medical costs borne by state taxpayers. The Hawai'i State Legislature established the Hawai'i Tobacco Settlement Special Fund to house the monies from the MSA (See HRS §328L-2). The state receives annual settlement payments from the tobacco companies. By law, $350,000 is set aside for the Tobacco Enforcement Special Unit Fund to be used by the Office of the Attorney General.

The remaining funds are distributed according to statute: 15% to the Emergency and Budget Reserve Special Fund; 25% to the DOH for health promotion and disease prevention programs; 10% to the Department of Human Services (DHS) for the children's' health insurance program (SCHIP); 28% to the John A. Burns School of Medicine; 25.5% to the State General Fund; and 6.5% to the Tobacco Prevention and Control Trust Fund (Refer to Diagrams)

From 1999 to 2011, the amount of funds from the MSA percentages allocated for the Tobacco Prevention and Control Trust Fund decreased from 25% to 0%.

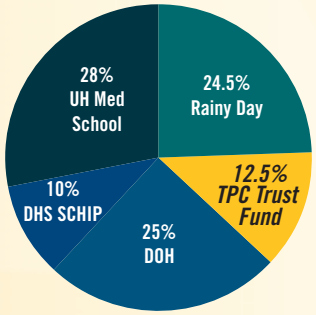
In 1999, the State Legislature established, as part of Act 304, the Tobacco Prevention and Control Trust Fund to ensure that the state would reduce the health and economic burden of smoking and tobacco use in perpetuity. The law provided that a portion of the MSA dollars would be invested and administered by a separate nonprofit organization in Hawai'i, selected by the Governor and the Director of Health. The organization selected to invest the trust fund monies and to conduct grant making was the Hawai'i Community Foundation. The original portion of the MSA distribution to the Trust Fund in 1999 was 25%.

Figure 11. **Tobacco Settlement Special Fund Structure 1999-2001**



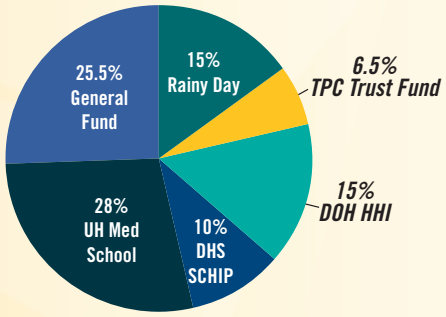
In 2002, the State Legislature reduced the percentage of the annual MSA distribution to the Trust Fund from 25% to 12.5%, along with reductions to the Rainy Day Fund to provide for the debt service on the bonds, to construct the new UH Medical School campus.

Figure 12. **Tobacco Settlement Special Fund Structure July 1, 2002 to July 1, 2007**



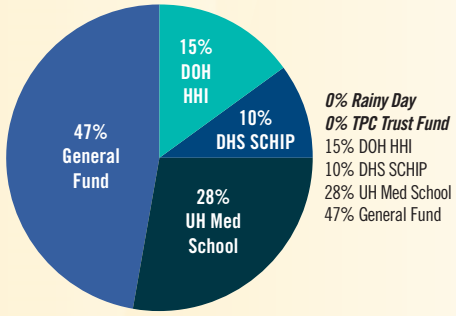
In 2009, the State Legislature reduced the percentage of the annual MSA distribution to the Trust Fund from 12.5% to 6.5%, along with reductions to the Rainy Day Fund and the DOH portion of the fund for chronic disease prevention, health promotion, and children's programs, to go to the General Fund.

Figure 13. **Tobacco Settlement Special Fund Structure July 1, 2009 to June 30, 2015**



In 2011, the State Legislature diverted the percentage of the annual MSA distribution to the Trust Fund of 6.5% along with the Rainy Day Fund to go to the General Fund.

Figure 14. **Tobacco Settlement Special Fund Structure July 1, 2012 to June 30, 2013, 2011 Session, Act 124 SB 120**



OPPORTUNITIES AND CHALLENGES

From 1999 to 2010, the amount of funds from the MSA percentages allocated for the Tobacco Prevention and Control Trust Fund decreased from 25% of the tobacco settlement to 6.5%.

The Tobacco Prevention and Control Trust Fund was established by the Legislature to ensure that the state could reduce tobacco use and smoking in perpetuity. State law provides that a portion (currently 6.5%) of the MSA monies will be invested and administered by a separate nonprofit organization in Hawai'i selected by the governor and director of health. The organization selected in 1999 was the Hawai'i Community Foundation.

By law, a maximum of 50% of the total market value of the trust fund can be expended every fiscal year. Expenditures must be made for tobacco prevention and control. Similarly, the trust fund monies must be invested in order to maximize the rate of return on the investment in a way that preserves the trust fund's principal.

While the Hawai'i Community Foundation invests the funds, the Tobacco Prevention and Control Trust Fund Advisory Board serves in an advisory role to the DOH regarding administration of the trust fund. The Advisory Board consists of eleven members, primarily appointed by the governor and director of health, who must be involved in tobacco prevention and control.

From 2001 to the present, the Tobacco Prevention and Control Trust Fund has funded 44 community grants, the Hawaii Tobacco Quitline, advocacy efforts, program evaluations, and a statewide communications campaign.

CDC, through its Office on Smoking and Health's National Tobacco Control Program, supports the DOH Tobacco Prevention and Education Program (TPEP), which is housed in the department's Chronic Disease Management and Control Branch. TPEP also receives funds from the DOH portion of the tobacco settlement.

Ensure Sustainability of Tobacco Control

Significant challenges lie ahead for tobacco prevention and control. Nationwide and locally, declining funding for tobacco control is a critical problem. Serious state budget issues motivate legislators to view previously dedicated MSA monies as alternate sources of funding for non-tobacco related programs and activities.

Funding has significantly dropped for tobacco prevention and control efforts. Large foundations nationally that funded initial state efforts no longer offer community-based grants. For example, the Legacy Foundation, an organization dedicated to preventing tobacco use among youth, eliminated its community grants program. However, there is increasing funding available for efforts to address obesity through improved nutrition and physical activity. As such, national tobacco control partners have grown to include or have merged with nutrition and physical activity efforts, including the Tobacco Control Legal Consortium, which is now part of the Public

Health Law Center, APPEAL (Asian Pacific Partners for Empowerment, Advocacy, and Leadership), and the LGBT Tobacco Control Network. Still, the myth remains that tobacco control is well-funded via MSA dollars and tobacco taxes. The reality in Hawai'i is that less than 10 percent of the annual tobacco settlement payment is dedicated to tobacco control, and no tobacco taxes fund tobacco control efforts.

Tobacco prevention and control efforts in Hawai'i face significant challenges locally, particularly regarding the long-term viability of funding to ensure a sustainable tobacco prevention and control effort. Since 2001, the Tobacco Prevention and Control Trust Fund has been reduced and used to compensate for budget shortfalls. In 2009, funding from the tobacco settlement was reduced by almost half. In fiscal years, 2012 and 2013, the annual tobacco settlement distribution to the trust fund is being diverted to the general fund. Going forward, the challenge will be to maintain and to build the viability of the fund.

More money is being spent toward continuing the community grant programs than is going into the overall trust fund because of the diversion of the revenue stream. Additional sources of funding for tobacco prevention and treatment will be needed if we are to sustain the accomplishments made so far and continue moving forward.

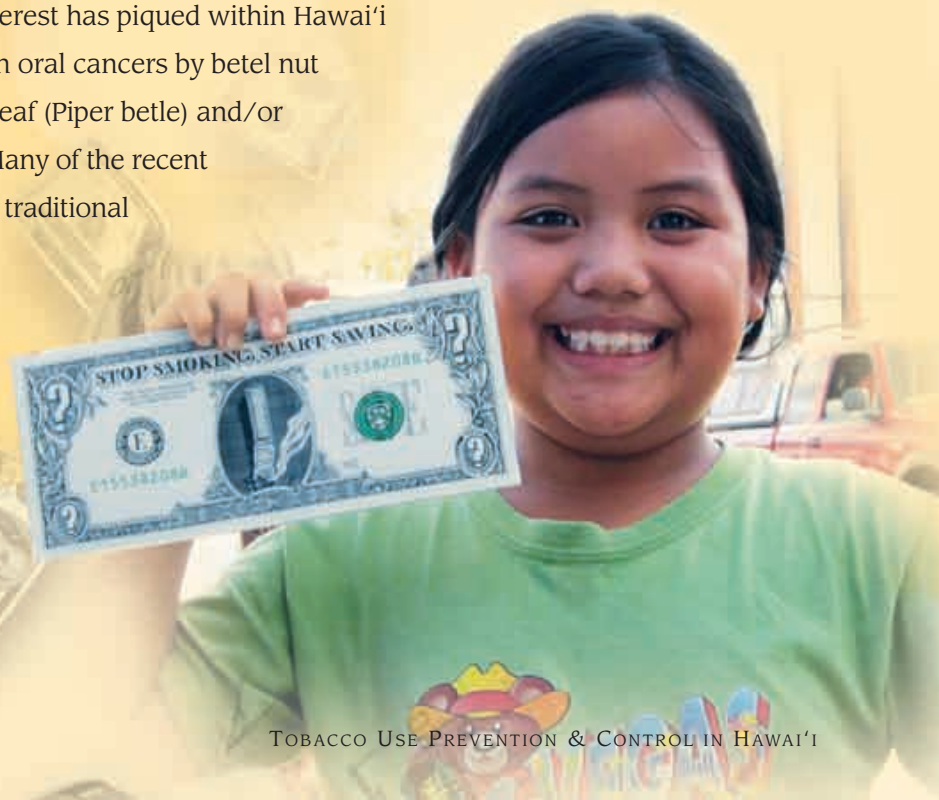
Other Tobacco Products

In addition to cigarettes and cigars, there are other tobacco products (OTP) on the market that come in many different shapes, sizes, flavors and prices. They are often promoted as alternatives to cigarettes that are safer, cheaper, lawful to use in non-smoking environments or more discreet than cigarettes.

New and emerging smokeless products being promoted include "snus," which are small pouches resembling tea bags that contain nicotine and tobacco. Snus products are marketed as an alternative for smokers when they cannot smoke, thus leading to dual tobacco use. Dissolvables are spitless, smokeless tobacco that can be dissolved in the mouth. Packaged similarly to candy, they resemble breath mints, breath strips and toothpicks. Dissolvables are currently being test-marketed on the mainland.

Electronic cigarettes (or e-cigarettes) are battery operated nicotine delivery systems which send vaporized nicotine into the lungs of the user. E-cigarettes resemble and emulate the look and feel of a real lit cigarette. They are marketed as a safe substitute for smoking or a means to quit.

Betel nut/areca nut (Areca cathecu) chewing is prevalent in South Asia, Southeast Asia and the Western Pacific islands (Melanesia and Micronesia). The traditional way to chew betel nut in the Pacific islands is by chewing immature betel nut, usually combining it with pepper leaf (Piper betle) and/or slaked lime and/or various forms of tobacco (originally introduced by the Spaniards). Because of the influx of Micronesian migrants into Hawai'i over the past decade, interest has piqued within Hawai'i public health circles regarding the link between oral cancers by betel nut chewing alone or in combination with pepper leaf (Piper betle) and/or slaked lime and/or various forms of tobacco. Many of the recent Micronesian migrants practice or have adopted traditional betel nut chewing and a small market niche has developed so that betel nuts, pepper leaf and lime are available for purchase at certain stores in Hawai'i (along with tobacco). However, the prevalence of betel nut chewing is very low and not likely to spread outside the state's small Micronesian communities.



Even so, betel nut chewing practices should be researched to discern if they are a significant risk to the public's health in Hawai'i.

Our Job Is Not Done

Tobacco control also suffers from "issue fatigue." Though tobacco is still the top cause of preventable disease and death in Hawai'i, growing attention to the problems of poor nutrition and sedentary lifestyles are pulling some of the focus and resources away from tobacco control.

While tobacco control has seen great success in educating young people about the risks associated with tobacco use and in countering aggressive tobacco industry tactics, the impact of such anti-tobacco efforts will fade if they are not funded or supported adequately. We can ill afford to have our future generations not hear about the harms of tobacco or respond negatively to burgeoning tobacco-free norms in the media and in the community.

And current smokers must have access to opportunities to address their tobacco dependence and to make the healthy choice to quit smoking. Media and communications that are culturally relevant and speak to the values of individual communities are essential to closing disparate smoking rates and eliminating related health disparities.

THE PLANNING PROCESS

The Hawai'i State Department of Health (DOH), the Tobacco Prevention and Control Trust Fund Advisory Board and the Coalition for a Tobacco-Free Hawai'i provided the leadership for developing the new Five-Year Strategic Plan for Tobacco Prevention and Control in Hawai'i for 2011-2016. Broad community input was solicited, and facilitation was provided by Linda Colburn of Where Talk Works.

The purpose of this plan is to serve as a guide for program planning, decision-making and strategic implementation of tobacco prevention and control in Hawai'i as well as to assure the appropriate coordination and integration of tobacco control activities across the multiple organizations that are concerned with promoting tobacco-free living and reducing the negative impact of tobacco on the people of Hawai'i.

The process to develop this plan included:

- review of the data on tobacco use in Hawai'i, including current rates and trends;
- review of the accomplishments in the past five years;
- review of current programs and resources in Hawai'i that are committed to tobacco prevention and control outcomes;
- identification of specific strategic directions and priorities to achieve the priority strategies set forth in 2005; and
- identification of infrastructure and resource needs to support consistent and sustained efforts for priorities identified in the plan.

The planning process included multiple opportunities for input from those around the state interested in tobacco prevention and control.

A Steering Committee of tobacco control, public health and medical professionals was convened in February 2010 to guide the process for the overarching plan. The members were specifically asked to research and review other states' tobacco control strategic plans and processes that were used to develop and revise these plans; to participate in selection of a facilitator; to oversee the creation of a plan with input from community partners, tobacco control providers, and DOH; to ensure that drafts of the Plan were reviewed and approved by the appropriate parties; and to ensure that the plan will be distributed to stakeholders and tobacco control providers.

Steering Committee members are listed in Appendix C.)

Key Informant Interviews with tobacco control leaders in the public and non-profit sectors were conducted in August and September 2010. Twelve individuals completed the 60-90 minute interviews by telephone.

Public Input was solicited at meetings, among other means. The public meetings were conducted in August 2010 and a total of 199 participants provided input at seven public meetings held on five islands and during one Skype call. Outreach for the public meetings was conducted via the internet, community coalitions, notices and public advertising. The majority of attendees were familiar with tobacco prevention and control issues.

Prior to the major planning summit, community members were encouraged to provide input via a variety of communication avenues, such as email, fax and the internet.

An Electronic Survey was conducted in September 2010 with providing the opportunity for further input from the attendees at the public meetings and those unable to attend but wished to provide comment.

A Youth Summit was held in July 2010 with 117 youth (under 20 years of age) and adult participants from across the islands. The half-day gathering was designed to provide youth their own opportunity to express their views and offer their unique perspective on tobacco issues. The youth were asked to focus on questions such as:

- What is working (regarding tobacco use prevention/cessation)?
- What isn't working?
- What advice would you give to public policy-makers regarding future efforts?

A Strategic Planning Summit drew together more than 100 invited tobacco control stakeholders representing health and civic leaders (both youth and adults) from around the state on September 28, 2010. Summit participants were selected based upon their knowledge, experience, and /or active participation in tobacco prevention and control. They were chosen as representatives of the diverse communities and perspectives that comprise the tobacco control movement in Hawai'i. The group was charged with setting priorities for tobacco prevention and control in each of the four CDC priority goal areas, giving due consideration to the progress and achievements since the previous five-year Plan, the public input, their own expertise, and other factors.

Summit participants were divided into four working groups, one dedicated to each of the four priority goal areas of prevention, cessation, secondhand smoke, and tobacco-related disparities among population groups. Each working group developed and prioritized a list of recommended strategies for their areas. The list of priority strategies were reviewed by the Steering Committee, the Tobacco Prevention and Control Trust Fund Advisory Board, and key evaluation teams and refined accordingly. Further reviews of the draft plan were conducted through multiple channels (including both live and electronic means) prior to its completion.

Public Input Meetings

The purpose of the Public Input Meetings was to gather input from community members across the state, other interested agencies and the general public regarding the issues, priorities and community concerns that the Plan should consider. The findings from the Public Input Meetings were a key source of information used to develop the Plan. The findings were presented to participants at the Tobacco Control Summit in September 2010.

A. Meeting Agenda

Overview of the Strategic Planning Process	(10 min)
Overview of the State of Tobacco Control in Hawai'i	(15 min)
Public Input	(90 min)
Other Ways to Register Your Thoughts	(5 min)
Informal Discussion (optional)*	(60 min)

B. Discussion Questions

The following discussion questions were used to drive the "Public Input" portion of the agenda.

- What are the most important tobacco control accomplishments in Hawai'i of the past five years?
- What are the most important assets Hawai'i can use in its tobacco control efforts over the next five years?
- What will be the most important challenges facing Hawai'i in tobacco control over the next five years?
- If you could change three things about the overall tobacco prevention and control efforts in Hawai'i currently, what would they be?
- For each of the following strategic priorities, please describe the things that should be done to significantly impact on tobacco control over the next five years:
  - Preventing the use of tobacco
  - Helping people who use tobacco to quit
  - Protecting people from secondhand smoke
  - Eliminating tobacco use and related health/disease disparities (where possible indicate the priority populations that should be addressed for each idea you have).
  - Creating a social climate in which tobacco use becomes less desirable and acceptable, counteracting the influence of the tobacco industry.
- What are the most important elements that should be included in tobacco control for the state other than money?
- What kinds of support (if any) do tobacco control organizations need most?
- What things would you suggest be done to enhance the public and decision-makers' understanding of the tobacco problem and/or control efforts in Hawai'i?
- What benchmarks should we use to define the success of tobacco control efforts in Hawai'i?
  - Is anyone missing from this discussion that MUST be included?
  - Do you have any suggestions for this planning process going forward?

Extensive data and information were gathered from the community at meetings through surveys and key informant interviews. Several significant themes emerged on the priorities that should be considered for the next five years. These themes include:

Social norm change
- Increase statewide and local media
- Consider new methods (social media, Twitter, Facebook)
- Revitalize media campaigns
- Youth involved in process and vetting
- Employ edgy messages
- Increase exposure about tobacco industry in media

Infrastructure
- Strengthen tobacco control system so more needs can be met
- Build a sustainable, robust infrastructure that will endure
- Fix internal infrastructure issues (how decisions are made and money is moved)
- Need coordinated clearinghouse for programs/data
- Need objective system to review and evaluate progress on goals

Coordination
- Crosswalk with social determinants and ethnic groupings
- Continue to invest in coordination
- Improve coordination efforts between funders and providers
- Increase engagement of public and stakeholders
- Maintain and expand coalitions
- Need better relationship with Hawai'i Department of Education

Training and Technical Assistance
- Focus on health care providers
- Help disparity populations
- Sustain process for community capacity building

Funding and Resources
- Preserve Master Settlement Agreement (MSA) dollars
- Dedicate MSA monies to tobacco; discontinue deviation of monies to programs other than tobacco
- Distribute grants more equitably among islands
- More grant monies to communities
- How funds are applied needs to be broadened to focus on comprehensive approach to tobacco
- Change spending formula; revisit process; increase funding for communities and reduce years in cycle
- Follow CDC Best Practices funding recommendation
- Cultivate other sources of funding; access new government funds
- Consider dedicated tobacco tax dollars

Surveillance, Evaluation & Research
- Increase data gathering on tobacco related disparities and priority groups and communities
- Increase information on the social determinants of health relevant to tobacco-related disparities
- Increase qualitative evaluation

Public Policy
- Need better enforcement of workplace law

- Legislative rules and regulations for taxes (penalties and other disincentives)
- Legislature needs education
- Keep increasing tobacco taxes
- Identify champions at legislature
- Focus on county ordinances
- Share information on Family Smoking Prevention and Tobacco Control Act (referred to as the "FDA Act") law and local implications
- Understand how to work with new federal legislation

Engaging New Partners
- Get better cooperation from insurance industry
- Cultivate more alliances
- Work better with community agencies involved with disparity populations

Addressing new tobacco/nicotine products
- Emphasize addressing new tobacco products

Prevention
- Funding should be dedicated to tobacco prevention not other topics
- School connectedness is too narrow for use of tobacco funds
- Need new and better ways to reach school age populations
- Revitalize media campaigns
- Maintain youth-led programs

Cessation
- Need more aggressive assessment of tools for working with youth who want to quit
- Work more closely with health professionals
- Need proactive cessation led by physicians
- Fair reimbursement for screening/counseling
- Train health personnel while in school (University of Hawai'i John A Burns School of Medicine, School of Nursing, School of Pharmacy, Public Health, etc.)
- Get insurance providers to the table

Secondhand smoke
- Need better enforcement of existing law
- Focus on homes
- Expand reach to condo boards, hotels, businesses
- Need public housing initiatives
- Use Big Island as model for cars, parks/beaches
- Address thirdhand smoke
- Teach youth to work with parents to reduce their smoking and exposure

Disparity populations
- Main disparity populations identified included: lower socioeconomic status (low education, low income and low employment), Micronesian, Native Hawaiian, Korean, Filipino men, pregnant women, lesbian, gay, bisexual, transgendered, mentally ill, homeless, youth and prisoners
- Need innovative new programming to address unique issues of disparity population communities
- More representation from disparity populations
- Need sustained outreach to disparity populations
- Need more accessibility to prevention and intervention

- Need monies dedicated to disparity populations
- Quitline doesn't and never will serve these populations
- Find respected individuals who come from disparity populations to deliver messages

Key Themes from Youth

Youth empowerment and leadership are critical

- Youth are making a difference and taking responsibility
- Initiatives work when youth are in charge
- Youth bring new ideas; they know what will work with their age group
- Engage youth to develop plans, curricula, etc.
- Have youth "do the work"
- Have youth testify

Evaluation

- For youth work, qualitative data is more important than quantitative.

It is important to celebrate youth work

Continuity of programs

- Put an end to stop-and-go campaigns. When smoking numbers go down, the campaigns are stopped. When the numbers go up, money is put into resumption of the campaign. We need a steady commitment if we want to create a generation of non-smokers.

Recommendations for youth-aimed media

- Realistic, simple and entertaining ads on TV, Internet, movies
- Media that is edgy/to the point /scares
- Youth-to-youth media
- Guerrilla tactics and messages
- More earned media attention for youth activities/program/actions
- Use TV, movies, posters, magazine ads and Internet (YouTube, Facebook, websites)
- Placement is important; tobacco industry ads are better placed than prevention ads
- Fast-paced, attractive ads that get straight to the point and are not too wordy (Truth campaign as a good example)
- More media participation that focuses on youth prevention programs
- More positive messages
- Focus on social norms

Recommendations for youth programs

- Gatherings, trainings, education needs to be fun and hands on
- After-school activities and youth-created media
- Youth need to come to the realization of what tobacco companies are doing
- Peer-to-peer (youth empowerment) approach works; teens are more likely to listen to other teens
- Teach self-respect and respect for others
- Use school events/community groups to get the word out
- Personal stories impact more
- Continue to hold a youth anti-tobacco summit
- Focus on cultural practices
- More youth coordinated programs that teach additional life skills

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This Glossary contains working definitions of key tobacco-related terminology found in the Tobacco Use Prevention and Control in Hawai'i Five-Year Strategic Plan for the State (2011-2016). This resource should not be considered exhaustive.

Administration and Management of Tobacco Control Programs: One of the 5 Best Practices endorsed by the Centers for Disease Control and Prevention and a key component of a Comprehensive Tobacco Control Program. Effective tobacco prevention and control programs require experienced staff with sufficient capacity to provide fiscal management, accountability and coordination.

Advocacy: The pursuit of influencing outcomes — including public policy and resource allocation decisions within political, economic and social systems and institutions — that directly affect people's lives. Advocacy also refers to actions directed at policy-makers and decision-makers to promote policies, regulations and programs to bring about change.

ATS: The Adult Tobacco Survey, which collects in-depth data through telephone interviews on the knowledge and atitudes of adults regarding the use of tobacco products, cessation efforts among smokers, attitudes and exposure towards secondhand smoke, and overall attitudes regarding smoking and its effects on smokers and nonsmokers. The Hawai'i Adult Tobacco Survey (HATS) has been conducted in 2001 and 2006.

Ban or Smoking Ban: Refers to the prohibition of the use, performance or distribution of tobacco products. A ban is a tighter regulation than a restriction, which only limits the use of tobacco products

Baseline Information: Data gathered on the target population before a tobacco control program begins.

Best Practices: Refer to methodologies, policies and procedures that provide guidance based on past experiences.

Betel Nuts: Chewed slowly over several hours and are commonly combined with tobacco. The nicotine in the tobacco has a synergistic effect with the arecoline (the active stimulant in the betel nut). The chewing of betel nuts causes mild stimulation and a feeling of well-being. Betel nuts' popular use throughout Asia, India and the Pacific makes it one of the most popular stimulants in the world.

Best Practices for Comprehensive Tobacco Control Programs: Refers to the 2007 published guide developed by the Centers for Disease Control and Prevention (CDC). It describes an integrated programmatic structure for implementing tobacco control interventions proven to be effective and also provides the recommended level of state investment to reach the goals and reduce tobacco use in each state.

BRFSS: The Behavioral Risk Factor Surveillance System, established by CDC, is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices and health care access primarily related to chronic disease and injury. The Hawai'i BRFSS has been part of the national BRFSS since 1986.

CDC: The Centers for Disease Control and Prevention, a part of the U.S. Department of Health and Human Services, is the primary federal agency for conducting and supporting public health activities in the United States.

Carcinogen: Any substance that causes cancer.

Cessation: The act of stopping or quitting smoking. Counseling, pharmacologic therapies and second–line therapies are common methods used to help individuals stop smoking.

Cessation Interventions: One of the 5 Best Practices endorsed by CDC and a key component of a Comprehensive Tobacco Control Program. Effective cessation interventions encompass a broad array of policy, system and population-based measures.

Cigar: A cylindrical roll of cured tobacco for smoking consisting of cut tobacco wrapped in a tobacco leaf. Cigars vary in size and shape, but large cigars typically contain between 5 and 17 grams of a single type of tobacco (as opposed to the tobacco blends found in most cigarettes).

Cigarette: A small roll of finely cut tobacco wrapped in a thin paper for smoking, usually with a filtered tip.

Clinical interventions: Represents an avenue for cessation efforts and includes the pharmacologic treatment of nicotine addiction. For best results, clinical interventions should be combined with behavioral support.

Collaboration: The process by which organizations or individuals make a formal, sustained commitment to work together to accomplish a common mission.

Coalition: An organization of individuals representing diverse groups, organizations or constituencies that combine their human and material resources to affect change that the members are unable to bring about independently.

Community: A unified body of individuals, usually sharing common interests and living in a particular area. Individuals within a community may also be linked by history or common social, economic and political interests.

Comprehensive Tobacco Prevention Program: A coordinated effort to establish smoke-free policies and social norms, promote and assist tobacco users to quit and prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic and social strategies.

Countermarketing: Marketing and communications efforts aimed at countering the marketing efforts (including but not limited to advertising) of the tobacco industry and other pro-tobacco influences. Countermarketing can include such efforts as media advocacy, media relations, in-school curriculum programs,sponsorships and promotions, as well as paid counter-advertising.

Data Analysis: The process of systematically applying statistical and logical techniques to describe, summarize and compare data.

Deterrence: A strategy used to discourage individuals from smoking. School-based education on the consequences of smoking is a common deterrence strategy applied to youth. Tobacco taxes and smoking restrictions also function as deterrents to smoking.

Direct Cost: Represents the dollar value of goods and services consumed as a result of smoking and smoking-related illness and for which a payment is made. Examples include health care costs of hospitalizations, physician services and medications to treat illnesses associated with tobacco use.

Disparities: Differences in the health status, burden of illness and death in certain population groups, such as racial and ethnic minorities, when compared to the U.S. population as a whole. Health disparities may result from poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, the need for effective prevention programs tailored to specific community needs and sociopolitical factors. A broader definition of disparity takes into consideration sensitivity to age, gender, sexual identity and socioeconomic status, among other things.

Dissemination: Process of communicating either the procedures or the lessons learned from an evaluation in a timely, unbiased and consistent manner.

Diversity: Refers to the broad range of human qualities that make individuals and groups different from one another. Primary dimensions of diversity are age, ethnicity, gender, physical abilities/qualities, race and sexual orientation. Secondary dimensions of diversity, which are alterable, include traits such as educational background, geographic location, income, marital status, military experience, parental status, religious beliefs and work experiences.

Ethnicity: Refers to an ethnic or racial group having a common origin, language, custom or history.

Evaluation or Program Evaluation: The systematic collection of information about the activities, characteristics and outcomes of programs to make judgments about the program, improve program effectiveness and/or inform decisions about future program development.

Evidence-Based: Refers to the conscientious, explicit and judicious use of current best evidence from systematic research in making decisions about the public health strategies and programs used to prevent tobacco use.

FDA: U.S. Food and Drug Administration

Focus Group: A collection of people selected for their relevance to an evaluation who are engaged by a trained facilitator in a series of discussions designed for sharing insights, ideas and observations on a topic of concern.

Formative Research: Seeks to assess the nature of a problem, the needs of a target audience, and the implementation process to inform and improve program design. Formative research (reviews of existing programs, surveys, interviews and focus group discussions) is conducted both prior to and during program development to adapt the program to audience needs.

Goal: Expresses the overall mission or purpose of a program and helps guide its development. In tobacco prevention and control, the overarching purpose is to reduce tobacco-related morbidity and mortality. Specific tobacco control programs have more specific goals as well.

Health Communication Interventions: One of the 5 Best Practices endorsed by the Centers for Disease Control and Prevention and a key component of a Comprehensive Tobacco Control Program. An effective health communication intervention should deliver strategic, culturally appropriate and high-impact messages in sustained and adequately funded campaigns integrated into the overall state tobacco control effort.

Healthy People 2020: The prevention agenda for the nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. This document contains important information about tobacco use and objectives covering a range of tobacco control and use issues from reducing tobacco use among adults and youth to eliminating laws that pre-empt stronger tobacco laws in all states to increasing the average federal and state tax on tobacco products.

Health Promotion and Disease Prevention Programs: The public health programs that attempt to reduce resources spent on treating preventable illness and functional impairment, enhance the quality of life and reduce disparities in the health status of populations.

HHS: The U.S. Department of Health and Human Services

Incidence: Number of new cases of a disease in a defined population within a specified period of time.

Indicator: A specific, observable and measurable characteristic or change that will represent achievement of an outcome.

Infrastructure: The basic, underlying framework or features of a system or organization.

Initiation: Refers to the first occurrence of cigarette use.

Inputs: Resources used to plan and set up a tobacco control program.

Intervention: The method, device or process used to prevent an undesirable outcome or create a desirable outcome.

KOI: Key Outcome Indicator. Specific, numerated, evidence-based indicators that have been scientifically linked to program outcomes and are listed in the document, Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs published by CDC in 2005.

Logic Model: A graphic depiction of the presumed causal pathways that connect program inputs, activities and outputs with short-term, intermediate and long-term objectives.

Long-Term Outcomes: Refers to the distant or future effects of a program and are typically focused on sustainability.

Marketing: Process or technique of promoting, selling and distributing a product or service.

Master Settlement Agreement (MSA): The legal agreement between 46 states, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Northern Mariana Islands, Guam and the District of Columbia and the major tobacco companies in the United States. Signed in November 1998, the MSA collectively settled the states' and territories' individual lawsuits against the tobacco industry for $206 billion to be paid to the states and territories over 25 years. Among the most significant milestones in tobacco control history, the settlement did not specify how the money should be spent; instead, each state or territory decides how to spend its settlement dollars.

Media Advocacy: The strategic use of mass media (film, television, radio, newspapers, magazines, billboards, posters or the Internet) as a resource for advancing a social or public policy initiative.

Medicaid: A joint federal-state program of health insurance for the poor, blind and disabled.

Menthol: An ingredient added directly to tobacco in a solution of alcohol, introduced into the cigarette filter or applied to the paper side of the cigarette pack foil.

NTCP: National Tobacco Control Program

Needs Assessment: A process for collecting information to understand a community's concerns, characterizing its needs and resources and eventually working together to respond to the issues identified.

Nicotine: A poisonous and powerful central nervous system stimulant found in tobacco leaves that is physically and psychologically addictive.

Objective: A statement describing the results to be achieved and the manner in which these results will be achieved. A well written and clearly defined objective is SMART: (Specific, measurable, Achievable/Ambitious, Relevant and Time-bound). SMART objectives set program priorities, aid in monitoring progress toward achieving goals and set targets for accountability.

Outcome Evaluation: The systematic collection of information to assess the effect of a program, or an activity within such a program, to reduce the adverse effects of tobacco use. Good evaluation allows evaluators to draw conclusions about the merit of a program and make recommendations about a program's direction or improvement.

Outcome Indicator: A specific, observable and measurable characteristic or change that will represent achievement of the outcome.

Outcome: The result of a program or activity. Outcomes can be short-term, intermediate or long-term.

Outputs: Direct products of a program.

Pharmacotherapy: The treatment of disease through the administration of drugs.

Policy: A system of laws, regulatory measures, courses of action and funding priorities concerning (in this case) tobacco-related issues put into effect by a governmental entity or its representatives.

Policy Advocacy: The effort to influence public policy through various forms of persuasive communication such as statements or prevailing practices imposed by those in authority to guide or control institutional, community and individual behavior.

Population-Based Approach: Focuses on groups of individuals. Population-based interventions, which emphasize multi-component programs that address social norms and the needs of individuals, have formed the core of the tobacco control efforts in the United States.

Prevalence: The total number of cases of a factor of interest (e.g. tobacco use) in a population at a given time; or the total number of cases in the population, divided by the number of individuals in the population.

Priority Populations for Tobacco Control: Traditionally underserved communities where tobacco has had a disproportionate negative impact. In Hawai'i, these populations include lower income, lesser educated, unmarried, young adults, high school girls, Native Hawaiians, Pacific Islanders, Filipino males, people with mental illness and/or substance addictions, and lesbian, bisexual, gay and transgender people.

Process Evaluation: The systematic collection of information to determine how well a program was implemented and operates.

Program Evaluation: The systematic collection of information about activities, characteristics and outcomes of programs to make judgments about a program, improve its effectiveness and/or inform decisions about future program activities.

Quitline: A dedicated telephone service staffed by professionals with special training in smoking cessation techniques. Quitlines are intended to help individuals working to quit smoking by offering them support, encouragement and answers to get them through tough spots.

Rate: A measurement of how frequently an event occurs in a certain population at one point in time or during a particular period of time.

Research: The investigation or experimentation aimed at the discovery and interpretation of facts, revision of accepted theories or laws in the light of new facts, or practical application of such new or revised theories or laws; the collecting of information about a particular subject.

Resources: Assets available or anticipated for operations. Resources include people, equipment, facilities and other items used to plan, implement and evaluate programs.

Restrictions: Aims to limit the use of tobacco products, such as restricting minors' access to tobacco products. Restrictions are less severe than bans, which prohibit the use, performance or distribution of tobacco products.

Risk Factor: Anything that increases a person's chance of developing a disease, including a substance, agent, genetic alteration, trait, habit or condition.

Sample: A subset of people in a particular population.

SCHIP: State Children's Health Insurance Program. A program administered by the U.S. Department of Health and Human Services that provides matching funds to states for health care to families with needy children.

Secondhand Smoke: Consists of sidestream smoke and the smoke exhaled by smokers. Secondhand smoke cannot be controlled by ventilation, air cleaning or spatial separation of smokers from nonsmokers.

Short-term Outcomes: Refers to the immediate effects of a program and often focus on the knowledge, attitudes and skills gained by a target audience.

Sidestream Smoke: The smoke emitted from the burning end of cigarettes, cigars and pipes; not the smoke which is drawn through the mouth end of a tobacco product during puffing.

Smokeless Tobacco Products: Includes snuff, chewing tobacco, snus, smokeless pouches or other forms of loose leaf tobacco that is not burned. New products include dissolvables., which resemble breath mints, breath strips and toothpicks that can be dissolved in the mouth.

Smoking: The drawing of smoke, fire and toxic substances into the lungs from any type of lighted pipe, cigar, cigarette or any other smoking equipment for the purpose of giving the body a dose of a drug, usually nicotine.

Social Change: Also referred to as social influence resistance model, is a shift in the norms of a community over time. Social change is regarded as one of the most effective approaches to tobacco control, as it emphasizes the social environment as a critical factor in tobacco use and recognizes the importance of influences outside of the individual, such as peer pressure and other social norms.

Social Determinants of Health: The non-medical and non-behavioral precursors of health and illness. Eleven key social determinants of health have been identified: aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, the social safety net, social exclusion, and unemployment and employment security.

Social Marketing: The application of advertising and marketing principles and techniques (e.g., applying the planning variable of product, promotion, place and price) to health or social issues with the intent of bringing about behavior change. The social marketing approach is used to increase the acceptability of a new idea or practice within a target population.

Social Norms or Societal Norms: The patterns or traits taken to be typical in the behavior of a social group. Successful tobacco control programs work within existing social norms to affect change and promote health.

Social Source: A person or location from which tobacco products are obtained other than a tobacco product retailer.

Socioeconomic Status (SES): The social standing of an individual or group in terms of their income, education and occupation.

State and Community Interventions: One of the 5 Best Practices endorsed by CDC and a key component of a Comprehensive Tobacco Control Program. These include interventions that support and implement programs and policies to influence social organizations, systems and networks that encourage individuals to make behavior changes consistent with tobacco-free norms. They unite a range of integrated programmatic activities, including local and statewide policies and programs, chronic disease and tobacco-related disparity elimination initiatives and interventions specifically aimed at influencing youth.

Surgeon General's Report (SGR): Started in 1964 and produced regularly ever since, serves as a critical resource to the tobacco control effort, as it outlines in great detail the problems associated with tobacco use and offers solutions for reducing and preventing tobacco use. The SGR offers a composite review of various tobacco control topics and provides a vision for the future of tobacco control.

Surveillance: Refers to the ongoing, systematic collection, analysis and interpretation of data essential to the planning, implementation and evaluation of public health practice, and is closely integrated with the timely dissemination of these data to those responsible for prevention and control.

Surveillance and Evaluation: One of the 5 Best Practices endorsed by CDC and a key component of a Comprehensive Tobacco Control Program. It is the process of monitoring program accountability for state policy-makers and others responsible for fiscal oversight and helps tobacco control professionals make judgments about programs, improve program effectiveness and/or inform decisions about future program development.

Survey: A quantitative method of collecting information on a target population at one point in time. Surveys can be conducted by interview (in person or by telephone) or by questionnaires.

Sustainability: Requires building capacity through training staff, creating leadership and maintaining staff, and building relationships with partners.

Synar Amendment Program: A federal and state partnership which requires states to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons younger than 18 years of age. States must report annually to the Substance Abuse and Mental Health Services Administration (SAMHSA) on the percentage of their retailer violation rates.

Systems Change: Refers to the act of making a difference in a systemic manner, such as with health care systems, legislation, policy and regulations.

Target Population: Refers to a specific intended audience for a given initiative, program or message.

Targeted Marketing: Refers to the practice of creating messages and materials intended to reach a specific segment of a population, usually based on one or more demographics or other characteristics shared by its members.

Technical Assistance (TA): Services provided by professional staff and consultants intended to give guidance to tobacco prevention and control programs at the state and local levels as well as community organizations to strengthen or enhance program effectiveness. The goal of TA is to build skills, expertise and capacity in tobacco prevention and control.

Tobacco or Tobacco Products: Any substances or items containing the tobacco leaf, including cigarettes, cigars, pipe tobacco, snuff, fine cut or other chewing tobacco, cheroots, stogies, perique, granulated, plug cut, crimp cut, ready-rubbed, snuff flowers, cavendish, twist tobaccos, dipping tobaccos, refuse scraps, clippings, cuttings, sweepings and other kinds or forms of tobacco leaf prepared in such manner as to be suitable for chewing, sniffing, or smoking.

Tobacco Control: Multiple programs, policies and cessation services designed to reduce the factors that influence tobacco use.

Tobacco Industry: The conglomerate of companies that manufacture, promote and sell tobacco products.

Youth Access: The ability of people younger than the legal purchasing age to obtain tobacco products. While many components of a comprehensive tobacco control program attempt to reduce youth demand for tobacco products, effective youth access policies focus on reducing the supply of tobacco to children.

Youth Engagement: Providing the opportunity for young people to gain the ability and authority to make decisions that help improve the policy environment, change social norms, and reduce smoking initiation and consumption in their communities.

YTS: The Youth Tobacco Survey is designed to collect comprehensive data on the attitudes, knowledge and behaviors of middle and high school students (grades 6-12) with respect to tobacco and on other influences that might make a youth susceptible to tobacco use in the future. The Hawai'i Youth Tobacco Survey (HYTS), conducted biennially, comprises state- and CDC-approved question to gather data that helps gauge the effectiveness of tobacco prevention and education programs, ensures accountability, and provides an index against which a state may compare results with the National Youth Tobacco Survey.

[1] Campaign for Tobacco Free Kids http://www.tobaccofreekids.org accessed on 4/20/11 and CDC, Data Highlights 2006 [and underlying CDC data/estimates; CDC's STATE System average annual smoking attributable productivity losses from 1997-2001 (1999 estimates updated to 2004 dollars); CDC, "State-Specific Smoking-Attributable Mortality and Years of Potential Life Lost — United States, 2000-2004," (MMWR) 58(2), January 22, 2009

[2] 2010 Hawai'i Behavioral Risk Factor Surveillance System (BRFSS) Program, Hawai'i State Department of Health. Available at: http://www.hawaii.gov/health/statistics/brfss/index.html

[3] 2009 Hawai'i Youth Tobacco Survey (YTS). Hawai'i State Department of Health.

[4] US Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004. Available at: http://www.cdc.gov/tobacco/data_statistics/sgr/2004/index.htm.

[5] US Department of Health and Human Services. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010. Available at: http://www.surgeongeneral.gov/library/tobaccosmoke/index.html.

[6] US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006. Available at: http://www.surgeongeneral.gov/library/secondhandsmoke/index.html

[7] Adult Smoking Rates. U.S. Centers for Disease Control and Prevention (CDC), "Vital Signs: Current Cigarette Smoking Among Adults Aged ≥ 18 Years - United States, 2009," Morbidity and Mortality Weekly Report (MMWR), Vol. 59, September 7, 2010. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5935a3.htm?s_cid=mm5935a3_w . State smoking rates: 2009 BRFSS, Behavioral Risk Factor Surveillance System.]

[8] Raphael, D. (2006). Social determinants of health: Present status, unanswered questions and further direction. International Journal of Health Services, Vol. 36. No. 4, pp. 651-657.

[9] World Health Organization. (2011). Definition of Social Determinants of Health. Available at: http://www.who.int/social_determinants/en/

[10] Lantz P. and Pritchard A. (2010). Socioeconomic Indicators that Matter for Population Health. Preventing Chronic Disease 7(4) June 22, 2010. Available at: http://www.cdc.gov/pcd/issues/2010/jul/09_0246.htm.

[11] Loppie, Charlotte. (2007). Power point presentation, slide 10 of 21, The Big Picture: Social Determinants and Smoking. Dalhousie University, Nova Scotia, Canada. Available at: http://www.gov.ns.ca/hpp/publications/TC/Loppie_Presentation.pdf

[12] Starr G, Rogers T, Schooley M, Porter S, Wiensen E, Jamieson N. (2005) *Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs.* Atlanta GA: Centers for Disease Control and Prevention; 2005.

[13] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007*. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

[14] Holden D, Pendergast K, Austin D. (2000) *Literature Review for American Legacy Foundation's Statewide Youth Movement Against Tobacco Use: Draft Report.* Washington, DC: American Legacy Foundation; September 2000.

[15] Centers for Disease Control and Prevention. *Best Practices User Guide: Youth Engagement-State and Community Interventions.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

[16] Curry SJ, Grothaus LC, McAfee T, Paviniak C. (1998) Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. *New England Journal of Medicine,* 339(10):673-679.

[17] US Department of Health and Human Services. *The Health Benefits if Smoking Cessation: A Report of the Surgeon General.* Atlanta. US Department of Health and Human Services, Centers for Disease Control and Prevention; 1990 DHHS Publication No, (CDC) 90-8416. Available at: http://profiles.nlm.nih.gov/NN/B/B/C/T/

[18] Fiore MC, Jaen CR, Baker TB, Bailey WC, Benowitz NL, Curry SJ, et al. Treating Tobacco use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville (MD): US Department of Health and Human Services, Public Health Service; 2008.

[19] Solberg LI, Maciosek MV, Edwards NM, Khanchandani HS, Goodman MJ. (2006) Repeated tobacco use screening and intervention in clinical practice: health impact and cost effectiveness. *American Journal of Preventive Medicine*,31(1):62-71.

[20] Centers for Disease Control and Prevention. *Telephone Quitlines: A Resource for Development, Implementation and Evaluation.* Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health;2004 Available at: http://www.cdc.gov/tobacco/quit_smoking/cessation/quitlines/index.htm .

[21] US EPA. Respiratory Health Effects of Passive Smoking (Also Known as Exposure to Secondhand Smoke or Environmental Tobacco Smoke ETS). U.S. Environmental Protection Agency, Office of Research and Development, Office of Health and Environmental Assessment, Washington, DC, EPA/600/6-90/006F, 1992.

[22] Fagan P, King G, Lawrence D, Petrucci SA, et al. (2004) Eliminating tobacco-related disparities: Directions for future research. *American Journal of Public Health* 94:2 (2004):211-217.

[23] Lasser I, et al., (2000) Smoking and Mental Illness: A population-based prevalence study. *The Journal of the American Medical Association*, 284:20 (2000):2606-2610.

[24] Grant BF, et. al., (2004) Nicotine Dependence and Psychiatric Disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry* 61:11 (2004)1107-15.

[25] American Legacy Foundation. Washington DC. A Hidden Epidemic: Tobacco Use and Mental Illness, 2011.

[26] CDC. Vital signs: current cigarette smoking among adults aged >18 years—United States, 2009. MMWR 2010; 59: 1135-40

[27] US Department of Health and Human Services, Office of the Surgeon General. Tobacco use among US ethnic/racial and minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islander, and Hispanics: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, CDC 1998. Available at: http://profiles.nlm.nih.gov/NN/B/B/F/Q.

[28] CDC. Health Disparities and Inequalities Report: Cigarette Smoking—United States, 1965-2008. United States, 2011. MMWR 2011; 60:109-113.

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