Tobacco Policy Change: A Collaborative for Healthier Communities and States
An RWJF national program

SUMMARY

Tobacco Policy Change: A Collaborative for Healthier Communities and States, which ran from 2004 to 2010, provided resources and technical assistance to local, regional, and national organizations and tribal groups to advance tobacco-control initiatives. The program aimed to foster grassroots efforts to promote policy changes in states and communities disproportionately affected by tobacco use. The Robert Wood Johnson Foundation (RWJF) authorized the national program for $11.7 million.

CONTEXT

Policy change is a powerful strategy for reducing harm from tobacco.

From 1993 to 2004, coalitions of advocates working through SmokeLess States, an RWJF national program, advanced numerous state policies designed to control the use of and exposure to tobacco.1 In the wake of that work, some 35 states raised tobacco excise taxes, 10 states enacted clean indoor air laws curbing smoking in workplaces and public spaces, and 13 states passed laws restricting youth access to tobacco products.

Tobacco-control advocates also blocked state-level bills that would have preempted stronger local laws, and four states repealed or partially repealed preemption laws. (Read the Program Results Report on SmokeLess States.)

“SmokeLess States was a tremendous success by many definitions,” said RWJF Senior Policy Adviser Marjorie Paloma, MPH. “However, major disparities persisted based on who you are and where you live.”

The reasons for the disparities are varied, Paloma observed, but one common denominator is socioeconomic status. For example, “if you look at the history of clean

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1 SmokeLess States supported coalitions in 48 states, plus coalitions in Washington, DC, and Tucson, Ariz, Because RWJF is prohibited by law from supporting direct or grassroots lobbying, SmokeLess States grantees raised matching funds for such work.
indoor air laws, they often do not extend to hospitality, bar, and restaurant workers,” who tend to be disproportionately low-income or minority.

Many southern states, which have disproportionately poor and minority populations, also have lacked state and local tobacco-control policies. “The tobacco industry is an economic driver in many states that had not been moving on tobacco control policies,” Paloma noted.

Tobacco-control laws were also rare in tribal nations, which are disproportionately low-income. Other factors limited tobacco-control policies in Indian Country. “Some tribes consider tobacco sacred and it is part of their cultural and historic beliefs and traditions,” Paloma said. “Another factor has to do with sovereignty. A state or local ordinance does not have, nor should it have, jurisdiction over tribal land. The tribe has to have its own policy, one that is grounded in their own values and rights to self-determination.”

Lesbian, gay, bisexual, and transgender (LGBT) communities are also disproportionately affected by tobacco. Although the LGBT community is often seen as having higher income and more access to resources, Paloma noted, “research does not bear that out. The notion that LGBT people make more money is a myth.”

RWJF launched Tobacco Policy Change to support efforts that would advance policy changes in these states and communities.

**RWJF’s Interest in This Area**

Since 1991, RWJF has invested some $700 million in efforts to prevent tobacco uptake, especially by children, and to help addicted users quit. For an overview of the Foundation’s history of grant-making in this area, see RWJF Retrospective: The Tobacco Campaigns of RWJF. In addition to SmokeLess States, key RWJF programs and projects have included, in order of the most influence on Tobacco Policy Change, according to Paloma:

- *Policy Advocacy on Tobacco and Health*, which implemented a comprehensive strategy to strengthen minority-led, community-based coalitions that engage in tobacco policy change in communities of color. See the Program Results Report for more information.

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2 According to U.S. Census Bureau publications, more than 17 percent of residents met the poverty threshold in the southern states in 2010 compared to 15.3 percent for the United States as a whole; these states’ populations were more than 34 percent minority.

3 Available [online](#).
Support for the American Nonsmokers' Rights Foundation to sustain it and the smokefree movement over the foreseeable future.4

The *Campaign for Tobacco-Free Kids* the first RWJF advocacy program. For more information, see the Program Results Report.

Voices in the Debate: Minority Action for Tobacco Policy Change, which worked to strengthen and expand the roles of minority organizations in advocating for tobacco prevention and control at the national, state and local levels within communities of color. Read the Program Results Report for more information.

A program to connect tobacco-control advocates in this country at the state and local level with technical assistance, the *National Tobacco Control Technical Assistance Consortium*. The Program Results Report offers more information.

Other RWJF programs in the tobacco area are:

- Two policy research programs: *Tobacco Policy Research and Evaluation Program* (see the Program Results Report) and *Substance Abuse Policy Research Program* (Also see the Program Results Report.)

- Two programs on the development of tobacco addiction: the *Tobacco Etiology Research Network* (TERN) (see the Program Results Report), which led to *Partners With Tobacco Use Research Centers* (See the Program Results Report.)

- *Smoke-Free Families: Innovations to Stop Smoking During and Beyond Pregnancy* (See the Program Results Report.)

- *Addressing Tobacco in Managed Care* (renamed *Addressing Tobacco in Health Care*), which focused on systems strategies to increase evidence-based tobacco-cessation treatment. Also see the Program Results Report.

Starting in the early 1990s, rates of tobacco use among youth and adults have declined, saving millions of lives.5 In 2009, 20 percent of high school students reported past-month smoking compared with 28 percent in 1991, for example.

After 20 years of funding, RWJF began to pull back from its major funding in the tobacco-control and cessation area in 2010. *Tobacco Policy Change* was one of its last significant investments, although the Foundation’s Public Health Team continues to make some grants in the tobacco-control area.

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4 Grant ID#s 58339, 60551. RWJF has also funded the foundation to do rapid response grants to communities, continue and update its databases on tobacco industry activities and tobacco control laws and provide education on clean indoor air to the public and policy makers.

THE PROGRAM

From 2004 through 2010, Tobacco Policy Change: A Collaborative for Healthier Communities and States provided resources and technical assistance to local, regional, and national organizations and tribal groups to advance tobacco-control initiatives. The program aimed to recruit a broad range of stakeholders to promote these policy changes.

Tobacco Policy Change awarded 75 grants ranging from $5,000 to $150,000 during four rounds of funding. Grantees could receive funding in more than one round. Total funding was $11.7 million.

Matching Funds Required

The RWJF grants supported staff and activities such as public education, communications, technical assistance, outreach and advocacy in support of tobacco-related policy change.

RWJF is prohibited by law from supporting direct or grassroots lobbying; Tobacco Policy Change required grantees to raise matching funds from other sources to support policy efforts to complement the RWJF-funded advocacy efforts. Many of the applicant organizations struggled with this requirement since only those organizations that raised money prior to grant aware were eligible. Once funded, RWJF provided grantees with individualized technical assistance to help each organizations build their development capacity and help them to diversify funding. RWJF also created the toolkit Meeting the Match: A Guide to Fundraising for the Tobacco Policy Change Program6.

Targeting Tobacco Policy Areas

Grantees advanced policies proven to prevent tobacco use, help smokers quit, protect people from secondhand smoke, and sustain tobacco control. These policies included:

- Comprehensive clean indoor air laws covering all workplaces
- Increases in local and state tobacco excise taxes or the price of tobacco, with at least a portion of the increased revenue devoted to tobacco prevention and treatment and other health care challenges, such as preventing obesity
- Increases in public funding for tobacco-related programs, including expanded and more equitable access to treatment7

6 Available online.
7 The agreement settled state Medicaid lawsuits against the industry. Under the agreement—originally between the four largest U.S. tobacco companies and the attorneys general of 46 states—the companies agreed to curtail certain tobacco marketing practices, and to make annual payments to the states to cover some of the costs of caring for people with smoking-related illnesses. In exchange, the agreement exempted companies from liability for harm caused by tobacco use.
• Public and private insurance coverage for tobacco-cessation treatment for people in
groups most affected by tobacco\textsuperscript{8}

• State and local licensing, zoning, and land-use regulations to control the number,
type, and location of tobacco retailers, especially in areas where youth congregate

**Expanding the Applicant Pool**

To focus on states and communities disproportionately affected by tobacco, and cultivate
new relationships and broader partnerships, RWJF aimed to diversify the pool of
applicants to *Tobacco Policy Change*.

“We wanted to get the word out about this funding opportunity,” Paloma said, “not just to
groups already working on tobacco, but to those working on policy advocacy for any
issue.” However, despite this aim, grantees in the first round, in 2004, were
predominantly those with a long history in tobacco control—many which had
participated in *SmokeLess States*.

In response, in 2006 RWJF launched an effort to engage new potential applicants,
holding “listening sessions” in some five cities in five days, all in the South, to inform
potential grantees about the program, and to learn about the challenges communities
faced in tackling tobacco use and exposure. The program also worked with consultant
Lori New Breast, a member of the Blackfeet Nation in Montana and member of the
program’s technical assistance committee, to reach out to officials and advocates in tribal
nations.

More organizations from the South and tribal communities applied as a result of these
efforts. “We wanted to authentically engage the organizations and residents of their
communities,” Paloma said, “and leverage people’s existing strengths and skills to
address an issue that was important to them. The listening sessions reinforced our belief
that strength and capacity for policy advocacy is alive and well in the communities most
affected by tobacco.”

A wide array of nonprofit groups from 33 states ultimately received grants, including
groups that had focused on community safety, Main St. redevelopment, rural health, and
housing. “The national lung, cancer, and heart associations had received 99 percent of the
grants in *SmokeLess States*, and *Tobacco Policy Change* started with the same grantees,”
Paloma said. “But by the end of the program, the grantees were not mainstream tobacco-
control organizations. Many of them were not one-issue organizations. They were
focused on improving their communities, working on a number of important social
issues, and tobacco was just one of them.”

\textsuperscript{8} This policy and the one above it on increasing public funding were not included in later rounds of
funding.
A number of the funded groups served particular populations, including the LGBT community, youth, college students, African Americans, Latinos, American Indians, and other ethnic minorities. (See Appendix 1 for list of grantees and their projects.)

**Tackling Other Public Health Challenges**

In the final round of *Tobacco Policy Change* in 2008, RWJF asked grantees to pursue policy change addressing another public health problem. Twelve grantees received six-month planning grants, and 11 grantees received 18-month implementation grants totaling $1.8 million. Grantees used these funds to promote policies designed to improve access to healthy food, boost physical activity, and expand health insurance coverage, for example.

“At the time, RWJF was broadening its perspective on public health policy beyond tobacco control,” Paloma said. “We saw it as an opportunity to use the skills of tobacco advocacy to advance another issue, and to leverage the relationships grantees developed in one arena and apply them to another arena of policy change.”

For more on the expanded strategy, see the sidebar Leveraging Policy Skills to Tackle the Nation’s Toughest Health Challenges: A Q&A with Marjorie Paloma.

**Management**

RWJF’s Public Health Team managed *Tobacco Policy Change* internally. The team contracted with three senior consultants with extensive experience in local and state tobacco-control campaigns. These consultants—Carla Freeman, MA; Kitty Jerome, MA; and Jerry Spegman, JD—helped shape the program, and provided technical assistance to applicants and grantees through site visits, conference calls, and webcast trainings.

The consultants also talked about the program at national, state, and local conferences held during its lifetime. (See Appendix 2 for contact information for the consultants.)

**Oversight Committees**

Two committees also helped guide *Tobacco Policy Change* and review grant applications:

- An Executive Committee, which included the directors of five organizations funded by RWJF. (See Appendix 3 for a list of the original members.)

- A Technical Assistance Providers Committee—“by far the more important group,” notes Paloma—was composed of staff from the seven organizations represented on the Executive Committee (American for Nonsmokers’ Rights Foundation, Campaign for Tobacco Free Kids, Asian Pacific Partners for Empowerment and Leadership, National African American Tobacco Prevention Network, National Latino Council on
Alcohol, National Technical Assistance Consortium, and The Praxis Project), and additional policy advocacy experts and consultants. Members used conference calls, webcasts, trainings and meetings to assist grantees on advocacy, communications, and outreach. “The Technical Assistance Providers Committee members were instrumental in the design and execution of the program,” says Paloma.

**Collaborating Organizations**

Staff of the Praxis Project,9 the National Consortium on Tobacco and Technical Assistance, the National African American Tobacco Prevention Network, the Latino Council on Alcohol and Tobacco, APPEAL, the Campaign for Tobacco Free Kids and Americans for NonSmokers’ Rights helped shape Tobacco Policy Change, review grant applications, and guide technical assistance to grantees.

In addition, staff from all of these organizations worked closely with the senior consultants and Foundation staff to help grantees develop their approaches to policy change.

**Other Subcontractors**

Burness Communications, Spitfire Strategies, and Theisen Consulting trained grantees in campaign development, strategic communications, and board and fundraising development and sustainability. Two independent subcontractors, Letetia Daniels and Onjewel Smith, worked on specific projects.

**The Evaluation**

Andrea A. Anderson-Hamilton, PhD, director of planning, and Mary Clare Lennon, PhD, professor of sociology—both of the Research Foundation of the City University of New York—evaluated the program. They used both quantitative (an online survey) and qualitative (key-informant interviews, site visits, and case studies) approaches to document grantees’ progress, and assess Tobacco Policy Change as a grant-making strategy for addressing disparities around tobacco harm.

- For findings, see Evaluation Findings. For more on the evaluation methodology, see Appendix 4.

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9 The Praxis Project managed Policy Advocacy on Tobacco and Health, and is now directing Communities Creating Healthy Environments, a childhood obesity program. See the Progress Report on this program.
OVERALL PROGRAM RESULTS

The three senior consultants and the evaluators reported these overall results:

- Many grassroots organizations used Tobacco Policy Change to play their first prominent role in the tobacco-control movement and become effective voices for communities most affected by tobacco. For example:
  - Coalitions in the Navajo Nation and the Fort Peck Tribe led tribal policy campaigns.
  - Coalitions in Houston and South Carolina, comprised of strong advocates for minority and low-income communities, led the clean air campaigns for their communities.

Many organizations also used their campaigns to tap the resources and technical assistance of mainstream tobacco-control groups for the first time. For more information, see Key Site Activities and Results.

- Many of the tobacco policy campaigns in which these organizations participated achieved the desired changes:
  - Some 18 states, communities, and tribal organizations passed comprehensive smoke-free indoor air laws covering all workplaces.¹⁰
  - Kentucky, North Carolina, Ohio, and Vermont approved significant increases in tobacco taxes.
  - Alaska, Kentucky, and Massachusetts extended Medicaid coverage to services that help tobacco users quit. California passed a bill, but the governor vetoed it.

Tobacco Policy Change coalitions also helped ban tobacco sampling and promotion at rodeos in the Southwest, ban the sale of flavored cigarettes in New York City, increase the number of smoke-free rental units in Maine, restrict signage for tobacco products in Boston, and cap the number of licenses to sell tobacco in New Orleans.

The community engagement fostered by the campaigns helped coalitions win higher-quality policies, such as tobacco-control laws with few or no exemptions, according to the evaluators.

- Grantees used the skills they developed through Tobacco Policy Change to tackle other critical public health needs, including childhood obesity, access to health care, outdoor air pollution, exposure to radon, intimate partner violence, and

¹⁰ States included Illinois, Georgia, Colorado, Hawaii, New Hampshire, Maryland, and New Jersey. Municipalities included Houston; Washington; Louisville, Ky.; Philadelphia; Charleston, S.C.; Bessemer, Ala.; Alton, Texas; and Maryville, Fulton, and Warrensburg, Mo. Tribal organizations included the Fort Peck Tribe in Montana.
**workforce wellness.** Though most of the coalitions found taking on another policy a challenge (see Lessons Learned), several achieved significant policy wins:

— The University of Missouri instituted domestic violence screening at university health clinics and a local hospital in Hannibal, Mo.

— West Virginia Wellness won Main Street designation—a community development program, created by the National Trust for Historic Preservation, that emphasizes preservation, walkable downtowns, civic engagement, and creative place-making—for two of the counties it targeted.11

— Indiana Rural Health’s efforts to promote greater access to the Healthy Indiana Plan, the state Medicaid program, contributed to an increase in enrollment—from some 9,000 in May 2008 to more than 46,000 in October 2009.

— The South Carolina tobacco-control coalition joined with the Coastal Conservation League to win an agreement with the port authority that will curb air pollution at the Port of Charleston.

For more on this work, see the next section.

**KEY SITE ACTIVITIES AND RESULTS**

The senior consultants and grantees reported these key efforts during *Tobacco Policy Change*—grouped under Project Highlights, Projects in the South, and Projects in Tribal Communities:

**Project Highlights**

**Houston: Clean Air in Restaurants and Bars**

For decades, cigarette smoke hung heavily in many Houston workplaces, undermining the health of thousands of employees. Some of the worst offenders were restaurants and bars, which traditionally have employed large numbers of minorities.

“Houston is the fourth-largest city in country,” senior consultant Jerry Spegman noted, “but the city had missed the boat on clean indoor air.”

**Houston Communities for Safe Indoor Air**, a coalition of minority groups headed by Helen Stagg, MSW, set out to convince Houstonians of the importance of curbing exposure to secondhand smoke.12

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11 The Main Street Program is a coast-to-coast community-development program created by the National Trust for Historic Preservation involving more than 5,000 American communities. It emphasizes preservation, walkable downtowns, civic engagement, and creative place-making. See its website.

12 Grant ID#s 52391, 55836, 63595, 64502.
The coalition included a wide range of groups: the African American Health Coalition, the Asian American Health Coalition, the Association for the Advancement of Mexican-Americans, the Chinese Community Center, Families under Urban and Social Attack, the Hispanic Health Coalition, the Native American Health Coalition, the Third Ward Community Cloth Cooperative, and the Vietnamese Culture & Science Association.

To raise awareness of the impact of secondhand smoke, particularly on minorities, the coalition:

- Sponsored town hall meetings, free movie nights, and a “Take It Outside” walk in a local park.
- Distributed information at community health fairs, parades, sporting events, and other events with minority audiences.
- Recruited and trained key members of the community—including restaurant owners who had voluntarily made their facilities smoke-free—to be spokespersons at local events and with legislators.

The coalition also coordinated Breathe Free Houston, a broader alliance of organizations interested in clean indoor air. Participants included the American Heart Association, the American Lung Association, the American Cancer Society, March of Dimes, M.D. Anderson Cancer Center, Baylor College of Medicine, and the Tobacco Education Campaign.

“The best thing was building those collaborative partnerships,” Stagg said. “We engaged a wide spectrum of the community all promoting the same message.”

The communications effort received a big boost when the Houston Chronicle got behind the smoke-free campaign, offering Houston Communities for Safe Indoor Air three guest editorial slots from February to October 2006.

The coalition also mounted a direct lobbying effort using matching funds. For example, Secondhand Smoke Kills—an ad asking citizens to contact the city council—ran in the Chronicle two days before the council voted on a smoke-free indoor air law. The coalition also delivered “balloon bouquets” hourly to council members carrying messages advocating safe indoor air. “It was another mechanism to get attention and provide education on the dangers of secondhand smoke,” said Stagg.

On October 18, the Houston City Council adopted an ordinance making all restaurants, bars, and clubs smoke-free. The ban went into effect September 1, 2007. The coalition then joined the leadership team of Smoke-Free Texas to engage communities of color in advocating for statewide clean-indoor-air policies.
Moving on to Childhood Obesity

The coalition also used funding from Tobacco Policy Change to encourage physical activity in the city’s historic Emancipation Park in its predominantly Black 3rd Ward. The group:

- Convened a childhood obesity taskforce to focus on education and awareness strategies aimed at helping Blacks live healthier lives through proper nutrition and physical activity.
- Sponsored “The Meltdown”—a block party with music, other entertainment, free healthy food, a basketball tournament, and a bike ride—to reintroduce the community to Emancipation Park.
- Worked with the Mayor’s Wellness Council to host a local 50 Million Pound Challenge, part of a national effort sponsored by State Farm Insurance to promote healthier lifestyles among Blacks.
- Cohosted a Fall Healthy Food Festival with a mini-farmers’ market, cooking and fitness demonstrations, food samples, nutrition education, and live entertainment.

The project “left an invaluable imprint in the neighborhood surrounding Emancipation Park,” the coalition reported. “Conversations around health and wellness are very limited, and this program fostered and empowered community members to become advocates and stand up to childhood obesity.”

For a video on this work, see the Promise Story: Empowering Community Health.¹³

New Orleans: No Sales Near Our Kids

Communities with a greater density of retail outlets selling tobacco products have higher rates of youth smoking, studies show.¹⁴ The Joseph Project, led by Rev. Patrick Keen, pastor of Bethlehem Lutheran Church, rallied New Orleans residents and organizations to support a law that would limit the sale of tobacco products in the predominantly Black neighborhood of Central City.¹⁵

At community meetings, advocates distributed more than 4,000 pieces of literature on tobacco use and substance abuse in New Orleans. With technical assistance from Tobacco Policy Change consultants, project staff educated policy-makers and trained local leaders and residents on how to engage lawmakers and get media attention for their cause.

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¹³ See Promise Story.
¹⁴ See the studies cited by the Campaign for Tobacco-Free Kids.
¹⁵ Grant ID#s 63590 and 64497
The effort paid off. On July 23, 2009, the New Orleans City Council voted unanimously to prohibit retailers from selling tobacco products within 300 feet (the length of a city block) of any playground, church, public library, school, childcare facility, or other entity providing organized care for youth. The ordinance also forbids tobacco retail in residential or park-zoned districts.

**Access to Healthy Foods**

The coalition has since turned its attention to other public health concerns in New Orleans, including access to healthy foods. “We feel along with the local lawmakers that this project has changed the quality of life for a great many residents of New Orleans,” the group reported. “This project is setting the tone for how to work with local lawmakers to improve community living.”

**Chicago: Motivating the LBGT Community**

Smoking rates are 40 to 70 percent higher among lesbian, gay, bisexual, and transgender (LGBT) adults and youth than the overall U.S. population. Bartenders and cocktail servers in LGBT-oriented nightclubs are also disproportionately exposed to secondhand smoke—partly because of the tobacco industry’s campaign to promote smoking in the LGBT community through promotions, sponsorships, and advertisements.

In Chicago, the Lesbian Community Cancer Project joined the Smoke-Free Chicago campaign to educate local leaders, nonprofits, and bar and restaurant owners about the importance of curbing tobacco exposure in LGBT communities. At its Coming Out Against Cancer Ball in February 2006, the group adhered to the policy in Chicago’s new clean-air law barring outdoor smoking within a radius of 15 feet from the entrance of a restaurant or bar, and talked about the importance of implementing the law early.

When Big Chicks, a popular lesbian bar, went smoke-free voluntarily right before the law passed, the project advertised the event and held several parties and meetings there. The group also partnered with the American Cancer Society in its Great American Smoke Out, held every year on the third Thursday of November to encourage smokers to quit for 24 hours in hopes that their decision will stick, distributing educational material during a smoke-free pub crawl.

The Lesbian Community Cancer Project also participated in Women's Health Day, Andersonville Street Fayre, Dyke March, Pride Parade, Halsted Street Days, and the Gay Games. By the end of the grant period in 2006, the group had enlisted 18 partners and 30 advocates to support its work.

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16 Grant ID# 55840.
“Focusing on smoke-free events as a way to get people out and celebrate, rather than lecturing about the ill effects of smoking tobacco or even secondhand smoke, proved effective for us,” the project staff reported.

“Shaping this with a political slant was also useful so people could take this on as a social justice issue…Most people, even those who were looking at this from a ‘freedom to smoke’ or ‘choice’ perspective, found it hard not to become involved after learning more about how the LGBT community was targeted, and how on top of that women, communities of color, people impacted by HIV/AIDS, and youth were also targeted.”

**South Bronx: The Danger of Flavored Tobacco Products**

Flavored cigarettes and cigars—ranging from Kool’s Mocha Taboo to Camel Exotics’ SnakeEyes Scotch—have strong appeal for young people, especially urban and minority youth.

The POINT Community Development Corporation, a youth organization in the South Bronx, worked closely with the American Lung Association of New York to educate policy-makers and the public about the dangers of flavored tobacco products, and the immediate need to restrict their sale.

A survey by The POINT found that 19 percent of local stores were selling candy-flavored cigarettes or cigars. Tobacco use in the neighborhood was high: 28 percent of underage women and 71 percent of underage men smoked. Among adults, 50 percent of women and 63 percent of men were smokers.

“Tobacco is very big in this community, and it is becoming more and more common to see young people smoking cigarettes,” a report from The POINT observed. “The addition of candy-flavored cigarettes makes it more apparent that the tobacco companies are targeting youth.”

Some 25 youth in The POINT’s Activists Coming to Inform Our Neighborhood (ACTION) leadership program received training in advocacy, including how to educate members of the New York City Council. After a council hearing in 2006 on a proposed ban on flavored tobacco products, the young people put their new skills to work, meeting with decision makers and participating in local forums and media events. But the council failed to act during the 2007 session.

The POINT and the New York chapter of the American Lung Association also worked with a coalition to push for a state ban on flavored cigarettes. Legislation passed the

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17 A state clean indoor air law prohibiting smoking in virtually all enclosed public places and places of employment, including bars and restaurants, went into effect January 1, 2008. More information is available [online](#).

18 Grant ID#s 55833 and 59319
assembly and advanced in the senate, but the 2007 legislative session closed without a vote.

On a national level, the American Lung Association educated members of Congress on the importance of giving the Food and Drug Administration (FDA) the authority to regulate tobacco products. On September 22, 2009, the FDA announced a ban on cigarettes with fruit, candy, or clove flavors, and said it would examine options for regulating both menthol cigarettes and other flavored tobacco products.

On October 14, 2009, Mayor Michael Bloomberg signed legislation prohibiting the sale of most flavored tobacco products in New York City. The law—more extensive than the FDA ban—covers “chocolate, vanilla, honey, candy, cocoa, dessert, alcoholic beverage, herb or spice flavors,” but exempts “tobacco, menthol, mint or wintergreen flavors.”

The POINT’s youth activists have since broadened their attack, targeting all tobacco advertising in their neighborhood. “We still have this great bunch of youth advocates that understand the issue,” said Michael Seilback, vice president of policy and communications at the American Lung Association of New York, “and there are still legislative victories to be won.”

**Projects in the South**

This region, including bordering states such as Missouri, Kentucky and West Virginia, has crippling rates of smoking, obesity, heart disease, stroke, and diabetes, coupled with higher poverty rates and lower education levels than other regions. Public health advocates working in southern states face a broad array of challenges.

**South Carolina: Cleaning Up Indoor and Outdoor Air**

Local tobacco-control policies have faced tough opposition in the tobacco-growing state of South Carolina.

In 2006, three South Carolina towns passed clean indoor air ordinances that included workplaces, restaurants, and bars. However, opponents immediately challenged two of the laws in court, effectively putting at risk any local efforts to go smoke-free.

The National African American Prevention Network joined with an unusual ally—a conservation group concerned about air pollution from the Port of Charleston—to push for policies to clean up both indoor and outdoor air.19

The network is one of six funded by the Centers for Disease Control and Prevention (CDC) that engage national and statewide partners in tobacco control and prevention

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19 Grant ID#s 59337, 63586, and 64505
activities in Black communities. For more information, see the sidebar Joint Campaign for Clean Indoor and Outdoor Air Scores Victories in South Carolina.

**Alabama: Secondhand Smoke at Work**

Alabama is the eleventh-worst among all states in workplace exposure to smoke, according to the CDC. In 2003, the legislature passed a clean indoor air law that excluded most workplaces.

In 2008, the DuBois Institute for Entrepreneurship, a nonprofit public health policy group in Dothan, Ala., created a coalition to work for a more comprehensive law.\(^{20}\) The partners held advocacy trainings and workshops, lobby days at the state capitol, and public forums, and conducted media outreach. The faith community was a strong ally in these efforts.

The Alabama Senate passed a comprehensive clean indoor air bill in 2008, but the measure never made it to the house floor. Proponents introduced legislation again in 2009, held a public hearing, and debated the bill on the senate floor, but it again failed to go to a full vote.

“We simply ran out of time,” the coalition reported. “The legislature got caught up in various wars around the budget, gaming, education funding, tax on food, etc. that caused a bottleneck of many important pieces of legislation.”

**Another Issue: Childhood Obesity**

Also in 2008, the coalition spearheaded an effort to reduce the state’s high childhood obesity rates. In particular, these advocates promoted a bill that would make physical education mandatory for K–8 students, as many were either exempt or allowed to substitute another class.

The Alabama House and Senate passed the bill by veto-proof margins. However, at the behest of the Board of Education, the governor pocket-vetoed the legislation by not signing it and letting the clock run out.

Though that was a setback, the coalition sees its work as a victory. “This was a major accomplishment because this was the first time any physical education/obesity legislation passed the legislature in Alabama,” the coalition reported.

**Kentucky: Promoting Medicaid Coverage of Tobacco Cessation Services**

Kentucky, one of the nation’s poorest states, also has the highest smoking rate. The state Medicaid Department spends $487 million annually to treat people with smoking-related

\(^{20}\) Grant ID#s 63591 and 64498
diseases. However, the agency did not cover services and prescriptions to help people stop using tobacco.

In 2007, the Kentucky Medicaid Consortium, led by the American Cancer Society’s Mid-South Division, worked to educate lawmakers about the importance of such services. The Kentucky Legislature passed a bill that year mandating Medicaid coverage for cessation services. However, an array of bureaucratic obstacles prevented the legislature from fully funding the law. In 2008, with the state facing a $600 million budget shortfall, including a $200 million Medicaid deficit, the legislature again failed to fund it.

In Alaska and Massachusetts, Tobacco Policy Change coalitions also helped pass laws mandating Medicaid coverage of such services. “The challenge was the same for all three,” said consultant Kitty Jerome. “Implementation needs a budget, and the states did not have the budget for it, so implementation was very slow to come.”

For Kentucky, the funding did come. The 2010–12 state budget provides $3 million for a smoking-cessation program, which the federal government will match with $8.4 million.

**North Carolina: Regulating Secondhand Smoke**

In this tobacco-growing state, the North Carolina Alliance for Health undertook a two-pronged effort: to make all public places and workplaces smoke-free, and to address the state’s obesity epidemic.

Alliance staff conducted advocacy trainings, spearheaded a signature campaign in support of the smoke-free measure, and provided research-based information to other advocates and legislators. Membership in the alliance grew to 75 organizations, including health groups, minority organizations, and the faith community.

In May 2009, the North Carolina General Assembly expanded previous legislation that banned smoking in state government buildings, schools, prisons, and long-term-care facilities to include bars, restaurants, and lodging establishments that prepare and serve food and drink. The law protects 69 percent of the workforce—or some 2.8 million workers—and will save the state some $48 million annually owing to a drop in the number of heart attacks and hospitalizations, according to the alliance.

Since the alliance began its work, conventional wisdom about the impact of tobacco has changed significantly, the group reports. “Policy-makers no longer openly question the science and the arguments. Instead, they question whether regulating secondhand smoke is the appropriate role of government. We felt significant strides were made in this tobacco state when folks stopped questioning the science.”

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21 Grant ID# 59341
22 Grant ID#s 52397, 63594, and 64501
The legislature also approved a law enabling local governments to raise sales taxes to encourage active living and expand public transportation. The legislature commissioned a Joint Legislative Childhood Obesity Task Force to review efforts of the Department of Health and Human Services, the Department of Public Instruction, and the Health and Wellness Trust Fund, and to develop a statewide strategic plan to prevent childhood obesity. The task force includes the alliance.

“Our education efforts are just beginning to scratch the surface of what needs to be done to raise awareness that obesity is a problem in need of more serious attention and funding from the state,” the alliance reported. The “challenge will be to educate and convince legislators, media, and the public that the price of ignoring the obesity epidemic is far more than the price of the intervention.”

**Projects in Tribal Communities**

For many tribes throughout North America, the use of traditional tobacco plants for spiritual, ceremonial, and medicinal purposes goes back thousands of years. Stories explaining how tobacco was introduced to native communities emphasize the plant’s sacred properties. The teachings are clear: if used properly, tobacco has the power to heal and help. If used improperly, tobacco hurts and harms.

Today much tobacco use among American Indians has changed dramatically from those original purposes, and the use of commercial tobacco is at epidemic proportions in many tribal communities. Some 34 percent of native adults smoke—the highest rate among all racial and ethnic groups in the United States. Use of commercial tobacco is the main cause of two of every five deaths in Indian Country. The Indian Health Service alone spends $200 million per year to treat smoking-related illnesses.

Organizations in seven tribal communities worked through *Tobacco Policy Change* to regulate commercial tobacco. The groups faced a number of challenges, including confusion about the difference between ceremonial and commercial tobacco, and concerns about the economic impact of smoke-free laws on enterprises that provide income and employment in tribal communities, such as casinos.

Two of the seven organizations added a second health issue to their agenda in the last round of funding under the program. Synopses of the work of several of the tribal organizations follow.

**Navajo Nation: Commercial Tobacco**

Navajos use commercial tobacco—including chewing tobacco, cigarettes, and other products—at a higher rate than the overall U.S. population. Tobacco use begins young. One-fifth of Navajo youth in grades 5 and 6 chew smokeless tobacco. By grades 9 and 10, 56 percent of youth do.
Beginning in 2008, the Black Hills Center for American Indian Health spearheaded the Southwest Navajo Tobacco Education Prevention Project, an ambitious effort to make workplaces and public places within the 300,000-member Navajo Nation free of commercial tobacco.\textsuperscript{23}

Read the sidebar Targeting Commercial Tobacco in the Navajo Nation for more details.

\textbf{Fort Peck Reservation: Prohibiting Commercial Tobacco}

The Fort Peck Tribal Health Department serves the Assiniboine and Sioux Tribes of the Fort Peck Reservation, in the extreme northeast corner of Montana. When the department began its Tobacco Policy Change effort in 2006, an existing secondhand smoke policy left nearly 80 percent of Fort Peck tribal members unprotected.\textsuperscript{24}

A survey found that most tribal members were concerned about the health effects of commercial tobacco and secondhand smoke. They also believed that prohibiting the sale of commercial tobacco would not undercut businesses. Eight of 10 people surveyed also wanted to learn about traditional tobacco teachings.

The Health Department asked tribal elders to describe tobacco-related rituals and beliefs for the community, “to help our people differentiate between traditional tobacco versus the commercial tobacco,” the department reported. “From there we were able to do work within the traditional law-making protocols and the Tribal Government.”

A youth-led movement called A Rizing Nation used hip-hop to focus on the traditional tobacco teachings. During a two-day event, tribal members participated in workshops, a two-mile walk to the tribal office, performances, and talking circles. Youth from outlying communities were brought to the event at no charge.

“The Tribal Executive Board came and spoke to all the people who walked, shook their hands, and let the community members know that their doors are always open and admire the passion they have for change,” the Health Department reported.

Two days later, on August 10, 2007, the tribal council passed the Fort Peck Tribes \textit{Ohinni Candi Wakandapi/Chani Wakan K/Nusa} (Keep Tobacco Sacred) law. It covers all 11,000-plus enrolled members of the tribes, as well as other residents of the Fort Peck Reservation.

On December 1 of that year, the Union for the Indian Health Services, which had previously opposed tobacco-control policies, adopted its own ordinance prohibiting the use of commercial tobacco on its two campuses within the reservation.

\textsuperscript{23} Grant ID#s 64495, 63588, and 59340
\textsuperscript{24} Grant ID# 59328
Nez Perce Tribe: Smoke-Free the Traditional Tribal Way

The roughly 3,300 members of the Nez Perce Tribe live predominantly on a reservation in southern Idaho. The tribe’s tobacco-control policies date back to 1995, when it established a policy prohibiting smoking and chewing in office buildings and vehicles.

In 2005, tribal members promoted a policy to make doorways, covered walkways, and ventilation systems of facilities smoke-free. The tribal council opposed the policy. In 2007, with funding from Tobacco Policy Change, a tribal coalition tried again, this time consulting tribal leaders first.

“It was important to have the tribal council involved early in our process of developing the Nez Perce Clean Air Policy,” the coalition reported, “so that we could build support long before submitting the policy to them for approval.”

Having the early involvement of the council helped the coalition anticipate and respond to objections. It also gave them time to understand and carefully explain the meaning of tobacco in Nez Perce culture. “Instead of relying on a ‘pan-Indian’ view of traditional tobacco use,” the group reported, “we thought that we needed to use our own tribal experience with tobacco.”

Youth on the staff of Students for Success, an existing organization serving Nez Perce young people, filmed interviews with nine tribal elders discussing their experience with tobacco used in the Nimíipuunewit or Nez Perce Way. The coalition used this information to gain community support for reducing exposure to secondhand smoke.

“The basic message was the contrast between use of traditional tobacco for healing and protection to the side effects of commercial tobacco products causing disease and harm,” the coalition reported. “It was also important to stress the traditional Nez Perce value of tobacco … and to respect traditional, ceremonial, and sacred use of tobacco. This added legitimacy to our policy development.”

A policy banning smoking in public facilities, and within 25 feet of their doorways, went into effect in March 2008—only the second such policy on tribal lands in the United States. “One lesson was to not attack smokers for their addictive habit,” the coalition reported. “If we engage them with understanding and compassion, they have been more open to working with the new changes.”

Indigenous Peoples Task Force: Campaigns Around Tobacco Control

The Indigenous Peoples Task Force was founded in 1988 to provide HIV education and direct services to the American Indian community in Minnesota. The task force has since broadened its focus to include the health effects of commercial tobacco.

25 Grant ID# 55931
With funding from *Tobacco Policy Change*, the task force set out to expand its Minnesota Native American Council on Tobacco. First, the task force funded the *Circle* newspaper—a local publication supported through mini-grants from Blue Cross Blue Shield—to publish a seven-part series on the dangers of commercial tobacco, beginning in May 2007.

The task force then created a poster campaign urging tribal members to keep homes, community centers, and other public buildings smoke-free. A third campaign, Respect Our First Medicine—Tobacco, highlighted the difference between ceremonial and commercial tobacco use.

In March 2006, six of eleven tribes in Minnesota were members of the tobacco-control network. By 2007, all tribes except the Shakopee had joined.

**Northwest Tribes: Economic Tensions Over Tobacco**

The Northwest Portland Area Indian Health Board represents 44 tribes whose members live mostly in Idaho, Oregon, and Washington. A coalition representing key tribal leaders held a tobacco policy summit in August 2007 that drew some 25 tribal leaders and 25 advocates representing more than 40 tribes.

As a result of the meeting, the health board drafted a resolution supporting a tobacco-control effort across all tribes in the United States. The effort would include preventing youth smoking, reducing exposure to secondhand smoke, promoting cessation efforts, eliminating the use of native imagery to promote commercial tobacco use, and respecting the ceremonial use of traditional tobacco.

The Affiliated Tribes of Northwest Indians approved the resolution, but the National Congress of American Indians did not. The health board reported:

“There was great tension between the issues of economics of smoking on tribal lands and the public health needs of tribal members. Sales of commercial tobacco and the attraction of smokers to economic enterprises situated on tribal lands is perceived to be an important contribution to many Tribes’ economic development efforts.”

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26 Grant ID# 59327
27 Grant IDs 59324 and 55862
EVALUATION FINDINGS

The evaluators reported these findings to RWJF:

Effectiveness of the Program Model

From a survey of 76 project directors and representatives of their project partners representing 66 projects, evaluators reported:

- 76 percent of survey respondents felt they understood more about the advocacy process as a result of their involvement with Tobacco Policy Change.
- 90 percent of survey respondents reported that the grant strengthened their relationships with allies.
- 86 percent of survey respondents felt that their project won them more support from local policymakers. Respondents also reported that their project won them support from state health and advocacy organizations (84%), city officials (52%), and national health and advocacy organizations (38%).
- 43 percent of survey respondents reported that their coalition is continuing to work on health challenges beyond tobacco.

Factors in Grantee Effectiveness

- The level of community engagement affected the ability of coalitions to inform and sustain policy changes.
- A legitimate presence and history working in a community enabled grantees to leverage relationships and social capital to engage the community in a policy agenda.
- Culturally relevant strategies are essential to policy change, as shown by groups working in tribal regions, Latino communities, and others.
- Tobacco Policy Change coalitions consisted of groups with varying backgrounds, access to power and resources, and priorities, and the ability of these groups to navigate complex new relationships was central to their success.
- Policy templates, training modules, and toolkits, often offered by technical assistance providers, provided important guidelines, blueprints, and educational support.

Recommendations for Future Work on Tobacco Control

In interviews, project directors and partner organizations expressed appreciation for RWJF’s efforts to broaden the tobacco movement to include the communities most affected, and to build social movements rather than relying on a technocratic approach to
policy change. Interviewees offered these recommendations to future funders of such work:

- Creating a foundation for policy work in communities that are disparately affected by an issue requires a significant investment.
- All communities, but especially those that are negatively affected by issues, need culturally relevant programs designed by people with a strong understanding of local social, political, and economic realities.
- The program staff of Tobacco Policy Change made notable efforts to work with credible community leaders. However, finding and assessing the capacity of leaders and groups that are “really doing the work” remains challenging. Informants called for mapping a community’s organizing infrastructure and leadership capacity before working to bolster them.

- Engaging communities, earning their trust, and allowing their voices to inform strategies require time and facilitation. Grant requirements and timelines need to accommodate and support this approach.

Informants also pointed to continued high smoking rates in these communities, and expressed concern that funders are no longer allies in this fight.

**SIGNIFICANCE OF THE PROGRAM**

In their report to RWJF, the three senior consultants noted:

“Tobacco Policy Change [TPC] has had a significant impact on the infrastructure supporting tobacco policy advocacy nationally and, through the project-specific work of its grantees, it has also impacted tobacco control at the state, local, and tribal levels.

“Nationally, organizations such as the Campaign for Tobacco-Free Kids, Americans for Non-Smokers Rights, and the American Cancer Society have been persuaded over the course of TPC’s four rounds of funding to generally be more inclusive of several of TPC’s less traditional partners, and more attentive in general to communities around the country that have not experienced significant progress in tobacco-policy advocacy. This impact has been partly the result of TPC consultants and RWJF staff advocating for new approaches among national partners, but more frequently due to the successes of TPC grantees in their policy campaigns that have validated TPC’s mission.

“When TPC began, it can safely be said that the tobacco policy advocacy movement nationwide generally understood that it was not doing a good job of engaging those communities most impacted by tobacco use. By demonstrating to the movement how that
engagement can happen and lead to successful policy outcomes, TPC has helped advance the movement in a meaningful and lasting way.”

**LESSONS LEARNED**

In interviews and reports, grantees, senior consultants, and evaluators suggested these lessons from *Tobacco Policy Change*:

**Strategies for Policy Campaigns**

1. **Working to pass local and state clean indoor air policies is far more cost-effective than encouraging businesses to go smoke-free voluntarily.** “We were surprised at how small an investment it took to achieve such a huge outcome,” said Dan Carrigan, who directed local campaigns in South Carolina that produced clean indoor air ordinances. An earlier effort to ask individual businesses to adopt such policies voluntarily had “yielded virtually no outcome.”

2. **Organizing and promoting large-scale community events is important to effective advocacy.** Houston Communities for Safe Indoor Air planned and promoted town hall meetings and other events that reached many people and won extensive media coverage. These efforts helped convince the city council to approve a clean indoor air policy, according to the coalition.

3. **To reach communities most exposed to tobacco, work with local organizations.** “As we engaged organizations that had little previous experience in tobacco-control work, the process shifted from ‘Here is what RWJF will do for you’ to ‘What does the community want and how can we help?’” said Senior Policy Adviser Marjorie Paloma.

4. **Effective education in support of policy change takes years.** The North Carolina Alliance for Health educated legislators, the media, and local residents about the need for both a tobacco tax and smoke-free indoor air policies for years. By 2009, these constituencies no longer questioned the dangers of secondhand smoke. Instead, the debate had shifted to the proper role of government in preventing exposure.

**Training and Preparing for Policy Campaigns**

5. **A successful policy campaign requires leaders with key personality traits and skills.** “You have to be fearless,” said Carla Freeman, senior consultant, “and not afraid to say, ‘This is our agenda. What is yours? Where can we negotiate? Here’s how much money we have. How much do you have?’ When you get into policy and all the intricacies…it’s a lot more than going to a health fair.”

6. **Ensure that a community can identify with campaign leaders.** Often “campaign leaders and the campaign team do not reflect the cultural essence of the community,” the Houston coalition reported. “Houston Communities for Safe Indoor Air was able
to break barriers by being representative of almost all populations in ways and on subjects not frequently discussed—childhood obesity and tobacco change policy.”

7. **A deep understanding of the culture in which advocates are working is essential.** For example, in the South, it is difficult for people to ask for things directly, so advocates must work with more subtlety, said Freeman. “Pushing back against leadership is just not what they do. They truly are ‘iron fists in velvet gloves’ type of people. It is a cultural thing.”

8. **Nonprofits need intensive training in policy advocacy.** “A certain skill set in the policy arena did not exist in the world of the smaller nonprofits,” Freeman noted. *Tobacco Policy Change* offered an array of workshops, webinars, and direct technical assistance to fill that gap.

9. **When targeting communities most affected by tobacco, engage minority-serving organizations to provide technical assistance.** A number of such organizations provided outreach and technical assistance to *Tobacco Policy Change* grantees, including the Praxis Project, the National African American Tobacco Prevention Network, the Latino Council on Alcohol and Tobacco, the National LGBT Tobacco Network, and Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL), said Freeman.

10. **Empower smaller organizations to work with major tobacco-control groups.** The Houston coalition forged a partnership with major heart, lung and cancer organizations. “The new people we funded did not say to the established organizations, ‘Beat it. We are new here. Your time is up,’” said senior consultant Jerry Spegman. “They said, ‘Okay, now that we have resources, how can we all work together?’”

However, the Lesbian Community Cancer Project (LCCP) hit a brick wall when attempting to work with larger advocacy organizations. “At that time, in those groups, it was pay to play,” said senior consultant Kitty Jerome. “The LCCP didn’t have any money to kick in to the campaign. The culture that says that those with money are going to run a campaign is hard to break.”

11. **Tobacco policy work requires a strong, diverse coalition.** During the project, membership in the North Carolina Alliance for Health grew to 75 organizations, including health groups, minority organizations, and the faith community. The alliance noted that this growth was key to their effectiveness in promoting a smokefree law covering all workplaces—including bars and restaurants.

12. **Consistent communication builds and sustains trust among coalition partners.** The North Carolina Alliance for Health relied on regular meetings, e-mail updates, and action alerts to keep coalition members informed.

13. **Plan advocacy campaigns carefully and well in advance.** During the first year of funding, an unexpected change in the city council’s timeline caught the Houston
coalition off guard. “We did not have time to prepare basic informational packets with materials such as fact sheets, studies, and research in a format helpful to the cause,” the coalition reported. “In the second year, we were well prepared with materials relevant to the community.”

**Executing Policy Campaigns**

14. **Cultivate strong relationships with key legislative champions and give them the information they need to push for policy change.** “Your local government leaders have to have total belief and buy-in to what you are trying to accomplish,” the New Orleans coalition reported. “You must … provide those leaders with research-based proof that the type of work has taken place elsewhere and was successful. If needed, bring in individuals that have had success to support your project.”

15. **Youth advocates are particularly effective in educating policymakers.** South Bronx youth played a key role in the campaign to ban flavored tobacco products in New York City. “Any time a youth advocate is before an elected official, that works so much better than when adult advocates are there,” said Michael Seilback, vice president of policy and communications for the American Lung Association in New York.

16. **When working with youth advocates, find ways to build continuity in the face of turnover.** As high school seniors working with The POINT in the South Bronx began leaving the program for college or work, the group asked older students to train younger ones. That not only ensured continuity but also helped older students develop as advocates and public speakers, the group reported.

17. **Be willing to shift gears when the political landscape changes.** After New York City and the FDA banned the sale of flavored tobacco products, youth activists in the South Bronx shifted their focus to banning all tobacco advertising in their neighborhood. “You have to be flexible enough so that your eggs are not all in one basket,” said Seilback. “Whether legislation passes or not, there are ways to redirect a campaign, to say, ‘Let’s do more. Let’s pivot to something else.’”

18. **State coalitions and their national partners need to communicate well to avoid conflicting messages.** Despite efforts of the North Carolina Alliance for Health, “at times there was no dialogue to appropriately inform the coalition of the messaging coming from the national organization [we worked with],” the alliance reported. “It takes time to build the trust and the relationships.”

19. **Policy wins can be hobbled if the legislature does not allocate funds for implementing new laws.** Several states approved policies supporting Medicaid funding for smoking-cessation services. But tough budget battles in state legislatures slowed, or stopped, implementation.
Policy Campaigns in Tribal Communities

20. Engage tribal elders and leaders early and keep them engaged throughout a policy campaign. The teachings of elders on sustaining tribal culture often reinforce health messages. “Personally invite all tribal leaders and elders to your events, so they can see your process of change,” advised the Northwest Portland Area Indian Health Board.

“The engagement of our local tribal leaders” helped the health board push its tobacco-control resolution forward.”

On the Nez Perce reservation, an effort to enact smoke-free laws originally faltered because tribal leaders were not on board. Under Tobacco Policy Change, coalition leaders engaged elders early, and that was key to winning approval of a smoke-free ordinance in 2008, said Project Director Joyce McFarlan.

21. Distinguishing between commercial tobacco and ceremonial tobacco is essential in most tribal communities. After interviewing tribal elders, the Nez Perce coalition stipulated that its clean indoor air policy would not infringe on traditional, ceremonial tobacco use. The coalition set up a tipi (tepee) at community events to draw people to learn about their tobacco policy and to highlight the differences between the healing purposes of traditional tobacco and the addictive and harmful results of commercial tobacco.

22. Outside partners and funders can play a significant role in tribal tobacco policy campaigns. During Tobacco Policy Change, several tribal groups worked with outside tobacco-control experts and organizations for the first time—and benefited from the partnership.

“Sometimes when you live in Navajo Nation, you feel very isolated from the rest of the world,” said Project Director Patricia Nez Henderson. “RWJF was phenomenal in saying, ‘You don’t need to stop here. Look beyond tribal communities. There are so many resources outside the tribe willing to help out.’”

23. When working with tribes with casinos, educate rather than conveying an “anti-tobacco” attitude. Staff of the Indigenous People’s Task Force said that having a neutral stance enabled them to maintain positive relationships with Minnesota tribes with casinos that also had varying political structures and traditions. (Indigenous People’s Task Force Report)

Expanding Policy Advocacy to Tackle a Second Area

24. It is possible to transfer policy advocacy skills from one issue area to another. “No matter what issue a person is working on, he or she can apply those advocacy skills to address tobacco policy,” Paloma said. “Policy skills like goal setting, coalition building, media development, strategic communications, and power
25. **Adding a second public health policy challenge can strain nonprofit capacity.**

Some coalitions reported that the cost of working on two health challenges outweighed the benefit. Some reported that the tobacco-control agenda required so much attention that the second agenda received short shrift.

Other coalitions reported that they were unable to marshal the kind of evidence base they had used to work on tobacco to tackle the second challenge, or found it difficult to broker essential new relationships. (Evaluation Report)

26. **Focusing on more than one policy issue can help diversify and/or broaden partnerships with community groups.** The South Carolina project found “the grant’s two-policy strategy to be an effective means of combining resources. Our partnership more than doubled our efforts and effectiveness. It provided a great synergy. We each had good relationships, contacts, and audiences that proved very useful to the other’s issue/effort in the arenas of government, the legislature, the medical and conservation communities, and local community or social issue leaders.”

The Kentucky grantee noted that “this project brought together groups that had not previously worked together to reach a common goal. Because the experience of working together was a positive and successful one, these organizations are continuing to work together on other tobacco projects in conjunction with the Medicaid smoking cessation project as well as focusing their energies to address the broader issue of access to healthcare.”

27. **A two-prong policy approach has the potential to build relationships with key decision makers and to diversify funding.** “The project helped to develop key relationships with legislators where there was no previous relationship,” the Kentucky project reported. “Along with expanding our tobacco control partnerships, the project has helped to generate continued funding resources through Pfizer. The project has also had an impact on the medical community as they have become increasingly involved in the issue as they discover that their recipients should have access to this benefit [smoking cessation treatment through Medicaid].”

The South Carolina project also found value in engaging “non-traditional” partners. “We found some of our most energetic advocates to be from groups not usually associated with health initiatives,” the project reported. “We continue to seek relationships with those who are actively engaged in community issues. These are the policy leaders in the community that elected officials trust and sometimes fear. This includes groups like the NAACP, the League of Women Voters, and Trident United Way.”

28. **Connecting tobacco policies with other health-related policies helps broaden the vision of what it means to be a healthy community.** The New Orleans Department of Health invited the project director for *Tobacco Policy Change* “to partner with
them in their planning to address the ‘upstream’ causes of social determinates of health for this city. It is now easier to have access to policy makers on issues important to the health of the city,” the project reported.

The Wellness Council of West Virginia’s second policy focus—reinvigorating the Main Street model for neighborhood revitalization—drew the support and backing of the First Lady of West Virginia. “[She] Lady invited the council to report recent successes and program endeavors to the Healthy Lifestyle Coalition established by Governor Manchin,” the grantee reported, “and is complimentary of the work the coalition is pursuing with regards to improving the health of the state’s people.”

**AFTERWARD**

A number of coalitions are continuing their policy advocacy efforts regarding tobacco control and other health challenges. However, with the close of the program, RWJF is not closely tracking former grantees’ activities.

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Program Area: Public Health
LEVERAGING POLICY ADVOCACY SKILLS TO TACKLE THE NATION’S TOUGHEST HEALTH CHALLENGES

An Interview With Marjorie Paloma

Marjorie Paloma, MPH, senior policy adviser at the Robert Wood Johnson Foundation (RWJF), reflects on Tobacco Policy Change, an RWJF national program that tested the notion that tobacco-control advocates can apply their skills to an array of health challenges.

Question: *RWJF has a long history of supporting tobacco-control work, starting in 1991. Early on, grantees focused on educating the public about tobacco’s harmful effects. Later, the focus shifted to advancing public policies, such as laws that prohibit smoking in workplaces and public spaces, higher tobacco excise taxes, more public funding for services that help people quit, and curbs on tobacco advertising. Why the shift in strategy?*

Answer: There are a couple reasons—the first is that the science matured. Research shows that policy change works—and in some cases far better than other interventions that aim to lessen the harm from tobacco. A good example is tobacco excise taxes, where research shows that raising the price of tobacco products is the most effective policy lever for keeping kids from starting to smoke.

The second is that the Foundation is uniquely poised to work with partners and support efforts to improve policies and communities so that everyone, no matter who they are or where they live, can live a longer, more productive life. A number of national partners focus on surveillance or public education on the harms of tobacco use and exposure. Our work begins with policy research to better understand which are the most effective policy levers. We then build on the research and use policy advocacy and strategic communications to create the social change so that individuals and families can make choices which can help them to live longer, healthier lives for themselves and their families.

“Strength and capacity in advocacy skills is alive and well in the communities most affected by tobacco. The challenge is to identify and work with the people on the ground who are making things happen.”—Marjorie Paloma
What did you do to reach out to the communities most affected?

In the first round of Tobacco Policy Change, we did not receive as many applications as we had hoped from communities that are disproportionately affected by tobacco use and exposure—many of which are in the South, and have higher percentages of low-income residents, blue-collar workers, and people of color. We were also concerned that we were not reaching the lesbian, gay, bisexual, and transgender community and also tribal communities, which have their own sovereignty.

So we held “listening sessions” in the South—we traveled to five states in five days—to determine the top concerns around tobacco in these communities. We got a better sense of the challenges that people are facing every day.

To work with Native American communities, we pulled together about a dozen leaders to have a very frank conversation and to advise us. There were representatives of rural tribes, the Great Plains, land-based tribes, tribes with no reservations, urban Indians, and Alaskan natives. We asked them, “Help us understand tobacco in your communities. What do you think is important? How should RWJF approach this issue with tribes?”

These listening sessions really reinforced our belief that strength and capacity in advocacy skills is alive and well in the communities most affected by tobacco. Yes, there are a lot of competing priorities, but there is power in these communities. The challenge is to identify and work with people on the ground who are making things happen.

Tobacco Policy Change required grantees to have experience in policy advocacy, but not necessarily in tobacco policy. What was your intention with that strategy, and how did it work?

We recognized that individuals and organizations can apply policy advocacy skills—things like setting goals, building networks, understanding power dynamic, and pursuing strategic communications—to any health challenge. By inviting policy advocates in other areas to the table, we hoped to broaden the base of advocates working on tobacco control and other health issues.

As a whole, the grantees did quite well on policy change—in fact, some better than we expected. Some 18 states and communities passed clean indoor air laws, four states raised tobacco excise taxes, and three states passed laws to provide Medicaid funding for tobacco-cessation services. There were also those that didn’t see a policy change come to fruition but who made real progress on their policy issue.

And even more significant than the policy change, we really broadened the base of tobacco advocates. Prior to Tobacco Policy Change, the field did not recognize the people and communities most affected by tobacco use. At the National Tobacco Control conference in 2008, so many of our grantees were standing on a national stage talking
about policy change and what it means for communities. And national organizations were even looking to our grantees to invite them to be a part of their board of directors. That was very gratifying.

**You required Tobacco Policy Change grantees to secure unrestricted matching funds from other sources. Why was that important?**

Matching funds are important for a couple reasons. In no particular order, first, we saw the funding match as an opportunity for applicants to reach out to other potential funders, to broaden the base of financial support for tobacco policy change, and to strengthen the organization’s capacity. Secondly, the match funds were flexible, meaning the project director had the ability to move funds to support activities that may not have been anticipated at the outset of the project. This is important because policy campaigns can shift very quickly and are very influenced by the current social, economic, political, and media context. And finally, the Foundation has clear guidelines that prohibit any direct or indirect lobbying. Match funding from other sources can support activities the Foundation cannot. This is important for any work on policy change.

**In the last round of Tobacco Policy Change, you asked grantees to use their advocacy skills to tackle another health policy challenge. How well did that work?**

We wanted to give folks the flexibility to address other challenges that were affecting their communities while exercising and using their policy advocacy skills.

So, for example, in South Carolina, the tobacco-control advocacy group partnered with a conservation organization that was confronting air pollution from the Port of Charleston. The two groups ended up pushing for clean indoor air and clean outdoor air. It was a good marriage. The organizations had complementary strengths that helped both policy efforts.

In New Orleans, a coalition working on zoning and redevelopment of the Ninth and Tenth Wards convinced the city to pass laws regulating the sale of tobacco and alcohol, and to push to get more grocery stores in these neighborhoods. The focus was less on tobacco control and alcohol and grocery stores, and more on the safety and vibrancy of those neighborhoods.

In Houston, the tobacco-control coalition worked to gain approval for the first clean indoor air ordinance in the city’s history, and then shifted to promoting physical activity in a historic but underused city park.

These projects reinforced the notion that skills and tactics related to policy change are transferrable. It is all about coming up with the collective vision, a timeline, understanding power relationships, building and leveraging networks and relationships, and strong communication strategies. I’m not saying that it’s easy—policy change is
inherently hard work. What I’m saying is that it’s doable—advocates from any issue can use their skills to create change on any [other] issue.

**Are there challenges in applying advocacy skills across issues?**

The everyday work of policy change is always challenging. Some grantees reported that their staff was spread too thinly across the two issues they tackled. In some communities the political environment completely changed, and advocates who had support of leaders felt very deflated after losing champions of their work.

Some of the grantees focusing on non-tobacco health issues had a greater need for technical assistance, support, and training than those working on tobacco. For example, a coalition in Kentucky pursued a policy to regulate indoor exposure to radon. To our knowledge, there is no advocacy infrastructure to support grassroots policy change in that area. That grantee could not plug into the same kind of technical assistance that is available for tobacco policy. That made the work harder.

**Is pursuing policy change worth the effort?**

Absolutely. Whether you win or lose a policy effort, people and organizations gain a lot of value from working together toward a collective goal. Policy change is not really the focus, the goal is for people to be engaged in changing their community in a way that makes it happier and healthier for them. Policy is the means to getting to that vision. Policy allows members of the community and other leaders to work together, build on their assets, and create the change they want to see. Those relationships and networks go far and can be tapped to influence any issue.

**How is RWJF applying lessons from Tobacco Policy Change to other programs?**

*Tobacco Policy Change* offers a lot of lessons that the Foundation’s Health Group has been putting into practice. The first lesson is to recognize the very important role of policy, environmental change, and law, and especially on communities most at risk and affected by today’s health challenges. Across all of the Health Group teams, there are examples of policy-focused programs such as *Healthy Kids, Healthy Communities, Health Impact Project* and *Start Strong*.

A second lesson is to ensure that the vision for change is being developed and designed by the members of the community whom the change will impact. Looking across our work, from ensuring that healthier foods are served in schools to advancing public health department accreditation, we recognize how critical the engagement process is—as much as the visioning and strategic planning.

The final lesson is that there are advocates with lots of skills and networks that exist in communities most impacted. The bigger challenge is ensuring that there is adequate
technical assistance and capacity support for folks to be successful on the ground. A good example of technical assistance to support policy advocacy is the advocacy institute led by Tandeka, Inc., which is focusing on connecting with advocates in the Southern region. The skills they are honing focus on advancing childhood obesity prevention, but the institute participants can apply them to any issue that is affecting their community.

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JOINT CAMPAIGN FOR CLEAN INDOOR AND OUTDOOR AIR SCORES VICTORIES IN SOUTH CAROLINA

Despite tough opposition in the tobacco-growing state of South Carolina, local tobacco-control policies flourish

In 2006, the towns of Sullivan’s Island and Liberty and the city of Greenville passed the first three local ordinances in the state prohibiting smoking in all workplaces, including restaurants and bars. Opponents immediately challenged the Sullivan’s Island and Greenville ordinances in court, effectively putting at risk any local efforts to go smoke-free. They did so on the basis of existing state legislation that prohibited localities from enacting laws that vary from state law or are more stringent.

Despite this challenge, the South Carolina African American Tobacco Control Network worked to pass local ordinances throughout the state. In so doing, the network joined with an unusual ally—an environmental group concerned about air pollution around the Port of Charleston—to push for policies to clean up indoor and outdoor air.

Starting With Education

The network’s early efforts focused on education—specifically, working with Black-owned businesses to go smoke free voluntarily. However, by 2004, with funding from Tobacco Policy Change, a national program of the Robert Wood Johnson Foundation (RWJF), and support and assistance from sophisticated advocacy groups such as Americans for Nonsmokers’ Rights and the Campaign for Tobacco-Free Kids, the network began to pursue policies to make whole cities and counties smoke-free.28

“We saw that it would be far more effective to support not only African-American businesses smoke free but help all businesses become smoke-free,” said Dan Carrigan, project director of the network’s clean indoor air effort and now program manager at Americans for Nonsmokers’ Rights.

But smoke-free opponents had a familiar and potent strategy at the ready to thwart local efforts: preemption.

28 No RWJF funds were used for lobbying.
If a state preemption law passes, local city councils and boards of health lose the power to enact their own—often stronger—tobacco-control laws. “Once a preemptive law is enacted,” a report from Americans for Nonsmokers’ Rights notes, “it can halt tobacco control efforts throughout the state and it is extraordinarily difficult to restore local control.”

**Focusing on Local Smoke-Free Laws**

In 2007, the South Carolina African American Tobacco Control Network secured a one-year grant from RWJF’s *Tobacco Policy Change* to advance local smoke-free laws in South Carolina, and to block preemption of those already on the books.

The group used the RWJF funds to build capacity and educate the public about the benefits of smoke-free policies, while raising other funds and tapping partnerships to support lobbying activities.

With no well-worn path to follow in South Carolina, the network connected with national tobacco-control experts for advice to navigate the rough terrain of the local legislative process. The network pushed for comprehensive ordinances, and refused to accept compromises that would leave some employees—such as those working in bars and restaurants—exposed to the harms of secondhand smoke.

Strong laws became the network’s “goal post and standard”—a stance that suited Project Director Carrigan, a former salesman, just fine. “In sales you are expected to get results, and that carried into my tobacco work,” he said. “I was out to win.”

In a number of towns, elected officials faced pressure to include broad exemptions in their ordinances. “We would call our advisors, and they would share a national perspective,” Carrigan said, “which was not to be passive, but to take action and make strong position statements. Elected officials need to be reminded that they have to stay strong.”

**A Marriage Made in Heaven: Clean Air Indoors and Out**

By the end of 2007, the network had helped 12 cities and towns pass strong clean air laws. Then, in the last round of *Tobacco Policy Change*, RWJF asked grantees to apply the skills of tobacco advocacy to another health policy arena. The network partnered with the Coastal Conservation League, a savvy organization fighting its own clean air battle with the Port of Charleston.

The port was building a new facility that would increase by thousands the number of diesel trucks entering the area. “The American Lung Association had given the area an F

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29 Grant ID# 59337
for air quality,” Nancy Vinson, program
director for the league, recalled, “and no one
knew it, and we couldn’t get the newspapers to
cover it.”

Vinson had heard that the network was testing
air quality in local bars and restaurants, and
asked to use the network’s device to test
outdoor air at the port. She was surprised to
discover that particulates in secondhand smoke
were very similar to those in diesel exhaust—
and equally hazardous to one’s health. The
findings inspired a joint public-awareness
campaign by the Coastal Conservation League
and the South Carolina African American
Tobacco Control Network calling for “clean
air everywhere”—both indoors and outdoors.

To bolster their case, the Conservation League
hired Abt Associates30, based in Cambridge,
Mass., to do a health impact assessment31 of the proposed port expansion. The study
estimated that pollution from the expansion would add $81 million to local health care
costs each year.32

Vinson shared the findings—along with the American Lung Association’s failing
grade—with members of the Charleston County Medical Society. An opinion piece by
then-president William Hueston, MD, appeared in the Charleston Post and Courier on
January 29, 2010, demanding that the port address air quality.

“That was a turning point in our campaign,” Vinson said. “It definitely educated the
public that we had an air pollution problem, and that it could make people sick. We then
educated policy-makers and finally got the attention of the port.”

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30 Abt Associates created the leading computer model—used by the U.S. Environmental Protection
Agency, at other ports, and around the world—to predict the health effects and costs of air pollution.
31 In 2009, RWJF and the Pew Charitable Trusts launched a national initiative to promote the use of health
impact assessments in arenas such as transportation, education, and housing. Charleston was the first city in
the Southeast to factor health considerations into its port operations.
32 See the assessment online.
Preemptive Laws: Wolves in Sheep’s Clothing

At the same time, the Conservation League, with its long experience and clout at the State House, was helping tobacco-control advocates fight back against a series of preemption efforts by the tobacco industry.

In 2007 and 2008, the legislature considered no fewer than five clean indoor bills that, according to tobacco-control advocates, were wolves in sheep’s clothing. As the bills passed through committees, they invariably accumulated amendments that would have eliminated new and existing local laws.

“They wanted us to cut a deal,” Carrigan said. “But if we had, we would have discredited ourselves and shut down our ability to mobilize people, and we would have gotten a terrible statewide law. The Conservation League helped us in ways we did not anticipate with their connections at the State House.”

Then, on March 31, 2008, help came in the form of a South Carolina Supreme Court on the Sullivan’s Island case. It ruled that the existing state preemption law did not prohibit local municipalities from passing ordinances stronger than the state law. This opened the flood gates for local smoke-free laws.

Municipalities Pass Dozens of Laws

By December 31, 2009, 30 local clean indoor air laws had passed, and that number rose to 43 by November 2011. The laws protect some 35 percent of the state’s population from secondhand smoke by prohibiting smoking in all indoor workplaces and public places.\(^{33}\)

“Most remarkable is the comprehensive nature of these ordinances, given the state’s status as a top tobacco grower,” the network reported. “We promoted a theme of social justice and insisted that all workers should have the right to breathe clean air, no matter where they work.”

The State Ports Authority also agreed to significantly reduce particulate air pollution from diesel use linked to all port facilities. A new measure, which went into effect in August 2010, calls for adding rail facilities, which emit far less diesel than trucks; an 85 percent drop in the number of pre-1994 trucks within three years, and air-quality monitoring.

\(^{33}\) In June 2009, South Carolina earned the Smoke-free Challenge Award from Americans for Nonsmokers’ Rights at the National Conference on Tobacco or Health in Phoenix, after municipalities in the state approved or strengthened 12 laws in 2008—more than in any other state that year. A Smoke-Free Map of the South Carolina Tobacco Collaborative, formed in 2011, tracks cities and counties that have approved regulations.
“We got 90 percent of what we were asking for,” Vinson said. “They would not have agreed to anything if we had not gotten the media to bring pressure to bear and made the public aware of the issue.”

The joint campaign for clean air in South Carolina underscores the potential to marry public health issues and leverage assets and relationships. “RWJF gave us the ability to have creative input into the work,” Carrigan said. “That enabled us to do far more than we anticipated.”

Next Steps

The South Carolina African American Tobacco Control Network continues to help municipalities introduce and advance clean indoor air laws. “Now we know that policy is the way to achieve the necessary change in public perception about the deadly nature of secondhand smoke,” Carrigan said.

For its part, the Conservation League—working with the Charleston County Medical Society and neighborhood groups—is now pushing to require cruise ships to use plug-in electrical power during their 8-to-10-hour port stays rather than run their engines and add more harmful emissions to the air.

TARGETING COMMERCIAL TOBACCO IN THE NAVAJO NATION

As a multi-funder effort to advance a commercial tobacco-free policy falls short, advocates continue to fight for the health of Navajo people

Commercial tobacco refers to all the branded tobacco products—34—including chewing tobacco, cigarettes, cigars, and other products—sold by tobacco corporations for profit. Navajo people use commercial tobacco at a significantly higher rate than the overall U.S. population.

Tobacco use begins young. One-fifth of Navajo youth in grades 5 and 6 chew smokeless tobacco. By grades 9 and 10, that share rises to 56 percent.

According to the fundamental laws of the Navajo, the air we breathe, the water we drink, everything around us, is sacred. If the tobacco industry comes up with products that we know are harmful to our health, why should we allow people to be exposed to them?

Patricia Nez Henderson, MD
Navajo Nation coalition leader

34 Marlboro, Lucky Strike, Camel, Winston, to name a few
Some 28 percent of Navajo men aged 15 to 24 smoke cigarettes daily. About 37 percent of Navajo men and 31 percent of Navajo women aged 20 to 39 chew smokeless tobacco.

With funding from Tobacco Policy Change, a national program of the Robert Wood Johnson Foundation (RWJF), the Centers for Disease Control and Prevention (CDC), and other funders, the Southwest Navajo Tobacco Education Prevention Project spearheaded an ambitious effort to curb the use of commercial tobacco and exposure to secondhand smoke in the Navajo Nation.

Patricia Nez Henderson, MD, a Yale-trained physician and Navajo who directs the Black Hills Center for American Indian Health in Rapid City, S.D, led the effort. The Black Hills Center created the prevention project.

**Traditional vs. Commercial Tobacco**

Commercial tobacco refers to regular, daily use of tobacco products. Traditional tobacco refers to tobacco used in ceremonies only. For many tribes, traditional tobacco has a historic and cultural importance in tribal life—and is sacred. Traditional Navajo healers emphasize the difference between the tobacco used for ceremonial purposes and commercial tobacco.

“According to the fundamental laws of the Navajo, the air we breathe, the water we drink, everything around us is sacred,” Henderson says. “If the tobacco industry comes up with products that we know are harmful to our health, why should we allow people to be exposed to them?”

The 330,000-member Navajo Nation occupies some 27,425 square miles of territory in Arizona, New Mexico, and Utah. Though these states have strong tobacco-control laws, they do not extend to tribal lands because they are sovereign nations with their own governments, laws, and jurisdictions. Of 564 federally recognized tribes, only a few, including the Black Feet and the Fort Peck Nation, have passed laws controlling commercial tobacco.

With the support of an array of outside experts, funders, and consultants, the Southwest Navajo Tobacco Education Prevention Project proposed legislation that would prohibit the use of commercial tobacco in all public places and workplaces within the Navajo Nation. The measure did not apply to traditional tobacco used in tribal ceremonies.

“Since our policy was very comprehensive and involved many organizations and departments within the Navajo Nation, we had to make sure all these organizations were involved in every step,” the project staff reported.

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35 Grant ID#s 64495, 63588, and 59340. No RWJF funding was used for lobbying.
36 No RWJF funds were used to draft or lobby for the proposed legislation.
The tobacco-control coalition won the support of five Navajo Nation Agency Councils—a prerequisite to presenting the legislation to the Navajo Nation Council. The coalition then won support from four council subcommittees, received letters of support from two tribal groups that promote health, and provided a training session for delegates to the council before introducing the bill in summer 2008.

On July 25, 2008, the Navajo Nation Council voted 42–27 in favor of the Commercial Tobacco-Free Act of 2008. The advocates expected the president of the Navajo Nation to sign the legislation into law, as he had been supportive throughout the process. Once passed, this would be the strongest tobacco control legislation in the United States.

**Blindsided by the Gaming Industry**

The gaming industry has been an impediment to tribal tobacco-control laws. Many tribes derive significant income from casinos, and the industry has blocked tobacco regulations by claiming that they will have a negative impact on business.37

When tobacco-control advocates began their work in the Navajo Nation, in 2005, the reservation had no casinos. “People in three different locations had voted down referendums to pass gaming as source of revenue for the tribe,” Henderson said.

But that was about to change—much to the dismay of the Navajo tobacco-control advocates.

What the advocates didn’t know was that the gaming industry had been working behind the scenes to bring casinos to the Navajo Nation. Front-page headlines of a Navajo newspaper declared that casino revenue would drop by 40 percent if the tobacco legislation went into effect. “‘What the heck?’” Henderson recalled. “Gaming had not even started in Navajo Nation yet. But within two weeks, gaming became a powerful force and convinced our leader to veto smoke-free legislation.”

An attempt to override the president’s veto fell short. The ordinance was dead. But not for long.

**If at First You Don’t Succeed...**

By the next legislative session, in 2009, the gaming industry had erected a casino and begun earning revenue for the Navajo Nation. The tobacco-control advocates presented new legislation, “but we were very concerned because by this time gaming was doing a lot of lobbying with the folks we had been working very closely with,” Henderson recalled.

37 More information on the gaming industry and smoking bans is available online.
As the bill worked its way through council committees, delegates weakened it by adding amendments to exempt gaming. As a final blow, moments before the bill was introduced on the council floor, a representative of the gaming industry presented a check for $5 million to the Navajo Nation.

“I turned to one of the legislators and said, ‘We have to kill this bill. This is not going to work,’” Henderson recalled. “As a coalition we all agreed that this [a law with exemptions for gaming facilities] would kill all the work we were doing. We were successful in killing the bill. It died on the floor.”

“This Is Not Health Policy”

By 2010, the gaming industry had built a couple more casinos—all allowing smoking. However, the Navajo Nation had also elected a new president, Ben Shelly, who vowed to create a smoke-free reservation. He drew up an executive order to that effect. However the nation’s attorney general advised that it would have no legal authority. The tobacco-control effort would require legislation.

In June 2011, the coalition was ready to introduce yet another commercial tobacco-free bill. This time, “gaming beat us to the punch with their own legislation,” Henderson said. The industry’s bill exempted casinos, of course, and the tobacco-control advocates again found themselves organizing to kill the legislation.

“We know that in states that have exempted gaming, it takes 13 to 14 years to repeal that,” Henderson said. “If it takes six years to pass our comprehensive bill, we would rather do that than have it take 13 years.”

The industry-sponsored bill passed the legislature, but when it came to the president’s desk, Shelly vetoed it, saying, “This is not a health policy. This will not protect all people on Navajo Nation.”

Taking a Stand

Despite the setbacks, Henderson and her team have no intention of giving up. A comprehensive tobacco-control bill will pass, she believes. “We look at how long it took to get to where we are, and we are optimistic that, in time, we will get there,” she said.

Henderson and her team have not won universal support for their efforts. An elected leader recently advised Henderson to “butt out” of matters best left to tribal leaders. “I

38 Shelly has received widespread recognition for his outspoken tobacco-control advocacy. In May 2011, he accepted an award at the National Smokefree Gaming Symposium in Las Vegas, Nev. In July 2011, the Indian Health Service gave Shelley the Director’s Special Recognition Award for Public Health Leadership—the first time an elected official had received the award.
was totally blown away by that,” Henderson said. “Our native leaders are putting policies in place to basically slowly kill people.”

“That is why I am butting in,” she said. “Who else? It is up to us to take a stand and build a healthier environment for our own people.”

**Next Steps**

The tobacco-control coalition expects to introduce a new bill during the 2012 legislative session. Meanwhile, with funding from the final round of Tobacco Policy Change, the advocates broadened their efforts to another policy arena: employee wellness.

Working with the tribal housing authority, the coalition pushed for a policy that provides an hour during the workday for Navajo employees to exercise. With the new policy now in effect at the housing authority, Henderson hopes it will be a model for the 12 other departments of Navajo Nation.

“With high rates of obesity and diabetes in the Navajo Nation,” Henderson said, “this is an important issue for us.”
APPENDIX 1

Project List

Alaska Native Health Board (Anchorage, Alaska)
ID# 52402 (December 2004–November 2005) $57,541

Project Director
Annette Marley, MPH
(907) 743-6110
amarley@anmc.org

Juneau Affiliate, Inc. National Council on Alcoholism and Drug Dependence (Juneau, Alaska)
Supporting an ordinance to end smoking in bars and private clubs
ID# 59330 (December 2006–December 2007) $69,855

Project Director
Wendy Hamilton
(907) 463-3755
Whamilton-ncaddj@ak.net

American Cancer Society, Inc., Mid-South Division (Birmingham, Ala.)
Building a grassroots campaign to support the introduction and passage of a smoke-free ordinance in Jackson, Mississippi
ID# 59333 (December 2006–December 2007) $80,701

Project Director
Jennifer Myrick
(601) 321-5501
jennifer.myrick@cancer.org

Developing and conducting a smoke-free campaign in Tuscaloosa, Ala.
ID# 59336 (December 2006–December 2007) $128,397

Project Director
Pam Bostick
(334) 875-6160
pam.bostick@cancer.org
Pursuing a public policy change to mandated coverage of smoking cessation services by Medicaid
ID# 59341 (December 2006–December 2007) $70,677

**Project Director**
Shannon Pratt
(502) 560-6027
shannon.pratt@cancer.org

**Dubois Institute for Entrepreneurship, Inc. (Dothan, Ala.)**
Advancing statewide smoke-free policies and implementing an anti-obesity project in Alabama
ID# 64498 (July 2008–December 2009) $151,913
ID# 63591 (January 2008–June 2008) $50,000

**Project Director**
Michael B. Jackson
(877) 233-5743, ext. 1
mjackson@dife.us

**Coalition for a Tobacco Free Arkansas (Little Rock, Ark.)**
Implementing a comprehensive smoke-free workplace education campaign
ID# 55846 (December 2005–November 2006) $5,164

**Project Director**
Katherine Donald
(501) 687-0345
kdonald@arfreshair.com

**American Nonsmokers’ Rights Foundation (Berkeley, Calif.)**
Expanding and enhancing the database system to track and report on tobacco-related laws
ID# 56051 (February 2006–April 2008) $148,178

**Project Director**
Cynthia D. Hallett, MPH
(510) 841-3045
cynthia.hallett@no-smoke.org

**Public Health Foundation Enterprises, Inc. (City of Industry, Calif.)**
Comprehensive campus-based effort to reduce tobacco use, sales, and events, and increase cessation treatment
ID# 52383 (December 2004–November 2005) $103,425

**Project Director**
Gordon Sloss
(916) 339-3424
gordon@cynanonline.org

**Mission City Community Network, Inc. (North Hills, Calif.)**
Promoting tobacco-free policies to reduce daily exposure to secondhand smoke among low-income people
ID# 52382 (December 2004–November 2005) $49,998

**Project Director**
Juanita Arvizu
(818) 895-3100
juanitaa@mccn.org

**Public Health Institute (Oakland, Calif.)**
Efforts to restrict tobacco sponsorship of rodeos
ID# 59344 (December 2006–December 2007) $88,137

**Project Director**
Andrea Craig Dodge, MPH, MSW
(510) 302-3324
acdodge@phi.org

**California Tobacco Control Alliance (Sacramento, Calif.)**
Educational campaign to promote insurance coverage of tobacco cessation treatment
ID# 52405 (December 2004–November 2005) $50,000

**Project Director**
Kirsten Hansen, MPP
(916) 554-0390
kirsten.hansen@tobaccofreealliance.org

**Youth Leadership Institute (San Francisco, Calif.)**
Land-use policy advocacy campaign to reduce tobacco use among Latino youth in San Francisco’s Mission District
ID# 55851 (December 2005–November 2006) $142,084

**Project Director**
Margaret Libby
Colorado Tobacco Education and Prevention Alliance (Denver, Colo.)
Colorado Youth Access Project
ID# 59322 (December 2006–December 2007) $102,409

**Project Director**
Kimberly Hills
(303) 756-6163
khills@ctepa.org

**Increasing the number of smoke-free sites in the Denver metropolitan region through collaborative educational activities**
ID# 55843 (December 2005–November 2006) $137,950
ID# 52403 (December 2004–November 2005) $149,500

**Project Director**
Christopher Sherwin
(303) 756–6163

Whitman-Walker Clinic, Inc. (Washington, D.C.)
Increasing the involvement of gay, lesbian, bisexual and transgender communities in clean air campaigns in Cleveland, Ohio, and St. Paul, Minnesota
ID# 052399 (December 2004–November 2005) $39,219

**Project Director**
Donald Hitchcock
(202) 797-3516
coalition@lgbthealth.net

Human Services Coalition of Dade County, Inc. (Miami, Fla.)
Building grassroots support for an increased tobacco tax to fund tobacco cessation programs and expand health coverage for low-income Floridians
ID# 59345 (December 2006–December 2007) $75,000

**Project Director**
Lisa Margulis, MSW
(954) 791-7314
lisam@floridachain.org
Georgia Public Interest Research Group Education Fund (Atlanta, Ga.)
Promoting smoke-free indoor air and clean outdoor air through the promotion of public transit
ID# 63587 (January 2008–December 2008) $45,422
ID# 64494 (July 2008–February 2009) $106,344

**Project Director**
Sandra Glaze
(404) 892-3405
sglaze@georgiapirg.org

Project Director
Matthew Davis
(404) 575-4060
mdavis@pirg.org

American Lung Association of Georgia (Smyrna, Ga.)
Recruiting, educating, and training advocates to achieve a goal of smoke-free public places and places of employment
ID# 052394 (December 2004–November 2005) $74,552

**Project Director**
June Deen
(770) 434-5864
june@alaga.org

American Cancer Society, Inc., Hawaii Pacific, Inc. (Honolulu, Hawaii)
Promoting an increase in smoke-free workplaces and protection of master settlement funds for tobacco control
ID# 52389 (December 2004–November 2005) $150,000

**Project Director**
Deborah M. Zysman, MPH
(808) 946-6851, ext. 203
dzysman@cancer.org

Nez Perce Tribe (Lapwai, Idaho)
Expanding tobacco policy control among the Nez Perce
ID# 59331 (December 2006–December 2007) $66,974

**Project Director**
Joyce McFarland
Le Penseur Youth and Family Services (Chicago, Ill.)
Supporting efforts to limit the number of tobacco retailers in the rebuilding efforts in the Lower Ninth Ward of New Orleans
ID# 63590 (January 2008–June 2008) $50,000
ID# 64497 (July 2008–December 2009) $174,956

Project Director
Patrick Keen
(504) 895-7050
elcano@bellsouth.net

Project Director
Reginald Summerrise
(773) 375-8637
lepenseur@att.net

Lesbian Community Cancer Project (Chicago, Ill.)
Lesbian, gay, bisexual and transgender advocates for a smoke-free Chicago project
ID# 55840 (December 2005–November 2006) $50,000

Project Director
Jessica Halem
(773) 561-5116
jessica@lccp.org

American Lung Association of the Upper Midwest (Dba American Lung Association of Illinois (Springfield, Ill.))
Public awareness campaign to increase the number of smoke-free communities in Illinois
ID# 52404 (December 2004–November 2005) $138,900
ID# 55839 (December 2005–November 2006) $148,737

Project Director
Katherine A. Drea
(217) 787-5864
kdrea@lungil.org
Indiana Latino Institute, Inc. (Indianapolis, Ind.)
Collaborative activities among faith leaders to advocate an increase in the tobacco tax and reduce tobacco use in Indiana
ID# 55849 (December 2005–November 2006) $48,027

**Project Director**
Aida McCammon, MSW
(317) 472-1055
amccammon@indianalatino.com

Indiana Rural Health Association (Terre Haute, Ind.)
Advancing smoke-free policy efforts in 20 Indiana communities and furthering state policies to fully fund the Healthy Indiana plan
ID# 63596 (January 2008–June 2008) $50,000
ID# 64503 (July 2008–December 2009) $155,145

**Project Director**
James E. Miller
(317) 769-4857
jmiller@indianarha.org

University of Kentucky Research Foundation (Lexington, Ky.)
Advancing comprehensive clean indoor air and radon policies in Northern Kentucky
ID# 63589 (January 2008–June 2008) $49,068
ID# 64496 (July 2008–December 2009) $220,032
Providing clean indoor air policy resources and technical assistance to policymakers and health advocates
ID# 52392 (December 2004–November 2005) $149,290

**Project Director**
Ellen J. Hahn, DNS, RN
(859) 421-6948
ejhahn00@email.uky.edu

Kentucky Action, Inc. (Louisville, Ky.)
Enlisting the help of the African-American and faith communities in a campaign to increase Kentucky's tobacco tax
ID# 52401 (December 2004–November 2005) $150,000

**Project Director**
Stephanie Uliana
Medical Foundation, Inc. (Boston, Mass.)
Building public support and increased funding for tobacco cessation programs in Boston
ID# 52386 (December 2004–November 2005) $49,893

  **Project Director**
  James T. White MSCED
  (617) 451-0049
  jwhite@tmfnet.org

American Cancer Society, Inc., Massachusetts Division, Inc. (Framingham, Mass.)
Sustaining Medicaid smoking cessation benefits in Massachusetts
ID# 59325 (December 2006–December 2007) $80,947

  **Project Director**
  Russet Breslau
  (508) 270-4652
  russet.breslau@cancer.org

Sociedad Latina, Inc. (Roxbury, Mass.)
Advocating for the use of state tobacco tax and master settlement dollars to support youth tobacco prevention
ID# 52384 (December 2004–November 2005) $46,500
ID# 55831 (December 2005–November 2006) $50,000
Mobilizing youth and families to campaign against the use of unregulated tobacco advertising practices directed at school children by local merchants

  **Project Director**
  Melissa Y. Luna
  (617) 442-4299, ext. 19
  melissa@sociedadlatina.org

Medchi Foundation, Inc. (Baltimore, Md.)
Providing policy education and grassroots outreach to encourage enactment of smoke-free air laws in Maryland
ID# 52398 (December 2004-November 2005) $76,214

  **Project Director**
  Kari M. Appler
City of Portland (Portland, Maine)
Eliminating smoking in rental housing units
ID# 59343 (December 2006–December 2007) $72,158

Project Director
Tina H. Pettingill, MPH
(207) 874-8449
thp@portlandmaine.gov

Indigenous Peoples Task Force (Minneapolis, Minn.)
Developing and implementing a statewide tribal smoke-free advocacy campaign
ID# 59327 (December 2006–December 2007) $99,939

Project Director
Sharon Day
(612) 870-1723, ext. 11
smarieday@aol.com

Mille Lacs Band of the Minnesota Chippewa Tribe (Onamia, Minn.)
Advocacy and information dissemination for the enactment of policies and procedures to reduce commercial tobacco use at cultural events
ID# 052390 (December 2004–November 2005) $47,960

Project Director
Peggy A. Frisch, RN
(320) 384-0149
pegannfrisch@hotmail.com

University of Missouri-Columbia Medical School Foundation, Inc. (Columbia, Mo.)
Using campus-community alliances to reduce both tobacco use and intimate partner violence
ID# 63583 (January 2008–August 2008) $38,737
ID# 64491 (July 2008–December 2009) $137,304

Project Director
Kevin d. Everett PhD
(573) 882-3508
everettk@health.missouri.edu
Lori New Breast (Heart Butte, Mont.)
Engaging Native American tribal governments in tobacco reduction policy development
ID# 57077 (April 2006–December 2006) $40,210

   **Project Director**
   Lori New Breast
   (406) 226-5520
   mahnokini@3riversdbs.net

Fort Peck Tribes (Poplar, Mont.)
Implementing and enforcing a commercial tobacco-free ordinance in a Native American tribe
ID# 59328 (December 2006–December 2007) $75,000

   **Project Director**
   Nicole Toves
   (406) 768-5973
   cocotoves@yahoo.com

North Carolina Pediatric Society Foundation (Raleigh, N.C.)
Promoting an increased tobacco tax to prevent tobacco use initiation and encourage tobacco cessation
ID# 52397 (December 2004–November 2005) $53,000
Building support for policy changes to make all workplaces smoke-free by 2010 and to halt and reverse the growing obesity epidemic in North Carolina
ID# 63594 (January 2008–June 2008) $50,000
ID# 64501 (July 2008–December 2009) $147,546

   **Project Director**
   Pamela Seamans, MPP
   (919) 968-6611
   pamseamans@nc.rr.com

American Lung Association of New Hampshire (Bedford, N.H.)
Promoting clean indoor air in New Hampshire, ensuring that all workplaces are covered and anti-preemption language is avoided
ID# 52388 (December 2004–November 2005) $65,667

   **Project Director**
   Mindy Sweeney
   (603) 641-8866
Institute of Medicine and Public Health of New Jersey, Inc. (Lawrenceville, N.J.)
Increasing public debate and demand for smoke-free environments and advancing state and local smoke-free policies
ID# 52385 (December 2004–November 2005) $147,625

**Project Director**
Lawrence Downs, JD
(609) 896-1766
ldowns@msnj.org

American Lung Association of the City of New York, Inc. (New York, N.Y.)
Promoting policies to deter the tobacco industry from targeting minority youth
ID# 55833 (December 2005–November 2006) $50,000
ID# 59319 (December 2006–December 2007) $62,243

**Project Director**
Corrina Freedman
(212) 889-3370, ext. 14
cfreedman@alany.org

Greater Cleveland Health Education and Service Council, Inc. (Cleveland, Ohio)
Promoting clean indoor air in the greater-Cleveland area
ID# 59320 (December 2006–December 2007) $147,273

**Project Director**
Catherine Roscoe-Herbert, DNP, APRN, BC, GNP
(216) 268-5381
roscoeherbert@aol.com
ID# 55837 (December 2005–November 2006) $150,000
ID# 052381 (December 2004–November 2005) $104,932

**Project Director**
Joyce A. Lee, MA, RN
(216) 851-2171

American Cancer Society, Inc., Ohio (Columbus, Ohio)
Educational campaign to increase tobacco taxes, protect tobacco prevention funds, and reduce tobacco use among minority populations
ID# 52393 (December 2004-November 2005) $127,808
Project Director
Tracy E. Sabetta
(614) 760-2848
tsabetta@cancer.org

Ohio African American Communities for Optimum Health, Inc. (Columbus, Ohio)
Advancing a tobacco retail licensure and charity care policies in Columbus, Ohio
ID# 63593 (January 2008–June 2008) $49,148

Project Director
Octavia Carter, BSW
(614) 306-1247
carter.octavia@sbcglobal.net

Tobacco-Free Coalition of Oregon (Milwaukie, Ore.)
Changing company insurance policies to cover tobacco cessation as a standard benefit
ID# 55844 (December 2005–November 2006) $103,248

Project Director
Dawn Robbins
(503) 774-4146
dawn@tobacofreeoregon.org

Northwest Portland Area Indian Health Board (Portland, Ore.)
Supporting tobacco control policy priorities among northwestern tribes, including clean indoor air laws and higher taxes on cigarettes
ID# 59324 (February 2007–January 2008) $75,000

Project Director
Gerry Rainingbird, MS
(503) 228-4185
grainingbird@npaihb.org
ID# 55852 (December 2005-November 2006) $127,666

Project Director
Nichole Hildebrandt
(503) 228-4185

Clean Air Council (Philadelphia, Pa.)
Workshops for restaurant and bar workers to encourage tobacco policy change in Pennsylvania
ID# 55835 (December 2005–November 2006) $43,791

**Project Director**
Tim Kelly
(215) 567-4004, ext. 110
tkelly@cleanair.org

**South Carolina African American Tobacco Control Network (Summerville, S.C.)**
Advancing local smoke-free laws in South Carolina by emphasizing the importance of local control and exposing the threat of preemption
ID# 63586 (January 2008–August 2008) $50,000
ID# 64505 (July 2008–December 2009) $300,000

**Project Director**
Dan Carrigan
(843) 509-5272
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Supporting smoke-free indoor workplace and public place ordinances in South Carolina
ID# 59337 (December 2006–December 2007) $81,000

**Project Director**
Dianne Wilson
(843) 209-3832
cwilson298@aol.com

**Aberdeen Area Tribal Chairmen's Health Board (Aberdeen, S.D.)**
Collecting and aggregating data from the 2008 American Indian adult tobacco survey
ID# 64092 (June 2008–May 2010) $110,925

**Project Director**
Donald K. Warne, MD, MPH
(605) 229-3846
dwarne@aatchb.org

Developing and strengthening a clean indoor air policy for the Northern Plains tribes
ID# 59339 (December 2006–December 2007) $74,960

**Project Director**
Favian E. Kennedy, MSW
(605) 721-1922, ext. 112
researchone@aatchb.org
Black Hills Center for American Indian Health (Rapid City, S.D.)
Advancing comprehensive tobacco-free and tribal wellness policies on the Navajo Nation
ID# 63588 (January 2008–June 2008) $49,969
ID# 64495 (July 2008–December 2009) $149,990
Implementing a comprehensive tobacco-free policy for the Navajo nation
ID# 59340 (December 2006–December 2007) $74,965

Project Director
Patricia Nez Henderson, MD, MPH
(605) 348-6100
pnhenderson@bhcaih.org

Texas A&M Research Foundation (College Station, Texas)
Implementing a grassroots education and advocacy campaign to protect nonsmokers from secondhand smoke
ID# 59338 (December 2006–December 2007) $63,906

Project Director
Jorge Vanegas
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Chud-director@tamu.edu

Project Director
Laura Trevino
(877) 447-9355
ltrevino@archmail.tamu.edu

Change Happens! (Houston, Texas)
Collaborative activities to educate the public and policymakers about the benefits of clean indoor air policies
ID# 052391 (December 2004–November 2005) $100,502
ID# 55836 (December 2005–November 2006) $100,900
Advancing the statewide clean indoor air act and educating Houston residents about health issues resulting from obesity
ID# 63595 (January 2008–June 2008) $50,000
ID# 64502 (July 2008–December 2009) $149,944

Project Director
Helen R. Stagg, MSW
(713) 374-1285
hstagg@fuusa.org
American Cancer Society, New England Division (Williston, Vt.)
Promoting an increased tobacco tax to prevent tobacco use initiation and encourage tobacco cessation
ID# 55832 (December 2005–November 2006) $50,848

**Project Director**
Deborah Dameron, MSPH
Advocating for programs to reduce adult smoking and address disparities in treatment among low-income and mentally ill people in Vermont
ID# 59346 (December 2006–December 2007) $81,295

**Project Director**
Kelly Stoddard
(802) 872-6352
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American Cancer Society, Great West Division (Seattle, Wash.)
Statewide coalitions to discourage tobacco use and promote responsible public policies for New Mexico’s minority communities
ID# 55848 (December 2005–November 2006) $150,000

**Project Director**
Cynthia Serna
(505) 260–2105
cynthia.serna@cancer.org
Statewide project focusing on educating, promoting, and implementing tobacco-free workplace policies among Latino-owned businesses
ID# 55847 (December 2005–November 2006) $50,000

**Project Director**
Cindy Roragen, MA
(775) 798–6877, ext. 13
croragen@cancer.org

Center for Multicultural Health (Seattle, Wash.)
Eliminating secondhand smoke exposure by supporting clean indoor air policies and the use Master Settlement funds for tobacco prevention and cessation
ID# 52406 (December 2004–November 2005) $50,000
ID# 55841 (December 2005–November 2006) $50,000
ID# 59323 (December 2006–December 2007) $50,000
Project Director
Shelley Cooper-Ashford
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Black Health Coalition of Wisconsin (Milwaukee, Wis.)
Organizing communities of color and others to advocate for clean indoor air policies
ID# 52395 (December 2004–November 2005) $43,071

Project Director
Patricia McManus, PhD
(414) 933-0064
bhcpmc@aol.com

Partnership of African American Churches (Institute, W.Va.)
Influencing tobacco use and prevention policy development by addressing issues that affect communities of color in West Virginia
ID# 52400 (December 2004–November 2005) $51,000

Project Director
James L. Patterson, MA
(304) 768-7688
patterson@paac2.org

Wellness Council of West Virginia (Saint Albans, W.Va.)
Addressing clean indoor air regulations and government change promoting local environments favoring physical activity in five West Virginia counties
ID# 63585 (January 2008–June 2008) $50,000
ID# 64492 (July 2008–December 2009) $254,948

Project Director
Patty M. Deutsch, MSW, MA
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Project Director
Sharon M. Covert
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Boys and Girls Club of Northern Arapaho Tribe (Riverton, Wy.)
Strengthening education and advocacy within the Native American community to reduce smoking and the effects of secondhand smoke
ID# 52396 (December 2004–November 2005) $45,000

   Project Director
   Glenda Trosper
   (307) 332-5880

APPENDIX 2

Senior Program Consultants

Carla Freeman
Roswell, Ga.

Kitty Jerome
Florence, Mass.

Jerry Spegman
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APPENDIX 3

Executive Committee—Original Members

William V. Corr
Executive Director
Campaign for Tobacco Free Kids
Washington, D.C.

Cynthia Hallett
Executive Director
American Nonsmokers' Rights Foundation
Berkeley, Calif.

Sherri Watson Hyde
Executive Director
National African American Tobacco Prevention Network
Durham, N.C.

Rod Lew
Executive Director
Asian Pacific Partners for Empowerment and Leadership
Oakland, Calif.

Felix Lopez, JD
Executive Director
National Latino Council on Alcohol and Tobacco Prevention
Washington, D.C.

Makani Themba-Nixon
Executive Director
Policy Advocacy on Tobacco and Health/The Praxis Project, Inc.
Washington, D.C.
APPENDIX 4

Evaluation Methodology

The evaluators invited 225 project directors and representatives of their project partners to complete an online survey, launched in August 2010. Some 76 respondents representing 66 projects completed the survey, for a response rate of 41 percent.

The evaluators conducted 81 interviews with project directors, representatives of partner organizations, and technical assistance providers at 30 sites. These represented varied geographic regions and racial and ethnic communities, and focused on a variety of policy changes. The evaluators also interviewed RWJF senior staff and program consultants about the most important factors to probe during the interviews with project directors and their partners.

The evaluators conducted four site visits: to the Team Navajo/Southwest Navajo Tobacco Education Prevention Project (Arizona), the Texas A&M/Colonias Project (College Station, Texas), Le Penseur/The Joseph Project (New Orleans), and Houston Communities for Safe Indoor Air.

To gain insight into the composition of the coalitions and their quarterly progress, the evaluators reviewed their project proposals, budgets, interim/benchmark reports, and final reports, as well as sample legislation, media campaign strategies, press clippings, and findings from studies conducted by the grantees.
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Report

Evaluation Report


Education or Toolkit

Toolkit, Toolbox or Primer


Meetings or Conferences

