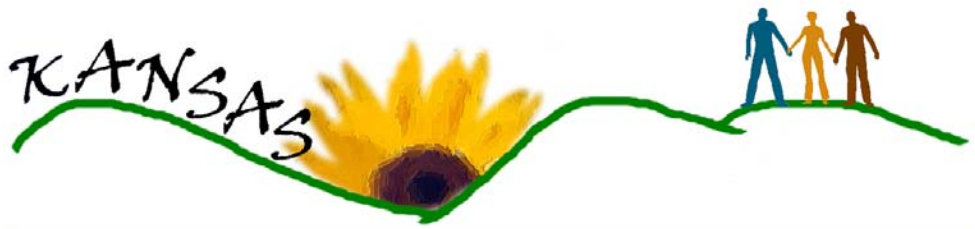

Tobacco Prevention *for* Specific Populations

Everyone Benefits: Kansas Tobacco Prevention Strategic Plan for Specific Populations

June 2007

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Foreword

The Kansas Tobacco Prevention Strategic Plan for Specific Populations: "Everyone Benefits" was developed by a statewide Tobacco Prevention for Specific Populations workgroup. The planning process was funded by a grant from the U.S. Centers for Disease Control and Prevention (CDC) to the Kansas Department of Health and Environment (KDHE).

For further information, contact:

Office of Health Promotion
Kansas Department of Health and Environment
1000 SW Jackson, Suite 230
Topeka, KS 66612-1274

Telephone: (785) 291-3742

Visit the Web site at http://www.healthykansans2010.com/tobacco/

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Background

Tobacco is the single most preventable cause of death and disease in our society, and in Kansas accounts for more than 4,000 deaths per year.[1] Lost work productivity as a result of illness from tobacco use is over $92 million annually.[2] Equally alarming are the disproportionate health and economic effects of tobacco on specific populations.

The U.S. Centers for Disease Control and Prevention (CDC) has four recommended goal areas for a comprehensive tobacco control program[3]:

1. Preventing the initiation of tobacco use among young people.
2. Promote quitting among young people and adults.
3. Eliminating nonsmokers' exposure to environmental tobacco smoke (ETS).
4. **Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.**

The burden of tobacco use, and the resulting disease, disability and death are not borne equally across population groups. An examination of the data reveals that smoking rates are higher among certain population groups. Health disparities are influenced by many factors, including disability, age, race/ethnicity, gender, geography, occupation, and socioeconomic status. The term "specific populations" is used to represent all of these population groups. For the purpose of this document, "health disparities" is defined as: differences in disease and death rates between specific population groups and the general population. Tobacco-related health disparities are differences in patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in Kansas; and related differences in capacity and infrastructure, access to resources, and environmental tobacco smoke (ETS) exposure (also known as secondhand smoke).

Students from the Wichita State University HEALTH organization work at a booth on campus that highlighted how the tobacco industry targets youth with their deadly product.

While Kansas is making progress in tobacco control, substantial and enduring reductions cannot be achieved by expecting past successes to continue. Recommendations to extend tobacco prevention efforts to specific populations are presented throughout this plan. These recommendations build upon earlier efforts, such as the Healthy Kansans 2010 process. Through Healthy Kansans 2010 (HK2010), recommendations were developed to encourage systematic change to reduce health risks. One of the cross-cutting issues

identified through the HK2010 process common to multiple health focus areas was "reducing and eliminating health and disease disparities". This process identified approaches highly targeted towards specific populations.

The Kansas Tobacco Use Prevention Program (TUPP) champions such efforts. The TUPP program provides resources and technical assistance to community coalitions for development, enhancement and evaluation of state and local initiatives to decrease the morbidity and mortality from tobacco use. A Kansas Tobacco Quitline was established in November 2003 as a cessation resource for all Kansans. This service is of particular value to lower income Kansans; nearly 40% of all callers report their household income as less than $15,000.

One of the top priorities for the TUPP program is to identify and eliminate the disparities related to tobacco use and its effects among different population groups. To assist in this effort, a Kansas Tobacco Prevention for Specific Populations Workgroup was convened and engaged in a strategic planning process from March to June, 2007. The Workgroup members met for four days during a three-month period to develop a strategic plan for addressing tobacco-related disparities in specific populations for 2007-2010. Through this process, critical steps were identified to help reduce tobacco-related health disparities among specific populations.

The resulting objectives and strategies identified in this strategic plan are aimed at fulfilling the Kansas vision to: *Identify and eliminate tobacco-related health disparities among specific populations.*

Workgroup Purpose

The purpose of the Kansas Tobacco Prevention for Specific Populations Workgroup was to develop a strategic plan to address tobacco (smoking and smokeless tobacco) prevention for specific populations in Kansas through a participatory process. Workgroup members participated from March to June, 2007 in a planning process to develop a strategic plan to guide efforts to eliminate tobacco-related disparities in specific populations in Kansas.

In addition to developing the strategic plan, Workgroup members were also charged with brainstorming strategies for marketing the strategic plan to key organizations statewide and reviewing a case study documenting lessons learned from the planning process.

Workgroup Membership

Twenty-four organizations and individuals representing groups that work with and/or personally experience disparities agreed to serve on the Kansas Tobacco Prevention for Specific Populations Workgroup. These individuals and organizations were selected because they reflect the populations in Kansas that data indicate experience tobacco-related health disparities, or groups for which tobacco-related health disparities may be unidentified. More than one hundred organizations and individuals were asked to submit nominations for Workgroup members.

Nominees were solicited through a community-based nominating process. Nominees were solicited from those who were from and/or had expertise in working with one or more of the populations listed below:

* People with low SES (socioeconomic status; e.g., low income or education, unemployed)
* Black/African Americans
* Asian Americans and Pacific Islanders (AAPI)
* American Indians/Alaskan Natives
* Hispanic/Latino
* Gay/lesbian/bisexual/transgender
* Medically underserved/uninsured
* Young people
* Pregnant women
* People facing mental or emotional challenges
* People living with disabilities
* Groups and affiliations for which tobacco-related disparities may be unidentified

Additional considerations for Workgroup participation included:

* People compatible with the issue of eliminating tobacco-related disparities.
* People who will commit to actively participate in the Workgroup process.
* People who are willing to take time to share their knowledge with the Workgroup.
* People with expertise (e.g., cultural expertise, tobacco use prevention/policy expertise) that will build the capacity of the entire Workgroup.
* People with an ability to provide leadership in implementing recommendations for improvements in specific populations.
* People from all geographic areas of the state.

The Strategic Planning Process

Beginning in September 2006, the Kansas Department of Health and Environment began the recruitment of a diverse, inclusive and representative statewide Tobacco Prevention Workgroup for Specific Populations to develop the goals and strategies of the "Everyone Benefits" Tobacco Prevention for Specific Populations Strategic Plan. It was emphasized that the planning process should be inclusive and representative, community-based, and data-driven.

Twenty-four individuals committed to this participatory process involving three meetings during four days between March and May, 2007, to develop the plan. Workgroup members were recruited through a broad, community-based nominating process. Members were asked to commit to attend all three meetings to ensure continuity. Only Workgroup members were considered voting members. KDHE staff, a contracted evaluator and facilitator served as resource and support staff. Other individuals attended as guests/resource partners. Two Workgroup members agreed to serve as Co-chairs of the Workgroup, and also served on the planning team with support staff. The planning team worked to facilitate the planning process for the Workgroup.

Meeting One focused on members becoming familiar with the planning process and planning roles, reviewing existing tobacco-related disparities data, and exploring critical issues for tobacco prevention for specific populations. A KDHE epidemiologist compiled and presented data to assist in defining the status of tobacco use in Kansas, identifying groups at risk for higher tobacco use in Kansas, and identifying data gaps related to subpopulations throughout Kansas. At the conclusion of meeting one, members had developed a list of critical issues impacting tobacco prevention for specific populations in Kansas.

"Thank you for doing this. I think there is a great need for this project in Kansas. The group represents a great proportion of specific population sectors and seems to be engaged in the process." - Comment from Workgroup evaluation

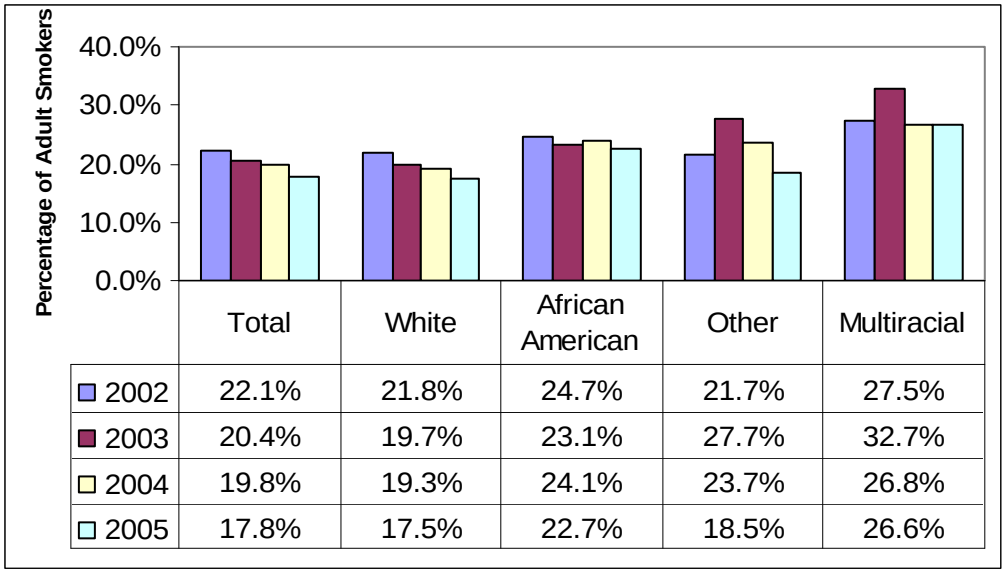
As part of Meetings Two and Three, members reviewed the critical issues and narrowed the list to the top three critical issues to be addressed during the next three years. The Workgroup chose not to limit the plan to particular groups, but instead developed overarching objectives for addressing tobacco prevention disparities among multiple populations. The Workgroup developed a strategic objective for each critical issue. Strategies and action steps for each objective were also identified.

The resulting plan includes an implementation plan, the identification of required resources for implementation, potential partnering organizations, and a communication plan for use by various organizations in Kansas. More information, including a timeline, can be found at the Web site: www.healthykansans2010.com/tobacco/.

Kansas Tobacco Data Highlights

* Thirty-four percent (34%) of adults aged 18 and older, with 14+ days in the past 30 days where their mental health was not good, are current smokers.[4]
* Nearly twenty percent (19.8%) of individuals living with a disability report being current smokers as compared to 17.4% of individuals living without a disability.[4] While the prevalence of smoking is not significantly higher among this population, the burden of tobacco-related diseases is intensified by other conditions.
* Thirty percent (30%) of adults aged 18 and older who are uninsured are current smokers.[4] These individuals represent a heavy economic burden on state and federal health care systems.
* Of the over $900 million in annual health care costs related to smoking, it is estimated that nearly $200 million is covered by state Medicaid.
* According to the 2005 BRFSS, 30% of adults aged 18 and older who are uninsured are smokers.
* The prevalence of current smokers among Hispanic individuals is 15.8% whereas among the non-Hispanic population this prevalence is 18%.[4] Further investigation is required to determine if access to health care increases the burden of tobacco related diseases specifically among the Hispanic population.
* Among the 18-24 year old age group, the prevalence of smoking during pregnancy is approximately 18%.[4]
* In 2005, 18.9% of males aged 18 and older reported being current smokers. Only 16.8% of women aged 18 and older reported being current smokers during this same time period.
* Greater than 30% of smokers who call the Kansas Tobacco Quitline report an annual income of less than $15,000.[5]
* In addition to age, education and income level correlate with smoking prevalence. In Kansas, more than 1 in 3 adults with less than a high school education are smokers, whereas only 1 in 10 college graduates are smokers.[5]
* The prevalence of smokeless or spit tobacco among High School males is 17.4% as compared to 13.6% nationally.[6]
* The prevalence of current smokers among High School students is 21% as compared to 23% nationally.[6] This prevalence has remained unchanged since 2002 in Kansas.
* The prevalence of smoking among enlisted Military personnel decreases as pay group increases. The highest prevalence is among males of rank E1-E3 who report a smoking prevalence of 51%.[7]

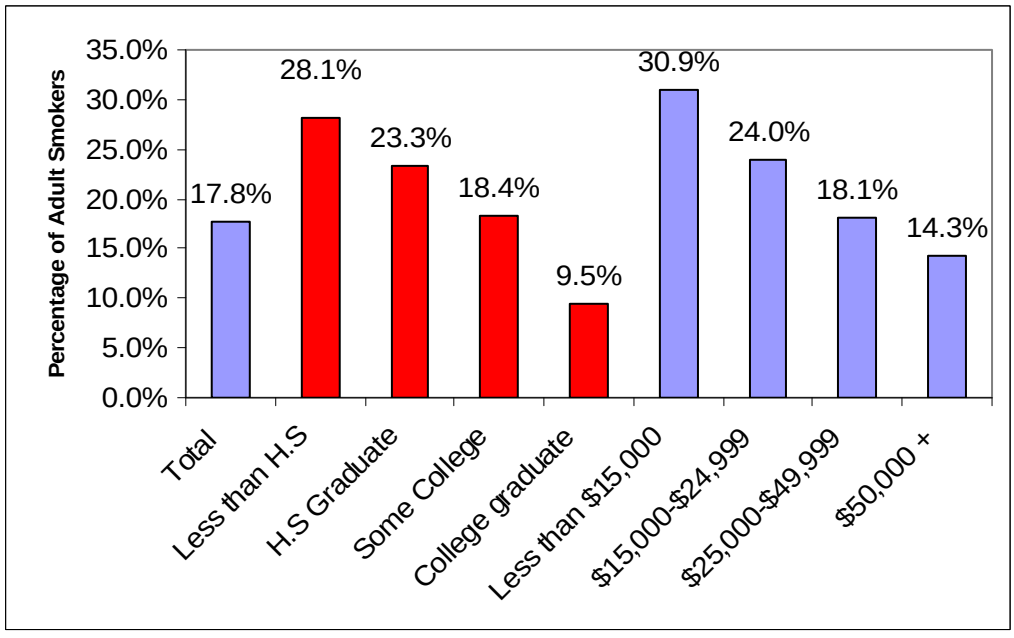
Prevalence of Current Smokers by Race, 2002—2005



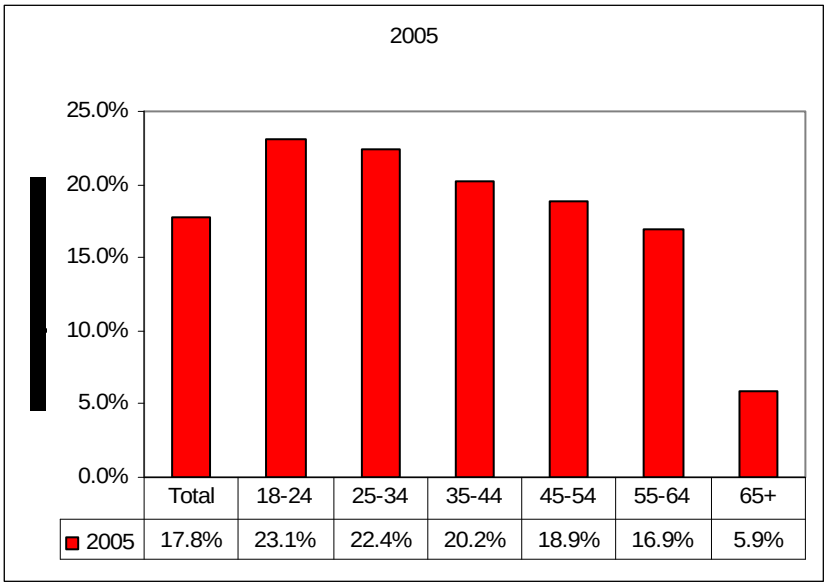
	Total	White	African American	Other	Multiracial
2002	22.1%	21.8%	24.7%	21.7%	27.5%
2003	20.4%	19.7%	23.1%	27.7%	32.7%
2004	19.8%	19.3%	24.1%	23.7%	26.8%
2005	17.8%	17.5%	22.7%	18.5%	26.6%

Socioeconomic Status

Percentage of Current Cigarette Smokers in Kansas Aged 18 and older by Education and Household Income (2005)



Prevalence of Cigarette Use by Age Group



Data Gaps

One of the largest obstacles to identifying and eliminating tobacco-related disparities among specific populations is the lack of consistent reporting of data. There is no or little state-specific tobacco use information related to some specific populations. The Workgroup expressed a need for increased data availability and access. As with many planning processes, improved data collection continues to be a recurring concern. Identifying disparities is an ongoing process. It requires both quantitative and qualitative data to identify differences that may adversely affect specific population groups. There are gaps in the information, but in order to move forward it is important to use existing data and strive to improve the data. In developing the strategic plan, the Workgroup acknowledged the following limiting factors related to data and specific populations:

* Inability to separate out racial/ethnic information into sub-populations beyond Asian Americans, Pacific Islanders, American Indian/Alaskan Natives. For instance, local studies have shown that smoking rates are highest among males in certain AAPI ethnic groups (i.e., Cambodian, Laotian, Samoan, Native Hawaiian).[8]
* Limited geographic information, i.e., small communities, such as in rural communities, or specific geographic groups like German Mennonites.
* Limited data on offender populations, i.e., prison populations, juvenile detention centers.
* College populations, i.e., multiple surveys make it difficult to identify and compare data among various datasets.
* Military populations in Kansas, i.e., very transient, limited information exists.
* Sexual Orientation and Gender Identity. No data existed to track this information in Kansas until spring 2007.

Defining Critical Issues

Through the strategic planning process, the Workgroup identified three priority critical issues. Objectives with associated strategies and action steps were developed and recommended by the workgroup for each critical issue.

Critical issues were defined as fundamental policy or program concerns that define the most important situations facing a specific population group or organization now and in the future. Critical issues can reflect:

* Long-standing problems having a significant impact on an organization and/or people served.
* Barriers to be overcome in order to meet the objectives.
* Major shifts in thinking that can change direction (priorities, policies, systems changes) of an organization and the nature of the environment.

Overarching questions considered by the Workgroup members when prioritizing critical issues included:

* **Urgency:** Is this a priority issue that needs to be addressed in the next 1-3 years?
* **Potential Impact:** Is it likely that addressing this critical issue will have a significant impact on one or more specific populations? Do you have reason to believe you can be successful on this issue?
* **Actionable/Feasible:** Are there opportunities for action to address the critical issue? Is there room to make meaningful improvement on the issue?
* **Resources:** Are resources (funds, staff, expertise) either readily available or likely resources can be obtained to address the critical issue? Are there resources through the state and community members to work on the issue? If not, can resources be acquired?
* **Community Readiness:** Is this a critical issue identified as important by the community? Are people in the community interested in the issue? Is there community momentum to move this initiative forward?
* **Integration:** Is there opportunity for collaboration? Is there opportunity to build on existing initiatives? Will this duplicate efforts?

Critical Issues and Goals

The resulting objectives and strategies identified in this strategic plan are aimed at fulfilling the Kansas vision to:
Identify and eliminate tobacco-related health disparities among specific populations.

The three critical issues and objectives are:

1. Increase community-level quantitative and qualitative data to eliminate identified data gaps among selected populations.

   Objective: By June 30, 2009, there will be a functioning statewide strategy regarding collection, dissemination, integration, and utilization of community-level quantitative and qualitative data to eliminate identified data gaps among specific populations.

2. Increase population-specific prevention and cessation resources that can be integrated in to community programs.

   Objective: By June 30, 2010, all KS communities will have access to culturally and linguistically appropriate prevention and cessation resources for at least 4 specific populations.

3. Increase advocacy for the elimination of tobacco-related health disparities among specific populations in Kansas.

   Objective: By June 30, 2010, conduct a campaign to educate and motivate communities, funders, and policymakers to support the elimination of tobacco-related health disparities among specific populations in Kansas.

Critical Issue: Data

Critical Issue: Increase community-level quantitative and qualitative data to eliminate identified data gaps among selected populations.

Objective One: By June 30, 2009, there will be a functioning statewide strategy regarding collection, dissemination, integration, and utilization of community-level quantitative and qualitative data to eliminate identified data gaps among specific populations.

Strategies and Action Steps:

1. Recruit a Data Action Team.

2. Conduct comprehensive assessments of available data to examine the range of factors related to tobacco use among disparately-affected populations.
    a. Compile comprehensive sources of data in Kansas and nationally.
    b. Create directory of available resources.
    c. Complete report with relevant data to guide the strategic planning process and enrich disparities elimination efforts for tobacco control.
    d. Coordinate distribution of report to key tobacco stakeholders and communities.

3. Improve existing surveillance systems for data collection.
    a. Catalog existing surveillance systems.
    b. Identify specific minimum data set.
    c. Assess existing surveillance systems and suggest modifications or additions.
    d. Define requirements for improvement of surveys, including cost requirements.
    e. Disseminate recommendations.
    f. Identify funding sources.
    g. Secure funding.

4. Develop new data collection methods to assess tobacco use where gaps in knowledge exist.
    a. Review alternative sources of data, including qualitative data.
    b. Create and test innovative data collection methods.
    c. Implement, evaluate, share methods and new information.
    d. Explore the possibilities for data collection around industry targeting.

5. Disseminate available data to key community stakeholders.
    a. Create a county community resource guide.
    b. Use all available resources to disseminate information (print, electronic, media) and communicate resources nationally.

6. Link the data and data collection system with statewide and national tobacco prevention and cessation strategies.
    a. Evaluate use of data collection systems.
    b. Share information with national tobacco communities.
    c. Make recommendations for future research.
    d. Share data for utilization in health care curriculum.
    e. Use data as method for additional funding.

Critical Issue: Specific Population Interventions

Critical Issue: Increase population-specific prevention and cessation resources that can be integrated in to community programs.

Objective: By June 30, 2010, all KS communities will have access to culturally and linguistically appropriate prevention and cessation resources for at least 4 specific populations.

Strategies and Action Steps:

1. Create an Intervention Action Team.

2. Identify four (4) specific populations based on current and evolving data.
    a. Evaluate and obtain population-specific data. Review data from Data Action Team.
    b. Create a process to identify specific populations in greatest need.

3. Identify potentially effective models and develop new models for existing gaps.
    a. Research existing models.
    b. Create directory of models.
    c. Identify gaps. Use data from Data Action Team.
    d. Develop or modify models.

4. Develop a community network to eliminate barriers by providing access to effective population-specific models.
    a. Convene potential community partners.
    b. Identify access barriers.
    c. Develop Web-based resource guide for population-specific prevention and intervention materials and techniques.
    d. Market Web site and provide training.

5. Evaluate dissemination process and network.

Critical Issue: Advocacy and Policy

Critical Issue: Increase advocacy for the elimination of tobacco-related health disparities among specific populations in Kansas.

Objective: By June 30, 2010, conduct a campaign to educate and motivate communities, funders, and policymakers to support the elimination of tobacco-related health disparities among specific populations in Kansas.

Strategies and Action Steps:

1. Develop an integrated statewide advocacy plan to address tobacco-related prevention and cessation issues for specific populations.
    a. Create an Advocacy Action Team.
    b. Convene the Advocacy Action Team.
    c. Partner with local and state organizations to facilitate, train, and provide data for Advocacy
    Action Team.
    d. Reach and convene the Cabinet members and legislative leaders regarding the advocacy action plan.

2. Conduct a tobacco biannual training/meeting for communities, funders, and policymakers to support the elimination of tobacco disparities.
    a. Identify and convene communities, funders, policy makers, and stakeholders.
    b. Provide training for communities, funders, and policymakers regarding tobacco-related health disparities.
    c. Evaluate the training/meeting of the above groups.

3. Recruit and train a minimum of five (5) sustainable community-based organizations per KDHE, TUPP (6) regions not previously involved in tobacco control work, in mobilization/ implementation activities.
    a. Develop and deploy a recruiting campaign for new specific-population groups (not involved in tobacco).
    b. Identify and recruit 5 community organizations for each region.
    c. Train each community organization in Tobacco 101 and Best Practices.
    d. Provide ongoing technical assistance (online via Web site).
    e. Select a project to complete in each region (e.g., clean indoor air).
    f. Evaluate the project (process, implementation) within each region.

Moving Forward

The strategic plan developed by the Kansas Tobacco Prevention Workgroup for Specific Populations is one in which **"Everyone Benefits**." It provides a framework for action in addressing tobacco-related disparities in Kansas. The Kansas Department of Health and Environment, community-based organizations, tobacco prevention advocacy groups, and tobacco prevention partners must work together for the plan to be effectively implemented.

"I'm very pleased overall and excited, engaged and empowered to move forward with action —let's do it!" - Comment from Workgroup evaluation

The Workgroup has agreed to convene twice a year to review progress on plan implementation. Three "action teams" will be created to work on each of the critical issues. Action teams will oversee the development, implementation and evaluation of action plans for each critical issue area. Interested Workgroup members will serve on the action teams. Each of the action teams will need to have a chairperson identified, and a mechanism to ensure ongoing communications between the action teams to stimulate cross-linkages and prevent duplication of efforts.

With the completion of the Strategic Plan, the Workgroup indicated a strong need for KDHE to identify a lead person to oversee plan implementation. The Workgroup stressed the importance of not relying solely on KDHE's Tobacco Use Prevention Program for implementation of the plan, but to identify other champions for the plan as well. Evaluation will also be critical to ensure activities achieve the desired outcomes and to track the extent to which the plan is implemented successfully.

Another critical task will be to inform people within various communities about the plan and to initiate and sustain collaborative partnerships to address tobacco control in specific population groups. The Workgroup identified preliminary strategies to achieve this. Workgroup members identified audiences that must be reached, recommended methods for reaching each group, and identified potential messages. A communications plan has been developed that outlines strategies for engaging potential partners in the effort.

As a result of the workgroup the Kansas Tobacco Quitline Manager was connected with a member of the Ft. Riley Army Base medical staff. The manager trained 50 army medical personnel on the Quitline and referral process.

The Workgroup recognized that partnering organizations are necessary to move the plan forward. Community leaders, community-based organizations and funding organizations can use this strategic plan as a guide in their efforts to reduce and eliminate tobacco-related health disparities in Kansas. The public and private sectors must work together to strengthen and implement tobacco control measures for the state of Kansas. Taking these steps would place the state on course toward reducing the tobacco burden, and reducing tobacco use so substantially that it is no longer a significant public health problem in Kansas.

Strategic Planning Workgroup Members

Aiko Allen, Co-Chair	Hunter Health Clinic, Wichita
James Jones, Co-Chair	Oakland United Methodist Church, Topeka
Gabriela Barron	Kansas Statewide Farmworker Health Program, Ulysses
Courtney Bell	Kansas Urban League, Wichita
Ana-Paula Cupertino	Department of Preventive Medicine-KUMC, Kansas City
Yvette Desrosiers-Alphonse	Sunflower Foundation, Topeka
Lisa Dinh	WSU HEALTH Student Association, Wichita
Shirley Dinkel	Washburn University School of Nursing, Topeka
Louis Goins	Judge James V. Riddel Boys Ranch, Goddard
Sharon Goolsby	Center for Health Disparities, KDHE, Topeka
Martha Hodgesmith	University of Kansas Research and Training Center on Independent Living, Lawrence
Miriam Ibrahim	Reno County Health Department, Hutchinson
Robert “BJ” Jones	Student
Nikki Keene	WSU HEALTH Student Association, Wichita
Rob Le	Healthy Options for Kansas Communities (HOP), Wichita
Helen Loewen	Kansas Statewide Farmworker Health Program, Copeland
Janice Love	Swope Health Services, Kansas City
Brandi Miller	Jewish Vocational Services, Kansas City
Cody Patton	Positive Directions, Wichita
Janet L. Schwarz	American Lung Association of Central States, Kansas City
Penny Selbee	Maternal and Child Health Division Manager, SCHA, Retired, Topeka
Toyin Sokari	National Cancer Institute’s Cancer Information Service – Heartland Region, Kansas City
Beverly J. White	Center for Health and Wellness, Inc., Wichita
Pete Wiemers	Irwin Army Community Hospital, US Army, Manhattan

Planning Team & Participating Organizations

Acknowledgement and appreciation are extended to all those who contributed their ideas and expertise through workgroup planning, participation and special presentations.

Strategic Planning Team

Aiko Allen, Co-Chair , Hunter Health Clinic, Wichita

Janet Brandes, Project Facilitator, Wichita State University

Carol Cramer, Interim Director , Tobacco Use Prevention Program, Office of Health Promotion, Kansas Department of Health and Environment

Harlen Hays, Epidemiologist, Office of Health Promotion, Kansas Department of Health and Environment

Jenna Hunter, Outreach Coordinator, Tobacco Use Prevention Program, Office of Health Promotion, Kansas Department of Health and Environment

James Jones, Co-Chair, Oakland United Methodist Church, Topeka

Karry Moore, Project Director, Tobacco Use Prevention Program, Office of Health Promotion, Kansas Department of Health and Environment

Ginger Park, Media and Policy Coordinator, Tobacco Use Prevention Program, Office of Health Promotion, Kansas Department of Health and Environment

Sherry Prior, Area Health Education Council (AHEC)

Connie Satzler, Project Evaluator, EnVisage Consulting, Inc.

Brandon Skidmore, Grants Manager, Office of Health Promotion, Kansas Department of Health and Environment

Participating Individuals/Organizations

Sandy Culig, National Cancer Institute

Becky Tuttle, Quitline Manager, Office of Health Promotion, Kansas Department of Health and Environment

Special Guests

S. Edwards Dismuke, Dean, Kansas University School of Medicine-Wichita

Howard Rodenberg, Director of Health, Kansas Department of Health and Environment

Marta Perrupata, Fenway Institute

Glossary

AAPI – Asian Americans and Pacific Islanders

Acculturation – process whereby attitudes and/or behaviors of people from one culture are modified as a result of contact with a different culture. Implies mutual influences in which elements of two cultures mingle and merge.

Action Team – a task force set up to address each of the three goal areas within the strategic plan, e.g., "data action team"

Assimilation – process of cultural absorption of a minority group into the main cultural body.

ATOD – alcohol, tobacco and other drugs

BRFSS – behavioral risk factor surveillance system

CDC – Centers for Disease Control and Prevention

Culture – thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices and customs

Cultural Competency – Having the capacity to function effectively as an individual and an organization within the context of cultural beliefs, behaviors and needs presented by consumers and their communities. An ability to understand and relate to others in a trustworthy manner, with respect for individual cultural differences.

Diversity – differences that exist within populations and communities (racial/ethnic, tribal, gender, age, sexual orientation, socio-economic status, geography, religion, education)

Disparities – see "Tobacco-Related Disparities"

Equity – exists when disparities are absent. Inequality implies basic unfairness that contributes to differences between groups being compared.

ETS – environmental tobacco smoke

HK2010 – Healthy Kansans 2010, Kansas' statewide planning process to identify and adopt health priorities to improve the health of all Kansans

HP2010 – Healthy People 2010, a national framework for prevention with national health objectives designed to identify the most significant preventative threats to health and to establish national goals to reduce those threats.

Inclusiveness – assurance that diverse population groups are represented and involved in a meaningful manner in the participatory planning process.

Inclusivity – promotion of representation and involvement of various populations in all levels of decision making.

Institutionalized Racism – procedures, practices and behaviors within an organization that support and encourage direct or indirect racial discrimination

KDHE – Kansas Department of Health and Environment

LGBT – lesbian, gay, bisexual, transgender

OHP – Office of Health Promotion, Kansas Department of Health and Environment. The Tobacco Use Prevention Program (TUPP) is located within the Office of Health Promotion, KDHE.

OMB – Office of Management and Budget

OSH – Office on Smoking and Health, Centers for Disease Control and Prevention

Parity - the condition whereby all members of the workgroup have equal opportunity for input and participation, as well as equal voice in priority setting and identifying critical issues during the strategic planning process

Quitline – 1-866-KAN-STOP - KDHE's toll-free quitline for one-on-one counseling for Kansas residents interested in quitting tobacco (includes spit/chew tobacco); various languages available

Racism – set of attitudes and behaviors towards another racial or ethnic group based on: 1) belief that natural differences in physical characteristics correspond directly to differences in ability and personality, 2) social and economic power of members of one racial or ethnic group to enforce and enact such attitudes and behaviors towards others

Representation - assurance that those who are representing a specific population group truly reflect that community's values, norms and behaviors

Strategic Planning – the process of determining long-term goals and then identifying the best approach to achieving those goals

Tobacco-Related Disparities – differences in patterns, prevention and treatment of tobacco use

TUPP – Tobacco Use Prevention Program, KDHE

Workgroup – voting members of the group which developed the Kansas Tobacco Prevention Plan for Specific Populations

Centers for Disease Control and Prevention (CDC) National Network on Tobacco

National Tobacco Prevention Networks

For more information about tobacco prevention for specific populations, the following is a partial list of Web sites used for the Kansas Tobacco Prevention for Specific Populations Strategic Plan:

Prevention and Poverty (NNTPP)
Web: http://www.nntpp.org/

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
300 Frank H. Ogawa Plaza, Ste. 620
Oakland, CA 94612
Ph: 510-272-9536
Web: http://www.appealforcommunities.org/

Association of Asian Pacific Community Health Organizations (AAPCHO)
300 Frank H. Ogawa Plaza, Ste. 620
Oakland, CA 94612
Ph: 510-272-9536
Web: http://www.aapcho.org/

The BACCHUS & Gamma Peer Education Network
P.O. Box 10043
Denver, CO 80250-0430
Ph: 303-871-0901
Web: http://www.baccusgamma.org/

National African American Tobacco Education Network
3950 Industrial Blvd., Ste. 600
West Sacramento, CA 95691
Ph: 916-556-3344
Toll-free: 888-442-2836
Web: http://www.naaten.org/

The National Alliance for Hispanic Health
1501 Sixteenth Street, NW
Washington, DC 20036
Ph: 202-387-5000
Web: http://www.hispanichealth.org/

The National LGBT Tobacco Control Network
The Fenway Institute
7 Haviland St.
Boston, MA 020115
Ph: 401-263-5092
Web: http://www.lgbttobacco.org
Email: lgbttobacco@gmail.com

The National Latino Council on Alcohol and Tobacco (LCAT)
1616 P St., Ste. 430
Washington, DC 20036
Ph: 202-265-8054
Web: http://www.nlcatp.org/

National Network on Tobacco Prevention and Poverty
Email: admin@healthedcouncil.org
Web: http://www.healthedcouncil.org/nntpp.html

Northwest Portland Area Indian Health Board
527 SW Hall, Ste. 300
Portland, OR 97201
Ph: 503-228-4185
Web: http://www.npaihb.org/

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