Tobacco 101
Part Two, Lesson Two
Introduction to Tobacco 101
Welcome to TTAC’s Tobacco 101! Tobacco 101 is a self-guided tutorial that provides the information and resources necessary to understand why tobacco use is considered the #1 preventable cause of death in the US, as well as the evidence-based and promising strategies that can reduce tobacco’s toll. You can benefit from this course whether you are new to tobacco control and need an introduction to key topics, or are an experienced professional looking to refresh and update your knowledge.

Tobacco 101 was revised in the spring of 2013 to contain the latest information, resources, and tools available. The user-friendly self-guided format allows you to complete the tutorial at your own pace and explore the various external resources and tools as needed. Tobacco 101 is organized into two parts comprised of four lessons each. Optional review questions are offered at the end of each lesson to allow you to check your understanding of the content, try some of the resources, and reflect on how the information applies to your role in tobacco control.

You can start at the beginning and read through the course from beginning to end or simply select those sections that are of greatest interest.

Part 1: Introduction to Prevention and Control of Tobacco Use
• Lesson 1: The Evolution of Tobacco Control
• Lesson 2: Tobacco Use in the United States
• Lesson 3: Impact of Tobacco Use
• Lesson 4: Factors that Determine Tobacco Use

Part 2: Reducing the Problem of Tobacco Use
• Lesson 1: Credible Tobacco Control Resources and Key Partners
• Lesson 2: Tobacco Control Models
• Lesson 3: Effective Tobacco Control Policies
• Lesson 4: Strategies for Success

TTAC also provides tailored, on-site Tobacco 101 trainings for organizations who want to include it in conferences and workshops. To learn more, visit our website www.tacenters.emory.edu or contact us at tacenters@emory.edu.
Table of Contents

PART 2: REDUCING THE PROBLEM OF TOBACCO USE

LESSON 2

Tobacco Control Models  Page 4

Check for Understanding  Page 26

Sources  Page 30
Tobacco 101 Part Two, Lesson Two

Tobacco Control Models

This lesson will explain the public health approach to tobacco control and describe two successful models for comprehensive, population-based approaches to reduce tobacco use.

At the end of this lesson you will be able to:

1. **Explain the public health approach to tobacco control.** We will talk about what the public health approach means and explain why this approach is successful in improving population health.

2. **Describe the six interventions included in the World Health Organization’s MPOWER model.** We will discuss the WHO’s MPOWER model, which recommends multiple interventions to reduce tobacco use and tobacco-related harm worldwide.

3. **Describe the components of the Centers for Disease Control and Prevention’s Best Practices for Comprehensive Tobacco Control Programs.** CDC’s Best Practices for Comprehensive Tobacco Control Programs outlines in detail the four goals of the National Tobacco Control Program and the elements of a science-based program to achieve those goals.

4. **Discuss how successful programs achieve long term goals.** Effective tobacco control interventions have multiple components, are adequately funded and are sustained for many years. We will look at how successful programs achieve long-term goals.
The Public Health Approach

The mission of public health is to protect and improve the health of populations, with a focus on preventing problems before they occur. When thinking about public health, educational campaigns and clinical treatment often come to mind. However, evidence shows that those efforts by themselves do not reach the population-level, and that more broad-based efforts are necessary to get there.

Because of this, the Public Health Approach focuses on changing the environment to make it more conducive to good health for an entire population, rather than on changing the behavior of individuals one at a time. Data and scientific evidence are used to describe public health problems and drive decision-making about these population-based solutions. In using this approach, public health professionals can protect and improve the health of entire populations.
The Health Impact Pyramid

The 5-tier Health Impact Pyramid pictured below provides a useful way to think about the public health approach. The Pyramid was originally presented by the Director of the Centers for Disease Control and Prevention, Dr. Thomas Frieden, in an article published in the *American Journal of Public Health* in 2010. Interventions that deal with changing systems and environments are at the base of the pyramid, which indicates the greatest impact. Interventions that educate and counsel individual patients, which have less of an impact at the population level, are at the top of the pyramid.

Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of the population. That isn’t to say that individual counseling and education efforts are not important – interventions working together at all levels of the pyramid are necessary. However, interventions that focus on the factors at the bottom of the pyramid affect a larger proportion of the population, which is more desirable from the Public Health standpoint.
The Public Health Approach to Tobacco Control

Government agencies and tobacco control advocacy organizations alike use the public health approach in their tobacco prevention and control efforts. In terms of the Health Impact Pyramid, tobacco control works at all levels. At the top of the pyramid are clinical interventions, counseling, and education for persons who use tobacco. However, the main emphasis is on interventions at the bottom of the pyramid - policy, environment, systems change, and communications campaigns to change social norms. To achieve these interventions often requires a well-organized collaborative or coalition commitment.

For example, consider these two tobacco interventions: individual counseling by a clinician in a workplace and a smoke-free law applied to all workplaces. The statewide smoke-free policy has a broad reach across the population and creates an environment where smoking is prohibited. Such an environmental change makes smoking more inconvenient and will prompt many more quit attempts than worksite counseling alone. Policy changes also have the advantage of being more sustainable than individual education or intervention programs. However, the combination of smoke-free policy and accessible cessation assistance will create many more successful quit attempts.
Models for a Public Health Approach to Tobacco Control

There are two main public health models that programs can use to reduce tobacco use:

1. MPOWER, the World Health Organization (WHO) model
2. Best Practices, the United States’ Centers for Disease Control and Prevention (CDC) model

While distinct, both models use the public health approach, and include some similar components, such as emphasizing the importance of enacting specific policies or laws (e.g., smoke-free laws).

We will first talk about tobacco control from a global perspective. The WHO Framework Convention on Tobacco Control (FCTC) is the World Health Organization’s first international public health treaty. The treaty, adopted in 2003, recognizes tobacco use as a global epidemic. It has since become one of the most widely embraced treaties in United Nations history, establishing international cooperation and standards to reduce tobacco use. As of January 2013, 176 nations have signed the FCTC. The US has not signed the treaty as of yet.
Global Tobacco Control: MPOWER

The FCTC and its guidelines provide the foundation for countries to implement and manage tobacco control. To help make this a reality, WHO introduced the MPOWER model in 2008. The model contains six policies and interventions that are intended to assist in the country-level implementation of effective interventions to reduce the demand for tobacco.

M – Monitor tobacco use and prevention policies.

P – Protect people from tobacco smoke.

O – Offer help to quit tobacco use.

W – Warn about the dangers of tobacco.

E – Enforce bans on tobacco advertising, promotion, and sponsorship.

R – Raise taxes on tobacco.

We will talk about each strategy separately next.
**MPOWER: Monitor tobacco use and prevention policies**

Monitoring tobacco use and tobacco control programs is essential to the success of the other five policy interventions. Monitoring systems must track:

1. The prevalence of tobacco use, secondhand smoke exposure, and tobacco-related disease.
2. Whether policy interventions are in place; and, if so, whether they work.
3. Marketing, lobbying, and promotion activities of the tobacco industry.

Monitoring data is necessary to determine the extent and causes of the tobacco problem, as well as to plan and implement effective solutions. Data collected through monitoring provide powerful evidence that a policy is working and has value, or is not working and may need further evaluation. Monitoring ensures that resources are allocated where they are most needed and will be most effective.

Read more about the Monitor intervention on WHO’s [website](http://www.who.int) and in the WHO MPOWER [brochure](http://www.who.int).
MPOWER: Protect people from tobacco smoke.

As discussed previously, there is no safe level of exposure to tobacco smoke. The creation of 100% smoke-free environments is the only way to protect the population from secondhand smoke. Smoke-free air policies also:

- Reduce the number of smokers and reduce tobacco use among smokers.
- Increase the prevalence of smoke-free homes, protecting family members and children.
- Help smokers quit.
- Discourage youth from starting to smoke.

The WHO recommends legislatively mandated smoke-free policies that offer universal protection. As the graph at right demonstrates, smoke-free air policies are popular and successful. Yet, the tobacco industry claims (falsely) that smoke-free air laws are costly to businesses, and difficult to enforce. A review of worldwide economic impact studies of smoke-free policies shows they do not have a negative effect on businesses. The 2006 Surgeon General’s Report states that smoke-free indoor environments are proven, simple approaches that prevent exposure and harm.

Read more about the Protect intervention on WHO’s website and in the WHO MPOWER brochure.
**MPOWER: Offer help to quit tobacco use**

Programs to treat tobacco dependence should include a variety of methods, from simple medical advice to pharmacotherapy and telephone help lines (quit lines).

**Primary Care and Other Health Care Systems**
- Visits to health care facilities give health care professionals an opportunity to remind patients that tobacco harms their health and the health of others around them.
- Repeated advice from health professionals greatly increases cessation rates.

**Quit Lines**
- Access to a quit line combined with nicotine replacement therapy is even more effective than nicotine replacement therapy alone.
- Quit lines reach people in remote places and can be tailored for specific populations.
- Quitlines are available daily and year-round, to be available when the tobacco user is ready to quit.

**Pharmacological Treatment**
- Treatment doubles or triples quit rates.
- Nicotine replacement therapy comes in patches, lozenges, gum, and nasal sprays.
- Prescription medications such as bupropion and varenicline are also available.

**Government Support for Treatment**
- Support consists of quit lines, subsidized nicotine replacement therapy, and counseling services.
- Funding services to help people quit using tobacco enables the government to reach those most directly affected by tobacco-related illness and death.
- The Affordable Care Act requires that insurance companies cover the cost of pharmacological treatment

---

Read more about the Offer intervention on WHO’s [website](http://www.who.int) and in the WHO MPOWER [brochure](http://www.who.int).
**MPOWER: Warn about the dangers of tobacco use**

Here are some of the most effective ways to warn people about tobacco use:

**Education**

One way to warn people is to educate them about the risks of tobacco use through mass media campaigns. The extreme addictiveness of nicotine and resulting health consequences have not been adequately explained to the public in graphic, realistic terms. Consequently, people believe they can reduce or stop tobacco use before health problems occur. In reality most tobacco users find it difficult to quit, and half of them will die of tobacco-related illnesses. A good example of a hard-hitting mass media campaign is the 2012-1013 Tips from Former Smokers Campaign from the CDC.

**Change the image of tobacco**

The tobacco industry wants people to associate its products with pleasure, but through community action that association can be disproved. We must work to have people associate tobacco with its extreme addiction and dangerous health consequences.

![SMOKERS APPROVE OF PICTORIAL WARNINGS](image)

**Place warnings with graphic pictures on cigarette packs.**

Most people support putting graphic warnings on cigarette packs, and the idea encounters little resistance outside the tobacco industry. Images have more impact on most smokers than words alone, causing emotional reactions to the health and social consequences of tobacco use.

The FDA Center for Tobacco Products proposed graphic warning labels on all cigarettes sold in the US; however, the tobacco industry challenged the constitutionality of this measure, tying up the implementation in the US Courts.

Read more about the Warn intervention on WHO’s [website](https://www.who.int) and in the WHO MPOWER [brochure](https://www.who.int).
MPOWER: Enforce bans on tobacco advertising, promotion, and sponsorship

The tobacco industry employs some of the best marketers in the world, as they have to sell a product that kills half the people who use it.

**Tobacco Marketing**
The tobacco industry says that its advertising and promotion activities are not to expand sales or attract new users but to reallocate market share among existing users. But their marketing in fact urges nonsmokers — especially young people — to try tobacco and become long-term customers.

**Effective Restrictions**
For a ban to work, it has to be comprehensive, fully enforced, and without loopholes or the possibility of preemption, which prevents local jurisdictions from enacting laws that are stricter or different from a state or national law. Restrictions on advertising, promotion, and sponsorship require preparation time to allow those affected to find replacement advertisers and sponsors. Bans may need to be amended periodically to overcome new industry tactics. For example, preemption is often used to limit stronger laws at the state or local level.

Read more about the Enforce intervention on WHO’s [website](http://www.who.int) and in the WHO MPOWER [brochure](http://www.who.int).
MPOWER: Raise taxes on tobacco

Increasing the price of cigarettes and other tobacco products through taxes is the single most effective way to prevent tobacco use and encourage users to quit.

- Tobacco excise taxes are well accepted by both the public and political leadership because tobacco is not an essential good and is straightforward to tax.

- An increase in tobacco prices by 10 percent decreases tobacco consumption by 4 percent in high-income countries and by about 8 percent in low- and middle-income countries.

- A price increase of 10 percent would reduce the number of smokers by 42 million worldwide and save 10 million lives.

- High taxes deter the people who are most sensitive to price (the young and the poor) from using tobacco.

Read more about the Raise intervention on WHO’s website and in the WHO MPOWER brochure.
MPOWER Summary

The worldwide tobacco epidemic is devastating, but preventable. MPOWER is a model that uses six policy interventions to move toward a tobacco-free world. The WHO Report on the Global Tobacco Epidemic, 2011: Warning about the Dangers of Tobacco has found that about 55% of the world’s population is covered by at least one of these interventions. This includes:

- Mass media campaigns reaching 1.9 billion people in 23 countries
- A total of 458 million people warned of the dangers of tobacco through pack labeling laws
- Comprehensive cessation services made available to 76 million people
- A total of 80 million people shielded from tobacco advertising, promotion, and sponsorship through complete bans

Despite this progress, there is much room for improvement and progress to protect people worldwide from the harms of tobacco. To counteract the tobacco epidemic, countries must have the political will to set up comprehensive tobacco control programs and adopt the six MPOWER policies.

For further information...about MPOWER

Check out the WHO Report MPOWER- A Policy Package to Reverse the Tobacco Epidemic
http://www.who.int/tobacco/mpower/mpower_english.pdf
**CDC Best Practices: Recommendations for Comprehensive Programs**

MPOWER is a global tobacco control model, yet there are also tobacco control programs specifically within the United States. The United States’ Centers for Disease Control and Prevention focuses its efforts on making tobacco control programs *comprehensive* to be the most effective.

Let’s start by defining a comprehensive program:

“A comprehensive approach is one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies.”

This is an excerpt from CDC’s *Best Practices for Comprehensive Tobacco Control Programs*. *Best Practices* is an evidence-based guide to help states plan and establish tobacco control programs to prevent and reduce tobacco use. The 2007 edition describes an integrated program structure for implementing proven interventions and recommends the level of investment needed to reduce tobacco use in each state.

The 2007 edition of *Best Practices* is a foundational tobacco control resource that has serves as a staple in tobacco control program development.
**Best Practices: Comprehensive Program Goals**

The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use.

The CDC’s *Best Practices* guide has four goals for comprehensive tobacco control programs:

1. Prevent initiation among youth.
2. Promote quitting among adults and youth.
3. Eliminate exposure from secondhand smoke.
4. Identify and eliminate tobacco-related disparities among population groups. Elimination of health disparities is a cross-cutting goal; in other words, interventions to achieve health equity should be included in all three other goal areas.

The *Best Practices* Guide further outlines what a tobacco control program should consist of to be considered “comprehensive” and able to achieve these goals.
Best Practices: Comprehensive Program Components

Research shows that the most effective population-based approaches to tobacco control have some common components, particularly the five listed below. These five components interrelate to produce better overall outcomes. A comprehensive approach is the most effective way of preventing people from starting tobacco use and getting people who already use tobacco to stop.

1. **State and Community Interventions**
   These consist of a range of integrated activities that work to enact local and state policies and systems changes that support and influence tobacco-free norms.

2. **Health Communication Interventions**
   These include the use of mass media and new media types (e.g. social media) to transmit hard-hitting messages about the harms of tobacco, as well as efforts to keep tobacco issues consistently in the news media.

3. **Cessation Interventions**
   These are system-based programs such as 1) worksite programs that refer tobacco users to quitline services in workplaces; 2) ensuring that all patients seen in healthcare facilities are screened for tobacco use, receive brief interventions to help them quit (if needed), and are offered appropriate counseling services and FDA-approved cessation medications; and 3) eliminating financial barriers to quitting by requiring coverage for cessation services in private and public health insurance plans.

4. **Surveillance and Evaluation**
   These include population surveys and other research activities to 1) determine the prevalence of tobacco use; 2) examine tobacco-related attitudes, behaviors, and beliefs; 3) monitor program activities; and 4) assess the resulting health outcomes.

5. **Administration and Management**
   This component is the staff, facilities, and equipment available to plan, run, manage, and evaluate a tobacco control program.
**Best Practices: Comprehensive Program Funding Levels**

In addition to describing the components of comprehensive tobacco control programs, *Best Practices* recommends funding levels for each state in the United States. The level of funding has a great effect on the success of tobacco control programs: **the higher the level of funding, the greater the impact.**

The recommended CDC annual investment is based on each state’s characteristics, such as tobacco use prevalence and socio-demographic and economic factors. The annual investment includes all revenue from governmental and non-governmental sources that is contributing to tobacco control interventions.

*Best Practices* breaks down the recommended budget into the amounts that should be allocated to each program component in each state:

- **Section B: Recommended Funding Level for All 50 States and the District of Columbia, Per Capita and Total**
- **Section C: Recommended Program Intervention Budgets, by State**

To better understand how funding impacts outcomes, let’s take a look at two states: one that invested an adequate level of funding for a sustained period and implemented a comprehensive program, and one that has not made the same comprehensive investment.
Comprehensive Program Example: Washington

Washington: Percent of Adults Who Are Current Smokers, 1995 to 2010

This graph shows the BRFSS adult smoking prevalence from 1995 to 2010 in Washington State compared to the national trend. Notice in the graph:

- In 2002, smoking in Washington started to decline as a sharper rate than the national trend. Based on BRFSS data, by 2010, Washington’s adult smoking rate lower than the US rate (15.2% compared 19.3%).

- The more pronounced decrease in smoking in Washington coincided with their investment starting in 2000 of up to $27 million annually into an integrated, comprehensive tobacco prevention and control program. That state program closely followed Best Practice recommendations and strategically adjusted as state tobacco taxes increased and a statewide smoke-free public place law was enacted. An evaluation of the program determined that the comprehensive program was the primary factor driving the decline in smoking prevalence.

- Starting in 2009, state funding decreased significantly due to economic problems. The decrease in funding coincides with the prevalence trend flattening out, and the gap between the state and national rates decreasing.
Comprehensive Program Example: Missouri

Missouri: Percent of Adults Who Are Current Smokers, 1995 to 2010

The graph above displays Missouri’s BRFSS data for the same period (1995 to 2010). In Missouri, no state funds (from the Master Settlement Agreement or other sources) were allocated for a tobacco prevention and cessation program. Notice from the graph:

- The percentage of adult smokers consistently exceeded the national average every year.
- The smoking prevalence from 1995 through 2010 in Missouri was just over 25%, and in 2004 it was just below 25%. With a poorly funded state tobacco control program, Missouri has one of the higher rates of tobacco use in the country, and has not kept pace with the national trend.
- By 2010, the national prevalence of adult smokers was continuing to decline and was partially attributable to a number of well-funded tobacco control state programs being implemented in the past decade.

Let’s now take a look at how well states meet CDC’s recommended funding levels.
The graph above shows state spending for tobacco prevention and control since Tobacco Settlement funds became available to states in 1999. As you can see, between 2008 and 2013, it has declined by 36% ($260 million).

Unfortunately, because of budget constraints, lobbying pressures, and misunderstandings about comprehensive tobacco control programs, few state programs, if any, are now funded at the levels recommended by CDC. The Campaign for Tobacco Free Kids’ Report *Broken Promises to our Children* documents the decline in state funding of tobacco prevention and control program based on 2011 spending levels. Conclusions from the report include:

1. Most states are falling short of funding levels for tobacco prevention programs recommended by the CDC. The $456.7 million the states have budgeted amounts to just 12.4% of the $3.7 billion the CDC recommends for all the states combined.

   - In 2012, only two states — Alaska and North Dakota — funded tobacco prevention programs at CDC-recommended levels. Only four other states provided even half the recommended funding, while 33 states and DC provided less than a quarter. Four states — Connecticut, Nevada, New Hampshire and Ohio — and DC provided zero state funds for tobacco prevention.

To compare how your state spending on tobacco control measures up to the CDC the recommendations, go to this [interactive map](#) published by the Campaign for Tobacco Free Kids.
Best Practices Summary

The CDC's *Best Practices for Comprehensive Tobacco Control Programs* is a useful evidence-based guide to help states plan and establish effective tobacco control programs to prevent and reduce tobacco use. It lays out the components of the most effective population-based approaches to tobacco control, and provides recommendations as to how much money should be budgeted towards each component in each state. Despite the impact implementing comprehensive tobacco control program structures at the CDC-recommended levels of investment would have, few states are currently funding tobacco control programs at the recommended levels. However, we know what works, and if proven strategies were fully implemented, staggering toll of tobacco can be prevented.
Part Two, Lesson Two Conclusion

In Lesson Two, we defined the public health approach to tobacco control from both a global and national perspective, which includes addressing the health of the entire population through widespread, sweeping policy and environmental changes.

We also described two useful tobacco control models: MPOWER from the World Health Organization and Best Practices from the U.S. Centers for Disease Control and Prevention. MPOWER consists of six types of policies and interventions to be implemented at the country-level to reduce disease and death from tobacco. Best Practices describes four tobacco control goal areas and the five components of state tobacco control programs needed to achieve those goals.

Finally, we looked at examples of how state tobacco control funding and provision of comprehensive programs as defined by the CDC relates to smoking outcomes.

So far, we have shown that changing tobacco policy and systems that reach large populations are the best way to positively change health outcomes. In the next lesson, we will focus on what constitutes an effective tobacco control policy.
Lesson Two Check for Understanding

1. True or False: Please determine whether the following statements are true or false.
   - ( ) a. The public health approach focuses on the health of populations, rather than the health of individuals.
   - ( ) b. In the Health Impact Pyramid, interventions at the top of the pyramid have a larger population-level impact than interventions at the bottom of the pyramid.
   - ( ) c. Interventions working together at all levels of the Health Impact Pyramid are necessary for improving population health.
   - ( ) d. The MPOWER acronym stands for:
     - M: Monitor tobacco use and prevention policies.
     - P: Protect people from tobacco smoke.
     - O: Offer help to quit tobacco use.
     - W: Warn about the dangers of tobacco.
     - E: Enforce bans on tobacco advertising, promotion, and sponsorship.
     - R: Raise taxes on tobacco.

2. According to CDC’s Best Practices, which of the following are the components of a comprehensive tobacco control program?
   a. Surveillance; Smoke-free policies; Cessation; Media outreach; Enforcement; Tax increases
   b. State and Community Interventions, Health Communication Interventions, Cessation Interventions, Surveillance and Evaluation, Administration and Management
   c. Prevent initiation among youth; Promote quitting among adults and youth; Eliminate exposure from secondhand smoke; Identify and eliminate tobacco-related disparities among population groups.
   d. Population-based community interventions; Counter-marketing; Program policy/regulation; Surveillance and evaluation
   e. None of the above

3. According to CDC’s Best Practices, Section C, the recommended program intervention budget for Maine is:
   a. $9.0 million
   b. $18.5 million
   c. $45.0 million
   d. $67.3 million
   e. $73.2 million

4. According to the Campaign for Tobacco-Free Kids, at what percentage of CDC recommendation is Maine funding its tobacco control program in 2013?
   a. 88.4% (ranks 2\textsuperscript{nd} among states)
   b. 58.8% (ranks 5\textsuperscript{th} among states)
   c. 40.7% (ranks 9\textsuperscript{th} among states)
   d. 6.6% (ranks 34\textsuperscript{th} among states)
   e. 0.1% (ranks 46\textsuperscript{th} among states)
5. What is CDC’s recommended program intervention budget in your state? At what percentage of this recommendation is your state funding its tobacco control program?

6. What are some of the reasons you think states are unable to fund tobacco programs at recommended levels?
Lesson Two Check for Understanding Answers

1. True or False: Please determine whether the following statements are true or false.
   ___  a. The public health approach focuses on the health of populations, rather than the health of individuals.
   ___  b. In the Health Impact Pyramid, interventions at the top of the pyramid have a larger population-level impact than interventions at the bottom of the pyramid.
   ___  c. Interventions working together at all levels of the Health Impact Pyramid are necessary for improving population health.
   ___  d. The MPOWER acronym stands for:
       ▪ M: Monitor tobacco use and prevention policies.
       ▪ P: Protect people from tobacco smoke.
       ▪ O: Offer help to quit tobacco use.
       ▪ W: Warn about the dangers of tobacco.
       ▪ E: Enforce bans on tobacco advertising, promotion, and sponsorship.
       ▪ R: Raise taxes on tobacco.

Correct Answers:
   a. True - Need to review? Go back to the “The Public Health Approach” page.
   b. False - Need to review? Go back to the “The Health Impact Pyramid” page.
   c. True - Need to review? Go back to the “The Health Impact Pyramid” page.
   d. True - Need to review? Go back to the “Global Tobacco Control: MPOWER” page.

2. According to CDC’s Best Practices, which of the following are the components of a comprehensive tobacco control program?
   f. Surveillance; Smoke-free policies; Cessation; Media outreach; Enforcement; Tax increases
   g. State and Community Interventions, Health Communication Interventions, Cessation Interventions, Surveillance and Evaluation, Administration and Management
   h. Prevent initiation among youth; Promote quitting among adults and youth; Eliminate exposure from secondhand smoke; Identify and eliminate tobacco-related disparities among population groups.
   i. Population-based community interventions; Counter-marketing; Program policy/regulation; Surveillance and evaluation
   j. None of the above


3. According to CDC’s Best Practices, Section C, the recommended program intervention budget for Maine is:
   a. $9.0 million
   b. $18.5 million
   c. $45.0 million
   d. $67.3 million
4. According to the Campaign for Tobacco-Free Kids, at what percentage of CDC recommendation is Maine funding its tobacco control program in 2013?
   - f. 88.4% (ranks 2nd among states)
   - g. 58.8% (ranks 5th among states)
   - h. 40.7% (ranks 9th among states)
   - i. 6.6% (ranks 34th among states)
   - j. 0.1% (ranks 46th among states)
   
   Correct Answer: c. Need to review? Go back to the “Comprehensive Programs: State Spending” page.

5. What is CDC’s recommended program intervention budget in your state? At what percentage of this recommendation is your state funding its tobacco control program?

   Correct Answer: Answers will vary.

6. What are some of the reasons you think states are unable to fund tobacco programs at recommended levels?

   Correct Answer: Answers will vary.
Sources


Slide 5, 6, 7, 8, 9, 10, 11, 12, 13: World Health Organization. *MPower: A Policy Package to Reverse the Tobacco Epidemic*. Available at: [http://www.who.int/tobacco/mpower/mpower_english.pdf](http://www.who.int/tobacco/mpower/mpower_english.pdf)


Images


