Michigan ASSIST Project

Site Analysis

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Cancer Institute

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Introduction

Tobacco Control Analysis

Priority Population Analysis

Channel Analysis

Coalition Resource Analysis

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Site Analysis

INTRODUCTION

The site for the Michigan ASSIST Project is the entire state. The Tobacco-Free Michigan Action Coalition (TFMAC), which was established in 1990, serves as the statewide coalition under ASSIST. TFMAC currently has 60 organizational members, represented by nearly 100 individuals. Staffing for the coalition is provided by the Michigan Department of Public Health.

The Michigan ASSIST Project has formed an Executive Committee, under the guidelines of the ASSIST RFP. The Executive Committee includes two representatives from the Michigan Department of Public Health, two representatives from the American Cancer Society-Michigan Division, and one TFMAC representative.

As indicated in our ASSIST application, prior experience suggests that when authority and responsibility for planning and decision-making are this closely held, it would be difficult, if not impossible, to achieve full cooperation and active participation of the key agencies and organizations with specific responsibilities under ASSIST.

Therefore, an ASSIST Project Steering Committee has been formed. Currently this committee includes 20 members, representing the major voluntary associations, the ASSIST channels, and potential priority populations. The Field Coordinators from the intensive intervention regions also sit on the Steering Committee. Because the membership of TFMAC is so large, Steering Committee members will be the primary participants in the site analysis and planning processes, with input solicited from other TFMAC members as possible and desirable.

Within the site, there are three intensive intervention regions. The city of Detroit was chosen because it is the largest city in Michigan and the majority of the population of the city includes many of the ASSIST priority groups (e.g., ethnic and racial minorities, lower income persons, blue collar workers). In addition, chronic disease rates are higher in Detroit than in other areas of the state. The Detroit coalition agreed to include the cities of Highland Park and Hamtramck in its interventions, since these cities are geographically enveloped by Detroit and share similar populations and resources as the city of Detroit.

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A second intervention region is Genesee County, including the city of Flint. Genesee County has a high percentage of the ASSIST priority groups, specifically African Americans, and because the county's employment has historically been tied to the General Motors Corporation, many blue collar workers and unemployed persons.

Genesee County has had a tobacco reduction coalition since 1987. The SMART (Smoke-Free Multi-Agency Resource Team) Coalition has made the transition to direct the ASSIST contract in Genesee County.

The third intervention region is the Upper Peninsula, which is made up of 15 counties. In contrast to the urbanized areas of Detroit and Genesee County, the Upper Peninsula represents a rural intervention site. In this area, the ASSIST Project will focus on smokeless tobacco users, Native Americans, blue collar workers, and low income persons.

A more complex structure has been established for the Upper Peninsula ASSIST Project because it covers a large geographic area. The 15 U.P. counties are served by six local health departments, which are the ultimate links to the ASSIST Project. Some health departments have chosen to develop one tobacco coalition for the entire health department district; others have opted to develop a coalition in each county in the district. Consequently, 11 ASSIST coalitions have formed in the Upper Peninsula. The coalition coordinators from each local health department meet as a coordinating body for the U.P. ASSIST Project, under the direction of the Marquette County Health Department.

Each intervention region is developing a site analysis for its community. Brief information from each region has been included in this document.

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TOBACCO CONTROL ANALYSIS

DEMOGRAPHICS

General Population

According to the 1990 Census, Michigan's total population is 9,295,297. The gender distribution in the state is roughly equal, with females slightly exceeding males.[1]

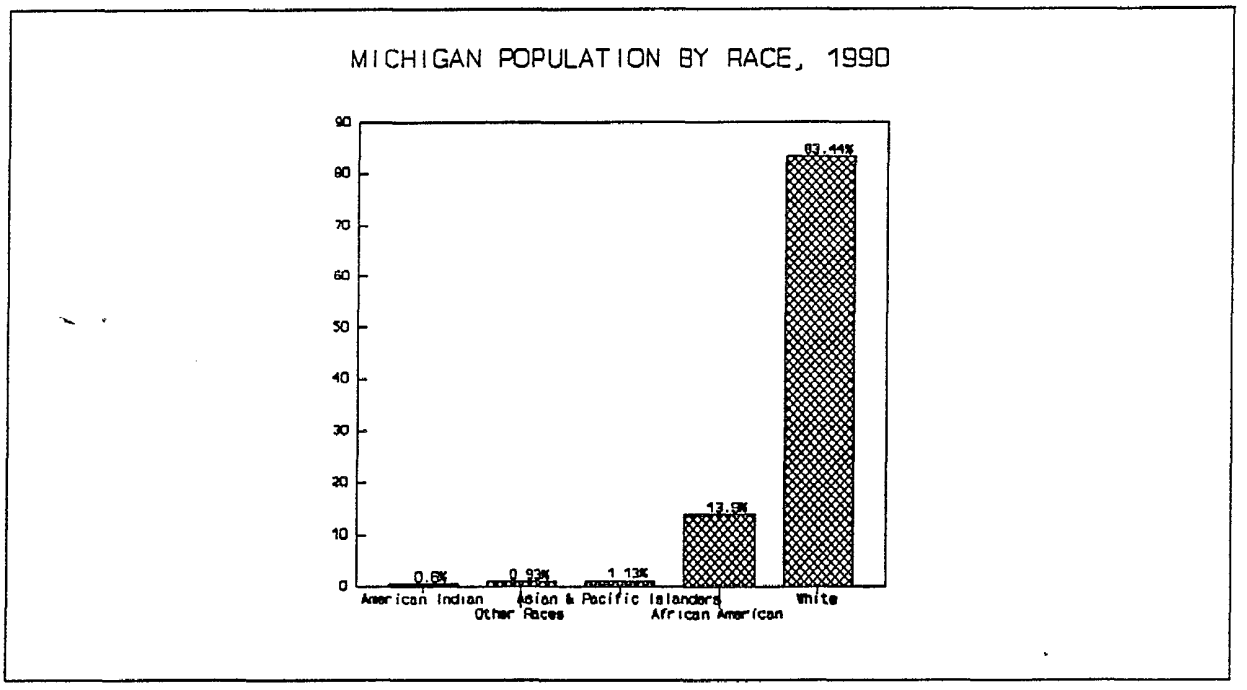
Most of Michigan's residents live in the southern half of the Lower Peninsula, and specifically in the southeastern corner which encompasses the Detroit metropolitan area. From central Michigan northward, the population diminishes in number, with the Upper Peninsula being the least populated area of the state.

Racial/Ethnic Breakdown

According to a study attempting to adjust for census undercounts, approximately 20 percent of Michigan's population belongs to one of five racial or ethnic minorities--African American, Latino, Asian/Pacific Islander, Arab, or Native American.[2]

Figure 1 displays the state's population by racial/ethnic group.

Figure 1



African Americans are the largest racial minority in the state, accounting for about 14 percent of the general population (1,291,706 people). Approximately 60 percent of Michigan's African American population lives in Detroit, with other concentrations in Grand Rapids, Saginaw, Flint, and Lansing.

The Native American population in Michigan numbers 61,384, which is an accepted figure resulting from a joint effort of the State Demographer's Office and the Michigan Commission on Indian Affairs in response to the glaring undercount of Native Americans in the 1980 Census. This represents less than one percent of the state's population. However, the Commission on Indian Affairs estimates that there are between 80,000-100,000 Native Americans in Michigan.

Seven federally-recognized tribes are found in Michigan, some of which are reservation-based. These seven tribes account for 75 percent of Michigan's Native American population. There are also five tribes recognized by the state, but who do not have federal recognition. Members of these tribes constitute about 10 percent of the Native American population in Michigan. Urban concentrations of Native Americans are found in Bay City, Lansing, Saginaw, Grand Rapids, Flint, Pontiac, Warren, and Detroit. Southeastern Michigan (primarily Detroit) is the home of about 33 percent of Michigan's Native Americans, while nearly 20 percent live in the Upper Peninsula. Less than 10 percent of Native Americans in Michigan live on or near reservations.

Asians and Pacific Islanders numbered 104,983 according to the 1990 Census, or slightly less than 2 percent of Michigan's population. This population is very heterogeneous, including the following groups (in descending order of numbers in the population): Asian Indian, Chinese, Korean, Filipino, Japanese, Vietnamese, Hmong, Laotian, Thai, and Cambodian. Only about 1,500 Michigan residents are Pacific Islanders. The highest concentrations of Asians and Pacific Islanders are in Wayne, Oakland, and Washtenaw Counties.

Michigan residents of Hispanic origin account for slightly more than 2 percent of the total population, numbering 201,596 in the 1990 Census. In 1980, the largest percentage of Latinos were of Mexican origin, followed by Puerto Ricans, Cubans, and persons from other Central and South American countries and Spain.[3] The Latino population has high concentrations in Wayne, Oakland, Ingham, Saginaw, and Kent Counties.

The Arab population in Michigan has grown rapidly in the past two decades due to immigration. Current estimates by service providers place 200,000-400,000 Arab Americans in the tri-county Detroit metropolitan area alone (Wayne, Oakland and Macomb Counties). However, 1990 census data note only 77,070 Michigan residents of Arab ancestry. Detroit has the largest concentration of Arab Americans, followed by Dearborn and Livonia.

Genesee County accounts for about 5 percent of Michigan's residents, with a population of 430,459. The county is about 20 percent African American, with all other racial and ethnic minorities comprising approximately 4 percent of the county's population. About 32 percent of Genesee County's population lives in Flint. Most of the county's racial and ethnic minorities are found in this city, which has 48 percent African American residents.[4]

Detroit is Michigan's only city with a population greater than 1 million. According to the 1990 Census, Detroit residents numbered 1,027,974, or about 11 percent of the total state population. More than 75 percent of the city's population is African American and 22 percent is white. About 3 percent of Detroit's population is of Hispanic origin.[5]

Michigan's Upper Peninsula has a population of 313,915, representing approximately 3 percent of the total state population. Racial and ethnic minorities are underrepresented in this region, accounting for only about 6 percent of Upper Peninsula residents. Half of this group is Native American, numbering 10,503.[6]

Income Distribution

In Michigan, the 1990 Census estimates that 25 percent of households have an annual income below $15,000; 31 percent of households have an annual income between $15,000 and $35,000; and 44 percent of households have an annual income exceeding $35,000. The median household income is $31,000 per year. It is important to remember that low income households are most likely to be undercounted by the Census.

Genesee County's income breakdown closely mirrors statewide figures. Income estimates for the Upper Peninsula are lower than for the state as a whole, with 36 percent of U.P. households having an annual income less than $15,000, 39 percent with an annual income between $15,000-35,000, and only 26 percent of households with an annual income above $35,000.

According to Census data, Detroit is the poorest of the three ASSIST regions. The data indicate that 43 percent of Detroit households have an income below $15,000 per year, with 29 percent having an annual income between $15,000-35,000, and only 27 percent with an annual income over $35,000.

The Census also reports that 13 percent of all Michigan residents live below the federal poverty level. A recent study by the Children's Defense Fund reported on child poverty rates for 200 cities with over 100,000 population. Detroit ranked at the top of the list, with approximately 47 percent of children under the age of 18 living in poverty. Michigan cities led the nation in increases in child poverty during the 1980s, with 10 of its major cities showing more than a third of their children in poverty.[7]

Education Levels

According to the 1990 Census, approximately 23 percent of Michigan residents over the age of 25 have not received a high school diploma. It can be assumed that this estimate is slightly lower than the actual percentage because persons with low education levels are more likely to be undercounted by the Census than persons who have more education. The Census reports that another 32 percent have graduated from high school, but have no further education.

These data on education level generally apply to Genesee County. In the Upper Peninsula there is a slightly higher percentage of persons with a only a high school diploma (40 percent). However, Census data for Detroit indicate that approximately 38 percent of adult residents over the age of 25 have not graduated from high school, while another 28 percent have a high school diploma but no further education.

SMOKING PROBLEM

Adults

The most current source of data on smoking among Michigan adults is the 1990 Behavioral Risk Factor Survey (BRFS). Due to the size of the confidence intervals, many of these data should be used as guidelines for planning rather than as strict measurements of smoking prevalence among population subgroups.

The 1990 BRFS reports an overall smoking prevalence of 29.2 percent in Michigan. Figures 2-7 illustrate Michigan's smoking prevalence, with breakdowns for gender, race (White and African American only), education, and income.[8]

Figure 2

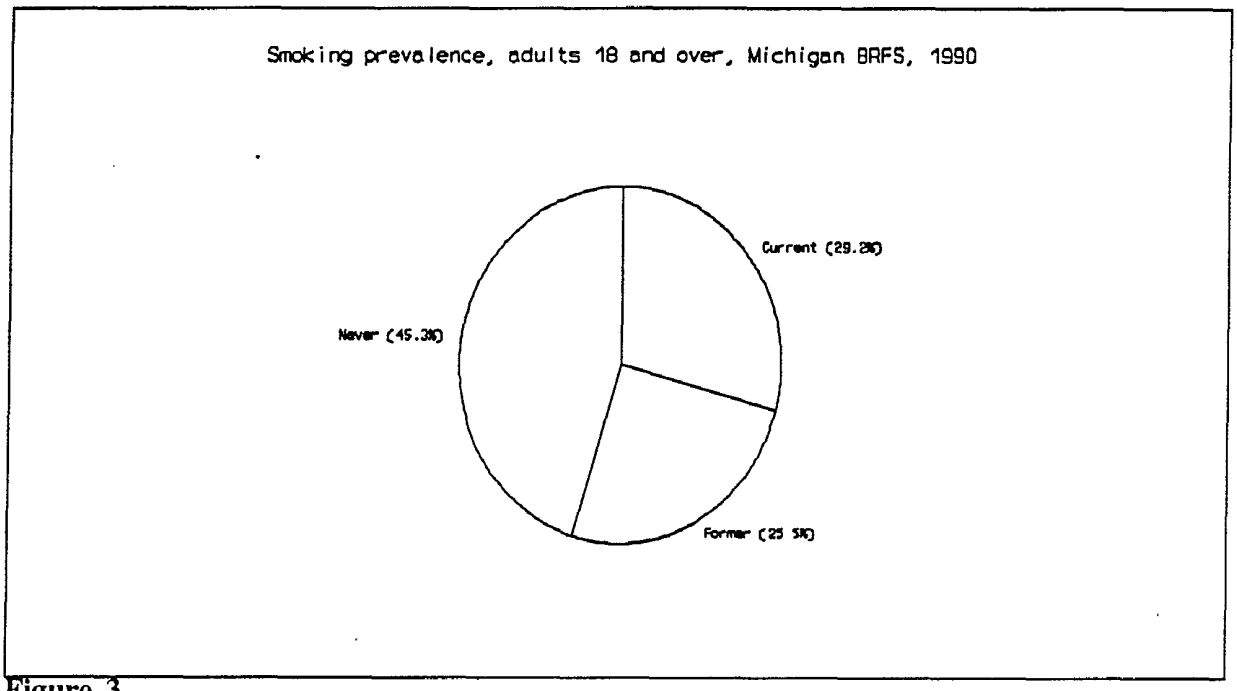


Figure 3

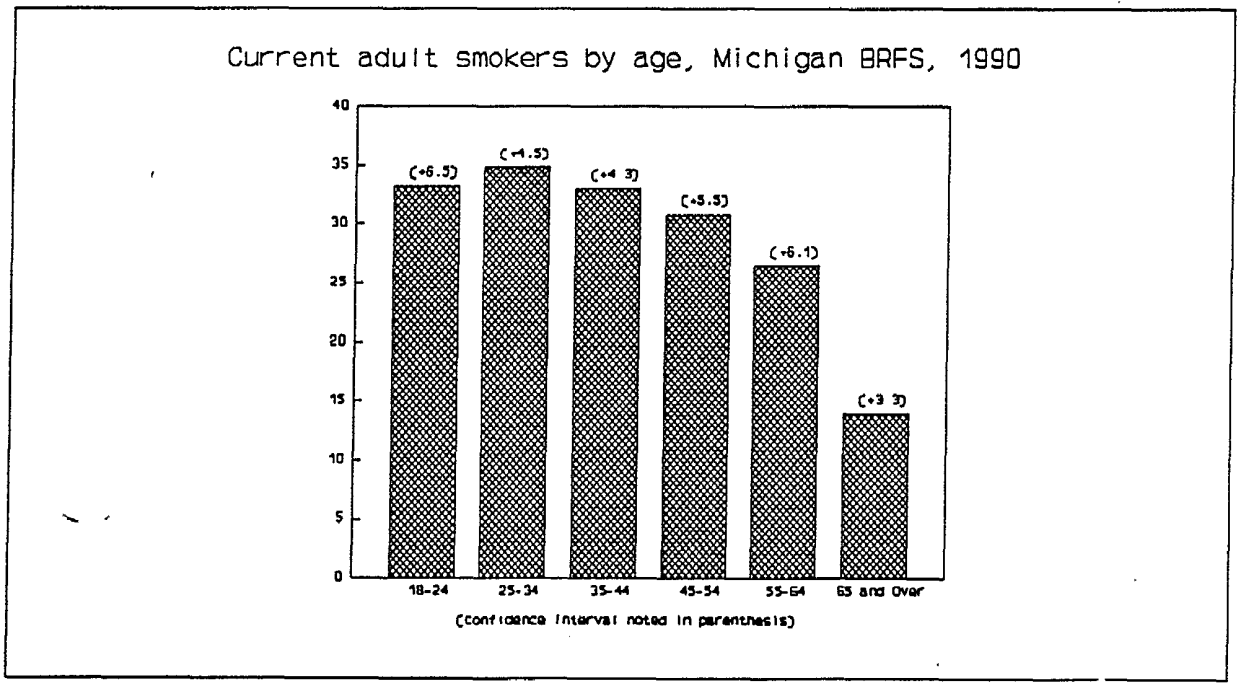


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Figure 4

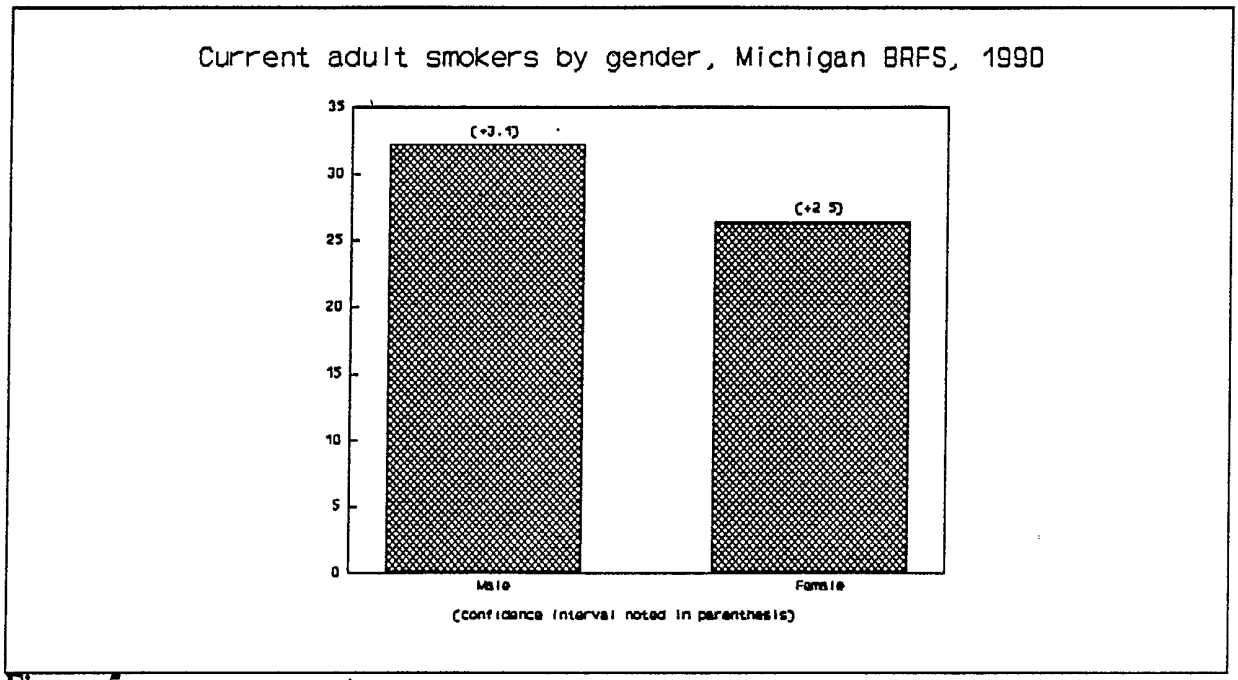


Figure 5

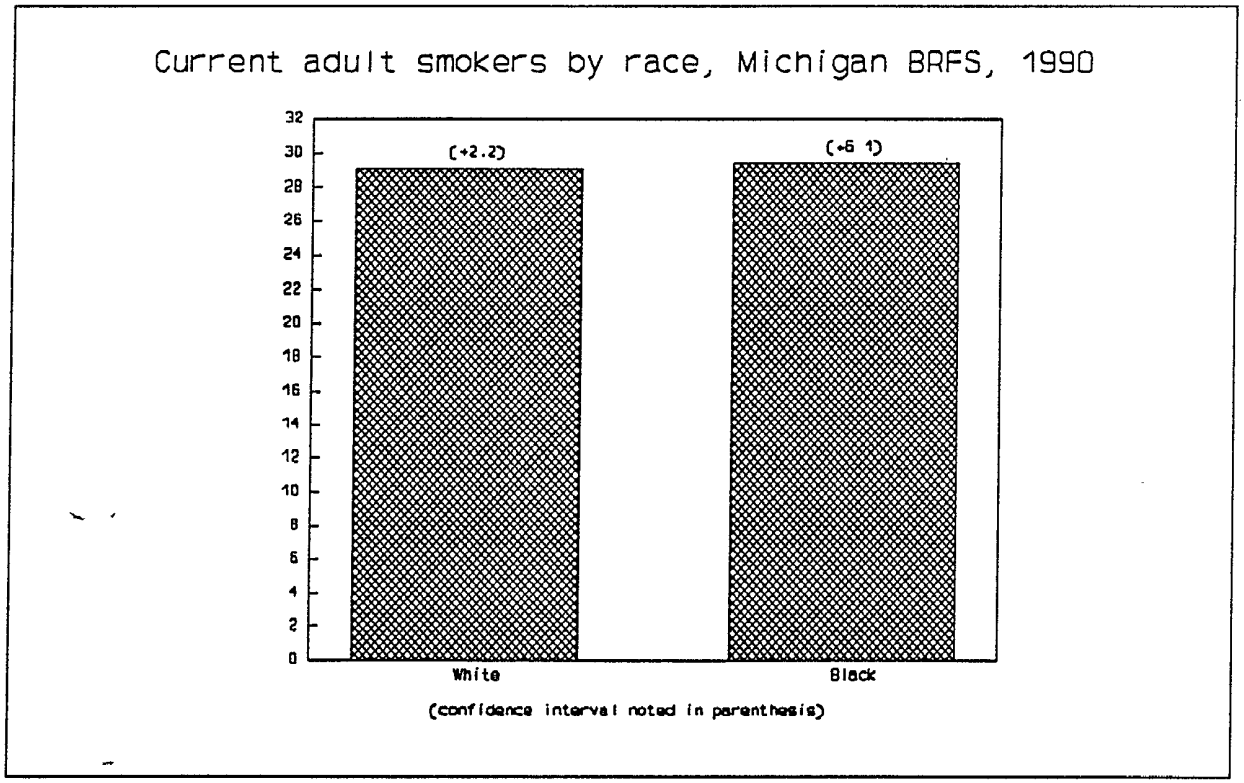


Figure 6

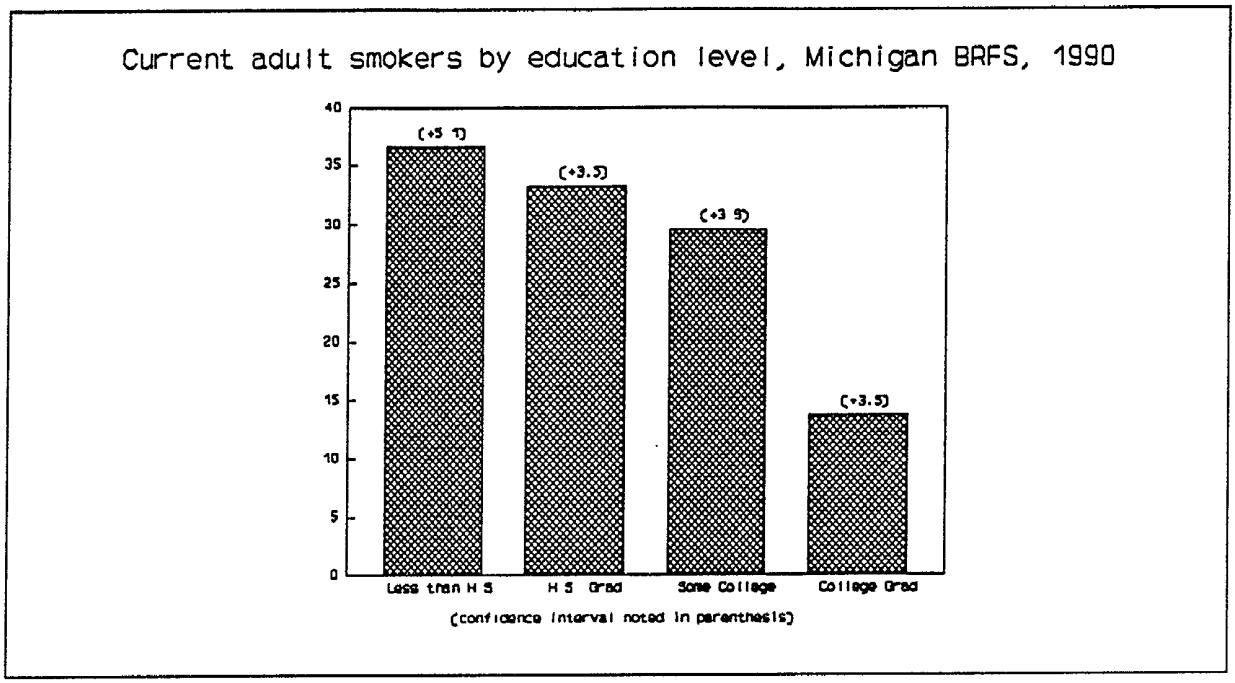
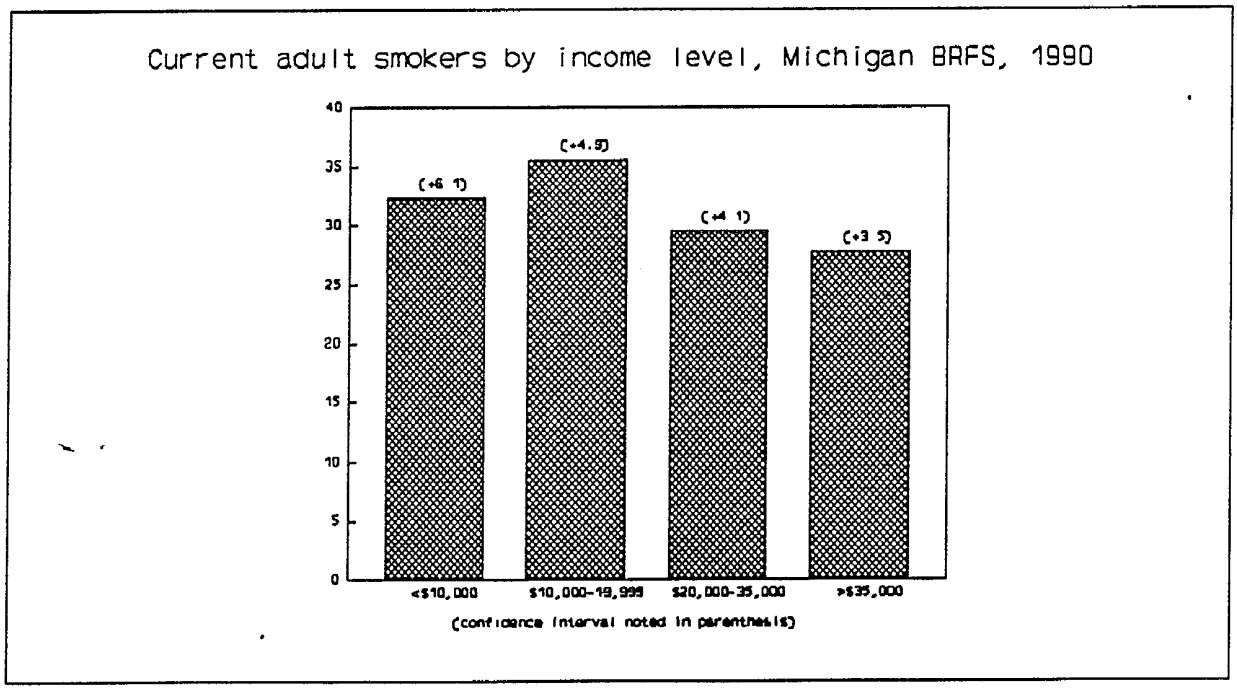


Figure 7



By aggregating BRFS data from three years (1988-90), an estimate of smoking prevalence among Michigan Latinos can be obtained. The data suggest that 24.6 percent of Michigan's Latinos are current smokers, well below the overall state smoking prevalence. There is no estimate of smoking prevalence among Native Americans in Michigan. However, a national survey of Native Americans suggests a smoking prevalence of 32.8 percent.[9]

The only known study of Arab American health practices is a study of cardiovascular risk factors among Arab Americans in the metropolitan Detroit area. According to this study, smoking prevalence among this group was 38.9 percent with a quit ratio of 22.2 percent. There was no significant difference in smoking rates between Arab American men and women.[10]

Applying the 1990 BRFS statewide smoking prevalence rate to the three ASSIST intensive intervention regions yields an estimate of approximately 69,000 smokers in the Upper Peninsula, 90,000 persons who smoke in Genesee County, and 212,000 smokers in Detroit.

Of those who were current smokers on the 1990 BRFS survey, 42.6 reported smoking less than one pack per day, while 46.4 percent reported smoking between one and two packs per day. The heaviest smokers (consuming more than two packs per day) accounted for 11.0 percent of smokers in the survey. The data indicate that persons between the ages of 35-64, men, Whites, and persons with annual incomes over $35,000 are most likely to be the heaviest smokers. On the surface, it seems contradictory that persons with more than $35,000 in annual income would have the lowest smoking prevalence but be the heaviest smokers. Possible explanations might be that the cost of a heavy smoking habit limits it to a higher income range or that the relatively small percentage of wealthier persons who continue to smoke are the most heavily addicted.

Almost 70 percent of current smokers reported that they had made a serious attempt to stop smoking at some point, with 40 percent having tried to quit in the past year. There were no significant differences between population groups on quitting attempts.

The quit ratio for the Michigan population (percent of ever smokers who are former smokers) was 46.6 percent. This figure is slightly lower than the national average. Figures 8-12 display quit ratios for various population groups.[11] Of persons who are currently not smoking, about one third (36 percent) are former smokers who have quit.

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Figure 8

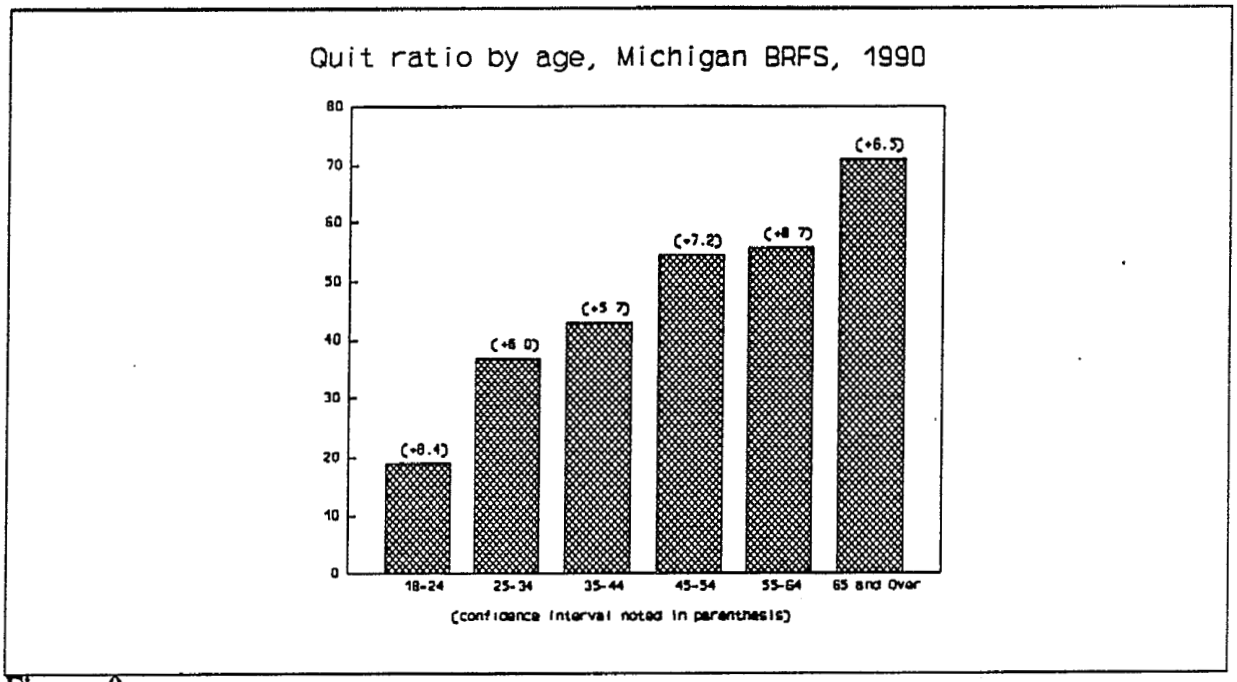


Figure 9

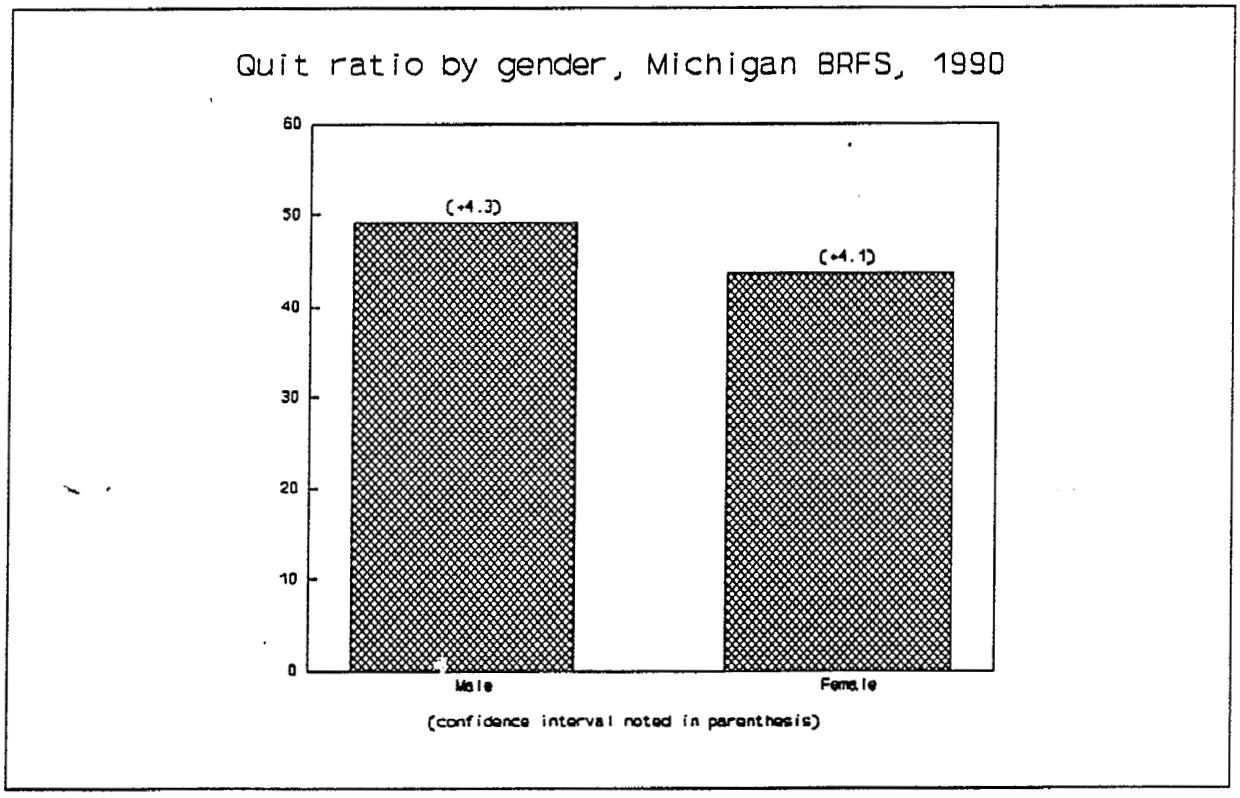


Figure 10

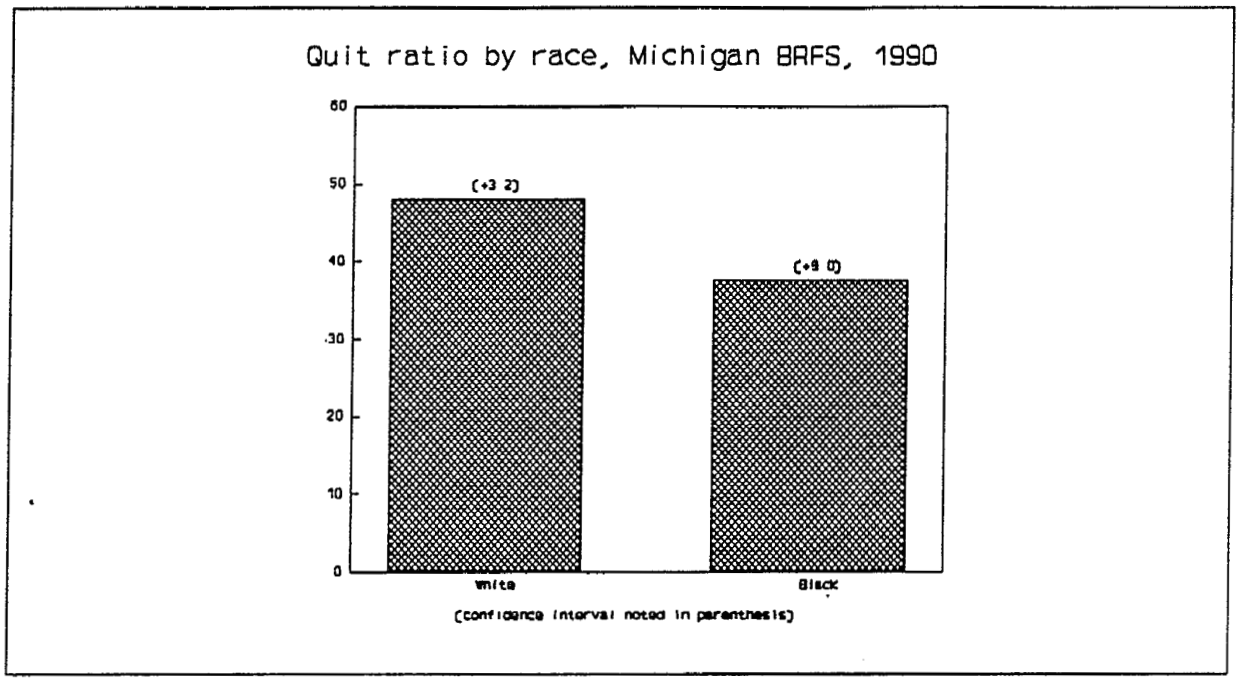


Figure 11

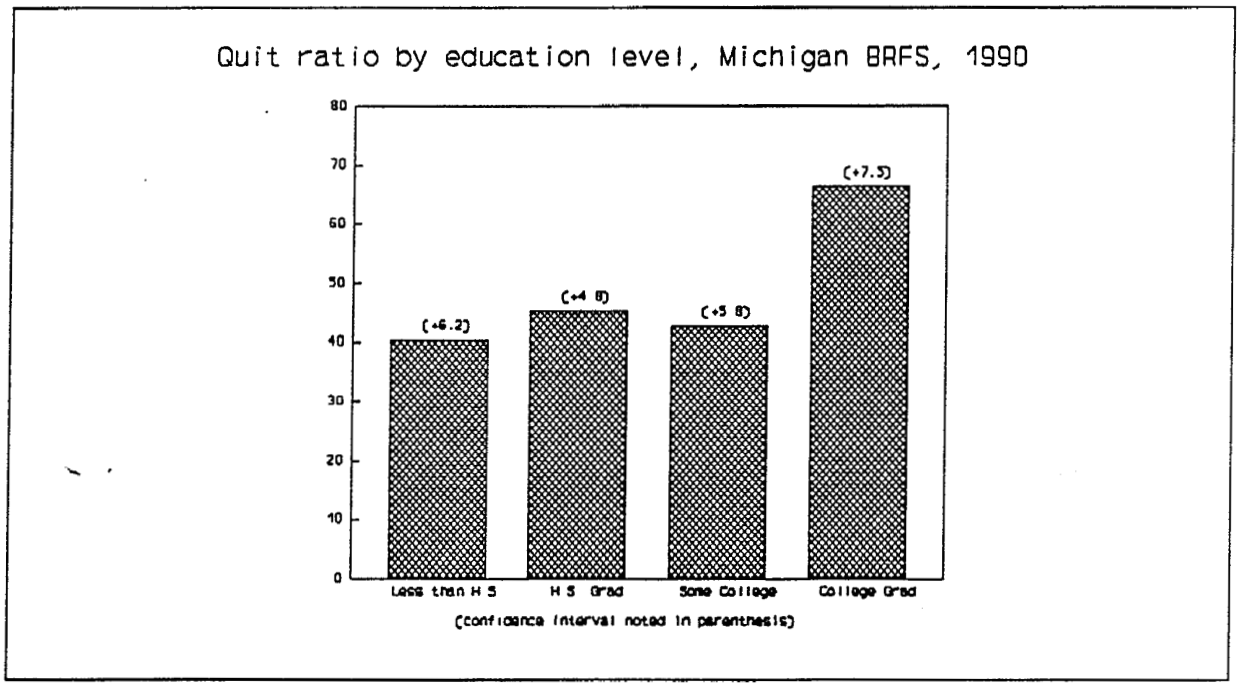
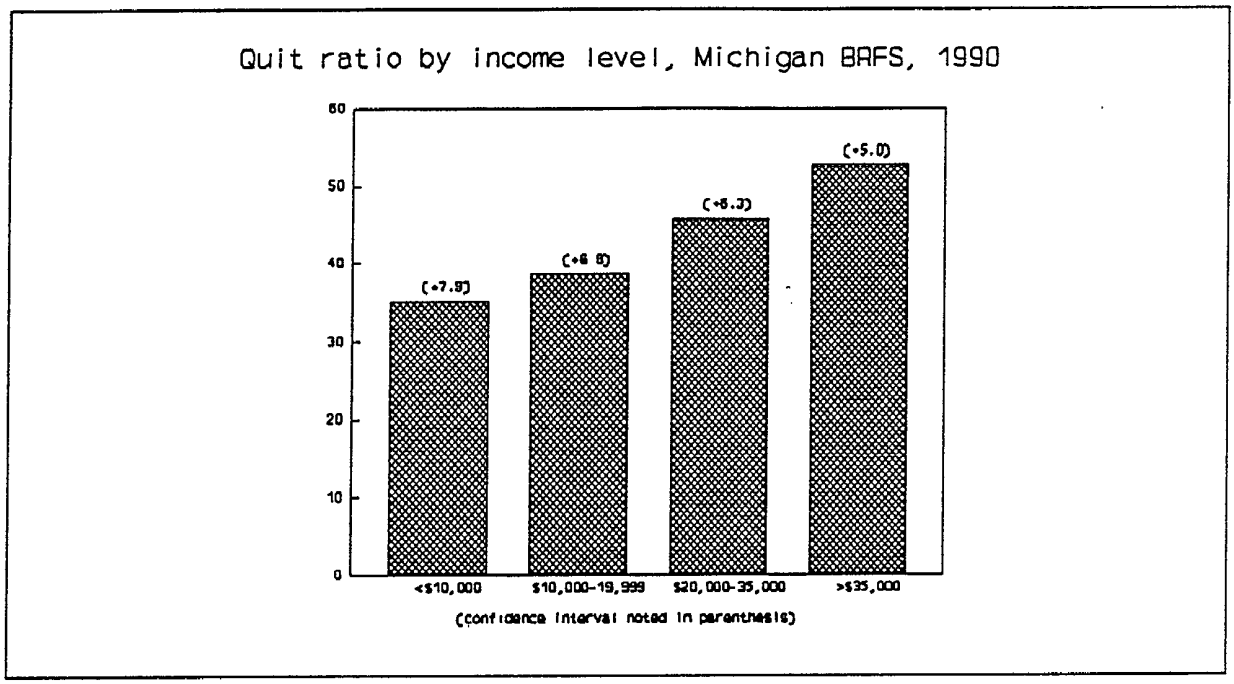


Figure 12



Overall, lower quit ratios are found among women, younger persons, African Americans, individuals who are not college graduates, and those with annual incomes less than $20,000. Since the data indicate little difference between population groups on quitting attempts, these groups appear to have the least success in remaining nonsmokers in spite of the fact that they are motivated to quit.

A review of BRFS data from the last several years shows a disturbing lack of change in Michigan smoking prevalence over time. Between 1987 and 1990, smoking prevalence in Michigan remained essentially the same. The 1990 prevalence of 29.2 percent is well above the median prevalence of the states participating in the BRFS (22.6 percent), placing Michigan second only to the tobacco-growing state of Kentucky in proportion of smokers.

Data on smokeless tobacco use among Michigan adults were last collected for the 1987 BRFS. This survey indicates that 3.0 percent of the state's population were regular users of smokeless tobacco. The practice was almost exclusively limited to males. Persons with less than a high school education and those between the ages of 18-24 and 45-54 had higher than average prevalence of smokeless tobacco use.[12]

Youth

Some surveys of youth tobacco use have been conducted in Michigan. Western Michigan University conducted a study with a sample of 97,000 Michigan students in the 8th, 10th, and 12th grades in participating school districts. Students were asked about their use of various substances, including cigarettes. The data have not been aggregated for the state at this time because the Detroit Public Schools have yet to participate in the survey.

However, in the intensive intervention regions, the Flint Community Schools (with a high African American enrollment) participated in the Western Michigan University survey. The results showed that 16 percent of 8th graders, 15 percent of 10th graders, and 15 percent of 12th graders had smoked at least once during the last month.

The Carman-Ainsworth Schools (a somewhat racially integrated suburban district) and the Kearsley Schools (a white, suburban district) also participated in the Western Michigan University survey in Genesee County. The results for both districts were slightly higher than for the Flint Community Schools.

Also in Genesee County, the Clio Area Schools (a rural, White, agricultural community) surveyed student athletes in grades 9-12 on tobacco, alcohol, and other drug use. The survey showed that 10 percent of athletes used tobacco (cigarettes or chew) weekly and 22 percent used tobacco during the last sports season. The Davison Community Schools (a White, blue collar community) conducted a survey of employees and students regarding their use and attitudes toward tobacco. Among the students surveyed, approximately 25 percent of 11th and 12th graders identified themselves as current smokers, while 8-14 percent identified themselves as currently chewing or dipping.

Information on smoking practices among youth are available for two Upper Peninsula communities. In Marquette County in 1987, 394 ninth and twelfth grade students were surveyed to determine rates of tobacco use, among other things. The survey found that 33 percent of this population smoked, with 16 percent reporting daily cigarette use. Females smoked at a slightly higher rate than males. Interestingly, an increase from 10 percent to 25 percent was noted from ninth to twelfth grade females for daily cigarette use. Thirty percent of males in the survey used smokeless tobacco, with 19 percent of the males using it daily. In the survey, 30 percent of males in grades 9-12 reported using smokeless tobacco within the last month.[13]

In 1990, the Chippewa County Tobacco Coalition (in the Upper Peninsula) conducted a school survey on tobacco use that involved nearly 1,500 seventh through twelfth graders. The survey showed that 14 percent of the students smoked or chewed tobacco regularly, with another 16 percent reporting occasional smoking or chewing.

All surveys that are specific to Michigan were conducted in the schools and therefore will not reflect smoking prevalence among drop-outs. Since drop-outs are known to have significantly higher smoking prevalence than teens still in school, we can assume these Michigan surveys underestimate smoking prevalence among Michigan youth.

National data can also be used as a guideline for smoking practices among Michigan youth if we assume that Michigan's children and teens do not differ significantly from the national population.

On a national level, youth smoking rates have been calculated from the Youth Risk Behavior Survey (YRBS) and the Teenage Attitudes and Practices Survey (TAPS). According to the YRBS, more than 32 percent of students in grades 9-12 reported smoking in the previous 30 days; nearly 13 percent reported smoking on at least 25 of the previous 30 days. Ten percent reported using smokeless tobacco. The prevalence of tobacco use was greater among males (40.4 percent) than among females (31.7 percent). The prevalence was much higher among white students (41.2 percent) than among Latino students (32.0 percent) or African American students (16.8 percent).[14]

TAPS data show prevalence figures that are lower than the YRBS data (16 percent smoked during the previous 30 days and 12 percent smoked during the previous week). This may be because younger age groups were included in TAPS (12-18 year olds). The TAPS data show an even greater difference between smoking rates of White and African American youth. In the TAPS survey, 13 percent of Whites reported that they had smoked in the last week, while only 4 percent of African Americans reported smoking in the last week.[15]

Regarding smokeless tobacco use, the YRBS reports that about 19 percent of males in the survey use smokeless tobacco. This practice is significantly higher among Whites than African American or Latino youth. A national survey of Native American youth shows a prevalence of smokeless tobacco use of about 12 percent for males in junior high school rising to about 16 percent in high school. Surprisingly, the use of smokeless tobacco among Native American girls in the survey was nearly 8 percent, which is dramatically higher than for girls of other races or ethnic backgrounds.[16]

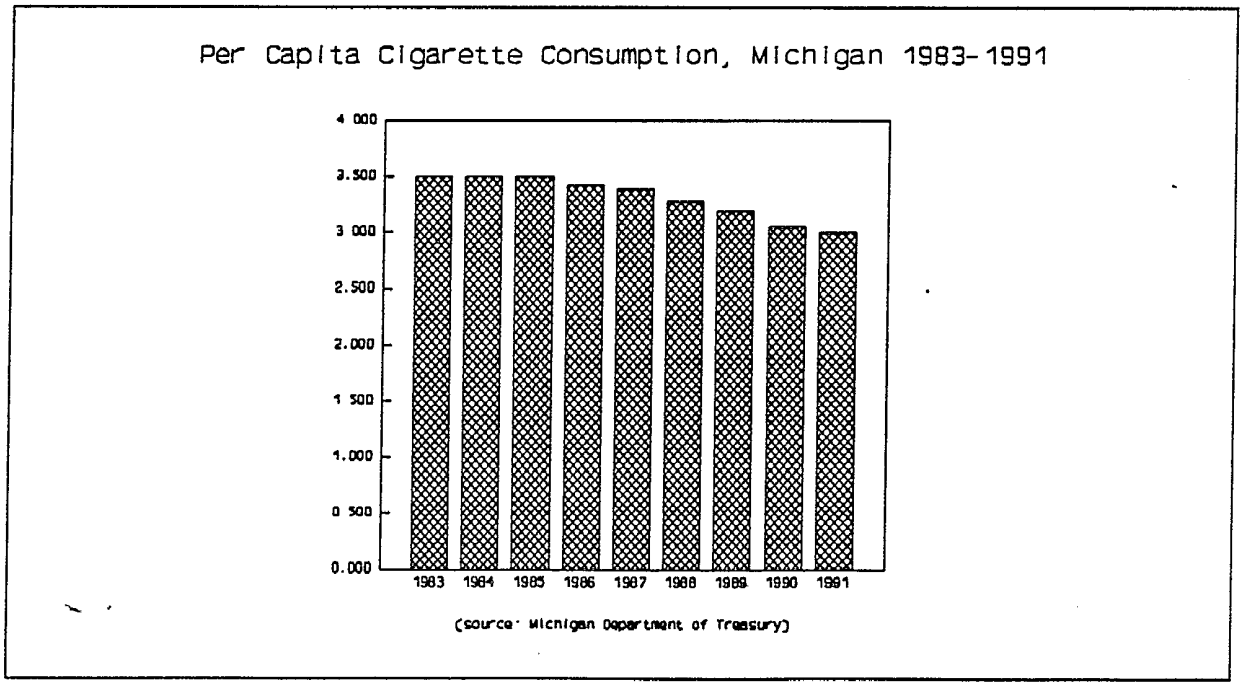
Tobacco Sales

According to the Michigan Department of Treasury, 1,025,286,358 packs of cigarettes were sold in Michigan in 1991.[17] This amounts to 3,008 cigarettes per Michigan adult. The per capita figure represents a decrease of 1.5 percent since the previous year, which is the smallest annual decline since 1987. See Figure 13 for Michigan per capita consumption data, 1983-1991.

It is possible that part of the slowing decline in Michigan cigarette sales could be attributed to cross-border purchases by Canadians. Canadian cigarette taxes rose sharply in the past few years and newspapers reported increased incidence of "buttlegging" by individual smokers coming across the border at Detroit, Port Huron, and Sault Ste. Marie. If this is true, Michigan's per capita sales could be somewhat inflated by increased purchases by Canadians and not necessarily increased use by Michigan residents.

On the other hand, Michigan's static smoking prevalence as measured by the BRFS, combined with consistently decreasing per capita cigarette consumption, might suggest that Michigan smokers may be smoking fewer cigarettes rather than quitting smoking. Alternatively, it may be that the BRFS is unable to measure real declines in smoking prevalence on a year-to-year basis.

Figure 13

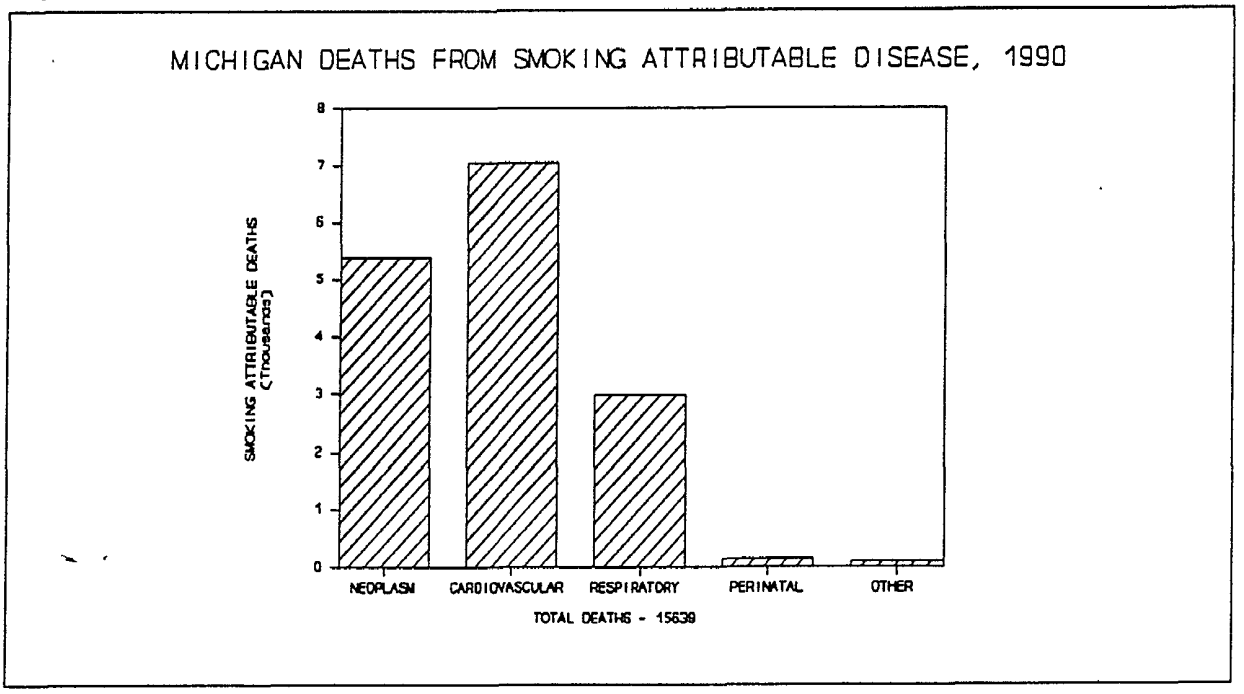


Smoking-Attributable Mortality and Economic Costs

Smoking-attributable mortality, morbidity and economic costs can be estimated for Michigan using the SAMMEC program.[18]

Figure 14 illustrates smoking-attributable mortality for Michigan. In 1990, an estimated 15,631 Michigan residents died due to smoking-attributable disease, resulting in 219,335 years of potential life lost. The main killer was heart disease, followed by various cancers and respiratory disease. The total includes 141 infants who died due to maternal smoking during pregnancy. Total smoking-attributable deaths in 1990 were virtually the same as for the previous two years.

Figure 14



Total economic costs attributable to smoking by adults age 35 and older were $2,152,946,774 in 1990. This includes $811,822,761 in direct medical costs, $214,806,744 in lost productivity due to smoking-attributable illness, and $1,126,317,268 in lost productivity due to premature death from smoking.

PUBLIC POLICIES

The following is an inventory of tobacco-related state and local public policies:

Clean Indoor Air Policies

1. Public Places

* The Michigan Clean Indoor Air Act (MCIAA) restricts smoking to designated smoking areas in all indoor publicly-owned or operated buildings. The law also covers some private sites, such as educational facilities, health facilities, auditoriums, arenas, theaters, museums, concert halls, and other privately operated facilities during the period of their use of performances or exhibits of the arts.

  Furthermore, the MCIAA prohibits smoking in certain licensed child care centers, bans smoking in the common areas and treatment areas of private practice offices of health professionals, and requires designated smoking areas in hospitals to be separately ventilated.

* Effective June 15, 1992, smoking has been prohibited in all non-residential buildings owned or leased by the state, by Executive Order of the Governor.

* Ottawa, Allegan, Wayne, and Ingham Counties have banned smoking in all or most county facilities. Schoolcraft and Alger Counties (in the Upper Peninsula) have banned smoking in their courthouses.

* The city of Livonia has incorporated the Michigan Clean Indoor Air Act into its local ordinances, providing for an enhanced ability to enforce those requirements.

2. Private Workplaces and Facilities

Three cites in Michigan--Marquette, Detroit, and East Lansing--have local clean indoor air ordinances that restrict smoking to designated smoking areas in private workplaces. The Marquette ordinance also prohibits smoking in certain places,

such as retail service establishments (e.g., barber and beauty shops), public transportation, pharmacies, restrooms (unless there is more than one restroom for each sex), and conference and meeting rooms in private office workplaces.

3. Restaurants

* State law requires restaurants with a seating capacity of 50 or more to maintain a nonsmoking area of a specified minimum size (three nonsmoking tables of four seats each for restaurants seating 50 to 100 people, six in restaurants seating 101 to 150 people, and nine in those seating more than 150 people).

* The Marquette city clean indoor air ordinance requires a minimum of 60 percent nonsmoking seating in food service establishments. The East Lansing ordinance requires 50 percent nonsmoking seating in restaurants.

4. Tobacco-Free Schools

A survey conducted last year by the Michigan Association of School Boards and the Tobacco-Free Michigan Action Coalition located 65 school districts with at least some tobacco-free buildings.

5. Jails

At least 17 counties in Michigan have smoke-free county jails, including the intensive intervention regions of Marquette County and Genesee County. The Kalamazoo County jail allows smoking by staff only in garages that are not accessible to inmates.

6. Other Locations

State law prohibits smoking in elevators and in the public sections of grocery stores.

Youth Access Policies

1. Ban on Tobacco Sales to Minors

* Michigan's Youth Tobacco Act states that anyone selling, giving, or furnishing tobacco products to persons under 18 years of age faces a fine of up to $50 or up to 30 days in jail for each offense. Fines for minors who purchase or possess tobacco products are also specified. In addition, the Youth Tobacco Act requires that a sign be posted at all points of sale for tobacco, warning that tobacco sales to minors and purchases by minors are prohibited.

* The cities of Warren and Ann Arbor impose additional fines on retailers who sell tobacco to minors. Ann Arbor's ordinance includes a local fine for minors who purchase tobacco.

2. Tobacco Retailer Licensing

Ordinances in Marquette County and East Lansing require a license for the retail sale of tobacco. A licensing ordinance was recently passed in Ingham County which will go into effect in January, 1993.

3. Restrictions on Tobacco Vending Machines

* Flushing (in the Genesee County intensive intervention region) prohibits all sale of tobacco through vending machines.

* Ordinances prohibit placement of vending machines in public places or places accessible to minors in Ann Arbor, Rochester Hills, Sterling Heights, Zeeland, and Warren.

* East Lansing and Marquette County both restrict the placement of tobacco vending machines and require the use of electronic disabling devices for machines in certain locations. Ingham County's ordinance, which becomes effective January, 1993, is similar to these ordinances.

* Oakland County prohibits tobacco vending machines on county property.

4. Ban on Free Tobacco Samples

East Lansing is the only community in Michigan that prohibits the distribution of free tobacco samples. The Ingham County ordinance which will be effective in January, 1993, will require a license for the distribution of free tobacco samples.

5. Display of Tobacco Behind the Counter

East Lansing was the first community in the country to prohibit the display of tobacco products for sale in a location or manner which allows delivery to the public without the assistance of an adult sales clerk. Exempted are products in cartons containing five or more packs.

Economic Policies

Michigan levies an excise tax of 25 cents for a 20-count pack of cigarettes and 28 cents for a 25-count pack. There is no tax on smokeless tobacco products, cigars, or pipe tobacco. Tobacco is not grown in Michigan, nor are tobacco products manufactured in the state since the Governor's Executive Order that banned the manufacture of cigarettes in state prisons.

Advertising Policies

State law requires warning statements on billboards for smokeless tobacco products. These statements are the same warning that are found on smokeless tobacco packages under federal law.

Public Education

The Michigan Health Initiative (MHI) earmarks between $9-12 million annually for health promotion and risk reduction activities in Michigan. One million dollars of this amount is set aside for health promotion mass media campaigns. Since its inception in 1989, the majority of this $1 million has been used for an anti-tobacco media campaign.

School-Based Education

The State of Michigan provides funding for the Michigan Model for Comprehensive School Health Education, a standardized health curriculum that includes a strong tobacco use prevention component for grades K-8. Approximately 90 percent of Michigan's schools use the Michigan Model.

POLICY ENVIRONMENT

Mirroring changes in society as a whole, there has been a noticeable increase in interest in tobacco control policies in Michigan. This is evidenced by the large number of tobacco control bills introduced during this legislative session. Since January, 1991, 26 pieces of tobacco control legislation have been introduced in the Michigan legislature and 11 of these have had public hearings in committee. One bill (a ban on smoking in certain child care centers) has been made law while three others have been passed by at least one house and are awaiting further action.

The bills cover a full range of tobacco policy strategies, including clean indoor air, youth access, and taxation. It is hoped that some of the remaining bills may be passed before the session ends in December, 1992.

A hopeful indicator of the growing strength of the tobacco control advocacy efforts in Michigan was the fate of the so-called "smokers' rights" bill in the Michigan House of Representatives. Senate Bill 484, which would protect employment rights for smokers in Michigan, was introduced in the Senate in October, 1991. The bill was heavily lobbied by the tobacco interests and was approved by the Senate in very short order. The House, which is historically pro-labor, was expected to pass the bill shortly thereafter. However, the bill was stalled in the House Labor Committee until the end of May, 1992, the day after the House passed a strong tobacco vending machine restriction. On the House floor, the bill was significantly amended to include prohibitions on discrimination based upon various political activities and to preclude discrimination against nonsmokers. According to Michigan law, a conference committee must meet to reconcile the vast differences between the House and Senate versions of the bill. This committee has not yet convened and, with the Governor hinting he might veto the bill, health advocates are hoping it will not convene before the end of the session.

Similar interest in tobacco control has been seen on the local level. Of the fifteen local tobacco ordinances in Michigan, seven have been passed since February, 1991.

Several events this year have helped to soften the way for stronger tobacco control policies, many revolving around Michigan's governor. In a New Year's Day speech, Governor John Engler floated a "trial balloon" on a doubling of Michigan's tobacco excise tax. Based upon the Governor's speculation, an Ad Hoc Tobacco Tax Coalition was formed, with more than 400 organizational and individual members. Support from the coalition has kept the tax issue alive and there are now bills proposing a doubling of the tobacco tax in both the House and Senate, with sponsors from both parties. Some sources feel that the tax will pass in November's "lame duck" session. Equally important, organizations in the tax coalition have taken this tobacco control message back to their memberships, increasing interest and awareness among constituencies that may not necessarily have a tobacco focus.

Governor Engler continued support for tobacco control in his State of the State address in which he mentioned the social and economic costs of smoking. Then in March, the Governor delivered a health message which focused strongly on reduction of tobacco use. In this speech he declared his support for various strategies to reduce minors' access to tobacco and protect nonsmokers from ETS. He also announced that he would sign Executive Orders banning smoking in state buildings, prohibiting the sale of tobacco in state buildings, and ending the manufacture of cigarettes in Michigan's correctional facilities. Gov. Engler's views were widely publicized in the media.

Casting a shadow on this victory, however, was a judicial ruling that the Governor does not have the authority to ban tobacco sales in state buildings. Furthermore, the Commission is actively pursuing legal recourse to prevent both the ban on sales and the ban on smoking in state buildings. The United Auto Workers and two other unions have filed unfair labor practice charges against the state for instituting the smoking ban.

Public awareness and support for stronger tobacco control policies was reflected in smoking policy changes in two of Michigan's sports stadiums this year. Tiger Stadium (Detroit's professional baseball field), which had allowed unlimited smoking, recently announced a policy that bans smoking from the seating areas of the stadium. In addition, the Pontiac Silverdome (home of the Detroit's professional football team) has further restricted designated smoking areas in the stadium.

A survey of Michigan residents commissioned in June, 1992, by the American Lung Association of Michigan and the American Cancer Society, Michigan Division, revealed that there is strong public support for anti-tobacco legislation. For example, 81 percent favored extending clean indoor air legislation to the private sector, 73 percent favored banning tobacco vending machines, and 59 percent favored licensing of tobacco sales, similar to alcohol.

In spite of heightened interest and some important successes in tobacco control, however, an examination of the enforcement of current laws shows that practice has not always kept pace with intention. While Michigan law has prohibited tobacco sales to minors since before the turn of the century, the law is seldom, if ever, enforced. "Sting operations," in which minors attempted to purchase tobacco products, were conducted in at least 6 Michigan communities in the past year. In these attempts, teens were successful in purchasing tobacco between 39 and 72 percent of the time.

Similarly, Michigan law requires a certain number of nonsmoking tables in restaurants of more than 50 seats. While this law is monitored by restaurant inspectors from local health departments, there is no realistic penalty or sanction for not following the law and so enforcement is often problematic.

Another obstacle to effective tobacco policy in Michigan is the previously-mentioned corps of lobbyists hired to defend tobacco practices. Nearly every multi-client lobbying firm in Michigan has a contract representing one or more tobacco interests. In combination with the retailer, grocer, and restaurant associations, they are formidable opponents. Their influence is particularly effective because members of Michigan's House of Representatives must run for re-election every two years, and financial support from this sector can be important.

The influence of tobacco lobbyists is also being felt on the local level. This year, representatives of the Tobacco Institute visited at least one Michigan community to lobby against a local youth access ordinance. In another community, a city council member proposed a vending machine ordinance and heard from a "grassroots smokers' rights group." However, this group failed to materialize at the hearing on the ordinance.

The tobacco industry also gains influence in the state through financial support of popular events and civic organizations. The tobacco industry sponsors several sporting events in Michigan, such as the NASCAR Winston Cup stock car race and the Marlboro 500 auto race at Michigan International Speedway. Communities receiving tobacco dollars include Muskegon, where events during the popular Lumbertown Music Festival have been underwritten by Philip Morris. In Bloomfield Hills, the new and innovative Bloomfield Hills Model High School has received more than 25 percent of its funding from the RJR Nabisco Foundation. Also, it is widely known that many services and facilities in minority communities are funded by the alcohol and tobacco industry. Communities or organizations that benefit from tobacco industry largesse may be reluctant to openly oppose the industry's promotional or lobbying efforts.

Michigan's economic climate is also used as a rationale for curtailing tobacco control efforts. The U.S. automobile industry has experienced a serious decline from many previous decades of growth and prosperity. For example, General Motors recently reported that since 1985 it has eliminated 79,000 jobs in Michigan and $5 billion in payroll and other contributions to the state's economy. This has created economic problems not only for the areas of the state that are directly dependent upon the automobile industry for employment, but also other areas that produced goods or services used by the industry or its employees. Consequently, economic issues have become an overriding concern in Michigan political decisions. To a certain degree, the tobacco lobbyists have been successful in convincing some Michigan policymakers that "anti-tobacco" means "anti-business," which hurts efforts toward stronger tobacco control policies.

In the intensive intervention regions, there are both support and obstacles to tobacco control policies. Genesee County has had an active tobacco control coalition since 1987, the SMART coalition. The coalition activities included public service announcements about the need to control smoking in restaurants, workshops to aid worksites in developing smoking control policies, and consultation with the sanitation division of the Genesee County Health Department to ensure adequate enforcement of current clean indoor air policies.

Support for tobacco control policies has also come from law enforcement officials in Genesee County. Genesee County Sheriff Joe Wilson spearheaded the banning of smoking in the Genesee County Jail. In Mt. Morris, the Township Police are conducting compliance checks for the Youth Tobacco Act and plan to issue citations to retailers who sell tobacco to minors.

On the other hand, public attitudes have not necessarily mirrored these actions. In 1989, the Davison School Board passed and then rescinded a resolution declaring its campuses smokefree, due in large part to its impact on enrollment in the adult education program. A survey of employee and student attitudes done in conjunction with the policy change showed a wide range of opinions regarding the need for banning smoking in schools. Davison is currently working on a phase-in plan for smoke-free buildings in the district.

Similarly, a SMART coalition survey of restaurant patrons found that most patrons had no preference for nonsmoking seating and were unaware of the health hazards of environmental tobacco smoke.

Also a factor in Genesee County are social and economic problems that have developed since the decline of automobile manufacturing employment in the last ten years. Problems of this nature take precedence over health promotion activities in the public's mind.

Finally, tobacco advertising and promotion is heavy within the city of Flint, which has a high minority population. As in other communities, the industry targets African Americans for promotional activities including billboard advertising and financial support for community activities. These efforts tend to strengthen the environment which support tobacco use.

With the exception of Marquette County, the Upper Peninsula is generally not a positive environment for tobacco control policy.

In many ways, Marquette County has led the state in tobacco control activities. The county has one of the longest-standing and most active tobacco control coalitions in the state. The Marquette County Tobacco OR Health Community Coalition began its activities with public education and smoking cessation efforts, which softened the community for the policy efforts that followed. Compliance checks on tobacco retailers show that the percentage who sell to minors has declined due to the coalition's efforts, from 80 percent in 1988 to 32 percent in 1990. The Marquette County Health Department is very supportive of tobacco control activities, as evidenced by its willingness to serve as the coordinating center for the Upper Peninsula ASSIST Project. Local law enforcement officials have also been supportive of the health department's efforts.

Other Upper Peninsula counties have not been as supportive of tobacco control policy activities. One county that tried to initiate a youth tobacco ordinance encountered opposition from a Board of Health member that was sufficient to derail the process. Likewise, enforcement of current tobacco control laws has not been a priority. Also active in the Upper Peninsula have been the tobacco retailers, who have opposed all efforts to regulate the sale of tobacco.

However, there are some indications that the public mood toward tobacco policies may be changing in the Upper Peninsula. The U.P. Tobacco OR Health Community Coalitions, along with the three major voluntary associations, recently conducted mailed interviews with over 800 U.P. business leaders, school officials, civic and service club members, media representatives, and local government officials. The purpose was to disseminate information on ASSIST and its goals and to identify support for the project. Issues discussed included youth access, tobacco advertising, clean indoor air, and tobacco taxes. In general, these leaders indicated that communities should do everything possible to make it difficult for youth to purchase tobacco, smoking should be allowed only in designated areas, and the tobacco tax should be increased.

The social environment in Detroit generally supports continuing tobacco habits. Surveys show that tobacco billboards inundate inner city neighborhoods, significantly outnumbering such ads in suburban neighborhoods. Stores regularly break up packs of cigarettes to sell them individually, making cigarettes easily accessible to children and persons with low income. Many organizations which are influential in the Detroit community receive financial support from the tobacco industry. These and other environmental factors will make it difficult to reach out with the ASSIST message in Detroit.

On the other hand, positive influences toward strong tobacco control policies can be found in the city. This year, the Detroit City Council showed initiative in proposing and passing a strong clean indoor air ordinance for private sector workplaces. Two members of the City Council, including Council President Maryann Mahaffey, participated in a press conference to protest Philip Morris' sponsorship of the Bill of Rights tour, which came to Detroit in November, 1991. Although they have separate civil and health department jurisdictions, Detroit is also influenced by the recent action of the Wayne County Commission, which declared county buildings smoke-free. Alberta Tinsley-Williams and the Coalition Against Advertising of Alcohol and Tobacco has been an important force in this area for several years.

Support is also evident in the private sector for stronger tobacco control policies. Recent actions to make the seating areas of Tiger Stadium and the Pontiac Silverdome smokefree send an important message to the residents of Detroit. And last year, Wayne State University voted to divest of tobacco company stock.

make sure that the ASSIST project takes maximum advantage of the unique resources and opportunities which exist in Michigan. Responsibility for implementing the ASSIST project management functions will be placed in MITOP. See Figures ?? - ?? for organization of the Michigan Department of Public Health and the ASSIST project.

State-wide COALITION: TOBACCO-FREE MICHIGAN ACTION COALITION (TFMAC)

Membership and Purpose

The Tobacco-Free Michigan Action Coalition (TFMAC) is a 53-member state-wide coalition dedicated to reducing tobacco use in Michigan through implementation of the Tobacco Reduction Task Force recommendations. Membership from the original Task Force has been augmented for TFMAC with organizations that will facilitate implementation of the recommendations, including one representative from each of the 8 community-based anti-tobacco coalitions which have been organized with the assistance of MITOP grants. TFMAC is co-chaired by the ACS, Michigan Division, and the ALA of Michigan. Current TFMAC membership and organizational structure are discussed more fully in Section VI. below.

TFMAC will serve as the state-wide ASSIST coalition and perform the following functions for the ASSIST project:

1. Advise the ASSIST Project Contractor on how the ASSIST project can best support the TFMAC goal of reducing tobacco use in Michigan by 50 percent by the year 2000.

2. Identify appropriate activities and advise the ASSIST Project Contractor with regard to planning and implementing state-wide and local intervention activities.

3. Serve as a resource base for state-wide and local ASSIST project intervention activities.

4. Facilitate access to intervention channels and target groups throughout the site.

5. Provide a means to disseminate information and news about ASSIST project activities to member constituencies, and a means for the ASSIST project to obtain information about other tobacco-related activities and issues.

Three of the MITOP-supported community based anti-tobacco coalitions will also serve as the core of the ASSIST intensive intervention region coalition. A fourth coalition will be

organized for the fourth intervention region, Detroit. When the ASSIST project is initiated, TFMAC membership will be augmented to ensure inclusion of three representatives from each of the four Assist project intensive intervention regions. Regional representatives will consist of one from the region's subcontracting local health department, one from the region's local ACS unit or units, and a third to represent the other members of the regional anti-tobacco coalition.

TFMAC ASSIST Project Decision Rules

TFMAC will use the following decision-making rules regarding the ASSIST project:

1. The ASSIST project will be a subject of at least 3 regularly scheduled meetings per calendar year. A minimum of four weeks notice shall be given. Notice shall consist of date, time, location and an agenda including the ASSIST project topics to be discussed.

2. Special meetings to discuss the ASSIST project may be called with shorter notice.

3. A quorum for ASSIST project business at a regularly scheduled meeting shall consist of TFMAC members present. TFMAC actions at regularly scheduled meetings regarding the ASSIST project will be based on a majority of those voting. Only members (or designees) may vote.

4. A quorum for ASSIST project business at a special meeting shall consist of 40 percent of TFMAC members, including (in the event that a member can not attend) member designees. TFMAC actions regarding the ASSIST project at special meetings will be based on a majority of those voting. Only members (or designees) may vote.

5. Any member (or designee) may nominate an individual or organization for membership in TFMAC. Membership will be determined by a majority of those voting at either a regularly scheduled or special meeting.

6. The chairperson(s) of TFMAC is elected by the membership. Currently, TFMAC is co-chaired by a representative from the ACS, Michigan Division and the American Lung Association of Michigan.

7. Currently TFMAC has no standing committees. However, three ad hoc committees have been established: a planning committee, responsible for overall agenda planning; and two legislative committees responsible

for drafting legislative initiatives in two priority areas--youth protection and clean indoor air. Upon receipt of an ASSIST award, ASSIST project standing committees will be organized as described below.

Administrative Support for TFMAC

Agenda planning for ASSIST project items will be the responsibility of the ASSIST Project Executive Committee, which is described below. All staff support functions for TFMAC will be performed by the contractor, specifically MITOP. It will be the responsibility of the Project Manager to supervise and coordinate support functions. These include arranging for printing and mailing notices of meetings, arranging for meeting locations and meals or refreshments, reimbursement of member travel expenses, preparation and distribution of minutes, etc.

ASSIST PROJECT EXECUTIVE COMMITTEE (APEX)

Membership and Purpose

An ASSIST Project Executive Committee will be formed according to the formula stipulated in the ASSIST RFP. It will consist of two representatives from the Michigan Department of Public Health, (the ASSIST Project Director and the ASSIST Project Manager), two representatives from the ACS, Michigan Division (one of whom will be the TFMAC co-chairperson, and the ALA co-chairperson of TFMAC. APEX will plan agenda items for ASSIST project business to be considered by TFMAC. APEX also will plan the agenda for the ASSIST Project Steering Committee, described below. APEX will provide a means of coordinating information and activities between the Michigan Department of Public and the ACS, Michigan Division. APEX will be responsible for final approval of site analysis, plan and budgets during Phase I and II.

APEX Decision Rules

1. A quorum shall consist of all members (or their designees).

2. In instances where there is no unanimous consensus, decisions shall be by majority vote.

Administrative Support for APEX

All staff support functions for APEX will be performed by the contractor, specifically MITOP. These include arranging for printing and mailing notices of meetings, arranging for meeting

locations and meals or refreshments, reimbursement of member travel expenses, preparation and distribution of minutes, etc.

ASSIST PROJECT STEERING COMMITTEE (APSC)

Membership and Purpose

The required Executive Committee formula permits, at most, only two representatives who are not from either the ACS, Michigan Division or the Michigan Department of Public Health. The prior experience of the applicant suggests that when authority and responsibility for planning and decision-making are this closely held, it will be difficult, if not impossible, to achieve full cooperation and active participation of the key agencies and organizations with specific responsibilities under the ASSIST project.

Therefore, an ASSIST Project Steering Committee (APSC) will be formed to ensure that agencies and organizations with specific responsibilities under the project contract will have an opportunity to fully participate in planning and decision-making. The APSC will consist of the co-chairs of TFMAC, the ASSIST Project Director and ASSIST Project Manager, two representatives from the ACS, Michigan Division, a local health department and local ACS unit representative from each intensive intervention region, and a representative from any other state or local organization with a specific contract responsibility under ASSIST, e.g., ALA of Michigan, AHA of Michigan, Michigan State Medical Society, Michigan Cancer Foundation, etc. It is anticipated that membership in the committee may change during the life of the contract, as different responsibilities are added or completed.

It will be the responsibility of the APSC to reach a consensus, consistent with the requirements of the ASSIST RFP, among the key agencies and organizations, on project priorities, delegation of responsibilities, methods of carrying out responsibilities, and allocation of resources among activities and participants. Consensus will be established prior to final approval of the Executive Committee.

Decision Rules for APSC

1. A regular schedule of APSC meetings will be established with a minimum of three weeks notice given. Notice shall consist of date, time, location and an agenda.

2. Special meetings may be called with shorter notice.

3. A quorum for a regularly scheduled APSC meeting shall consist of APSC members (or designees of absent members) present. If there is not consensus on an issue, decisions will be by majority of those voting. Only members (or designees) may vote.

4. A quorum for a special APSC meeting shall consist of 40% of APSC members (including designees of absent members). If there is not consensus on an issue, decisions will be by majority of those voting. Only members (or designees) may vote.

Administrative Support for APSC

Agenda planning for APSC will be the responsibility of the ASSIST Project Executive Committee. All staff support functions for TFMAC will be performed by the contractor, specifically MITOP. The Project Manager will be responsible for supervision and coordination of the functions. These include arranging for printing and mailing notices of meetings, arranging for meeting locations and meals or refreshments, reimbursement of member travel expenses, preparation and distribution of minutes, etc.

INTENSIVE INTERVENTION REGION COALITIONS

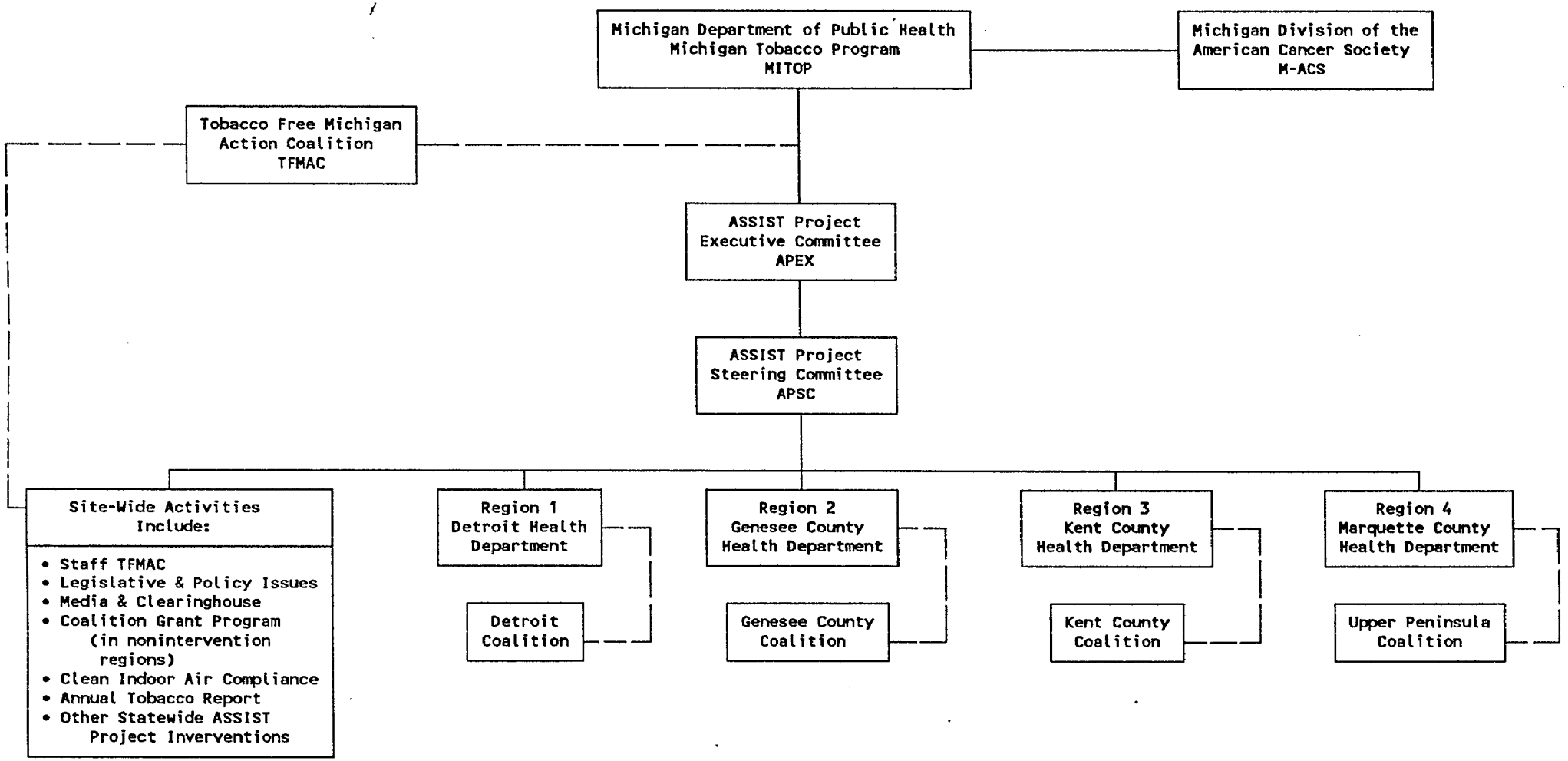
Each of the four intensive intervention regions will have community-based coalitions. As previously described, three of these coalitions are currently active (Kent County, Genesee County, and the U.P.) and a fourth is being organized for the ASSIST project in the city of Detroit. The subcontracting local health departments in each of these areas will be the administratively and fiscally responsible agencies at the regional level. ASSIST subcontracts will be negotiated by the Michigan Department of Public Health with local health departments. Local health departments may in turn subcontract with local agencies as appropriate.

B. Present an organization chart that delineates lines of authority for project management and decision making.

See these charts that follow:

Organizational Chart of the Michigan Department of Public Health
Organizational Chart of the Center for Health Promotion
Organizational Chart of the Program Development Section
Organization of the Michigan ASSIST Project

ORGANIZATION OF MICHIGAN ASSIST PROJECT



C. **Propose a management structure and decision making process that will ensure ACS (or other QVHA) - health department communication and will support the fulfillment of requirements for Phase I. Address the performance of the following functions:**

1. **Agenda and meeting planning and meeting support** is provided by the contractor, Michigan Department of Public Health, MITOP, or the subcontracting local health departments, in consultation with the ACS, Michigan Division, and local ACS units and other agencies, as described above.

2. **Recruitment of chairs and membership of coalition committees and subcommittees** at the state level is based on the operating rules described above. These rules largely reflect existing coalition structures and established precedents. Recruitment of new members for specific active participation in the intensive intervention regions has been shared by MITOP, the ACS, Michigan Division, the local health departments in each intervention region, and the local ACS units in the intervention regions.

3. **Coordination of communication with coalition member groups** including developing and keeping up-to-date ASSIST project mailing and telephone lists will be the responsibility of the contractor, specifically MITOP. The ACS, Michigan Division, local ACS units, and the subcontracting local health departments will help MITOP by keeping up-to-date address and telephone lists of members and by directly distributing such materials as may be appropriate to facilitate communications. Coordination of communication between members within individual regional coalitions will be the primary responsibility of the subcontracting local health department.

4. **Coordination and dissemination of training** will be the overall responsibility of MITOP. MITOP will be responsible for identifying and communicating training opportunities through the ASSIST project. MITOP will also identify appropriate individuals to receive training with the assistance of the of the ACS, Michigan Division, local ACS units, and the subcontracting local health departments. Training plans will be reviewed and approved by the APSC as described above.

5. **Consultation with member groups** will be the responsibility of MITOP. This will include explaining ASSIST project requirements to various coalition members and to those with specific obligations under the ASSIST project. In those cases where specific expertise may be required to facilitate implementation of a specific planning or intervention activity, MITOP will provide consultation or arrange for other expert consultation using the resources of NCI, the ACS, Michigan Division, or other agencies and institutions which are available to MITOP. Consultation may take place with individual agencies, in larger regional groups, or at APSC meetings.

6. **Coordination of site analysis** is the overall responsibility of MITOP. It will be the responsibility of each subcontracting local health department to obtain data which is local in origin and to participate in preparation of that part of the site analysis which covers its intervention region. The entire state-wide analysis will be reviewed and approved by the APSC. The analysis will also be submitted to TFMAC members for review and comment. The ACS, Michigan Division, will participate in the preparation of the state-wide analysis, and local ACS units will work with the subcontracting local health department in the preparation of the regional portions of the analysis.

7. **Coordination and production of Project Action Plan** is the overall responsibility of MITOP. It will be the responsibility of each subcontracting local health department to participate in preparation of that part of the site analysis which covers its intervention region and to ensure appropriate participation by members of the regional coalitions in the development of the plan. The entire state-wide plan will be reviewed and approved by the APSC. The plan will also be submitted to TFMAC members for review and comment. The ACS, Michigan Division, and local ACS units will assist MITOP and the subcontracting local health departments in the preparation of the plan.

8. **Coordination of the development, approval and negotiation of Phase II proposal** is the specific responsibility of Michigan Department of Public Health, MITOP. The proposal will be prepared with the participation of the ACS, Michigan Division,

subcontracting local health departments, and regional coalition members including local ACS units. The proposal will be submitted for review and comment to TFMAC and to APSC for review and approval. The Michigan Division of ACS and the other members of APSC will be consulted during the negotiation process for Phase II.

9. **Distribution of materials** is the overall responsibility of the Michigan Department of Public Health, MITOP. The ACS, Michigan Division, local ACS units, and the subcontracting local health departments will help MITOP by keeping up-to-date address and telephone lists of members and by directly distributing such materials as may be appropriate to facilitate activities.

10. **Oversight of project activities** is the general responsibility of the Michigan Department of Public Health, MITOP. Subcontracting local health departments will be responsible for oversight within their respective intervention regions and accountable to the general contractor, the Michigan Department of Public Health, MITOP.

11. **Management of the contract and the use of contract funds** will be the sole responsibility of the Michigan Department of Public Health, specifically MITOP. Subcontracting local health departments and any other subcontractors which may be selected will be accountable to the contractor, the Michigan Department of Public Health, MITOP.

12. **Maintenance of program records** will be according to the schedule provided by NCI or, in the absence of specific instructions or guidelines, according to the Michigan Department of Public Health's well-established policies and procedures.

13. **Production of quarterly reports** is the responsibility of the contractor, Michigan Department of Public Health, MITOP. Subcontracting local health departments or any other subcontracting agencies which may be selected in the course of the ASSIST project will be required to submit reports to MITOP on a schedule that will permit MITOP to submit quarterly reports to NCI on timely basis.

14. **Consultations with ACS Units will be a shared responsibility** between ACS, Michigan Division, and MITOP. This will include working with the units

in the intervention regions to enable them to take on leadership roles in their respective coalitions. In addition, the ACS, Michigan Division, will help the Units organize and train the volunteers that will be necessary to achieve ASSIST objectives.