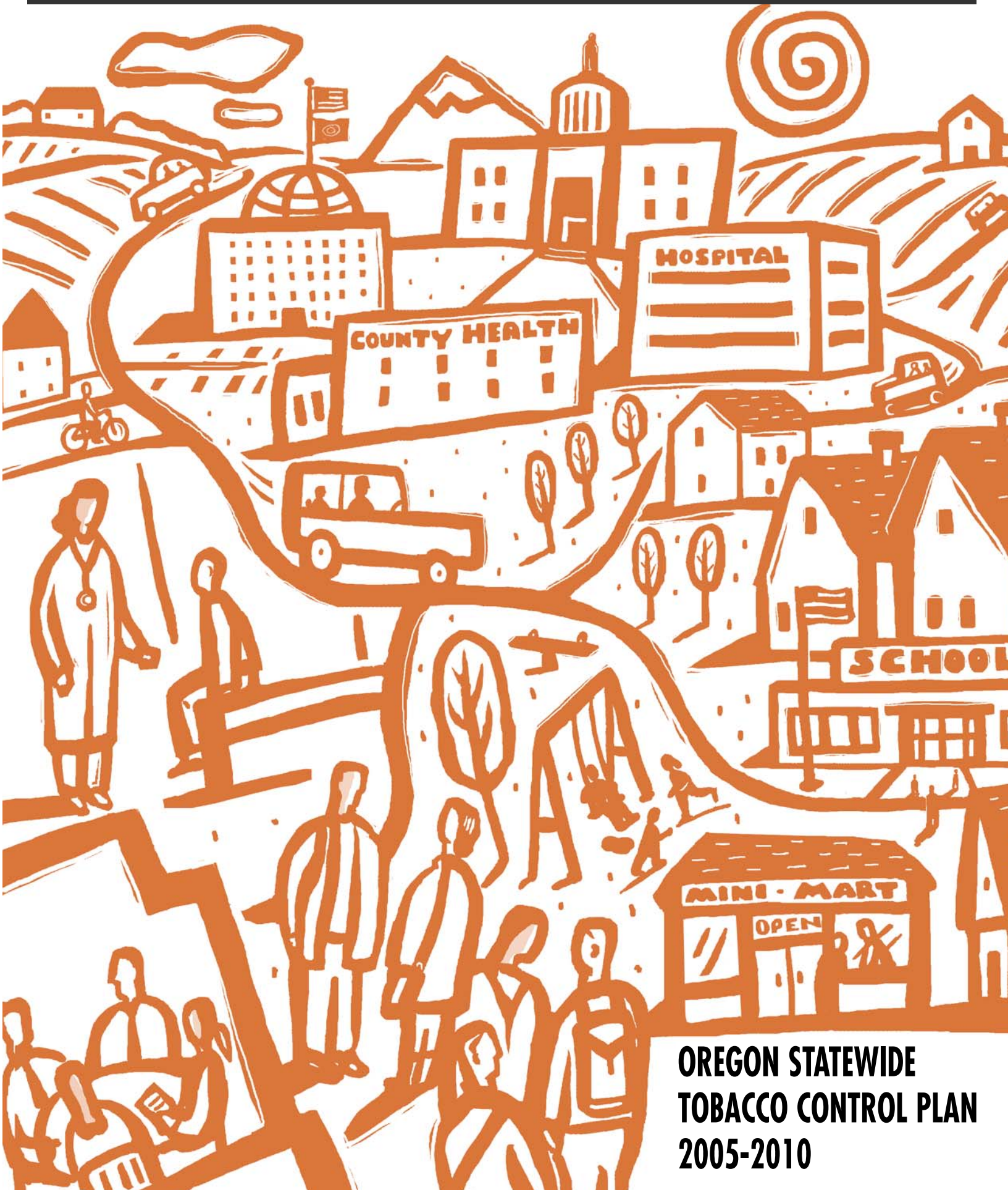


Taking Action for a Tobacco-Free Oregon



**OREGON STATEWIDE
TOBACCO CONTROL PLAN
2005-2010**

Contributors

We thank the following organizations for their participation in the series of meetings and collaborative goal setting sessions that led to the development of this plan:

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Oregon Department of Education
Oregon Department of Human Services
 Office of Child and Family Health Services
 Office of Disease Prevention and Epidemiology, Tobacco Prevention and Education Program
 Office of Medical Assistance Programs
 Office of Mental Health and Addiction Services
Oregon Department of Justice Civil Enforcement Division
Oregon Human Development Corporation
Oregon Medical Association
Oregon Research Institute
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Table of Contents

Background

| | |
|-----------------------------------|---|
| Taking Action | 1 |
| Tobacco's Effects | 2 |
| Why People Use Tobacco | 3 |
| Overview of Tobacco Use in Oregon | 4 |
| Timeline | 6 |

Goals

| | |
|-------------------------------|----|
| Oregon's Tobacco Control Plan | |
| Goal 1 | 9 |
| Goal 2 | 11 |
| Goal 3 | 13 |
| Goal 4 | 15 |
| Goal 5 | 17 |

Data Sources

| | |
|------------------|----|
| Surveys | 18 |
| Vital Statistics | 18 |
| Other | 19 |

Taking Action

Each year in Oregon, tobacco use kills more than 6,000 people. It claims more lives than motor vehicle crashes, suicide, AIDS, and murders combined.

In 2003, 500,000 Oregon adults still smoked cigarettes, and 75,000 still chewed tobacco. For most smokers, addiction to tobacco began in their youth, before they were 18. Despite gains in preventing youth from starting to smoke, 45,000 Oregon youth still smoke and 13,000 still chew tobacco.

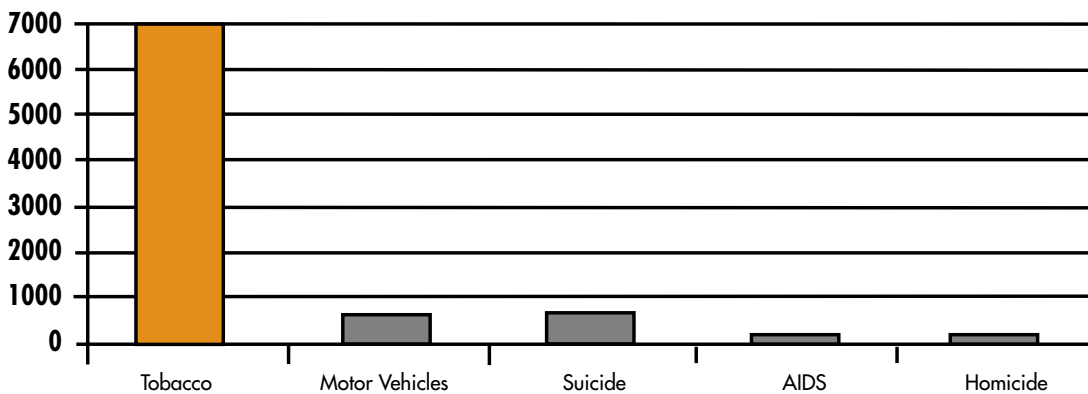
In addition to the cost of tobacco to Oregonians in lives, tobacco also imposes a staggering financial burden—of particular concern at a time of serious economic difficulties in the state. Tobacco use cost Oregonians \$1.8 billion in 2000. The direct cost to the healthcare system alone in Oregon was nearly \$900 million, and every pack of cigarettes sold costs our economy \$7.18—\$3.45 in medical costs and \$3.73 in lost productivity due to premature death and disease.

As a state, we simply cannot afford tobacco.

Taking Action on Oregon's Number One Health Problem: Tobacco Use

Background

Number of Deaths-Selected Causes: Oregon, 2002



Tobacco's Effects

Smoking and Spit Tobacco Cause

Stroke

Mouth Cancer

Throat Cancer

Heart Disease

Lung Cancer
and Emphysema

Pancreatic Cancer

Kidney Cancer

Cervical Cancer

Osteoporosis

Exposure to Secondhand Smoke Increases Risk of

Stroke

Heart Disease

Lung Cancer

Asthma Attacks

Exposure to Secondhand Smoke Increases Risk of

Ear Infection

Asthma Attacks

Pneumonia

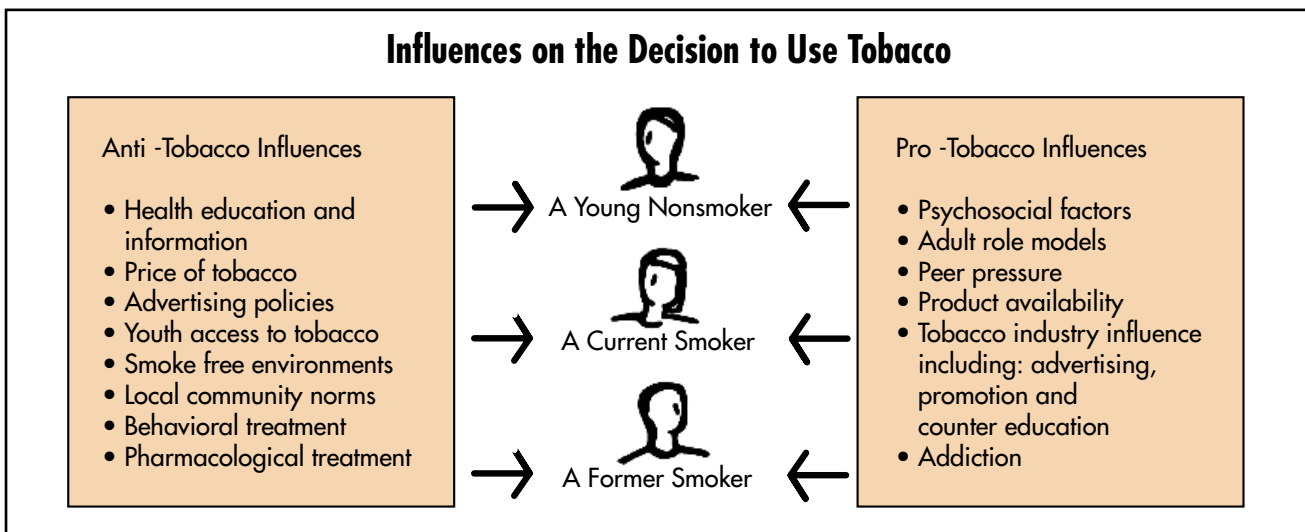
Bronchitis



Why People Use Tobacco

The Office of the U.S. Surgeon General has been telling us since 1964 that tobacco use can cause death. Given that most everyone knows smoking is dangerous, why do people still use tobacco?

The issue is complex. Smoking exists within a network of social norms, political controls and tobacco industry influence. Tobacco use is a cultural issue, with many interwoven factors ultimately affecting a person's decision to start or continue smoking.



Background

Some cultures use tobacco differently than the mainstream U.S. smoker. **Sacred or traditional use of tobacco by American Indians is very different from commercial tobacco use.** Tobacco has an important role in traditional American Indian life. For tribes throughout North America, the use of traditional tobacco plants for spiritual, ceremonial and medicinal purposes goes back thousands of years. This historic and enduring relationship with sacred tobacco must be recognized and addressed when shaping meaningful, culturally appropriate tobacco prevention in American Indian communities.

In spite of all the factors that contribute to tobacco use, we do know that when done well, tobacco control works! Comprehensive state tobacco programs reduce tobacco use. These programs, with community and school programs and policies, counter-marketing campaigns (such as anti-smoking tobacco ads), and cessation programs for current smokers have proven effective time and again.

Overview of Tobacco Use in Oregon

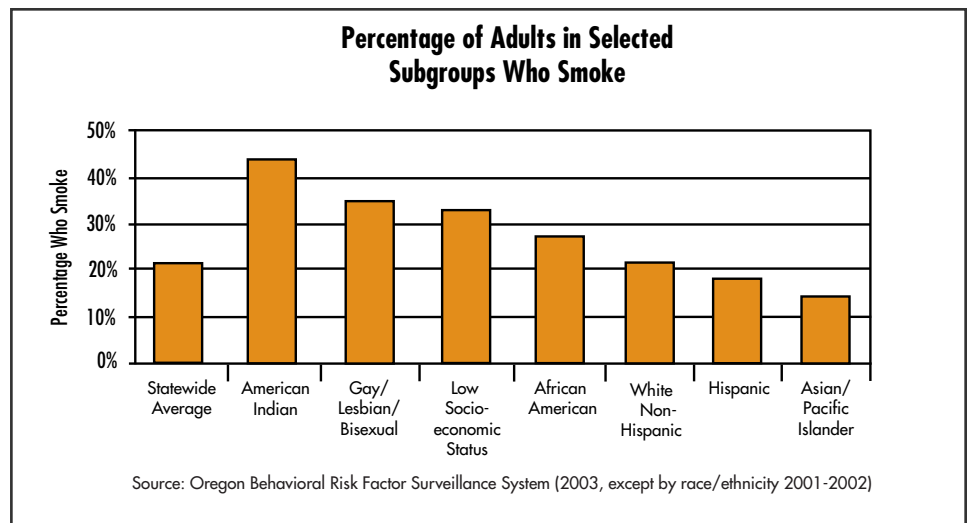
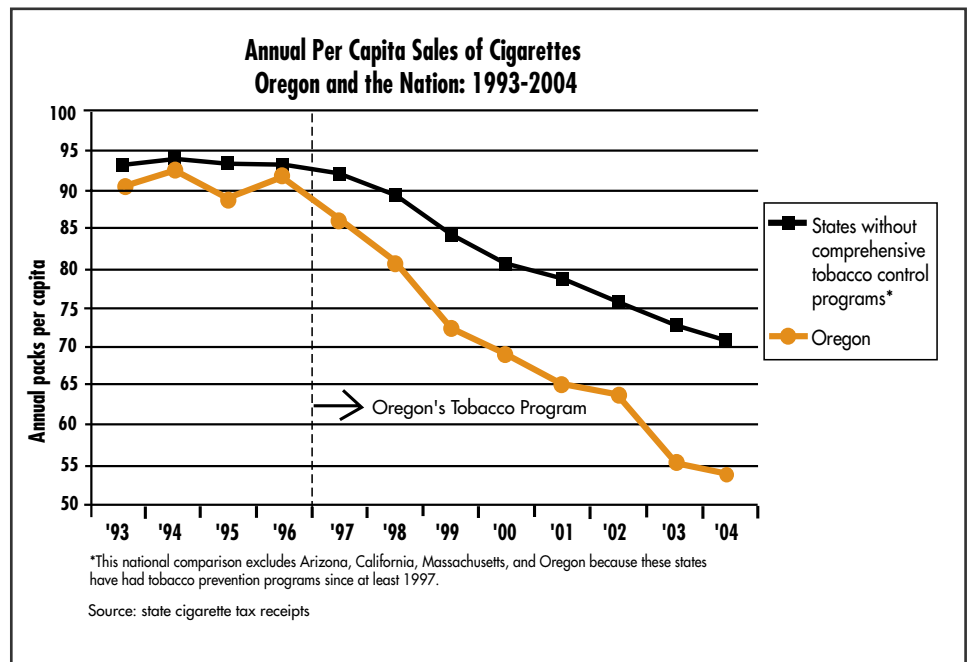
Smoking and chewing tobacco are prevalent among both adults and youth in Oregon today. Twenty-one percent of adults smoke cigarettes, as do 16% of 11th graders. Chewing is less common overall, but use of this still-deadly form of tobacco is more common among 11th grade males (11%) than adult males (6%). Lower levels of education and income are both linked to increased tobacco use.

These dire statistics have motivated the growing trend against tobacco use, and have created an increasing awareness of the dangers of second-hand smoke. Only 17% of Oregonians in 2003 allowed smoking in their homes, down from 29% in 1997. The 2002 Smoke Free Workplace Law protects a full 95% of Oregon workers from secondhand smoke.

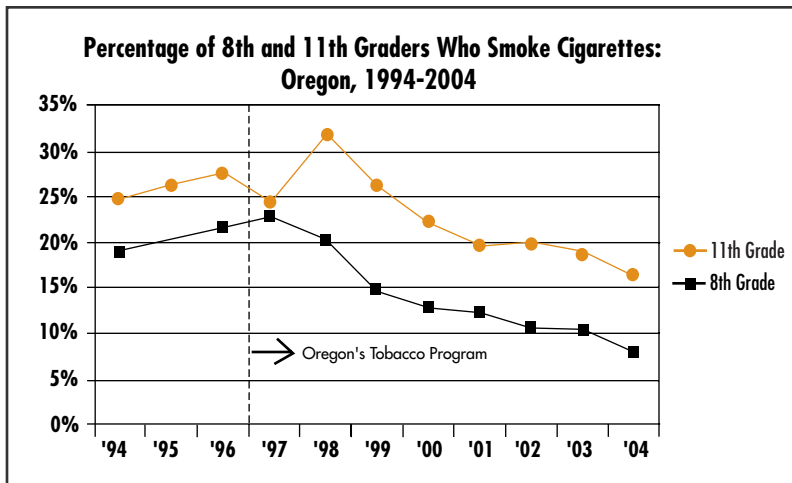
The national downward trend in tobacco use has become clear in per capita cigarette sales. The dramatic drop is even more pronounced in states like Oregon, where comprehensive tobacco reduction programs are in place.

While it is true that overall cigarette consumption in Oregon is decreasing, smoking prevalence remains higher in some communities than in others. For example, American Indians, the Lesbian/Gay community and African Americans have a high prevalence of smoking in relation to the statewide average. Furthermore, while the overall prevalence among Hispanics, Asians and Pacific Islanders is lower than the statewide average, some population groups within these communities experience a significantly higher prevalence than the non-Hispanic white population. The Oregon Statewide Tobacco Control Plan addresses these disparities.

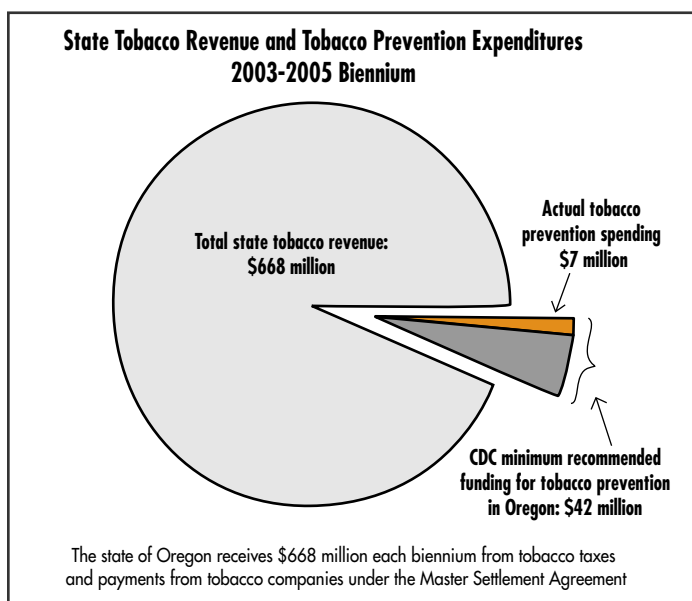
A Brief Overview of Tobacco Use in Oregon



Youth are a group particularly at risk for tobacco use. Eight percent of 8th graders smoke; by 11th grade 16% smoke. There are growing efforts to reduce and eliminate smoking among young people. For example, the state school board has ruled that all campuses must be tobacco-free by January 1, 2006.

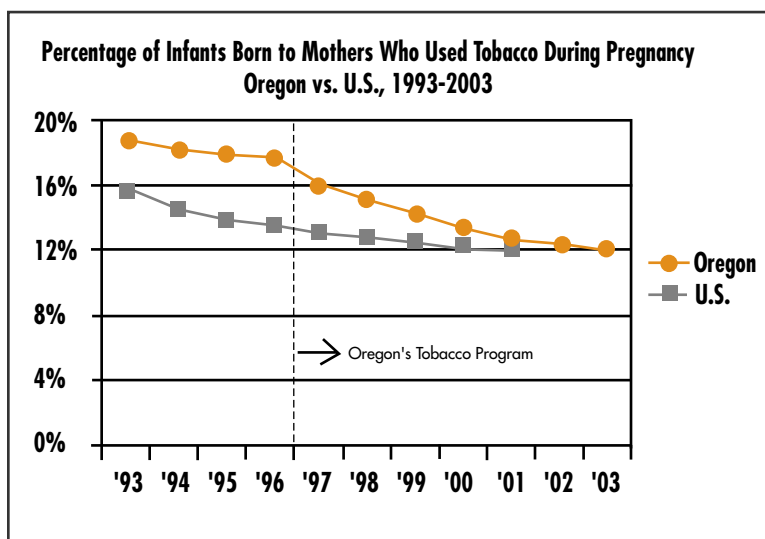


Unfortunately, funding cuts threaten progress. At present, Oregon's budgets for tobacco control comprise only a small fraction of what the Centers for Disease Control and Prevention considers minimum funding for effective tobacco prevention programs.



Interventions that reduce people's exposure to tobacco smoke, both primary and secondary exposure, can begin to reap immediate financial savings. Childhood pneumonia, otitis media, certain birth defects, SIDS and heart attacks all show immediate risk reductions and associated cost savings with reduced exposure.

The problem of low birth weight babies due to smoking mothers is another area where decreased exposure gives an immediate benefit. In Oregon, the percentage of infants born to mothers who smoke has decreased 33% since 1996, resulting in a biennial savings for Medicaid in Oregon of \$2 million.



For additional data about tobacco use in Oregon, please refer to Oregon Tobacco Facts. This document, which is updated annually, is available online at www.dhs.state.or.us/publichealth/tobacco.

Timeline



Oregon Receives CDC Funding
Oregon receives funding from the Centers for Disease Control and Prevention for tobacco prevention.

1993-1994

Voters Approve Tobacco Prevention and Education Program

Together with healthcare partners, tobacco control advocates are successful in their campaign to raise tobacco excise taxes by 30 cents and dedicate a portion to a tobacco use prevention program. Ballot Measure 44 passes by a wide margin despite millions of dollars spent by tobacco companies to defeat it.

November 1996

Master Settlement Agreement

In a landmark agreement in federal court, the tobacco industry agrees to pay out an estimated \$206 billion over 25 years to state governments. Oregon's attorney general joins other states in signing the Master Settlement Agreement.

1998

1997 - 2004 Local policy makers take action

1994

Oregon Receives Grant from RWJ Foundation
Oregon receives a grant from the Robert Wood Johnson Foundation to organize statewide tobacco control efforts.

November 1995

First State Plan for Tobacco Control
Oregon tobacco control advocates launch the state's first Statewide Strategic Plan for Tobacco Control.

1997

A Statewide Tobacco Program is Launched

The Oregon Department of Human Services launches the Tobacco Prevention and Education Program (TPEP). This new program is grounded in one basic premise: the only way to reduce tobacco use is to attack the problem from multiple fronts. Towards this goal, local tobacco control coalitions are established, schools begin to implement comprehensive prevention programs, and the Department of Human Services establishes a statewide Quit Line for smokers.

1997-2004

Local Policy Makers Take Action

Local policy makers on county commissions, city councils, tribal councils, park boards, schools boards and rodeo boards all over Oregon change local tobacco laws. They pass ordinances banning smoking in work and public places, they change local regulations about where tobacco can be placed in stores, and they ban tobacco company sponsorship of community events.



Making Tobacco History in Oregon

Oregon Indoor Clean Air Act

The Oregon State Legislature improves Oregon's Indoor Clean Air Act by covering more workplaces and public places. Some workplaces, such as bars, are exempted.

2001

TPEP De-funded

Faced with a significant budget shortfall, the Oregon State Legislature de-funds the Tobacco Prevention and Education program.

2003

1999

TPEP in Full Swing

As a result of the Tobacco Prevention and Education Program in Oregon, cigarette consumption drops, secondhand smoke exposure decreases and smoking-related medical costs are reduced.

2002

Measure 20

Voters approve Ballot Measure 20, which again increases the tobacco excise tax and dedicates a portion of the funds to the Tobacco Prevention and Education Program.



2004

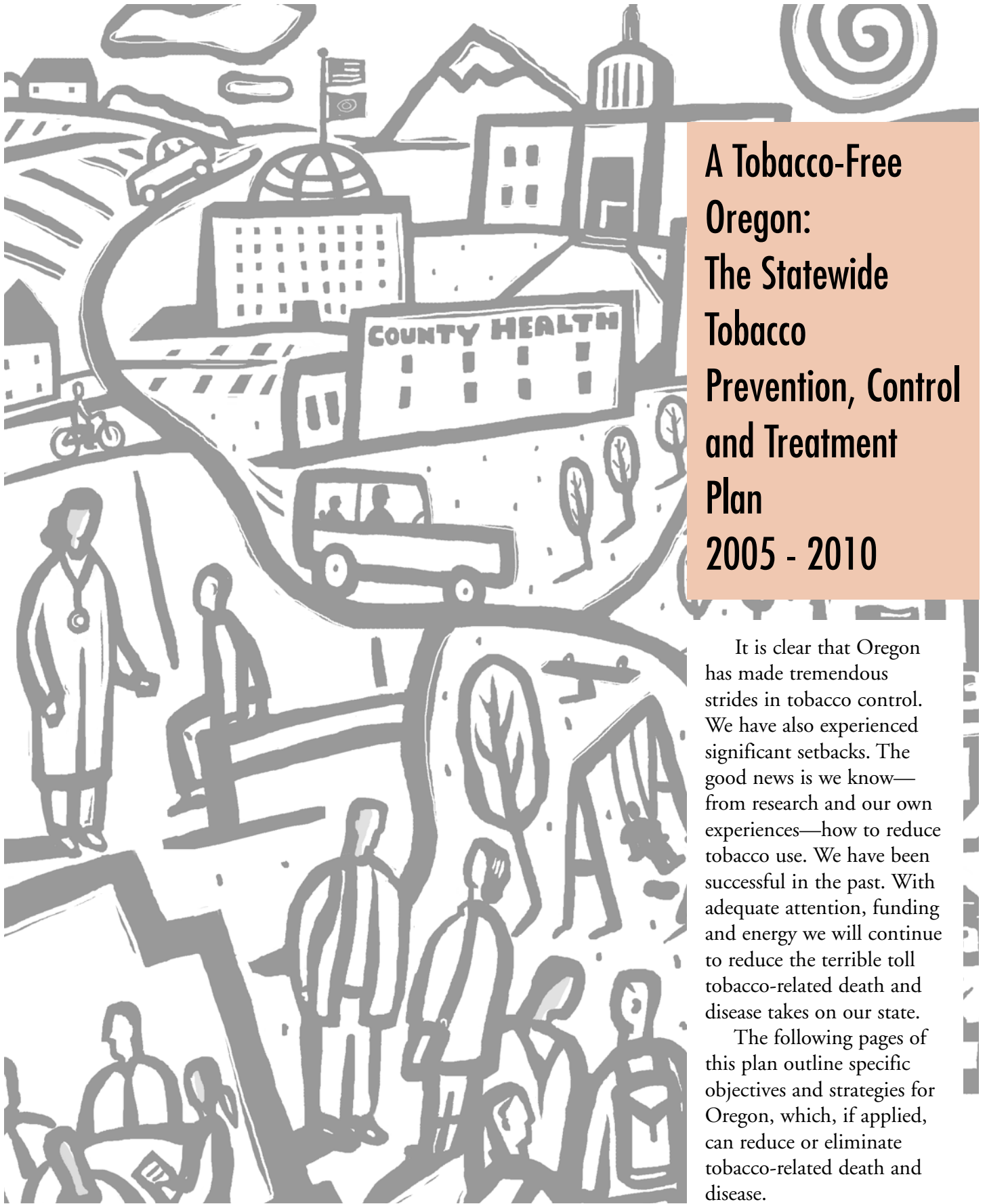
Partial Restoration of Funding for Tobacco Programs

The Oregon State Legislature restores tobacco prevention education funding to \$5.8 million per biennium—73% of previous biennia, and 14% of the CDC recommended minimum level.



Background

Tobacco Control Plan



A Tobacco-Free Oregon: The Statewide Tobacco Prevention, Control and Treatment Plan 2005 - 2010

It is clear that Oregon has made tremendous strides in tobacco control. We have also experienced significant setbacks. The good news is we know—from research and our own experiences—how to reduce tobacco use. We have been successful in the past. With adequate attention, funding and energy we will continue to reduce the terrible toll tobacco-related death and disease takes on our state.

The following pages of this plan outline specific objectives and strategies for Oregon, which, if applied, can reduce or eliminate tobacco-related death and disease.

Goal 1



Eliminate Exposure to Secondhand Smoke

Exposure to secondhand smoke is a problem almost as serious as smoking. Those caught in this carcinogenic haze are at increased risk for many of the same diseases afflicting smokers, such as lung cancer and heart disease. Reducing and eliminating secondhand smoke exposure, then, must be an integral part of tobacco control.

Objective 1

Reduce the percentage of individuals exposed to secondhand smoke by increasing the percentage of indoor public places and workplaces that prohibit smoking.

Strategy

- a. Improve the current law by removing exemptions and strengthening statutory enforcement, penalty language and surveillance of the State Indoor Clean Air Act.

Objective 2

Reduce the percentage of individuals exposed to secondhand smoke in homes and vehicles.

Strategies

- a. Identify and evaluate best practices for how to reduce smoking in homes and vehicles.
- b. Pilot a research-based education/media campaign.
- c. Maintain an ongoing research agenda.
- d. Ensure coordination of groups around the state.

Objective 3

Increase the number of outdoor places that prohibit smoking.

Strategy

- a. Promote local policies prohibiting smoking around building entrances, in parks, at public transit stops, and in other outdoor public places.

This table outlines benchmarks that will be tracked for progress towards the objectives listed under each program goal.

| Benchmark | Current Status | 2010 Target | Data Source |
|--|----------------|-------------|--|
| number of workers who are protected from secondhand smoke | 95% | 100% | Local ordinances and state laws, Oregon Department of Employment data. |
| percentage of homes where there is smoking indoors | 14% | 5% | BRFSS |
| percentage of adults who allow any smoking in their cars | 28% | 15% | BRFSS |
| number of local policies that prohibit smoking in an outdoor place | 2 | 15 | DHS Ordinance Database |

Goal 2



Prevent the Initiation of Tobacco by Youth

Young people start to use tobacco for a variety of reasons. In spite of their protests to the contrary, this process of youth initiation has long been a target area for tobacco companies. The hard-fought battle to remove cartoon advertising from cigarettes is only one example of the struggle to stop the creation of new school-age smokers.

Only through continued efforts to prevent young people from starting to smoke and chew in the first place can we decrease overall tobacco use in Oregon.

Objective 1

Decrease young people's desire to use tobacco.

Strategies

- a. Implement culturally appropriate youth strategies using a comprehensive, coordinated paid and earned media campaign at the state and local levels. Select messages based on evidence of effectiveness with youth.
- b. Develop a regionally representative, diverse youth coalition to participate in developing and implementing effective strategies and media approaches to address the problem of tobacco use among youth.
- c. Increase the percentage of school districts with comprehensive tobacco use prevention policies and programs.
- d. Support and expand the Coordinated School Health Program infrastructure to implement and enforce a statewide comprehensive school tobacco policy and assure effective tobacco prevention programs.

Objective 2

Decrease youth access to tobacco.

Strategy

- a. Increase tobacco taxes where a portion of the revenue is dedicated in perpetuity to support comprehensive tobacco prevention programs as recommended by the CDC guidelines, including effective strategies for preventing youth access to tobacco.

This table outlines benchmarks that will be tracked for progress towards the objectives listed under each program goal.

| Benchmark | Current Status | 2010 Target | Data Source |
|---|----------------|-------------|------------------------------|
| percentage of 8th graders who smoke | 8.1% | 5% | Oregon Healthy Teens Survey |
| percentage of 8th grade males who use smokeless tobacco | 4% | 2% | Oregon Healthy Teens Survey |
| percentage of 11th graders who smoke cigarettes | 16.5% | 10% | Oregon Healthy Teens Survey |
| percentage of 11th grade males who use smokeless tobacco | 11% | 6% | Oregon Healthy Teens Survey |
| percentage of 8th graders who say that it is very easy to get tobacco | 21% | 10% | Oregon Healthy Teens Survey |
| Oregon tax on cigarettes | \$1.18 | \$2.00 | State Law |
| SYNAR non-compliance rate | 15% | 10% | Department of Human Services |

Goal 2

Goal 3



Studies have shown that people who try to quit smoking are two to three times more likely to succeed if they use specific medications or patches and get professional counseling. But in 2003, of people trying to quit, only 39% tried the medications and patches that can reduce the physical cravings, and only a tiny fraction (6%) received the counseling that teaches how to quit and builds confidence. The Oregon Tobacco Quit Line, which offers free counseling and connects tobacco users to their health systems' assistance programs, currently only reaches about 1% of tobacco users.

Oregon has a long way to go in helping tobacco users end their dependence on nicotine, but the path is clear. We must make high quality medication and counseling assistance readily available, and must increase the number of tobacco smokers and chewers who use that assistance.

Increase Access to Cessation Resources for Adults and Youth

Objective 1

Increase the percentage of Oregonians who have access to cessation benefits through their employer or health insurance.

Strategies

- a. Create a widespread communication plan targeting businesses, the uninsured, labor, the health industry, the insurance industry, and brokers. The communication plan will build awareness in these target groups, sending the message that tobacco cessation assistance works and provides health improvements, financial benefits and productivity gains for everyone.
- b. Convene a Task Force to coordinate campaign efforts and encourage public sector employees and major labor unions to secure cessation benefits for their employees and families.

Objective 2

Increase the demand for and use of cessation services and programs for adults, youth and populations with tobacco use disparities.

Strategies

- a. Raise tobacco taxes significantly, with new revenue to enhance the comprehensive tobacco prevention program (including the expansion of cessation services).
- b. Research, promote and implement cost effective population-based approaches to prompt large numbers of tobacco users to quit.
- c. Engage a public-private partnership in finding and funding creative ways to increase access to pharmacological interventions and cessation counseling support.
- d. Develop earned media strategies to drive calls to the Quitline, and evaluate their effectiveness as compared to paid media strategies.

This table outlines benchmarks that will be tracked for progress towards the objectives listed under each program goal.

| Benchmark | Current Status | 2010 Target | Data Source |
|--|----------------|-------------|---------------------------------|
| percentage of Oregonians whose health insurance covers cessation services | 39% | 50% | Survey of health plans by TOFCO |
| percentage of smokers who plan to quit in the next 30 days | 27% | 32% | BRFSS |
| percentage of smokers who say that it would be very helpful to have assistance when trying to quit smoking | 34% | 40% | BRFSS |
| percentage of adults who say their health insurance covers smoking cessation | 19% | 25% | BRFSS |

Goal 3

Goal 4



Eliminate Disparities in Tobacco Use

Despite all of Oregon's tobacco control successes, some population groups are not experiencing the benefits equally. Declining tobacco use exposes disparities among distinct populations, such as American Indians and people of low socioeconomic status. The tobacco companies aggressively target these and other groups in an effort to maximize profits and expand markets.

Disparities in tobacco use prevent everyone from having equal access to the benefits of tobacco use reduction. An effective tobacco control effort must work to eliminate these disparities.

Objective 1

Develop and implement effective population-specific tobacco control programs directed at specific ethnic and cultural groups affected by tobacco use disparities.

Strategies

- a. Increase the involvement of tobacco control partners and populations affected by tobacco related disparities in the development and implementation of tobacco control programs.
- b. Develop a task force to disseminate the results of the CDC - sponsored disparities planning project. Inform influential community leaders from the disparate groups, advocating for tobacco control programs and activities targeted toward specific populations.

Objective 2

Expand data collection and develop innovative data collection strategies for populations affected by tobacco-related disparities.

Strategy

- a. Obtain funding for effective data collection on those affected by tobacco-related disparities.

This table outlines benchmarks that will be tracked for progress towards the objectives listed under each program goal.

| Benchmark | Current Status | 2010 Target | Data Source |
|---|----------------|-------------|-------------|
| African American adult smoking prevalence | 27% | 15% | BRFSS |
| American Indian adult smoking prevalence | 44% | 15% | BRFSS |
| Asian/Pacific Islander adult smoking prevalence | 14% | 10% | BRFSS |
| Hispanic adult smoking prevalence | 18% | 15% | BRFSS |
| lesbian, gay and bisexual adult smoking prevalence | 34% | 15% | BRFSS |
| low socioeconomic status adult smoking prevalence | 35% | 15% | BRFSS |
| percentage of African American homes where there was smoking indoors | 17% | 5% | BRFSS |
| percentage of American Indian homes where there was smoking indoors | 28% | 5% | BRFSS |
| percentage of Asian/Pacific Islander homes where there was smoking indoors | 9% | 5% | BRFSS |
| percentage of Hispanic homes where there was smoking indoors | 12% | 5% | BRFSS |
| percentage of lesbian, gay and bisexual homes where there was smoking indoors | 29% | 5% | BRFSS |
| percentage of low socio-economic status homes where there was smoking indoors | 23% | 5% | BRFSS |

Goal 4

Goal 5



Develop the Infrastructure for Tobacco Use Prevention

The activities that create an environment for tobacco prevention do not happen in isolation. Legislation, medical services and counseling for the smoker, and community education programs for the general public all require adequate funding and organization.

Objective 1

Reevaluate and rebuild the infrastructure for tobacco use prevention and control and the level of funding and commitment necessary to implement the new Statewide Plan.

Strategies

- a. Enhance and advance the communication, coordination and cooperation among all partners to implement the Statewide Plan.
- b. Develop a Communications, Coordination and Implementation Plan that includes all stakeholders and addresses public relations, organizational activities, message development, and policy and program strategies for the Statewide Plan.
- c. Ensure that all partners have adequate funding to implement the Statewide Plan.
- d. Enhance and advance the systems (procedures, organizations and programs) among all partners to implement the Statewide Plan.

Benchmark

The Centers for Disease Control and Prevention (CDC) recommends that Oregon spend \$21 million annually on public health tobacco prevention and education programs.

Data Sources

A. Surveys

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing random-digit dialed telephone survey of adults concerning health-related behaviors. The BRFSS was developed by the Centers for Disease Control and Prevention (CDC) and is conducted in all states in the U.S. Each year, between 3,000 and 7,000 adult Oregonians are interviewed. The BRFSS includes questions on health behavior risk factors such as seat belt use, diet, weight control, tobacco and alcohol use, physical exercise, preventive health screenings, and use of preventive and other healthcare services. The data are weighted to represent all adults aged 18 years and older. A core set of questions, which includes the question of smoking prevalence, is asked annually and other topics are surveyed on a rotating basis of two years. Each state may add questions to the CDC survey, and Oregon asks an additional sixty questions on attitudes and behaviors regarding tobacco. Except as noted below, 2003 BRFSS data are used in this report.

Data presented by race/ethnicity are from a special combined 2000 & 2001 file which includes additional surveys from an oversample among African Americans, American Indians, and Asian/Pacific Islanders. The oversampling ensured that there would be a minimum of 100 surveys in each county and a minimum of 250 surveys for each racial/ethnic group. Data for each region and each racial/ethnic group were weighted to represent the group's population by age and gender.

Oregon Healthy Teens Survey

Since 2000, the Youth Risk Behavior Survey and the Oregon Public School Drug Use Survey have been combined into a single annual survey, Oregon Healthy Teens. In 2004, approximately 13,503 8th graders from 119 middle schools and 9,247 11th graders from 99 high schools were surveyed.

Youth Risk Behavior Survey

The YRBS was developed by the Centers for Disease Control and Prevention and was administered in a sample of Oregon schools every other year from 1991-2000. The sample size varied between 1,600 and 32,000 and the final data were weighted to more accurately represent the Oregon high school population. The questionnaire assessed behavioral risks among Oregon high school students (grades 9 through 12) in the areas of vehicle safety, weapon carrying and violence, tobacco use, alcohol use, other drug use, sexual activity and pregnancy, HIV knowledge and attitudes, eating behaviors, nutrition, exercise, and access to healthcare including use of school-based health centers. A sample of middle school students (grades 6 through 8) was added in 1997. In 2000, over 7000 students participated in the survey.

Oregon Public School Drug Use Survey

The Oregon Office of Mental Health and Addiction Services (OMHAS) administered this anonymous survey every other year from 1986-2000 through the Oregon public school system. It was patterned after the ongoing national surveys of the National Institute on Drug Abuse and included eighth and eleventh graders since 1986; a sixth grade sample was added in 1994. Schools were randomly sampled using a cluster sample design and in 2000 included over 15,000 students. The questionnaire assessed community characteristics, tobacco use, drug use, alcohol use, drug/alcohol use in student's peer and family network, refusal skills, susceptibility to future use, and attitudes toward school and family.

B. Vital Statistics Data

Birth Certificate Statistical File

Data from the Birth Certificate Statistical File are coded from birth certificates collected by the State Registrar and represent all births occurring in Oregon and all

births occurring out-of-state to Oregon residents. This database includes parental demographic information, conditions of the newborn, congenital anomalies, medical factors of pregnancy, method of delivery, complications of labor and delivery, smoking, drinking, or illicit drug use during pregnancy, antenatal and intrapartum procedures, and payor source. The birth data analyzed for this report consist of births to Oregon residents and exclude missing and unknown values.

Death Certificate Statistical File

The Death Certificate Statistical File includes all deaths occurring in Oregon and deaths occurring out-of-state to Oregon residents. Data are obtained from death certificates that are collected by the State Registrar. The data are used to examine trends in mortality and causes of death. Variables in this database include cause of death, date and place of death, decedent demographic information, whether the death was related to tobacco use, and county, place, and date of injury (if applicable). The mortality data analyzed for this report consist of deaths of Oregon residents.

C. Other

Oregon Department of Revenue Cigarette Tax Receipts

Data on the number of cigarettes smoked by Oregonians are estimated based on tobacco tax revenue collected by the Oregon Department of Revenue. The Department of Revenue's Monthly Receipt Statements include data on cigarette tax collections. The number of packs of cigarettes sold is calculated by dividing the cigarette tax receipts by the tax rate per pack. The number of packs per capita is calculated by dividing the total number of cigarette packs sold by the smoking population estimate for Oregon.

Smoking-Attributable Morbidity, Mortality and Economic Costs (SAMMEC)

SAMMEC is a computer software program developed by the Centers for Disease Control and Prevention to calculate several measures of the impact of cigarette smoking for the entire U.S. and for each state. Using state-specific data on smoking prevalence, overall mortality rates, and population data, SAMMEC generates the number of deaths and death rates due to smoking, years of life lost due to premature death from cigarette smoking, and lost productivity (earnings) due to illness and premature death from smoking-related diseases.

Tobacco Sales to Minors Inspection Reports (Synar)

In July 1992, Congress enacted the Alcohol, Drug Abuse and Mental Health Administration Act, which includes an amendment aimed at decreasing access to tobacco products among youth under 18. Named for its sponsor, Congressman Mike Synar, the regulation requires states to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing products to individuals under 18. In addition, the regulation requires that each state annually conduct random, unannounced inspections of a sample of tobacco vendors to assess their compliance with state law.

Oregon has conducted these inspections annually since 1994. The sample size has ranges from 352 in 1995 to 860 in 2004. Oregon Liquor Control Commission lists are used as a sampling frame after exclusion of certain classes of licensees that customarily do not sell tobacco products. Retired state police accompanied by a teen "buyer" conduct the inspections. Purchase attempts are recorded in a database which includes the following variables: county, region, inspection data, type of business, type of access to tobacco product, type of purchase attempted, whether age and/or ID was requested, results, whether illegal vending machine was present, whether signs are posted for minimum age requirements, and whether single cigarettes are available.

For more information, contact:

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