# Voluntary Policy Adoption among Faith-based Organizations in South Los Angeles County: *Final Evaluation Report*

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***Submitted to:***


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## Abstract

The primary objective of WHCC's South LA Community Tobacco Control Program for the 2 year period beginning 7/01/2013 was: "By June 30, 2015, at least 12 African American and Latino faith-based community organizations or churches will adopt and implement a policy that prohibits or restricts smoking on their grounds and at events." This objective addressed priority area (2): Reduce Exposure to SHS, and Communities of Excellence Indicator # 2.2.20, "The number of faith community organizations (e.g., churches, synagogues, mosques, and temples) with a policy that regulates smoking on their grounds and at events."

Churches and faith-based-organizations (FBOs) are key community institutions in the African American and Latino-Hispanic populations in Service Planning Area (SPA) 6 in South LA County; the area served by this project. SPA 6 is an urban corridor with a greater population than any one of seven states. The population is 96% minority (67.7% Latino/ Hispanic and 28.5% African-American) and includes the highest proportion of households (31.1%) among LA County SPAs at less than 100% of the fed poverty level. SPA 6 has some of the poorest health indicators in Southern California, including disproportionately high rates of smoking (25%) among African Americans and 19.3% of households including children 0-17 who are regularly exposed to SHS at home. High levels of urban air pollution from surrounding freeways and the Port of LA interact with SHS to compound health risks.

The intervention sought to capitalize upon the activism of African American and Latino churches to reduce health disparities between people of color & whites. It consisted of community outreach and education activities focusing upon pastors and FBO community leaders at their churches and facilities. Coordination and collaboration activities helped to tailor educational materials and policy-related signage for the target settings. Although youth involvement was initially viewed as a strong asset, because the pastor alone frequently had sole decision-making authority, the deployment of youth to promote the adoption of policies restricting smoking should be viewed as optional.

A non-experimental, multiple measures evaluation design was employed to assess outcome attainment. Structured observational checklists were developed, extensively field tested and revised to record the presence and salience of policy-related signage (implementation) and compliance (persons observed smoking, presence of tobacco-related litter, and ashtrays) at FBOs that adopted policies to prohibit smoking on their premises. Trainings were conducted to support the collection of valid and reliable observational data at baseline (near the point of policy adoption) and at follow-ups occurring at seven month intervals. Aerial view Google maps depicting building footprints and lots were used to label doorways, vents and operable windows to maintain consistency across observations over time.

Process evaluation consisted of focused group discussions with pastors, and participant/ education surveys conducted to evaluate data collection trainings and seminars conducted to educate youth advocates. A questionnaire was administered to140 congregation members to better understand their perceptions regarding voluntary policies and their own experience with

SHS. Question wording to gauge support for policies restricting smoking in outdoor areas requires further study. Here, “general” policies received far less support than policies specifically aligned with “your church.”

A technical sample selection approach gave way to networking through established relationships and cold calling “likely prospects.” This resulted in a sample of convenience.

WHCC's primary objective was met. 13 policies were voluntarily adopted and observational results indicated moderate to highly successful implementation and compliance over time. No more tobacco-related litter was observed around doorways opening to public streets and sidewalks at post-policy adoption compliance checks than those opening on to private property.

Just three of 13 policies were adopted by churches with Latino/Hispanic congregations. To penetrate evangelical Latino churches, pastoral resistance to the formal adoption of tobacco control policies must be better understood and creatively addressed.

Subsequent interventions to encourage policy adoption in faith-based organizations should align with the existing activism in Black and Latino churches to reduce health disparities. The disproportionate rate of tobacco use and exposure to second-hand smoke among African Americans in Los Angeles and the interaction of tobacco smoke with high levels of urban air pollution are risk factors that can be better controlled through change in key community institutions like faith-based organizations.

## Project Description

The goal of CTCP's social norm change approach to tobacco control is to influence current and potential future tobacco users by creating an environment in which tobacco becomes less desirable, less acceptable, and less accessible. The environmental prevention approach presumes that the ideas, values, and behaviors of individuals are moderated by their community. Following this theory, change occurs through shifts in local social norms ranging from unspoken rules of etiquette to local policies to municipal, county and state laws. The South Los Angeles Community Tobacco Control Program implemented by Watts Healthcare Corporation (WHCC) sought to change social norms by encouraging the adoption and implementation of policies that limit exposure to second-hand smoke in key community institutions such as faith-based organizations. We hypothesized that establishing these policies and advertising them in the community would begin to change social norms in the institutions central to African American and Latino-Hispanic community life.

### *Background*


Because of its size (4,300 square miles), as illustrated at left, the Department of Public Health partitioned Los Angeles County into eight geographic regions referred to as Service Planning Areas (SPAs). Watts Healthcare Corporation (WHCC) is located in South Central Los Angeles (Service Planning Area 6) which includes the cities and communities of Athens, Compton, Crenshaw, Florence, Hyde Park, Lynwood, Paramount, and Watts. The population of SPA 6 in 2013 was estimated to be 1,009,550; greater than the individual populations of Montana, Delaware, both Dakotas, Alaska, Vermont, the District of Columbia and Wyoming.[1] This population is 96% minority (67.7% Latino/ Hispanic and 28.5% African-American) and includes the highest

[1] http://www.census.gov/compendia/statab/cats/population.html United States Census Bureau, The 2012 Statistical Abstract, Estimates and Projections—States, Metropolitan Areas and Cities. Cited in: Key Indicators of Health by Service Planning Area. Los Angeles County Depaartment of Public Health, March 2013.

proportion of households (31.1%) among Los Angeles County SPAs at less than 100% of the federal poverty level.[2]

Service Planning Area (SPA) 6 in Los Angeles County has some of the poorest health indicators in Southern California. The Los Angeles County Department of Public Health reports that 13.3% of adults smoke cigarettes in SPA 6, however disparities in smoking rates persist in Los Angeles County. A higher proportion (25%) of African Americans smoke than adults in other racial ethnic groups (15% among Whites, 12% among Latino/ Hispanics and 11% of Asian/ Pacific Islanders).[3] The lung cancer death rate (age adjusted per 100,000 population is 39.9; the second highest among the eight SPAs in LA county. Almost one in five (19.3%) households includes children ages 0-17 years of age who are regularly exposed to tobacco smoke at home[4]. The WHCC medical staff sees many patients with asthma and other respiratory diseases.

Racial and ethnic health disparities are now common topics in national debates about health care and civil rights. Health disparities have been demonstrated in chronic and infectious diseases and in maternal and child health. Disparities are particularly well documented for cardiovascular disease. African Americans have the highest lung cancer incidence and mortality rates (72 new cases per 100,000 in 2006) in California. The risk of developing coronary heart disease is two to four times greater among cigarette smokers than among nonsmokers. Exposure to other people's smoke increases the risk of heart disease even for nonsmokers.

The South Los Angeles Health Equity Scorecard report produced by the Community Health Councils, Inc. in December, 2008 summarized these circumstances as follows:

> The area known as South Los Angeles has become an icon for the plight and struggle of the inner city. …South Los Angeles encapsulates the health consequences resulting from the disturbing inequality in the distribution of power, income, goods, and services in Los Angeles County. Options and opportunities for healthy choices are constrained by fewer and often inferior basic healthcare and physical resources. …The social and economic impact is a population with the highest overall rates of disease and premature deaths in the county from such preventable conditions as coronary heart disease, homicide, diabetes, lung cancer, and motor vehicle crashes. More than any other region of the county, South LA is disproportionately disadvantaged and harmed by inequities in the healthcare and physical resource environments.

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[2] July 1, 2011 Population and Poverty Estimates, prepared for Urban Research, Los Angeles County ISD, Released 10/15/2012.

[3] Los Angeles County DPH, Office of Health Assessment and Epidemiology, Cigarette Smoking in LA County: Local Data to Inform Tobacco Policy. A Cities and Communities Health Report, June, 2010.

[4] 2011 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, LADPH. Estimates are based on self-reported data by a random sample of 8,036 adults and 6.013 parents/ guardians/primary caretakers of children, representative of the population in Los Angeles County.

These critical facts alone underscore the need for interventions in the African-American and Latino-Hispanic communities of South Los Angeles, but the importance of tobacco control in SPA 6 is elevated by another factor: urban air pollution. Funded by the National Institute of Environmental Sciences, researchers at the University of Southern California's Keck School of Medicine studied air pollution levels in ten Southern California cities, and found that, "the closer children live to a freeway, the greater their chances of being diagnosed with asthma." The researchers also found that children who had higher levels of nitrogen dioxide in the air around their homes were more likely to develop asthma symptoms. Nitrogen dioxide is one of many pollutants emitted from the tailpipes of motor vehicles."[5]

Located inside a rectangle bordered by four of the busiest freeways in Southern California (the 5 Santa Monica/ Santa Ana Freeway on the north, the 710 Long Beach Freeway on the west, the 105 Century Freeway on the south, and the 110 Harbor Freeway on the east) and just a few miles away from the Alameda belt (a major thoroughfare for commercial trucks transporting goods from the Port of Los Angeles) Watts Healthcare Corporation and the community it serves are heavily exposed to mobile sources of emissions, which cause most of the air pollution in the South Coast Region.

An interaction between the ultra-fine particulates and airborne toxins generated by traffic and exposure to second hand tobacco smoke (SHS) has been demonstrated to potentiate and/ or exacerbate asthma and other forms of respiratory disease in addition to adversely affecting fetal development[6]. Reductions in birth weight and head circumference among infants prenatally exposed to both SHS and urban air pollution were greater than those exposed to air pollution alone. Lower birth weight and a smaller head circumference have been linked in previous studies to later problems in learning and poorer school performance. In this context, policies promoting protection from SHS are extremely important in SPA 6, as a means of changing social norms in the intermediate and long term and as a critical contribution to protecting children and adults in the short term.

### *Objective*

The primary objective of Watts Healthcare Corporation's South Los Angeles Community Tobacco Control Program for the two-year renewal beginning July 1, 2013 was:

[5] See: http://www.niehs.nih.gov/health/docs/asthma-triggers.pdf

[6] Perera FP, Rauh V, Whyatt RM, et al. Molecular evidence of an interaction between prenatal environmental exposures and birth outcomes in a multiethnic population. Environ Health Perspect. Apr 2004; 112(5): 626-630.

> By June 30, 2015, at least 12 African American and Latino faith-based community organizations or churches will adopt and implement a policy that prohibits or restricts smoking on their grounds and at events.

This primary objective addressed priority area (2): Reduce Exposure to SHS, and Communities of Excellence Indicator # 2.2.20, "The number of faith community organizations (e.g., churches, synagogues, mosques, and temples) with a policy that regulates smoking on their grounds and at events."

### *Rationale for Selecting this Objective*

This objective was chosen by staff of Watts Healthcare Corporation and their community advisors to capitalize upon the central role of churches and faith-based organizations in the African American and Latino/ Hispanic populations of SPA 6. As indicated by this excerpt from an article published by the New York Times on October 30, 1860[7], churches in America have a long history of admonishing against the use of tobacco:

> "To detect the secret antagonism that exists between the eternal principles of Christianity and the evanescent smoke that curls from the good man's pipe, might puzzle an Oriental mystagogue or confound the metaphysics of AQUINAS himself. But it has been discovered in our own epoch, and is now authoritatively announced, in this, the fourth year of BUCHANAN, by the General Conference of the M.E. Church of the State of Ohio. The faith of the Ohio Church and the fumes of the Virginia weed are authentically proclaimed to be mutually destructive. … At the session of the Conference held in Gallipolis a few weeks ago, the following action was taken upon this subject:
>
> Whereas, The use of tobacco is a great evil, and leads to other evils, therefore,
>
> Resolved, By the Ohio Conference, that after the present session we will not receive any person into full communion who persists in the use of tobacco."

The "fourth year of Buchanan" refers to the Presidential term of James Buchanan, from 1857 to 1861. Clearly contemptuous of the idea that the prohibition of tobacco has a moral basis, the author characterizes this ban as an, "absurd and preposterous resolution." He goes on to tout the health and economic benefits of tobacco use in a manner that likely represented the popular point of view at that time.

Both public knowledge regarding the actual effects of tobacco use and the number and role of minority churches have evolved remarkably in the past 155 years. By 1984, the importance of the Black church had been documented in four areas of community medicine: primary care

[7] See: http://timesmachine.nytimes.com/timesmachine/1860/10/30/issue.html

delivery, community mental health, health promotion and disease prevention, and health policy[8]. While certain biblical passages are construed to discourage tobacco use, for example, the passage in First Corinthians referencing the body as the temple of the Lord, the health promotion activities of the African American Church are also a pragmatic response to historic inequality and health disparities in the United States.

In *Cross Currents*, a publication of the Association for Religion and Intellectual Life, the authors observe:[9]

> The historical uniqueness of the Black Church has been its primary focus on the social, political, cultural, and religious well-being of its parishioners. From the days of religious gatherings on hilltops, cotton fields, and barns to revivals in open fields or abandoned shacks to worship services in modern, stately buildings, the Black Church has been a place of worship, teaching and learning, and a place to gather in order to seek refuge from the turbulent times. To that end, the Black Church has assumed many roles in the African American community. It has been described as an epicenter for artistic and leadership development, and politics, a social club, and a cultural and health center.
>
> The Black Church has strong roots in African traditions that naturally link religion and medicine in a very holistic manner. Hence, our natural inclination to improve conditions for people may be partially inherited from African spirituality. This natural tendency was reinforced by the Great Awakening emphasis on sanctification as improving people and society. In the 19th century, anti-slavery and temperance efforts were merged in the Black Church and congregations were given a thorough education against tobacco use, the over indulgence of alcoholic beverages, along with other activities that could adversely affect them.
>
> The Black Church stands in a unique position to serve as an advocate for eradicating health disparities among African Americans by continuing to show how important health education and health promotion are to the African American community and through the exercise of its "prophetic" role to challenge the norms and standards of the larger society to create an equal healthcare system.

One of the most active proponents of the role of the African American church in recent years has been the National Black Church Initiative (NBCI); a coalition of 34,000 African-American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment**.**

[8] Levin JS. The role of the black church in community medicine. J Natl Med Assoc. 1984;76:477–483.
[9] Isaac, E. Paulette, Rowland, Michael L. and Blackwell, Lewis E. Fighting health disparities: the educational role of the African American church. Cross Currents, 57: 2, June 22, 2007.

NBCI issued a "Health Emergency Declaration" in 2010, espousing seven core values: 1) Know your body, 2) Visit the doctor, 3) Increase your fruit and vegetable intake by 150%, 4) Increase your physical activity by 150%, 5) Get enough sleep (8 hours), 6) Take "mental breaks" to reduce stress, and 7) *Quit smoking or do not start smoking*[10].

Interim findings from the three-year investigation, "Hispanic Churches in American Public Life" (HCAPL), funded by the Pew Charitable Trusts, offer some counterintuitive insights about Hispanic Christians' political opinions and activities. And the Hudson Institute's Faith in Communities initiative, with support from the W.K. Kellogg Foundation, has conducted a year-long study revealing much about the community-serving activities of Hispanic Protestant churches. A 2004 survey found that the percentage of Hispanic congregations reporting engagement in social services appeared similar to that of African American churches involved in community outreach.[11] With the large proportion of Latino/Hispanic and African American families in SPA 6, Watts Healthcare Corporation staff and their community advisors selected this objective with these facts in mind.

### *Intervention Activities*

Staff of Watts Healthcare Corporation's South Los Angeles Community Tobacco Control Program sought to promote and support the voluntary adoption and implementation of policies designed to prohibit or restrict smoking on the premises of faith-based facilities by implementing the following strategies:

Coordination /Collaboration Activities: These activities remained important during the two year renewal project which is the focus of this report. Staff coordinated with Change Lab Solutions, AATCLC (African American Tobacco Control Leadership Council) and other agencies with expertise on smoke-free policies for faith-based organizations. They perused the CTCP Secondhand smoke (SHS) website on Partners for additional resources and then began to Identify and contact pastors and faith-based organization leaders to discuss the advantages of having a smoke-free facility for church members and visitors. Staff also recruited and trained youth from local South Los Angeles faith-based organizations, schools, and recreation centers to be a part of a youth tobacco free coalition.

Community Education Activities: With this coordination and collaboration background, community outreach and education activities began in earnest. Staff met with pastors and

[10] See: http://www.naltblackchurch.com/health/

[11] Good News from the Hispanic Church: The Community-Serving Activities of Hispanic Protestant Churches by Amy Sherman. See: http://www.centeronfic.org/v2/equip/publications/articles/good_news_churches1.htm

faith-based community leaders to provide educational presentations about the health effects of SHS, the need for smoke-free policies to reduce exposure to SHS, and to discuss model policies and enforcement procedures.

Education Materials Development: Activities in this category enabled intervention staff to articulate the science behind the pitch. Intervention staff worked with the Tobacco Education and Materials Lab (TEAM Lab), ChangeLab Solutions, the Local Lead Agency (LLA), and The Center for Tobacco Policy and Organizing (The Center) to develop a faith-based fact sheet focusing on health effects of secondhand smoke (SHS) exposure which was widely distributed. They also procured "No Smoking" signs to be posted near doorways at faith-based organizations adopting and implementing a policy.

Behavior Modification Materials: Gift cards and movie tickets reinforced behaviors exhibited by the youth and community residents who helped establish the smoke-free policies at faith-based organizations.

Policy Activities: Intervention staff checked with The Center, ChangeLab Solutions, and other CTCP appropriate agencies for examples of model smoke-free policies that could be shared with interested faith-based organizations facilitated smoking prevention and cessation presentations at interested faith-based organizations.

Training/ Technical Assistance Activities: Key to the success of this project, intervention staff remained in contact with the faith-based organizations that adopted policies, providing technical assistance throughout the 2 year contract to support policy implementation and enforcement.

## Evaluation Methods

### *Outcome Evaluation Design*

The evaluation design was non-experimental. Outcome data collection consisted of an on-site baseline measure conducted before policy implementation and structured compliance check observations administered about every seven months following policy adoption. Data collection training was conducted to establish inter-rater reliability. Twenty foot lengths of twine weighted at each end were used to standardize the distance from vents, operable windows and entryways. These would have been useful during measurement at organizations that adopted doorway smoking bans. Collaboration between the evaluator and intervention staff on pilot tests led to multiple revisions culminating in the confirmation of a final Faith-based Organization (FBO) Observational Checklist.

The FBO Observational Checklist assessed the presence and salience of signage prohibiting or restricting smoking, the presence of smokers, ashtrays, and the amount of tobacco-related litter found on the premises (Smoke Free policies) or within 20 feet of the primary and secondary entryway doors, and operable windows, vents or other openings. Because Faith-based Organization facilities in South Los Angeles County are primarily located in urban settings, an item was included to indicate whether doors opened directly onto a public street or sidewalk. Google map aerial views of the facility were attached to the observational checklist whenever possible to diagram entryways, operable windows and vents, assuring continuity between baseline and follow-up observations at each site.

### *Evaluation Questions*

The primary outcome evaluation questions were:

- Was the policy adoption objective accomplished?
- Were the policies implemented as indicated by the presence and salience of "No Smoking signs?
- What was the level of compliance with the policy, as indicated by the presence of tobacco-related litter, persons observed smoking and ashtrays on the premises of faith-based organizations?

### *Process Evaluation Design*

Process evaluation activities were conducted to complement the outcome evaluation:

**Data Collection Training** was conducted to build skills among program staff to collect valid and reliable data using interviewing techniques and observational checklists.

**Focused Group Discussions** were conducted with church and faith-based organization leaders to document the attitudes and opinions of the persons making decisions about voluntary policy adoption and to identify barriers/ obstacles and the factors and resources that facilitated policy implementation and compliance.

**An Education/ Participant Survey** was administered to assess youth satisfaction, knowledge gain, and perceived preparation to support the issue of smoke-free policies in churches/ faith based organizations.

**A Public Opinion Poll** was conducted to assess congregants' perceptions and attitudes toward SHS and policies of various types that might be adopted to restrict it.

**A Policy Tracking Database** was maintained by the evaluator to verify voluntary policy adoptions among faith-based organizations.

### *Outcome Data Collection: Sampling, Instrument, Data Collection and Analysis*

Data were collected at the sites of churches and faith-based organizations located in nine Zip Code areas distributed throughout Service Planning Area 6 in the cities of Los Angeles and Compton. The samples, data collection procedures and data analytic strategies for each evaluation activity are described in detail below. All instruments described here may be reviewed in Appendix A.

**Sample Selection—**Quantitative outcome assessment began by enumerating the churches and faith-based organizations in LA County's Service Planning Area 6. "Crosswalk" tables listing the Zip Code areas and Census Tracts in SPA 6 were obtained from a GIS specialist to facilitate preparation of the sample frame. A detailed listing of about one third (*n*= 811) of the faith-based organizations (NAICS code 813110/ SIC code 8661—Religious Organizations) randomly selected from all organizations of this type located in the designated Census Tracts comprising SPA 6 was purchased from Dun and Bradstreet.

The plan was to randomly select potential faith-based organizations from this list and to pre-screen these organizations to confirm that they did not have an existing policy restricting smoking on their premises at baseline. This soon gave way to a process of networking mixed with cold calls to "likely prospects" identified by the intervention staff. This was a deliberately selected sample of convenience.

**Observational Checklist—** A preliminary structured observation checklist was developed by the evaluator with input from the Tobacco Control Evaluation Center (TCEC) and repeatedly pilot-tested and revised prior to full-scale use. The structured observational checklist included 85 data elements including initial information about the faith-based organization, its location and type of policy, followed by a repeating series of items soliciting information about cigarettes and tobacco-related litter, ash trays or ash cans, the number of persons observed smoking, whether policy-related signage was posted within 20 feet of each entryway, operable window or vent and if so, a rating of signage visibility.

After pilot-testing the observational form, the item, “Does this door/window/vent open directly onto a public sidewalk or street?” was added to each series of questions to support comparison of these locations to similar locations at the same site that opened onto private property. The identical checklist was used to structure baseline and follow-up observations.

**Data Collection—**To assess implementation and compliance with the voluntary policies adopted by faith-based organizations to restrict smoking, detailed observations of persons smoking, the presence of ashtrays, tobacco-related litter and the presence and salience of policy-related signage near doorways, operable windows and vents were conducted just before, or on the day of policy adoption. Multiple post-adoption follow-up observations were planned after this baseline at intervals of approximately seven months. The initial data collection plan specified that observations were to be conducted at the same time as church services, during which congregants were most likely to be on the premises. Because of difficulty assigning staff to work on Sundays, however, most observations were conducted early in the week during business hours.

Observations were completed by project staff working in teams, who were instructed to append to each observational checklist an aerial view Google Map depicting the building footprint and indicating the position of primary and secondary entryways and all operable windows and building vents. Marking these elements on the building footprint map permitted the comparison of measures related to specific facility doors, operable windows and vents between baseline and the follow-up compliance checks.

**Data Analysis—**Completed observations were provided to the evaluator, who entered them into a database developed to support analyses. Counts of persons smoking and pieces of tobacco-related litter were recorded as continuous variables and the presence of ash trays and signage were recorded as dichotomous “yes/no” variables. The salience of signage was noted on a categorical scale as: 3= Very Visible 2= Somewhat visible 1= Not visible. Open-ended comments and description on the observational forms were transcribed verbatim into the database. Simple descriptive statistics were calculated to assess policy implementation and compliance at baseline and to perform comparisons at follow-up. Paired-samples T-Tests and Analyses of Variance were computed to assess mean differences on the continuous measures and a Chi Squared statistic was computed to assess the significance of differences between categorical measures. With a sample size of 12, however, it was understood that differences were unlikely to achieve the threshold for statistical significance.

### *Process Data Collection: Sampling, Instrument, Data Collection and Analysis*

### *Data Collection Training*

The evaluator provided data collection training to intervention staff that assisted with evaluation activities. This training included extensive use of the observational checklist in the field until a high degree of inter-rater reliability with regard to data input and to the ability to accurately "pace off" a distance of 20 feet was demonstrated. The data collection training also provided an overview of the environmental prevention approach to tobacco control and acquainted staff with structured CTCP approach to evaluation.

### *Focused Group Discussions*

Participants included Pastors, lay leaders and members of the ministry and staff of African-American and Latino/ Hispanic churches and faith-based organizations. Topics for discussion were written to elicit conversation regarding theology, and local pastoral direction regarding tobacco use. To inform intervention activities, barriers to policy adoption and the support required to overcome these obstacles as well as the factors that facilitate policy adoption were discussed, as was the broader community response to policies restricting smoking. Audio-recorded discussions were transcribed and content analyzed to extract themes which were summarized in qualitative reports.

### *Education/ Participant Survey*

Fifteen youth recruited and trained by intervention staff were administered a youth training assessment questionnaire adapted from a well-tested California Youth Advocacy Network instrument. Items assessed youth satisfaction, knowledge gain, and perceived preparation to support the issue of smoke-free policies in churches/ faith-based organizations. Descriptive statistics were computed to analyze fixed-response items, and open-ended items were content-analyzed to characterize youth responses to the training.

### *Public Opinion Poll*

Administered to convenience samples totaling 135 members of congregations in SPA 6, the survey instrument consisted of 31 fixed response, short-answer and open ended items designed to gauge respondent knowledge of the health effects of exposure to second-hand smoke, attitudes toward various types of policies formulated to prohibit or restrict smoking and the locations in which it would be appropriate to implement such policies, personal exposure to

second-hand smoke, smoking history, smoking rules or restrictions in respondents' households, if any, and demographic descriptors. Descriptive statistics were computed to analyze fixed-response items, and open-ended items were content-analyzed to characterize youth responses to the training.

### *Policy Tracking Database*

This spreadsheet, verified by the evaluator, includes the faith-based organization name, street address, policy description, policy adoption date, baseline observation Date (T1), date of the first compliance check (T2), date of the second compliance check (T3) and dates of any subsequent compliance checks.

## Evaluation Results

### *Adoption and Implementation of Voluntary Smoking Restriction Policies (Outcome Data)*

Between July 22, 2013 and January 16, 2015 thirteen "smoke-free facility" policies prohibiting smoking anywhere on organization premises were voluntarily adopted by faith-based organizations (all 13 were churches) located in Service Planning Area 6. The policy tracking database indicates that the first step of the primary objective, that "By June 30, 2015, at least 12 African American and Latino faith-based community organizations or churches will adopt and implement a policy that prohibits or restricts smoking on their grounds and at events" was achieved.

To assess policy implementation and compliance, 12 first compliance checks (T2), eight second compliance checks (T3) and two third compliance checks (T4) were completed. All 13 faith-based organizations had a primary entryway door and 12 had non-emergency secondary entryways. Series of architecturally clustered windows are considered together as one location at some facilities.

Table 1 shows that at baseline, between zero and 18 cigarette butts and pieces of tobacco-related litter were observed at 13 faith-based facilities totaling 88 pieces of tobacco-related trash, for an average of 6.77 pieces of litter per site. This number diminished at each of the 12 facilities at T2 (first compliance check), for a total of 28 pieces, about one third of the baseline count. A matched-pairs T-Test of the diminishing counts of tobacco related litter at the 12 facilities between baseline ($M$= 6.77 pieces) and T2 ($M$= 2.33) is statistically significant, $t$ (11)=4.151, $p$=.002.

The tobacco-related litter count rose at three facilities and diminished further at five of the eight faith-based organizational facilities observed at T3 (second compliance check), resulting in a slight increase in the average from 2.33 to 2.5 pieces of litter per site. The slight increase in the mean count of tobacco-related litter between T2 (*M*= 2.33 pieces) and T3 (*M*= 2.5) fails to attain the threshold for statistical significance, *t* (7)=0.568, *p*=.588.

Considering *just the eight sites measured at all three points in time*, the overall count of tobacco-related litter diminished from 69 pieces at baseline (*M*= 8.63 pieces per facility) to 25 at the first compliance check (*M*= 3.13), to 20 at the second compliance check (*M*= 2.5 pieces of tobacco-related litter). Viewed in this manner, these data suggest that the policies had a very positive effect.

**Table 1. Summary of Baseline (B), First Compliance Check (T2), and Second Compliance Check (T3) Observations at Faith-Based Organizations Voluntarily Adopting Smoking Policies**

| Site | Litter | | | Ash Trays | | | Smokers | | | Signs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | B | T2 | T3 | B | T2 | T3 | B | T2 | T3 | B | T2 | T3 |
| Faith in Christ Ministries | 18 | 9 | 12 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 2 |
| Greater Westside Missionary Baptist | 15 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Liberty Baptist Church | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Igesia De Dios Septimo Dia | 6 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Iglesia De Restauracion | 6 | 5 | 3 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 2 |
| Bryant Temple Church | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 4 | 4 |
| Miracle Missionary Baptist Church | 8 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 3 |
| Macedonia Baptist Church | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 3 |
| Mision Cristo Rey | 0 | 0 | . | 0 | 0 | . | 0 | 0 | . | 0 | 3 | . |
| Bethesda Missionary Baptist Church | 10 | 2 | . | 0 | 0 | . | 0 | 0 | . | 0 | 1 | |
| Blance is Our Goal Misistries | 0 | 1 | . | 0 | 0 | . | 0 | 0 | . | 0 | 1 | . |
| Village Missionary Baptist | 4 | 0 | . | 0 | 1 | . | 0 | 1 | . | 0 | 2 | . |
| Beulah Baptist Church | 5 | . | . | 0 | . | . | 0 | . | . | 2 | . | . |
| **Total** | 88 | 28 | 20 | 0 | 1 | 1 | 1 | 1 | 1 | 2 | 25 | 14 |
| **Average per Site** | 6.77 | 2.3 | 2.5 | 0.0 | .08 | .125 | .077 | .077 | .125 | .15 | 2.1 | 1.75 |

"." Indicates that an observation was not completed.

There was generally more tobacco-related litter on the premises of faith-based organizations with doorways that opened directly onto public streets or sidewalks than was observed at

facilities with doorways that opened on to private property. Because of the small number of cases in the procedure, however, analyses of variance (ANOVAs) performed to test the statistical significance of post-policy adoption differences by doorway type did not achieve the threshold for statistical significance. For example, at baseline (T1), more litter was observed at the eight facilities with doorways that opened onto public streets and sidewalks (*M*= 8.875 pieces) than at the five facilities with doorways opening onto private property (*M*= 3.4 pieces); *F* (1,11)= 3.962, *p* = .072.

The difference between doorway types reversed at the first compliance check (T2). These observations showed an average of 2.25 pieces of tobacco-related litter on the premises of the eight facilities with doors that opened onto public sidewalks or streets, compared to an average of 2.5 pieces per facility at the four faith-based organizations with doors opening onto their property. There were too few cases at the second compliance check (T3) to make an inference, however the six faith-based organizations with doorways opening onto public streets or sidewalks and the two facilities with doorways opening to private property had the same average number of pieces of litter (*M*= 2.5 per facility). The fact that there is not more tobacco-related litter at facilities with doorways opening to public streets after policy implementation suggests that this common circumstance in urban settings is not detract from the ability to enforce a voluntarily-adopted policy.

Table 1 also shows that no ashtrays were observed on the grounds of faith-based facilities at baseline, however one at the first compliance check and another ashtray at a separate organization was observed at the second compliance check (T3). The number of persons observed smoking on these premises remained at one per facility at each measurement, and because the number of faith-based organizations observed at baseline (N= 13), T2 (N= 12) and T3 (N= 8) diminished, the arithmetic average of smokers per facility increased from 0.077 to 0.125 to 0.15 per facility.

The number of "No Smoking" signs rose steadily from just two at one of the 13 faith-based organization facilities at baseline to 25 signs with one or more posted at each of the 12 facilities observed at the first compliance check (T2). This increase is statistically significant, *t* (11)= -7.244, *p*< .001. Between the first (T2) and second (T3) compliance checks, the number of signs remained the same at three faith-based organizations, increased at two, and diminished at three sites. All "No Smoking" signs were rated as "highly visible." Given that policy implementation depends in large measure upon multiple, salient "No Smoking" signs, this result is extremely positive. That the number off signs provided by project staff decreased between the first and second compliance checks at three sites is not good however. Intervention staff always offered to replace missing signs, and when they were not accepted, it

was due to the aesthetic preferences of the pastor or site manager, not to a lack of support for the policy.

## Process Evaluation Results

### *Summary of the Data Collection Training Evaluation*

A two-part training was developed to increase knowledge among intervention staff at Watts Healthcare, Inc. regarding environmental prevention and the CTCP approach to evaluation. Part two of the training focused on collecting valid and reliable data using observational surveys. Staff feedback indicated appreciation for the "big picture" explanation of environmental prevention and the structured CTCP approach to evaluation. Analysis of subsequent observational checklists prepared by staff indicated the importance of continued monitoring and review meetings in which the evaluator collaborated with staff to improve measurement quality and standardization. By the second year of the contract period, missing data were rare.

### *Summary of the Focused Group Discussions*

A total of 14 pastors attended one of three focused group discussions conducted at a meeting room in a faith-based facility or a conference room at Watts Healthcare, Inc. Most participants were comfortable with an indirect connection between theology and abstention from smoking, for example:

> "In the faith-based community, we recognize that our bodies are a temple of God and he takes up residence within us and so we would not want to have anything to have a mastery type of a position over us."

Each of the pastors exhibited a passion for promoting the health and general welfare of his congregation. Clearly, pastors in South Los Angeles County are very willing to be conduits for the message that smoking and exposure to SHS is contrary to good health. The participating pastors' philosophy was to spread the message widely, understanding that not everyone will take it to heart, but that many will be reached and will support smoke-free policy adoption. Pastors unanimously agreed that congregants would respect whatever policy may be adopted with regard to smoking.

> "It's a biblical respect issue. When you come to learn the Word of God one of the first things you learn is to respect the grounds of the church and respect the people of the church."

Appeals to protect family members and especially children were mentioned in this context. Youth involvement is viewed as a strong asset to the program.

The issue of implementing policies using signage remains a problem in Latino/ Hispanic churches. Pastors working with these congregations suggest that paving the way by educating their congregations and reminding them of the forthcoming policy and "No Smoking" signage repeatedly before the signs are posted may mitigate negative responses. Some African-American Pastors also believe that "No Smoking" signage is either inappropriate or unnecessary:

> "And so where you would normally have signs in a public facility, the members of the congregation are the signs. …they will say, "That's not allowed here," or "We don't do that here, we'd appreciate it if you didn't do that here." And so they will ask the person ' If you must do it, then go out to the sidewalk or down the street or whatever'."

This assessment was generally supported by the outcome data showing that signage at policy-adopting faith-based organizations increased dramatically between the pre-adoption observation and first compliance check, but then diminished at several facilities after that point. The removal of signage does not necessarily convey disinterest in, or a lack of compliance with the policy.

### *Summary of the Education/ Participant Survey*

This training was conducted to increase the knowledge and skills of youth, and to recruit, engage and retain them in the campaign to persuade faith-based organizations to voluntarily adopt tobacco control policies. Mean ratings on knowledge gains and perceived preparation to talk to others about the training topic suggest that it was successful.

Respondents rated the attributes of their training experience on a four-point scale where 1 = "Strongly Disagree," 2= "Disagree," 3 = "Agree," and 4 = "Strongly Agree." Tables 1 and 2 present mean scores for each of these attributes. Higher means indicate higher rates of agreement with each positively-worded statement.

Table 1. Q1 through Q5 Quantitative Item Means

| Item | | |
|---|---|---|
| **Q1. The purpose of the training was made clear.** | N | 15 |
| | Mean | 3.67 |
| **Q2. The training was well-organized.** | N | 15 |
| | Mean | 3.80 |
| **Q3. The PowerPoint presentation was very good.** | N | 13 |
| | Mean | 3.69 |
| **Q4. The speakers were knowledgeable.** | N | 15 |
| | Mean | 3.67 |
| **Q5. The speakers held my interest.** | N | 14 |
| | Mean | 3.43 |

There were no significant differences on any attribute of the training or the speakers by gender, race-ethnicity or age of the young participants. These means reflect very good ratings, ranging from just less than half-way between "Agree" and "Strongly agree" up to two tenths a point below the highest response alternative (4= Strongly agree).

Table 2 presents the mean rating of knowledge gain, expressed by agreement on a four-point scale with a positively-worded statement, "I know a lot more now about the health effects of exposure to second hand smoke." Preparation is assessed by responses to the statement, "I am now prepared to talk to others about the dangers of smoking and second hand smoke."

Table 2. Mean Knowledge Gain and Perceived Preparation to Talk to Others about the Dangers of Smoking and Second Hand Smoke

| Item Text | | |
|---|---|---|
| I know a lot more now about the health effects of exposure to second hand smoke. | N | 14 |
| | Mean | 3.79 |
| I am now prepared to talk to others about the dangers of smoking and second hand smoke | N | 15 |
| | Mean | 3.53 |

On a scale from 1="Strongly Disagree" to 4= "Strongly Agree," these mean responses suggest that the purpose of the training was achieved. Again, there were no differences in mean knowledge gain by gender, race-ethnicity or age, nor are there any significant differences in

perceived preparation to talk to others about the dangers of tobacco use and second hand smoke.

### *Summary of the Public Opinion Poll*

Congregants completing the faith-based organization survey ranged from 15 to 64 years of age and were racially and ethnically diverse. Half (*n*=61, 50.0%) were African American, about one quarter (26.2%) were White, 18 (14.8%) were Latino-Hispanic, and 11 (9.0%) self-identified as Asian or Pacific Islander.

Support for policies that limit or prohibit smoking is positively, although not significantly correlated with tobacco knowledge (*r*=.335). There are no differences in the distribution of policy support score by gender, age group, race/ ethnicity, employment status or educational attainment.

More than one in three (36.4%) survey respondents report they are frequently exposed to second-hand smoke, either at home, work or another location. More than 9 of 10 respondents in this survey sample also report rules completely prohibiting smoking at home. In comparison, 78.4% of Californians report having a smoke-free home[12]. Large proportions of respondents reported asking someone not to smoke in the past twelve months (88.6%) and find exposure to other people's smoke either very annoying (32.3%) or extremely annoying (56.5%).

In spite of the reported annoyance resulting from other people's smoke, increasingly higher proportions believe smoking *should be allowed* in all outdoor areas around non-profit and other worksites (58.5%), health care facilities (83.1%) and churches (85.5%). When the issue is personalized, however, specifically asking whether respondents favor or oppose tobacco control policies at their church, <u>all</u> respondents either "Somewhat favor" (*n*=21, 17.2%) or "Strongly favor" (*n*=101, 82.8%) "a policy at <u>your</u> church that bans smoking within 20 feet of all doorways, operable windows and vents." Similarly, although there were a few dissenters (*n*= 4), 21 (17.2%) "Somewhat favor" and 103 (84.4%) "Strongly favor" "a policy at your church that prohibits smoking anywhere on church property."

This is a key finding. It may reflect differential responses based upon question wording, i.e. the general: "In the following locations, do you think that smoking *should be allowed* in all areas, some areas, or not allowed at all?" Followed by outdoor areas around "buildings owned by nonprofit organizations and private businesses like retail and manufacturing," "churches and

[12] http://www.cdph.ca.gov/programs/tobacco/Documents/CTCPFactShSHSinCA2008.pdf

other faith-based organizations," and "health care facilities" vs. the more specific, "Do you favor or oppose *a policy at your church that bans smoking* within 20 feet of all doorways, operable windows and vents?" and separately, "…*that prohibits smoking* anywhere on church property?

An alternate view is consistent with qualitative work that has identified a strong disposition to react negatively to "being told what to do," in this case by externally imposed policies. De facto segregation, social and economic disadvantage and mixed feelings with regard to authority subtract from support for policies that seek to control behavior, however positive the intended outcome. A community that feels pushed around is reticent to support general policies perceived as telling others what to do. On the other hand, when the policy is adopted by one's Pastor, or is phrased as applying "to your church," support increases substantially. The inherent contradiction in responses to these two questions observed among respondents in South Los Angeles County merits further investigation.

## Conclusions and Recommendations

These evaluation results indicate unequivocally that Watts Healthcare Corporation's primary objective was met. In view of the urban locations and the high prevalence of smoking among African Americans in the surrounding communities, these policy adoptions and the moderate to highly successful implementation and compliance results represent a significant accomplishment. Although the Latino/ Hispanic population of South Central Los Angeles is growing at a rapid pace, just three of the thirteen churches that adopted policies in this program have Latino/ Hispanic congregations.

The evaluation surfaced an issue that bears upon post-policy adoption compliance checks in urban areas: whether doorways open to public streets or sidewalks, or on to public property. As one might expect, more tobacco-related litter was observed on the premises of faith-based organizations with doorways opening to streets and sidewalks at a baseline (pre-policy implementation) observation. Post-policy adoption compliance checks however showed a reversal of this pattern. There was actually <u>less</u> tobacco-related litter on the premises of facilities with doorways that open to public streets and sidewalks than on facilities with doorways opening onto their own property. Although this difference wasn't great, it contradicts the evaluation findings in the previous three-year work period.

Other evaluators conducting studies in urban environments may wish to add a doorway description item (Does this door open directly onto a public sidewalk or street?) to observational checklists. The number of cases included in this evaluation (*n*= 13) was too few

to serve as a basis for generalization, but this new information suggesting that doorways opening to public thoroughfares do not necessarily mean more tobacco-related litter, more ashtrays or more persons observed smoking has implications for the interpretation of outcome measures in large studies in urban environments.

These data support several recommendations:

- Interventions targeting faith-based organizations should emphasize the adoption of smoke-free facility policies. Doing so led to 13/13 smoke free policies during this two-year contract period, as opposed to a split between smoke-free and "doorway smoking ban" policies.
- The perceptions among evangelical pastors of Latino/ Hispanic congregations regarding the formal adoption of tobacco control policies require further elucidation. The dynamic between a pastor and his congregation around openly prohibiting smoking remains opaque.
- Utilization of aerial-view Google Maps to depict a building footprint and to indicate the position of primary and secondary entryways and all operable windows and building vents continued to add value to multiple measures conducted over time by ensuring consistency between locations over time.
- Subsequent interventions to encourage policy adoption in faith-based organizations should align with the existing activism in Black and Latino churches to reduce health disparities. The disproportionate rate of tobacco use and exposure to second-hand smoke among African Americans in Los Angeles and the interaction of tobacco smoke with high levels of urban air pollution are risk factors that can be better controlled.

# APPENDIX A

## 5-E-1 Faith-Based Organization Observational Checklist

Organization Name: _____ Date: _____

Organization Address: _____

Type of Organizational Site: _____

Contact with: ☐ Clergy ☐ Site Manager ☐ Other (please describe) _____

N of employees/ staff: _____ Estimated N of unique members, clients, etc. per week: _____

**Do you have any church members, visitors, or employees that smoke or use smokeless tobacco?** ☐ Yes ☐ No

**Would you like any quit smoking materials?** ☐ Accepted ☐ Declined

Previous Policy Adoption: ☐ Yes ☐ No

Policy Description: _____

_____

_____

**Site Layout (Diagram and describe faith-based organization location, showing streets, sidewalks, patio and parking areas, etc. Attach google map aerial view if possible. Number doors, vents & operable windows and use these numbers in descriptions below.)**

**Primary Entryway # and Door Description**: _____

_____

Does this door open directly onto a public sidewalk and street? ☐ Yes ☐ No

Are there cigarette butts or tobacco related litter anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of the primary entryway door?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No
Comment/Description: _____

_____

Is there an ash tray or ash can near the primary entryway door? ☐ Yes ☐ No

Number of persons observed smoking anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of primary entryway door: _____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Secondary Entryway1 (e.g. Other Public Entrance, Staff Entrance, Loading Dock) # and Description:** _____

_____

Does this door open directly onto a public sidewalk and street? ☐ Yes ☐ No

Are there cigarette butts or tobacco related litter anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this entryway?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No
Comment/Description: _____

_____

Is there an ash tray or ash can near secondary entryway 1? ☐ Yes ☐ No

Number of persons observed smoking anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of secondary entryway: _____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Secondary Entryway2 (e.g. Other Public Entrance, Staff Entrance, Loading Dock) # and Description**: _____

_____

Does this door open directly onto a public sidewalk and street? ☐ Yes ☐ No

Are there cigarette butts or tobacco related litter anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this secondary entryway?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No

Comment/Description: _____

_____

Is there an ash tray or ash can at or near this location? ☐ Yes ☐ No

Number of persons observed smoking anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this entryway:_____

Is a sign posted "No Smoking?" ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Operable Window, Vent or Other Opening 1 # and Description:** _____

_____

Does this door/vent/window open directly onto a public sidewalk and street? ☐ Yes ☐ No

Are there cigarette butts or tobacco related litter within policy-specified distance of this opening?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No

Comment/Description: _____

_____

Is there an ash tray or ash can at or near this opening? ☐ Yes ☐ No

Number of persons observed smoking anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this opening:_____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Operable Window, Vent or Other Opening 2 # and Description:** _____

_____

Does this door/vent/window open directly onto a public sidewalk and street? ☐ Yes ☐ No

Are there cigarette butts or tobacco related litter anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this opening?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No

Comment/Description: _____

_____

Is there an ash tray or ash can at or near this opening? ☐ Yes ☐ No

Number of persons observed smoking anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this opening:_____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Operable Window, Vent or Other Opening 3 # and Description:** _____

_____

Does this door/vent/window open directly onto a public sidewalk and street? ☐ Yes ☐ No

Are there cigarette butts or tobacco related litter anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this opening?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No

Comment/Description: _____

_____

Is there an ash tray or ash can at or near this opening? ☐ Yes ☐ No

Number of persons observed smoking anywhere around (smoke free) or within policy-specified distance (doorway smoking ban) of this opening:_____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Other Designated Non-Smoking Area 1 (SKIP this section if Smoke-free Policy)**

Please Describe: _____

_____

Are there cigarette butts or tobacco related litter within policy-specified distance of this designated non-smoking area?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No

Comment/Description: _____

_____

Is there an ash tray or ash can at or near this location? ☐ Yes ☐ No

Number of persons observed smoking within policy-specified distance of this location:_____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

**Other Designated Non-Smoking Area 2 (SKIP this section if Smoke-free Policy)**

Please Describe: _____

_____

Are there cigarette butts or tobacco related litter within policy-specified distance of this designated non-smoking area?

☐ Yes → Number of butts & pieces of other tobacco related litter _____ ☐ No

Comment/Description: _____

_____

Is there an ash tray or ash can at or near this location? ☐ Yes ☐ No

Number of persons observed smoking within policy-specified distance of this location:_____

Is a "No Smoking" sign posted? ☐ Yes ☐ No

How visible is posted sign? ☐ Very Visible ☐ Somewhat Visible ☐ Not Visible

## Other Notes/ Comments/ Observations (e.g. "Displaced Smokers" nearby, other evidence of policy violation, "No Smoking" signage or other evidence of policy implementation)—Please use back of page:

Watts Healthcare Corporation

## Data Collection Training, Part I: Context and Overview

**August 8, 2013**

# Participant Evaluation

***Instructions:*** For questions 1-12, please put a check in the appropriate box.
For all other questions please write out your answer. Thanks!

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| 1. The objectives of the training were made clear. | | | | |
| 2. The training was well-organized. | | | | |
| 3. The speaker was well-prepared. | | | | |
| 4. The speaker was knowledgeable. | | | | |
| 5. The speaker held my interest. | | | | |
| 6. I will be able to use the information I learned in this training. | | | | |
| 7. This training was a good use of my time. | | | | |
| 8. I would recommend this session to someone else with an interest in this topic. | | | | |
| 9. I am now significantly more knowledgeable regarding the basic concepts and vocabulary associated with evaluation research. | | | | |
| 10. I am now significantly more knowledgeable regarding CTCP's approach to evaluation. | | | | |
| 11. I now have a better understanding of the WHCC South LA Community Tobacco Control Program's Evaluation Plan. | | | | |
| 12. The learning aids, handouts and other materials were useful. | | | | |

A. What was the most useful component/ section of this training?

_____

_____

_____(Over)

B. What questions, if any, about the fundamentals of evaluation, the CTCP approach to evaluation, or the WHCC evaluation plan do you still have after this training?

_____

_____

_____

C. How could this training be improved?

_____
_____
_____

D. Any other comments you would like to make about this (session/ training/ workshop/ presentation)?

_____
_____
_____

***The following questions are for descriptive purposes only:***

Your Age: _____ Are you: Male _____ Female _____

Please indicate your race or ethnicity: (Please select only <u>one</u>):

_____White (Non Hispanic) _____Middle Eastern
_____Latino/Hispanic _____ African American
_____Native American
_____Asian (Please specify) _____
_____Other (Please specify) _____

***Thank you!***

Watts Healthcare Corporation

# Data Collection Training, Part II: Observational Checklists

**August 21, 2013**

## Participant Evaluation

***Instructions:*** For questions 1-10, please put a check in the appropriate box.
For all other questions please write out your answer. Thanks!

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| 1. The objectives of the training were made clear. | | | | |
| 2. The training was well-organized. | | | | |
| 3. The speaker was well-prepared. | | | | |
| 4. The speaker was knowledgeable. | | | | |
| 5. The speaker held my interest. | | | | |
| 6. I will be able to use the information I learned in this training. | | | | |
| 7. This training was a good use of my time. | | | | |
| 8. I would recommend this session to someone else with an interest in this topic. | | | | |
| 9. I am now significantly more knowledgeable regarding the procedure to accurately complete Observational Checklist Forms for Objective 5. | | | | |
| 10. The learning aids, handouts and other materials were useful. | | | | |

A. What was the most useful component/ section of this training?

_____
_____
_____

B. What questions, if any, do you still have about the process of completing an Observational Checklist for Objective 5?

_____
_____
_____

C. How could this training be improved?

_____
_____
_____

D. Any other comments you would like to make about this training?

_____

_____

_____

***The following questions are for descriptive purposes only:***

Your Age: _____ Are you: Male _____ Female _____

Please indicate your race or ethnicity: (Please select only <u>one</u>):

_____White (Non Hispanic) _____Middle Eastern
_____Latino/Hispanic _____ African American
_____Native American
_____Asian (Please specify) _____
_____Other (Please specify) _____

***Thank you!***

# Watts Healthcare Corporation
# South Los Angeles Community Tobacco Control Program
### Evaluation Activity 5-E-2
### Faith-based Community Organization Focus Group Topics for Discussion

## Introductory Comments

Good morning/ afternoon/ evening. We're here today on behalf of the Watts Healthcare Corporation, South Los Angeles Community Tobacco Control Program which has been funded by the California Department of Public Health to change the way people think about tobacco use in South Los Angeles.

Instead of addressing the negative health effects associated with smoking by educating individuals, to reduce smoking and exposure to second-hand smoke by nonsmokers, the California Tobacco Control Program focuses upon changing environments. Our goal is to change the extent to which every-day environments like worksites and places of worship are accepting and permissive of cigarette smoking.

Today, we'd like to discuss the issues around voluntarily adopting a policy to formally signify the restrictions on smoking that may already be in place at your church or other faith-based facility. A formal policy might designate your grounds completely smoke free, restrict smoking to a designated outdoor area, or ban smoking within 20 feet or more of all doorways, windows, vents, and openings. Eight years ago, in 2006 the California Air Resources Board classified second-hand smoke as a toxic air contaminant on the same list as benzene, arsenic and diesel exhaust. We're aware that although a voluntary policy like this protects nonsmokers, it also affects any smokers among your staff and congregation. Moreover, at many churches, temples and other faith-based organizations it "goes without saying" that smoking is unwelcome. We'd like to understand the way that leaders in the faith community like yourself think about these issues.

## Confidentiality

Your participation in this discussion is entirely voluntary and you don't have to answer any question that you do not want to. Your responses will remain confidential. We would like to audio-record this discussion, however. Everything that you have to say is very important, and having the audio tape will enable us to carefully review what is said. Any notes or quotations from this interview will be attributed to a generic title only, such as "A faith-based community leader in South Los Angeles." Under these circumstances, may I please have your permission to tape this discussion?

We have no expectations about what is going to be said during this discussion, and I hope that you'll communicate what you honestly think, and feel free to share whatever

is on your mind. Our goal is to hear as many different opinions, ideas, and stories as possible.

## Interview Questions

1. First, are there any theological issues or articles of faith that affect smoking on church/ organization property? Please describe these issues.

   [If beliefs prohibit smoking on church/ organization property, would you be open to expressing these restrictions in a formal policy, and perhaps posting signs saying something like, "Please respect our faith. No smoking on church (or organization) property" or another message that you create?]

2. What are the administrative issues at this church/ faith-based organization that must be considered before adopting a policy to restrict smoking by going completely smoke free, permitting smoking in designated outdoor areas only, or to ban smoking within 20 feet of doorways, operable windows and vents?

   [Probe: Who is authorized to make decisions like this? Would input be solicited from any church/ organization members or employees?]

3. In general, what are the factors that might make adopting a policy like this easier for this decision-maker/ these decision-makers?

4. What obstacles, challenges, or sources of resistance do you foresee with regard to adopting a smoke-free policy, restricting smoking to a designated area, or a policy to ban smoking within 20 feet of doorways/ windows/ vents on church/ organization property?]

   [Probe: Do you expect resistance from staff? Members of the congregation? Do you anticipate any problem with posting signs to inform people about the policy? What about enforcing the policy?]

5. What strategies might be effective to overcome these challenges to adopt a policy restricting smoking?

6. How do you think that the South Los Angeles community will respond to restrictions on smoking on the grounds of faith-based organizations and churches? Do you believe that community members will be supportive?

7. Is there anything else that might help us to understand the things that make a voluntary policy restricting smoking easier to adopt, or to understand the obstacles, barriers, or challenges to adopting a policy restricting smoking?

[Probe: Is there anything else you'd like to add?]

Thank you very much. Your time is deeply appreciated.

July 30, 2013
5-E-4 Youth SHS Presentation

# Participant Evaluation

***Instructions:*** Please put a check in the appropriate box or on the line by the answer of your choice, or write out your answer. Don't forget to complete both sides of this form. Thanks!

| | Strongly Agree ☺ | Agree | Disagree | Strongly Disagree ☹ |
|---|---|---|---|---|
| 1. The purpose of this training was made clear. | | | | |
| 2. The training was well-organized. | | | | |
| 3. The PowerPoint presentation was very good. | | | | |
| 4. The speakers were knowledgeable. | | | | |
| 5. The speakers held my interest. | | | | |
| 6. I know a lot more now about the health effects of exposure to secondhand smoke (SHS). | | | | |
| 7. I am now prepared to talk to others about the dangers of smoking and secondhand smoke (SHS). | | | | |

A. What was the best part of this training?

_____
_____
_____

B. What questions, if any, about the negative health effects of smoking do you still have after this training?

_____
_____
_____

C. How could this training be improved?

_____
_____
_____

***The following questions are for descriptive purposes only:***

Your Age: _____ Are you: Male _____ Female _____

Please indicate your race or ethnicity: (Please select only one):

_____White (Non Hispanic) _____Middle Eastern
_____Latino/Hispanic _____ African American
_____Native American
_____Asian (Please specify) _____
_____Other (Please specify) _____

Please check the box by the option that best describes how often you spend time on each of the following social media sites:

| | Not at all | Once a week | Few times per week | Once a day | More than once a day |
|---|---|---|---|---|---|
| a. Facebook | ❑ | ❑ | ❑ | ❑ | ❑ |
| b. MySpace | ❑ | ❑ | ❑ | ❑ | ❑ |
| c. YouTube | ❑ | ❑ | ❑ | ❑ | ❑ |
| d. Twitter | ❑ | ❑ | ❑ | ❑ | ❑ |
| e. Other Social Media site (describe) _____ | ❑ | ❑ | ❑ | ❑ | ❑ |

How do you usually access your social media?

❑ Mobile (Cell) Phone
❑ Laptop /Notebook or Ipad
❑ Home desktop computer
❑ School computer/ public computer (e.g. library, Internet café)
❑ Other _____

***Thank you!***

**Watts HealthCare Corporation**
**South Los Angeles Community Tobacco Control Program**

# Faith-based Organization Survey

***Instructions:*** Please put a check in the appropriate box or on the line by the answer of your choice, or write out your answer. Don't forget to complete both sides of this form. Thanks!

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| 1. I know a lot about the health effects of tobacco use. | | | | |
| 2. Inhaling smoke from someone else's cigarette causes lung cancer in a nonsmoker. | | | | |
| 3. Inhaling smoke from someone else's cigarette harms the health of babies and children. | | | | |
| 4. Tobacco advertising targets certain groups such as young adults, low income groups, and specific racial and ethnic groups. | | | | |
| 5. Smoking outdoors may harm the smoker, but has little to no effect on bystanders. | | | | |
| 6. Restrictions on smoking in public places are necessary to protect the health of nonsmokers. | | | | |
| | | | **True** | **False** |
| 7. Second hand smoke is a toxic air contaminant on the same list as benzene, arsenic and diesel exhaust. | | | | |
| 8. The effects of second hand smoke are so bad that it is already illegal in California to smoke in cars with children. | | | | |

| In the following locations, do you think that smoking should be allowed in all areas, some areas, or not allowed at all? | All Areas | Some Areas | Not Allowed at All. |
|---|---|---|---|
| 9. Outdoor areas around buildings owned by nonprofit organizations and private businesses like retail and manufacturing. | | | |
| 10. Outdoor areas around churches and other faith-based organizations. | | | |
| 11. Outdoor areas around health care facilities. | | | |

12. Are you often exposed to other people's tobacco smoke…
[Please check all that apply]

☐ Not exposed to tobacco smoke anywhere OR
☐ At home ☐ In cars ☐ At work
☐ At another location (please describe) _____

13. How annoying do you find other people's smoking?

☐ Not annoying at all ☐ A little annoying ☐ Moderately annoying
☐ Very annoying ☐ Extremely annoying

14. In the past 12 months have you ever asked someone not to smoke?

☐ Yes ☐ No

15. On the most recent occasion you asked someone not to smoke, who was that person?

☐ Spouse or partner ☐ Parent ☐ Child
☐ Other relative ☐ Friend ☐ Co-worker
☐ Someone else you knew ☐ A stranger

16. Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes is 5 packs)

☐ Yes→ Please Continue ☐ No→ Please Skip to Question 22 on the next page.

17. Do you now smoke cigarettes…

☐ Every Day ☐ Some Days ☐ Not at All

18. Did you smoke any cigarettes during the past 30 days?

☐ Yes ☐ No

19. Would you like to stop smoking?

☐ Yes ☐ No

20. Are you planning to quit smoking in the next 30 days?

☐ Yes ☐ No

21. Are you contemplating quitting smoking in the next six months?

☐ Yes ☐ No

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22. Now, think about a random sample of 100 Californian adults. On average, how many California adults do you think currently smoke cigarettes?

____ out of 100.

23. Do you favor or oppose a policy at your church that bans smoking within 20 feet of all doorways, operable windows and vents?

☐ Strongly Favor
☐ Somewhat Favor
☐ Somewhat Oppose
☐ Strongly Oppose

24. Do you favor or oppose a policy at your church that prohibits smoking anywhere on church property?

☐ Strongly Favor
☐ Somewhat Favor
☐ Somewhat Oppose
☐ Strongly Oppose

***The following questions are for classification purposes only.***

Are you… ☐ Male ☐ Female

25. Are you currently …

☐ Employed for wages
☐ Out of work for more than 1 year
☐ A Homemaker
☐ Retired
☐ Self-employed
☐ Out of work for less than 1 year
☐ A Student
☐ Unable to work (Disabled)

26. Would you say that in general your health is:

☐ Excellent ☐ Very good ☐ Good
☐ Fair ☐ Poor

27. What was the last grade in school that you completed?

- ☐ Less than high school diploma/GED
- ☐ High school diploma/GED
- ☐ Some college, no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ A graduate or professional degree (e.g. Masters, Ph.D., JD)

28. In what year were you born?

19___

29. How do you describe your race or ethnicity?

- ☐ Asian/ Pacific Islander
- ☐ Black or African-American
- ☐ Caucasian or White
- ☐ Hispanic/ Latino
- ☐ Other, Including more than One Race

30. How many children do you have younger than eighteen years of age in your household?

___ NUMBER OF CHILDERN

31. Lastly, what are the smoking rules or restrictions in your household, if any?

- ☐ Smoking is completely prohibited
- ☐ Smoking is generally prohibited with few exceptions
- ☐ Smoking is allowed in some rooms only
- ☐ There are no restrictions on smoking

*Thank You!*