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Healthy Stores for Healthy Communities

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MPH Candidate 2016

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Abstract:

Overall smoking rates in California, and nationwide, have steadily declined since the first surgeon's general report, in the 1960s, stated that tobacco may lead to cancer. In the past five years, the emergence of Electronic smoking devices or Electronic Nicotine Delivery System (ENDS), little cigarillos, vapes, and hookah have increased smoking rates among teenagers and young adults throughout California. The rise of smokeless tobacco products can be attributed to a variety of reasons from marketing, product availability, flavor availability, and public misconceptions. In 2016, the Santa Clara County Department of Public Health launched the Healthy Stores for a Healthy Community (HSHC) campaign through their Tobacco Free Communities program. This campaign, previously conducted in 2013, is a statewide campaign that assesses product availability and marketing of tobacco, alcohol, healthy/unhealthy food and beverages in local communities. While there are other important factors being observed, the main focus of HSHC is tobacco. The HSHC campaign essentially has three phases (1) Observational store surveys (2) Public Intercept Surveys (3) Key informant interviews. The observational surveys were conducted first, and there was a 66% completion rate in Santa Clara County, and as of August 12, 2016 there are 355 public intercept surveys completed. The key informant interviews will be conducted in fall 2016. The implications of this campaign can help create a healthier community for Santa Clara County through a healthier retail environment.

I conducted my fieldwork internship at the Santa Clara County Department of Public Health: Center for Chronic Disease & Injury Prevention (CDIP). The use of smokeless tobacco products among Santa Clara County residents has been increasing in recent years. Youth, in particular, show an increased use of electronic smoking devices, little cigarillos, e-liquids, hookah and vapes . The Healthy Stores for a Healthy Community (HSHC) campaign is a statewide collaboration between tobacco use prevention, nutrition, and alcohol prevention partners. The goal of this campaign in Santa Clara is to improve the health of residents through changes in community stores and to educate people on how in-store product marketing influences consumption of unhealthy products. Through several phases, the campaign accumulates valuable information that Santa Clara County uses to address behaviors associated with increased use of smokeless tobacco.

Over the years, smoking has repeatedly been proven to be detrimental to human health. In the 2004 Surgeon Generals report, it was stated that smoking affects nearly every organ of the body. The long list of diseases caused by tobacco use and exposure to tobacco smoke is still growing. The 2004 report stated that active smoking is now causally associated with: age-related macular degeneration, diabetes, colorectal cancer, liver cancer, adverse health outcomes in cancer patients and survivors, tuberculosis, erectile dysfunction, orofacial clefts in infants, ectopic pregnancy, rheumatoid arthritis, inflammation, and impaired immune function (USPHH 2014). Additionally, exposure to secondhand smoke has now been associated with an increased risk for stroke (USPHH 2014). Valiant efforts to expose the health effects of smoking and to reduce smoking rates in the U.S. through medicine and public health has resulted in a decreased use of conventional cigarette over the years, however, there has been an increased use of electronic smoking devices, particularly among youth in recent years. These electronic devices

have not been proven to be safer than cigarettes nor an effective smoking cessation tool, but, for a variety of reasons, including harm reduction, are becoming more and more popular.

Trends in smoking in the US

According to the Centers for Disease Control (CDC), smoking rates among high school students and adults, between 1965- 2014, have drastically decreased. In 1965, 42.4% of US adults smoked cigarettes; by comparison, in 2014, only 12% of adults identified as current smokers. In 1991, 27.5% of high school students smoked and that number has dropped to 16% in 2014.

The trend in reduction of smoking cigarettes has not been uniform, and occurred in different demographics over several decades since 1950. Cigarette smoking became very popular among Americans following the First World War, and steadily increased throughout the 1930s and 1940s (Garfinkel 1997). During the 1950s, the tobacco industry aggressively fought new scientific evidence that suggested that there was a link between smoking and adverse health effects like cancer (Garfinkel 1997). Drawing on data from the second half of the 20th century, Gilpin and Pierce tracked discrepancies in cessation patterns in the US across key socioeconomic groups (1998). As early evidence suggested that smoking was linked to cancer first emerged in surgeon general's reports in the 1960s, middle-aged men began to quit smoking. Then in the 1970s, younger women began to quit or reduce smoking because the surgeon general warned that smoking affects fetal development during pregnancy, and smoking was also linked to cardiovascular problems for women using birth control pills (Gilpin 1998). Additionally, younger smokers began quitting throughout the 1970s and 1980s more than middle-aged smokers, and reasons for this change could have resulted through pressure to quit in households with young children. Then, in the late 1970s, when both the public health community

and the tobacco industry appeared to promote “safe” cigarettes, smokers may have switched brands rather than quitting (Giplin 1998). This had serious implications because it deferred smokers from quitting; exposing them to years of adverse smoking health effects before it was known that there isn’t a safe cigarette.

Healthy policy campaigns had a major impact on cessation behavior. The 1980s saw an increased efforts to educate and encourage the public not to smoke through public policy changes, for example, several states and communities raised taxes on cigarettes (Garfinkel 1997), and mass media health messages about smoking reduced smoking rates among lower educated demographics as well. Notably in 1993, California decreased cigarette consumption when the Environmental Protection Agency released a report on the effects of passive smoking declaring that environmental tobacco smoking is a human lung carcinogen and is responsible for 3,000 lung cancer deaths annually (Garfinkel 1997). By 1993 only 25% of Americans over the age of 18 were currently smoking (Garfinkel 1997). Through the late 90s and early 2000s smoking rates continued to drop until the emergence of a new tobacco product with a very similar marketing tactic emerged on the market.

The emergency of smokeless tobacco products

The emergence of electronic cigarettes and other devices (ENDS), little cigars/ cigarillos, and other flavored tobacco products are causing a resurgence of tobacco use among adults and youth in the United States. E-cigarettes are battery, operated devices that heat a liquid solution until it turns into an aerosol that is then inhaled, and this liquid typically contains nicotine, chemicals, and many of these devices are unregulated (SCDPH 2016). They are perceived to pose less of a threat to the individual smoker than conventional tobacco cigarettes. More than 250 e-cigarette brands are currently on the market, and these products have evolved rapidly in

recent years (Benowitz 2013). Electronic cigarettes are also sold using characterizing flavors (eg, strawberry, licorice, chocolate, margarita etc) that are banned in cigarettes in the United States because of their appeal to youths (Glanz 2014). Notably, a survey conducted by Yale Researchers, appealing flavors was one of the top reasons students experimented with e-cigarettes (SCDPH 2016).

In 2015, the CDC estimated that 3 million middle and high school students were current users of electronic cigarettes, up from 2.46 million in 2014. California Healthy Kids survey data from 2013- 2015 shows that the rate of e- cigarette use among seventh, ninth, and eleventh graders far surpasses the rate of cigarette smoking (SCDPH 2016). With this being said, it cannot be denied that tobacco companies are targeting a new generation. Smoking tobacco in a hookah and use of LCCs is high among adolescents and young adults. Recent data from the nationally representative Monitoring the Future survey show that among 12th graders, 22.9% reported hookah use and 18.9% reported small cigar use in the past year (Cornacchione 2016). Cigars and cigarettes are the most common two-product combination among young adults older than 18. E-cigarettes, hookah and LCCs have many of the chronic health consequences that aren't typically associated with smokeless tobacco. These consequences are similar to those of cigarette smoking, such as cancer, heart disease, chronic bronchitis, and nicotine addiction. Adolescents and young adults believe hookah and LCCs to be less harmful and less addictive than cigarettes, and these misperceptions are positively associated with current use of these products (Cornacchione 2016).

Why smokeless tobacco products versus traditional combustible products?

The US Centers for Disease Control and Prevention cites probable reasons for e-cigarettes' escalation in popularity to include increased availability, marketing, less expensive

costs, and the belief that they are safer than conventional cigarettes (Cooper 2016). Young adults are more likely to perceive e-cigarettes as less harmful than conventional cigarettes as compared with older adults. A study asked participants to describe why they began using E-cigarettes and many users reported that e-cigarettes satisfied their cravings for conventional cigarettes, which was a benefit to help them quit smoking (Cooper 2016). Additionally, there was a reoccurring belief in this study that e-cigarettes were less addictive than cigarettes, and some current users in this sample reported that e-cigarettes did not contain carcinogens, and believed that the only harmful chemical in e-cigarettes was nicotine. Among current smokers, 11.4% report ever using e-cigarettes and 4.1% used in past 30 days (Cooper 2016)

The tobacco industry has been aggressively marketing e-cigarettes, and many e-cigarette companies market their products as a cessation tool (ALA 2016).). The FDA's Center for Drug Evaluation and Research has not approved any e-cigarette as a safe or effective method to help smokers quit. In 2013, 76.8 percent of the people who recently used e-cigarettes also currently smoked conventional cigarettes (ALA 2016). Additionally, the tobacco industry markets e-cigarettes to youth, by glamorizing e-cigarette use in advertisements and offering e-cigarettes in candy flavors like bubble gum and gummy bears (ALA 2016). Their marketing tactics, similar to marketing done for cigarettes, uses young models and celebrities to convey images of the product as glamorous and modern (Garfinkel 1997).

Taken together, this marketing has likely led to the substantial increase in the use of the product, which is not a surprising result given the historic success of traditional combustible cigarette advertising. Marketing and advertising have been proven to have a strong effect on teenagers, children, and even young adults. In 1998, longitudinal study provided evidence that tobacco industry advertising and promotional activities can influence non-susceptible 'never

smokers' to start the process of becoming addicted to cigarettes. The study estimated that tobacco industry marketing/advertising activities in the mid 1990s influenced 17% of those who turn 17 years old each year to experiment with cigarettes. (Pierce 1993). It is possible that these influences also encourage experimenters to continue smoking until they become addicted and act to prevent addicted adolescent smokers from quitting. In conclusion, this study found that tobacco industry advertising and promotional activities are causally associated with young people starting to smoke (Pierce 1993). From this study's representative sample survey in 1993, they estimated that there were about 1.18 million 12- to 17-year-old adolescents in California who were non-susceptible never smokers, and the incidence rate of experimentation among those receptive to tobacco advertising and promotion activities was 34% (Pierce 1998). This is a high incidence rate, and it shows that there is a correlation, not necessarily causation, between aggressive advertising and a teenagers attempt to begin smoking in the 1990s. Tobacco companies are using similar marketing tactics with e-cigarettes, and the potential health consequences to teens could be just as catastrophic.

E-cigarettes as a cessation tool

Effective promotion of e-cigarettes could be advantageous if it was determined there was individual health benefit and a lower level of harm—for example, if e-cigarette use was proven to be a tool for smoking cessation the flawed logic in this approach is that electronic cigarettes are encouraged for dual use and appeal to youth as a novel nicotine product through using models and flavors to entice youth (SCDPH 2016). There would be no use in creating flavors to mimic candy or sweets if E-cigarettes were primarily advertised for cessation.

Two longitudinal population studies of adult smokers contradict claims that e-cigarettes are effective cessation aids: one (in the United States, United Kingdom, Canada, and Australia)

found that e-cigarette use is not associated with quitting conventional cigarettes and the other (in the United States) found significantly less quitting (Glanz 2014). This randomized clinical trial found that e-cigarettes were not better than Nicotine patches for smoking cessation, but both interventions showed low quit rates and there was no control group of spontaneous quitters. E-cigarette users are heavier smokers and less likely to have stopped smoking cigarettes, these results suggest that e-cigarette use is aggravating rather than ameliorating the tobacco epidemic among youth (Glanz 2014). These results call into question claims that e-cigarettes are effective as smoking cessation aids.

Regulation (or the lack thereof)

The Food and Drug Administration (FDA) is authorized to regulate tobacco products, and in 2011 the agency announced plans to regulate e-cigarettes as tobacco product. Regulations are also occurring at the state and municipal level. As of June 2016, electronic smoking devices will now be classified under tobacco products In California. The FDA needs to decide how marketing should be regulated in the context of potential benefits and population risks. (Benowitz 2013).

The potential for spillover effects

Marketing and advertising play a crucial role in getting youth and adults to use electronic cigarettes, however, the retail setting, like price promotions for unhealthy products, in communities also influences behaviors. Often the act of smoking is usually associated with other unhealthy behaviors like alcohol use, more sugary beverage consumption, and increased consumption of junk food as well. For example, a study found that in high school neighborhoods, targeted advertising exposes African Americans to more promotions and lower prices for the leading brand of menthol cigarettes compared to other racial demographics (Henrikeson 2016). This evidence from this study contradicts the manufacturer's claims that the availability of its

promotions is not based on race. It also highlights the need for tobacco control policies that would limit disparities in exposure to retail marketing for cigarettes. This study is one of the first known to examine the availability of promotions as well as the price of menthol cigarettes by neighborhood demographics (Henrikeson 2016). It is suggested that a disproportionate amount of menthol advertising and price promotions, and likely other price promotions involving tobacco, alcohol, and sugary beverages, are more available for menthol brands which means lower prices for menthol cigarettes near California high schools with more African-American students (Henrikeson 2016). This area of study is new and further research needs to be conducted on price promotion availability for tobacco and alcohol products because if certain communities, primarily lower income communities, are only given opportunities to purchase unhealthy products compared to higher income communities, unhealthy behaviors will become embedded into less fortunate communities.

A call to action

Electronic smoking devices are the ‘next generation cigarette’, and tobacco companies are using similar tactics to market and advertise them to younger generations. Whether it is with enticing, candy-like flavors or with the notion that e-cigarettes are cessation tools, the use of these smokeless tobacco products are on the rise, and the consequences of using them are still unknown. E-cigarettes are perceived to be less harmful than conventional cigarettes by the public, but much too often perception isn’t a correct depiction of reality. The public is susceptible to e-cigarette and tobacco marketing, but the influence of retail advertising, product availability, and price promotions have the ability to affect communities even more than youth targeted media. Youth and adults alike are more likely to purchase what their community has to

offer, this will influence behaviors associated with tobacco, alcohol, and sugary beverage and junk food consumption as well.

I conducted my fieldwork at the Santa Clara Department of Public Health (SCDPH). SCDPH is a diverse workforce with over 30 programs and services organized across 7 divisions. Specifically, I interned for the Center for Chronic Disease & Injury Prevention (CDIP). CDIP coordinates with other local health agencies and community partners to reduce death and disabilities in Santa Clara County through preventing chronic diseases and injuries. By increasing access to healthy and safe environments, healthier food options, physical activity through culturally appropriate education, policy development, and leverage community engagement, and local and regional leadership CDIP hopes to accomplish their mission by promoting environmental changes to support a healthy community by enhancing opportunities where people can live, work and play.

CDIP has several programs that aim to support their mission of disease prevention. I have been fortunate enough to be a part of the Tobacco-Free Communities program (TFC). TFC works to improve the health of all Santa Clara County residents and the workforce by reducing illness and premature death attributed to the use of tobacco products. The goal of TFC is to increase community awareness of the harmful impact of tobacco use by engaging community residents, key community partners, and elected leaders in inputting a variety of evidence-based strategies. They work with community-based organizations at the local, state, and federal health level to promote a healthy lifestyle and create a tobacco-free Santa Clara County. TFC focuses their efforts primarily on reducing tobacco use and secondhand smoke exposure for populations

that use tobacco at higher rates as these groups experience a relatively greater burden of tobacco-related diseases. With this in mind, TCP activities are focused on:

1. Prevention of initiation of tobacco use & reducing youth access to tobacco products, including electronic smoking devices
2. Reduction of tobacco use, particularly among populations with the highest rates
3. Reduction of exposure to secondhand smoke and third hand smoke

As a part of CDIP, the TFC is currently conducting **The Healthy Stores for a Healthy Community (HSHC) Campaign**. This campaign is lead statewide by the California Tobacco Control program, and emphasizes the need for collaboration between tobacco use prevention, alcohol prevention, and nutrition partners at the county and state-level. That said, while there is a focus on alcohol prevention and sugary drink/ junk food availability, the primary focus of HSHC is tobacco. The HSHC seeks to make changes in product availability in community stores by educating the public on the influence of in-store marketing of unhealthy products. The observations are intended to focus on three tobacco policy objectives: (1) Increase the price of tobacco products; (2) reduce the availability of menthol cigarettes and other flavored tobacco; (3) reduce tobacco advertising in storefront windows. This campaign was previously conducted in 2013, collecting local data relating to the availability of, marketing, and cost of tobacco, alcohol, and food and beverage products were collected and released. The results from the previous campaign helped to inform the Healthy Stores for a Healthy Community Recognition Project, which was developed to build upon the overall goal of the statewide campaign by supporting and acknowledging local store owners who are making positive changes and creating health promoting environments in Santa Clara County, and it has begun again in 2016. Statewide, the

long term objective is to make a the retail environment healthier for all Californians. This campaign will also be conducted in 2019.

Project implementation

The data collected is composed of three distinct phases: (1) observational surveys, (2) intercept surveys, and (3) key informant interviews. These three components are meant to be representative of all of Santa Clara County so the surveys were conducted in all of the following cities: San Jose, Milpitas, Campbell, Sunnyvale, Los Gatos, Palo Alto, Gilroy, Morgan Hill, Palo Alto, Los Altos, Los Altos hills, Mountain View, and Santa Clara.

Phase 1: observational surveys

The observational surveys were administered from April through June. Each observational survey was conducted on an I-pad using Survey Pocket. The survey was composed of a primary ‘core’ module then four additional modules: E-cigarettes, Vapor Devices and E-liquids module, Flavored Products module, price and promotions module, and placement and exterior ads module. Each survey took approximately 15-25 minutes to complete at the discretion of the store-owner, and the owner was allowed to ask us to leave at any time during the survey. The target sample of the survey stores comprised of liquor stores, gas stations, cafes, smoke shops, markets, and supermarkets in aforementioned cities. The stores were randomly selected by the state based on predetermined criteria (i.e., whether they sold tobacco) and they were given random store IDs so an individual store could not be identified. The reassurance of anonymity was key in owners letting us survey their store. Sixteen interns, including myself, collected the data. In total, we were given over 700 stores across the county to survey; we roughly were

allowed to survey and complete 66% of them. The survey questionnaire was developed by Stanford University, and the questions primarily focused on tobacco. We were asked to identify what type of tobacco products were sold in the store like types of cigarettes (Camel vs Malboro), menthol cigarettes, E-cigarettes, chewing tobacco, snus, flavored tobacco, E-liquids, and little cigarillos. We were asked to identify whether these tobacco products came in flavors like cherry or grape. Another big component of the survey involved the pricing of tobacco products, and what price promotions or discounts were given at the store. Additionally, there were questions about alcohol availability like what types of alcoholic beverages were available in the store and where they placed. Also, certain nutrition questions about the availability of 1% milk, and whole-wheat products, and condom availability were on the survey as well. This is a condensed version of all the questions the survey contained.

The survey information data was uploaded to Stanford, so at the time of my internship I was not able to access the data from the survey results. The results will be available to the county most likely in October.

Phase 2: Intercept surveys

The intercept surveys assessed public opinion about (1) tobacco, alcohol, and sugary beverage availability in their local communities; (2) alcohol, tobacco, sugary drink, and junk food advertising; and, (3) potential policies about tobacco and sugary drinks.

Intercept surveys began in late June and will go through August. Data was again collected using survey pocket technology. The survey was developed by CDIP/TFC, which allowed the county access to the data. The survey took roughly 10-15 minutes to complete, and

based on population demographics each city was goaled to hit a certain number of surveys, for our grant we only had to hit 300 surveys, but we aimed to hit 450 countywide.

City Goals:

Sunnyvale: 60

Santa Clara: 60

Campbell: 60

Morgan hill: 50

San Jose: 120

Gilroy 50

Other cities like Palo Alto, Los Gatos, Cupertino, Mountain View, Saratoga and Los Altos were goaled to be hit in the above target cities with a total of 50.

The only criteria to participate in the survey was that the individual had to be a Santa Clara county resident, and we asked no one younger than 13 years of age. While anyone 13-18 cannot vote on potential policy questions, the county is interested to see what the youth feel about the availability of tobacco and alcohol, particularly because of the rising popularity of electronic smoking devices. Surveys were administered by 6 interns, which include myself. Incentives were given to people who took the survey (\$5 Starbucks gift cards). The results are not yet available because they are still being conducted them.

Survey tips to avoid bias were given by the Epidemiology Department. We were instructed to (1) ask every third person we saw and (2) to go out at different times of the day to allow for variation in sociodemographic characteristics of respondents.

As of August 12, 2016, 355 residents were surveyed all over Santa Clara County, hitting most of the targeted amount in each city. While I did have access to the results of these surveys, I think it is notable to state that we did interview smokers and non-smokers. Surprisingly, their opinions about support or opposition about tobacco policies did not differ very much. Several smokers stated to me that they thought it would be beneficial to impose stricter store guidelines, like requiring tobacco store-owners to buy a license to sell tobacco, over 60%, for example, to help defer teenagers from smoking.

Phase 3: Key informant interviews

I will not be part of TFC while they conduct the key informant interviews, but my preceptor has told me that the interviews are conducted with city council members and mayors to assess their support for potential policies associated from results of the HSHC. It is a way to figure out who will be a good partner/support to help pass changes concerning tobacco for the community through changes in policy.

Future of the HSHC

The HSHC data collected throughout Santa Clara County will be used as a basis for a variety of community interventions.. There are a variety of different cultures, subcultures, and socioeconomic factors that result in communities using and viewing tobacco and alcohol differently. That's why it is essential that all socioeconomic differences and differing cultures are

equally represented in this data collection to depict an accurate portrayal of what Santa Clara county residents feel about tobacco and alcohol to better address public health issues and needs. During my time with TFC, from discussions with TFC staff, meetings, and interactions with the public I really noticed the prevalence of electronic cigarettes among youth. Conducting surveys, I would interact with parents that would tell me their children use vapes or E-cigs, but they themselves don't really know what they are and if they are dangerous. The potential effects of electronic cigarettes/ smokeless tobacco can be fatal for millions of people. A whole new generation of kids will become addicted to tobacco, and the time to change behaviors is now. The surveillance data, from all three phases, will help guide Santa Clara Health department direct their interventions strategically to communities that need it the most, and media campaigns can be created as well. This data can also help raise public awareness and educate consumers and retailers about industry marketing practices.

What fascinated me about completing my fieldwork was realizing that I applied several MPH coursework competencies into real life applications ;I also learned a variety of new skills. I demonstrated leadership abilities through collaboration and coordination throughout the HSHC. I collaborated with my preceptors to come up with successful strategies to maximize the chance of store- owners letting our team survey their store during the observational survey phase. I also collaborated with my preceptors and other managers on detailing what the best way is when approaching a person during the intercept surveys. I coordinated schedules and deadlines with my undergraduate and high school interns during the observational survey collection. I also coordinated debrief sessions with all 16 interns and my preceptors too get accurate representation of data collection timelines and feedback on how the process was going. I also coordinated a smaller team of interns (6) during the intercept surveys. I helped identify

new avenues of tobacco control and prevention policy, applying theoretical constructs of health behavior associated with tobacco use to better understand populations that were included in the HSHC. Since I was able to access the data that was coming in from the public intercept surveys, my preceptor and I evaluate information collected at the city-level, assessing whether we were capturing the target numbers in each city (see discussion above). If certain ages, demographics or cities were not being accurately targeted we would change the process in which we were doing the surveys. Throughout the fieldwork process, our department had weekly meetings to discuss the project and our progress as well as other emerging tobacco related issues.

Additionally, I learned about many new public health issues associated with electronic smoking devices and the marketing and advertising tactics used. I effectively communicated my questions and thoughts among my preceptor and department staff but to the public as well. I was able to answer and engage the public whenever I was asked questions about why we were doing these surveys or specific questions about survey topics. Additionally, at health wellness fairs, I was able to answer questions and discuss the facts and potential dangers of vapes and electronic smoking devices to parents when I was asked about them. See appendix for MPH competency list.

Looking back at this experience, there are several key lessons that I will take away with me. I was thrown into a subject matter that I had very little knowledge about, and was previously not aware of the magnitude of the public health problem. The rising popularity of smokeless tobacco products is not going to go away, and it's incredible to see the similarities of tobacco companies marketing these products compared to their marketing tactics of cigarettes in the 20th century. SCDPH and TFC in particular vastly educated me on electronic smoking devices, little cigarillos, vapes and hookah. Not just on their popularity, but also all of the carcinogens and

chemicals that are in the vaporized smoke. Conducting observational stores surveys, and public intercept surveys I got a glimpse into how effective and influential marketing, advertising, and product placement has on the human mind. With that being said, retailers and stores have a powerful effect on their communities, which is something I did not realize before, but healthier stores really do have a hand in creating healthier communities. Another important take-away for me, is the power of education. Educating the public and parents about the adverse health effects of smokeless tobacco can positively impact local communities. The future policy implications from the results of this campaign can potentially decrease the sale of smokeless tobacco products to youth.

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Appendix:

Objectives:

USF Fieldwork Internship: Objectives

Santa Clara County Department of Public Health: Center for Chronic Disease &
Injury Prevention: Healthy Stores for Healthy Communities Program

I. Become well versed and assist with Santa Clara's "Healthy Stores for Health Communities" program and Assist with the implementation and completion observational surveys in Santa Clara county associated with program.

- a. Assist Project Lead with researching and developing list of data collection schedules and sites
- b. Disseminate list of stores to Student Interns and Volunteers
- c. Coordinate Student Interns and Volunteers schedules and project completion
- d. Assess, monitor, and report to Project Lead on data collection progress
- e. Identify new and ongoing needs of program
- f. Help project lead clean the initial data due to multiple survey submission

II. Visit and collect data on all assigned list of stores with the end goal of data from these observational survey's to be used to analyze tobacco (cigarettes, chewing tobacco, E-cigarettes, Vapes, etc), alcohol, and sugary drink availability, advertising, and price promotions in SC stores.

- In coordination with the Project Lead, facilitate debrief sessions with all data Collectors
- Compare initial observational data instruments from 2013 with previous

survey outcomes and present staff with findings

- Assist the Project Lead with evaluating the data collection process and provide any recommendations for improvement as needed

III. Observe, collect, and upload HSHC Observational Survey data to assess and study behavioral, social, cultural factors related to Santa Clara County population health associated with tobacco advertising in local stores.

- Interact with diverse communities and store owners to collect data through cultural competency

IV. Observe, collect, and interpret HSHC Public Intercept Surveys

- Aim to collect 450 Surveys with 5 other interns
- Collaborate with preceptor to identify best possible ways to collect data
- interact with diverse communities to gage public opinion on potential smoking policies, advertising and product availability

Master of Public Health Program

MPH PROGRAM COMPETENCY INVENTORY

USF MPH Competencies	Proposed Activities	Number of Hours (Estimated)
1. Assess, monitor, and review the health status of populations and their related determinants of health	N/A	0
2. Demonstrate the ability to utilize the proper statistical and	N/A	0
3. Identify and prioritize the key dimensions of a public health problem by critically assessing public health literature utilizing both quantitative and qualitative sources.	Was exposed to documents, factsheets, research to help me understand the scope of the problem in general and county wide	5
4. Specify approaches for assessing, preventing, and controlling environmental hazards that pose	N/A	0

<p>5. Apply theoretical constructs of social change, health behavior and social justice in planning community interventions.</p>	<p>applied theoretical constructs of health behavior associated with tobacco use to better understand populations that were targeted in the HSHC. Also why certain communities or populations have higher smoking rates and social behaviors associated with that.</p>	<p>30</p>
<p>6. Articulate the relationship between health care delivery and financing, public health systems, and public policy.</p>	<p>N/A</p>	<p>0</p>
<p>7. Apply evidence-based principles to the process of program planning, development, budgeting, management, and evaluation in public health organizations and initiatives.</p>	<p>Evaluated results with preceptor from intercept surveys as we got them to see if we needed to re-adjust target cities and demographics.</p>	<p>4-6</p>
<p>8. Demonstrate leadership abilities as collaborators and coordinators of evidence based public health projects.</p>	<p>I coordinated interns for both phases of surveys. I coordinated schedules between interns and preceptors to conduct debrief sessions. I would update preceptors on project progress, and help interns with any problems or concerns they had.</p>	<p>250</p>
<p>9. Identify and apply ethical, moral, and legal principles in all aspects of public health practice.</p>	<p>N/A</p>	<p>0</p>
<p>10. Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.</p>	<p>N/A</p>	<p>0</p>

<p>11. Effectively communicate public health messages to a variety of audiences from professionals to the general public.</p>	<p>Discussed campaign and smokeless tobacco facts and health effects with preceptors and staff. Then was able to divulge information to public during survey collection.</p>	<p>100</p>
<p>12. Advance the mission and core values of the University of San Francisco.</p>	<p>Aimed to Fulfill USF mission to communicate and apply knowledge (about tobacco and retail environment) to a world (Santa clara community) shared by all people to help future generations.</p>	<p>300</p>
<p>CEPH Core Knowledge Areas</p>	<p>Proposed Activities</p>	<p>Number of Hours (Estimated)</p>
<p>Biostatistics</p>	<p>N/A</p>	<p>0</p>
<p>Epidemiology</p>	<p>Used Epi. Principles to reduce bias when collecting public intercept data.</p>	<p>50</p>
<p>Social and Behavioral Sciences</p>	<p>Conducted store surveys and intercept surveys in diverse communities. Exposed to different cultures and attitudes toward tobacco control and health disparities.</p>	<p>250</p>
<p>Environmental Health</p>	<p>N/A</p>	<p>0</p>
<p>Public Health Administration and Leadership</p>	<p>Demonstrated leadership skills through project coordination, helped with many of the administrative aspects of project, like logging progress.</p>	<p>275</p>
<p>Cross-Cutting/Interdisciplinary Values</p>	<p>Proposed Activities</p>	<p>Number of Hours (Estimated)</p>
<p>Communication and Informatics</p>	<p>N/A</p>	<p></p>

Diversity and Culture	Communities I interacted with had variety of different cultures, languages, socioeconomic backgrounds	175
Leadership	Collaborated and coordinated interns. They would come to me for guidance, questions and problems. Lead debrief discussion calls.	75
Professionalism	Conducted myself in a professional manner in workplace concerning all parts of my work with preceptors, department staff, interns, and public .	300
Program Planning	Briefly exposed to program planning by hearing about how this campaign was created and implemented	5
Public Health Biology	N/A	
Systems Thinking	N/A	