



HHS Public Access

Author manuscript

Health Promot Pract. Author manuscript; available in PMC 2014 January 22.

Published in final edited form as:

Health Promot Pract. 2013 September ; 14(5 0): 88S–95S. doi:10.1177/1524839913484469.

Building Tobacco Cessation Capacity in the US-Affiliated Pacific Islands

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Abstract

Tobacco control stakeholders in priority populations are searching for culturally appropriate cessation training models to strengthen cessation capacity and infrastructure. We adapted the University of Arizona model for Brief Tobacco Cessation Interventions (BTI) training for Pacific Islanders and pilot-tested it in four Pacific Islands - Palau, the Federated States of Micronesia, the Northern Mariana Islands and the Marshall Islands.

All participants completed a post-training knowledge assessment exam, pre- and post-confidence assessments and a quality improvement evaluation. Of 70 participants, 65 (93%) completed the training. Forty-one (63%) passed the post-training knowledge assessment exam at the 1st attempt; an additional 9 (14%) successfully passed on their 2nd attempt, for a total pass rate of 77%. The pre and post confidence surveys demonstrated a statistically significant increase in confidence across all competency areas for delivering brief advice. The quality improvement survey revealed high acceptance and approval for the content and delivery of the locally adapted training model.

As Pacific Island communities enact tobacco control policies, cessation demand is growing. The Guam cessation training model used culturally relevant data, materials and training approaches and appeared effective in four different Pacific island countries. This underscores the importance of culturally competent adaptation of cessation training for priority populations like Pacific Islanders.

Keywords

tobacco cessation; Pacific Islander; cultural competence

Introduction

Tobacco use remains a major public health challenge in the US-affiliated Pacific Islands (USAPIs). Adult consumption is high; with male smoking prevalence ranging from 30% in Guam (Guam DPHSS, 2010) and the Federated States of Micronesia (FSM) to 49% in American Samoa (World Health Organization, 2012). Female smoking prevalence, while still below 10% in the Republic of the Marshall Islands (RMI) and Palau, hovers around 20% in Guam and FSM, and approaches 30% in American Samoa (World Health Organization, 2012). Youth smoking prevalence mirrors the adult rates, with over 30% of high school boys in Guam and FSM, and over 50% of boys in Palau reporting smoking within the past 30 days (WHO, 2012). Moreover, the practice of adding tobacco to betel quid is widespread; over 43% of adult males and over 16% of adult females in FSM, and 47% of high school boys and 34% of high school girls in the Commonwealth of the Northern Mariana Islands (CNMI) (World Health Organization, 2012) reported chewing betel quid with tobacco. Not surprisingly, tobacco-related noncommunicable diseases (NCD) now comprise the top causes of mortality in these islands (World Health Organization, 2012).

The growing concern about NCD across all the USAPIs and the ratification of the WHO international Framework Convention on Tobacco Control (FCTC) by the 3 USAPI nations (FSM, RMI and Palau) have catalyzed action on tobacco control, through higher tobacco taxes and smokefree policies. As the USAPIs enact and implement these policies, cessation demand is growing (Guam State Epidemiological Outcomes Workgroup, 2012). Unfortunately, health system infrastructure and capacity building for tobacco cessation within these priority populations remains underfunded and neglected, mirroring the significant gap in cessation research for Pacific Islanders (Lawrence, Graber, Mills, Meissner, & Warnecke, 2003; Chen, 2001). Moreover, the lack of culturally and linguistically tailored tobacco control programs retards the USAPIs' ability to slow down the tobacco epidemic (Lew & Tanjisiri, 2003). Public health professionals in these communities are recognizing the need for a population approach to cessation. Towards this end, tobacco control stakeholders in the USAPIs are searching for culturally tailored, feasible and sustainable population-based cessation training models to strengthen their cessation infrastructure and capacity. This manuscript outlines the adaptation of the Brief Tobacco Intervention (BTI) Skills training curriculum, developed by the University of Arizona for smoking cessation advice and follow-up, for use in Guam and other USAPIs. It describes how adaptation of existing programs can help with systems level tobacco efforts.

Background

The BTI certification training curriculum, which focuses on building capacity to deliver brief tobacco cessation advice, was developed by the University of Arizona based on the clinical practice guideline *Treating Tobacco Use and Dependence* (Fiore, et al, 2000). It was

originally intended to serve Arizona's population, mainly comprised of Caucasian, Hispanic and Native American residents, where smoking is the predominant form of tobacco consumption. The four-hour training assumes participants have no prior knowledge or skills in tobacco cessation. Using Prochaska's transtheoretical model for the stages of behavior change (Prochaska & Velicer, 1997), participants are taught to assess a client's readiness to quit, to deliver a stage appropriate brief tobacco cessation intervention, and to provide further assistance, referral, and follow up as appropriate, using an algorithm that provides guidance during the intervention. A certified tobacco cessation specialist facilitates the training using formal presentations on core content, augmented by a training video, and skills demonstration by participants using role-plays. Training materials include a participant guidebook, a training video in VHS format and a set of tools provided to participants that include a pocket sized algorithm outlining the basic steps of a brief intervention, a handout emphasizing the benefits of quitting for those not yet ready to quit, a fill-in-the-blank basic quit plan for the tobacco user interested in setting a quit date, and client oriented information cards on pharmacotherapy, to be used as appropriate.

The BTI training comprises six (6) modules, and requires all participants to demonstrate proficiency in providing brief cessation advice. Certification requires satisfactory demonstration of skills and a passing score on a 25-point multiple choice knowledge assessment examination, based on course content, administered at the end of the training class. Participants are allowed to take the knowledge assessment a second time if they fail to make the passing grade at their first attempt. An evaluation of the training curriculum in Arizona demonstrated significant and durable increases in self-efficacy across 8 competency areas. Post-training follow-up revealed that 80.9% of trainees had performed at least one brief intervention and 74.8% had made a referral to intensive cessation services (Muramoto, et al, 2000).

The training works best within a comprehensive system of care, with brief advice supplemented by the ability to refer to intensive counseling, quitlines and physician-supervised drug treatment of tobacco dependence. However, there is evidence that brief advice alone, conducted systematically as a population approach to cessation, by different types of health workers, leads to a 2-4% reduction in overall smoking prevalence (Fiore, et al, 2000). Further, the widespread use of brief advice by community health workers can link smokers who are ready to quit in the general population to existing cessation services, prior to the development of tobacco-related disease. Brief advice capacity building can also represent the first step towards gradually developing a cessation infrastructure in resource-challenged settings such as the USAPIs, where health system capacity and infrastructure for cessation remains suboptimal.

Guam's tobacco control efforts were accelerated in 2003, following the first infusion of money from Guam's portion of the Master Settlement Agreement (MSA). Informal stakeholder consultations identified population approaches to cessation as a program priority in 2004 (P. Cruz, personal communication, May 2012). In mid-2005, the BTI certification training was first used in the US Territory of Guam through a collaborative public-private initiative of the Guam Department of Public Health and Social Services, the Guam Department of Mental Health and Substance Abuse, the American Cancer Society-Guam

chapter and Health Partners, L.L.C. Working with the original developers from Arizona, cessation specialists from Hawai'i conducted the initial training, followed by a Training of Trainers that created a local BTI trainers' pool. Guam's team of BTI trainers started conducting trainings using the University of Arizona curriculum throughout Guam and Saipan, Commonwealth of the Northern Mariana Islands (CNMI) in late 2005.

Following a series of consultations with the initial batches of BTI-trained Guam participants and other key stakeholders in tobacco control and prevention, the original training was adapted to better fit the needs of Pacific Islanders. In May 2009, the World Health Organization (WHO) South Pacific Office requested the Guam trainers' team through Health Partners, L.L.C. to conduct BTI training workshops in four (4) Pacific Island countries: the Republic of Palau, the Federated States of Micronesia (FSM), CNMI and the Republic of the Marshall Islands (RMI).

Methods

Participant feedback from the initial training workshops conducted from 2005 - 2006 indicated that while the course content and skills-based approach were well received, gaps existed in a number of areas, indicative of "cultural mismatch" (Castro, Barrera & Martinez, 2004):

1. Smokeless tobacco use, including chewing tobacco with betel quid, was not addressed, yet this is an important category of tobacco consumption in Guam and the other USAPIs;
2. Tobacco data focused on US mainland data, which is significantly different from local data;
3. The training video and other materials used Caucasian and native American images, which local participants could not relate to;
4. The emphasis on lectures as the major information delivery approach was considered "too Western" and inconsistent with the more informal, participatory style that Pacific Islanders favor; and,
5. The pace of the course, intended to take up 4 hours, was too rapid for participants with no previous tobacco control knowledge and cessation skills to fully absorb.

Using feedback from informal consultations with various Pacific Islander tobacco control stakeholders who participated in the 2005 - 2006 BTI trainings in Guam and CNMI, a multisectoral core group of BTI trainers revised the original curriculum to tailor it to the local Pacific Islander context. The US Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention's (SAMHSA-CSAP) State of the Art Review Finding the Balance: Program Fidelity and Adaptation in Substance Abuse Prevention (US Department of Health and Human Services) 2002) provided the framework for the revisions. Following correspondence with the developers, the trainers' group identified core components of the original training curriculum that should be retained. Then, aspects where revisions could enhance the training

curriculum's "fit" with the USAPIs' context were selected, and modifications were carried out.

Specifically, the changes involved

1. Incorporating forms of tobacco use other than smoking into the text and skills sets – For example, instead of using "Do you smoke?" to ask about tobacco use, we substituted "Do you use any form of tobacco?" The brief advice, "Quitting smoking is the best thing you can do for your health!" was modified to "Quitting all forms of tobacco use is the best thing you can do for your health!"
2. Replacing US mainland statistics with local data on tobacco use prevalence, including smokeless tobacco consumption, and tobacco-related morbidity and mortality
3. Modifying the training materials to promote a more distinctive Pacific Islander "look" (using local symbols, images, terminology and models). For instance, we included role play scenarios that reflected common local social situations where providing brief advice would be appropriate, such as a coach with his student athlete, rather than just clinic-based scenarios. We also changed the video format from VHS to CD-ROM, and developed a set of PowerPoint slides consistent with the modules for facilitators to use, to ensure better standardization of information delivery.
4. Substituting the more formal didactic teaching approach with a more informal and participatory training method utilizing icebreakers and group exercises to reinforce course content, consistent with adult learning principles (Harthun, Dustman, Reeves, Hecht, & Marsiglia, 2008)
5. Extending the training time to 6 hours, with coffee and lunch breaks built in.

The trainers' group was mindful to retain all of the core components of the original curriculum, including curriculum content (other than the data section), format (6 modules of information delivery followed by skills demonstration), and credentialing requirements.

In 2009, the multisectoral trainer core group further adapted the curriculum for use in the other USAPIs. Trainers undertook a search and review of locally relevant regional and island-specific tobacco data, with corresponding amendments made in the participants' guidebook, training PowerPoint presentations and knowledge assessment questions to reflect the tobacco situation for each island. Workshop registration was limited to no more than 20 participants, because in these communities, individuals are less likely to assert themselves in larger groups. In the FSM, where social organization is demarcated by gender (Marshall, 1999), the workshop was organized to ensure same-sex partners for the skills practice sessions.

All participants had to demonstrate acceptable performance of cessation skills, as evaluated by training facilitators using a standardized score sheet. Participants also had to obtain a score of 80% or higher on the knowledge assessment examination, administered at the end of the training class. A pre and post confidence assessment survey was administered to all

participants. The survey looked at 8 competencies for delivering brief tobacco cessation interventions: (1) assessing motivation to quit, (2) exploring issues with someone not interested in quitting, (3) accurately assessing dependence, (4) providing accurate information on the benefits of quitting, (5) personalizing the benefits of quitting, (6) providing simple advice about Nicotine Replacement Treatment (NRT), (7) helping develop a quit plan, and (8) arranging for follow-up.

In addition to the pre and post training confidence assessment, a 17-item quality improvement evaluation survey was administered at the end of the training, using a 5-point Likert scale, where 1 representing the position “Strongly disagree” and 5 represented the position “Strongly agree,” except for item 17, where 1 represented “None” and 5 represented “All” (Table 1). The quality improvement evaluation instrument looked at how well the educational objectives were met, competence of the instructors, usefulness of the course contents, relevance to participants’ work and adequacy of time allotted for learning. Additionally, participants were given the opportunity to provide open-ended feedback on the curriculum materials and content and training approach.

Quantitative data were entered into Microsoft Excel. Knowledge assessment exam scores were tabulated for each group of participants and a group pass rate calculated. Results from the pre and post assessment confidence surveys were tabulated and compared. Mean ratings across all 8 competency areas were derived, and a paired t-test analysis conducted. Descriptive statistics were used for the quantitative results from the quality improvement survey. Responses to the open-ended questions were reviewed and categorized for thematic congruence.

Findings and Discussion

Participants’ feedback was overwhelmingly positive. The participants were appreciative of the new skills they gained.

“Everything that was taught was very valuable and useful. They were very informative and they gave me knowledge and ideas on how I can help my clients who are chewing and smoking tobacco.”

“This certification class has given me the basic skills necessary for me to assist individuals who are dependent on tobacco. I felt confident that I will be able to conduct brief tobacco interventions with clients that my program serves.”

Majority identified the skills demonstration component as the most valuable part of the training.

“The role playing exercises were a valuable component to learning being that it allowed me to use the concepts & materials as I would in real-life setting to be comfortable with it.”

“(The most valuable part of the BTI training was) ...the “Acting” part, where we pretend to be the professional person helping the tobacco users with the steps we've learned.”

Limiting the number of participants per training session was viewed as an advantage, because it allowed for greater interaction between trainers and participants and provided a less threatening workshop atmosphere:

“The small number of attendees provides ease for questions/discussions.”

“This was an excellent workshop. I felt comfortable with other people and not forced to do anything.”

Numerous participants pointed out that the simple methods and approaches espoused by the training workshop for delivering brief advice were effective and appropriate given the local situation in the USAPIs where tobacco cessation resources and capacity are suboptimal.

“Learning the simple way to assess patients whether they use tobacco where they can be referred for help when they are ready to quit!”

“...the modules...are very informative, easy to use. Very practical.”

“Steps simple yet very helpful.”

Participants also expressed appreciation for the local adaptations that made the modules, information, audio-visuals and other materials more locally relevant:

“I (was) really encouraged (that the) short video clips...are homemade for islanders. Very helpful and was easy to do the role plays.”

“(The most valuable part of the training was that)...the contents/context were relevant to the CNMI.”

Overall, a total of 70 participants were trained, with 65 (93%) participants completing the training. Participants were selected by the national tobacco control program staff, and comprised a diverse group of individuals from both the public and private sectors. Forty-one (63% of total) of the participants passed the knowledge assessment examination at the 1st attempt, and an additional 9 (14%) successfully passed on their 2nd attempt, for a total pass rate of 77%. Pass rate was highest for FSM, which had a 100% successful pass rate, and lowest for RMI, which had a 60% pass rate. Facilitators assisted participants who failed initially by reviewing their mistakes on the knowledge assessment instrument. Participants who failed the knowledge assessment on both attempts were advised to repeat the training course.

The pre and post confidence assessment results indicated that for every rating of confidence in each competency, there was an observable increase in confidence after the training workshop. This effect was noted across all 4 training sites. The largest increase in confidence overall was in helping smokers to develop a quit plan. A paired t-test was run on the means of the 8 confidence parameters; the two-tailed P value was less than 0.001 for all competencies. This difference was statistically significant, indicative of a true increase in confidence along the 8 competencies.

Feedback from the quality improvement survey indicated that the training was positively received. Most of the items referring to the quality of the training course had scores that averaged above 4.5. The highest ranked item was “I would recommend this program to my

colleagues,” which was scored at 4.82. There were 2 items intentionally inserted into this survey to ensure that responder fatigue did not bias the results; these were items 12 and 16 (“The length of the class was too long” and “The level of information presented during the course was too advanced.”) For both of these items, the average scores hovered around 3 (“Neither agree nor disagree”) in contrast to the quality improvement items, indicating that participants did not exhibit responder fatigue when completing the survey.

Suggestions for further improvement mainly focused on: (1) developing training materials in local languages, particularly among participants from Pacific Islands where English is not the dominant language (Palau, FSM), (2) creating a local pool of trainers in each USAPI to conduct BTI training in local dialects; (3) extending the training to reach a greater percentage of health care workers and tobacco control advocates, especially from the outer islands which are often excluded from workshops because of the travel distance and costs; and, (4) increasing the time for the training workshop.

“(It would help) to translate (the materials) into Pohnpeian”

“Maybe (it would be worthwhile to conduct the training) in local languages and settings.”

“(Have a...) local trainer or translator.”

“Those in the outer islands need these kinds of information to deliver.”

“Follow up this workshop in other FSM states.”

“Conduct the training more often.”

“It would be great if the session is longer...so that participants can take one step at a time absorbing all that they can get from the instructors.”

“...the class hours could be increased.”

“...allow more time to hear some testimonies of those who were successful.”

Majority of participants were interested in becoming BTI trainers, indicating significant interest in sustained local capacity building for tobacco cessation. Several individuals also mentioned interest in undertaking intensive tobacco cessation counseling to augment brief cessation advice.

Program resources were insufficient to allow for translation of the training curriculum into the local languages. This was a major limitation of the adaptation effort because a significant proportion of the participants were not native English-speakers. The lack of trainers fluent in any of the local languages was another limitation; during the skills demonstration, the non-native English speakers required more time for the role-play to translate their thoughts into English to allow their facilitators to complete the skills assessment.

No independent evaluation of program fidelity was performed; an assessment of the adapted curriculum for “program drift” is a future research area. Moreover, this paper focused on changes in knowledge and self-efficacy for brief cessation interventions in the immediate period following training. We are currently in the process of collecting information from

past training participants to determine the long-term impact of training on cessation service delivery behavior and the durability of increases in knowledge and confidence for cessation.

Conclusions

Developing an evidence-based cessation training program specifically for Pacific Islanders can be a time-consuming and resource-intensive effort. Given the urgency for building cessation capacity in the USAPIs, and the relative paucity of resources, adapting existing evidence-based programs for the USAPIs is a more feasible strategy to address the cessation capacity gap.

The Guam model for BTI training, based on principles contained in the 2000 publication and 2008 update of the US Department of Health and Human Services *Treating Tobacco Use and Dependence Guidelines* (Fiore, et al, 2008), and adapted from the model originally developed by the University of Arizona, appeared effective when delivered in four different Pacific island countries and territories. Results of a pre and post confidence survey demonstrated a highly statistically significant increase in confidence across 8 competencies for delivering brief interventions among all participants after completing the training. A quality improvement survey revealed high acceptance and approval among participants for the locally tailored content and delivery of the Guam training model. Thus, it would appear that in resource-challenged settings, the Guam model has utility for increasing cessation capacity through brief advice, as the initial strategy for establishing a comprehensive cessation infrastructure.

Guam's experience in comprehensive tobacco control highlights the interrelatedness of policy interventions with the demand for cessation services. Tobacco tax increases in 2003 and 2010 and adoption of smoke-free public places legislation in 2005 and a tobacco-free campus policy for all government facilities in 2007 have raised public demand for assistance with quitting tobacco use (Guam DPHSS, 2010). Building cessation capacity through widespread BTI training is a systems level intervention designed to complement and augment the impact of these and other future tobacco control policy initiatives.

Moreover, strengthening the capacity for cessation presents various entry points for addressing other tobacco control and related health issues. Cessation is non-controversial, and, as a health service, is perceived to be wholly relevant to the mission and mandate of the Department or Ministry of Health. Thus its acceptance and support by various stakeholders is relatively easier to procure. BTI training can be framed as a health systems strengthening strategy (working towards creating a sustainable and comprehensive cessation infrastructure), a health workforce capacity building strategy (with the goal of eventually mandating BTI training as a core competency for all health care workers), a settings-based health promotion approach (working to promote tobacco-free lifestyles through Healthy Hospitals, Healthy Workplaces, Healthy Islands, etc.), or a component of “green” environments (by helping to eradicate second hand smoke, an environmental pollutant). It would be strategic to use BTI training as an entry point towards mobilizing greater support for national tobacco control policies and programs for the Pacific.

As Pacific islands enact more tobacco control laws and policies, the demand for cessation will predictably increase. The USAPIs that are independent nations have all ratified the WHO international Framework Convention on Tobacco Control (FCTC), and are bound to implement the articles of the treaty. The remaining USAPIs that are under the jurisdiction of the US federal government are not yet covered by the WHO FCTC, but they are also actively pursuing tobacco tax increases and smoke-free public policies. Thus, strengthening cessation capacity is emerging as a priority public health need.

Given the suboptimal capacity and resources for cessation in the USAPIs, simple population approaches that can be scaled up incrementally are needed. Identifying existing evidence-based cessation programs and carefully adapting them for use in the Pacific islands setting are likely the most cost-effective and beneficial strategies. Using culturally competent and relevant data, materials and training methods increase the probability that tobacco control stakeholders in these islands will accept the cessation training. The Guam model for BTI training, adapted from the original University of Arizona training curriculum, showcases how adaptation of an established evidence-based practice can promote successful cessation capacity building in priority populations.

Scaling up of the BTI training will necessitate greater investments in “Train the Trainers” models to expand the trainer pool. Ultimately, it would greatly benefit the Pacific if a core group of local cessation trainers were created for each USAPI, ensuring that future cessation training workshops are fully culturally competent. This will also maximize the potential for sustainable cessation capacity building that will enable Pacific Islanders to address the rising demand for cessation stemming from tobacco control policy implementation.

References

- Castro FG, Barrera M, Martinez CR. The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*. 2004; 5:41–45. [PubMed: 15058911]
- Chen MS Jr. The status of tobacco cessation research for Asian Americans and Pacific Islanders. *Asian Am Pac Isl J Health*. 2001; 9(1):61–65. [PubMed: 11720415]
- Fiore, MC.; Bailey, WC.; Cohen, SJ., et al. Treating tobacco use and dependence. *Clinical Practice Guideline*. US Department of Health and Human Services. Public Health Service; Rockville, MD: 2000.
- Fiore, MC.; Jaen, CR.; Baker, TB., et al. Treating Tobacco Use and Dependence 2008 Update. *Clinical Practice Guideline*. US Department of Health and Human Services. Public Health Service; Rockville, MD: 2008.
- Guam Department of Public Health and Social Services. Behavioral Risk Factor Surveillance System, 2010 Survey. 2010. Retrieved from <http://www.cdc.gov/brfss/Program>
- Guam State Epidemiological Outcomes Workgroup. Guam substance abuse epidemiological profile 2011 update. Guam Department of Mental Health and Substance Abuse; Hagatna, Guam: 2012.
- Harthun ML, Dustman PA, Reeves LJ, Hecht ML, Marsiglia FF. Culture in the classroom: developing teacher proficiency in delivering a culturally-grounded prevention curriculum. *Journal of Primary Prevention*. 2008; 29(5):435–54. [PubMed: 18807191]
- Lawrence D, Graber JE, Mills SL, Meissner HI, Warnecke R. Smoking cessation interventions in US racial/ethnic minority populations: an assessment of the literature. *Prevention Medicine*. 2003; 36(2):204–216.
- Lew R, Tanjasiri SP. Slowing the epidemic of tobacco use among Asian Americans and Pacific Islanders. *American Journal of Public Health*. 2003; 93(5):764–768. [PubMed: 12721139]

- Marshall, M. Partial connections: Kinship and social organization in Micronesia.. In: Kiste, RC.; Marshall, M., editors. *American Anthropology in Micronesia*. University of Hawai'i Press; Honolulu, Hawai'i: 1999. p. 107-143.
- Muramoto M, Connolly T, Strayer L, et al. Tobacco cessation skills certification in Arizona: application of a statewide, community based model for diffusion of evidence-based practice guidelines. *Tobacco Control*. 2000; 9(4):408–414. [PubMed: 11106711]
- Prochaska JO, Veliver WF. The transtheoretical model of health behavior change. *American Journal of Health Promotion*. 1997; 12(1):38–38. [PubMed: 10170434]
- U.S. Department of Health and Human Services. [July 1, 2012] Finding the balance: Program fidelity and adaptation in substance abuse prevention: A state of the art review. 2002. from <http://modelprograms.samhsa.gov/pdfs/Finding-Balance1.pdf>
- World Health Organization. *Noncommunicable diseases in the Western Pacific Region: A profile*. World Health Organization Western Pacific Regional Office; Manila, Philippines: 2012.
- World Health Organization. *Reducing tobacco use prevalence by 10% in 2014: Can we do it? (A mid-term progress report of the Tobacco Free Initiative in the Western Pacific prepared for the Ministers of Health, 63rd session of the Regional Committee Meeting, 24-28 September 2012)*. World Health Organization Western Pacific Regional Office; Hanoi, Vietnam: 2012.

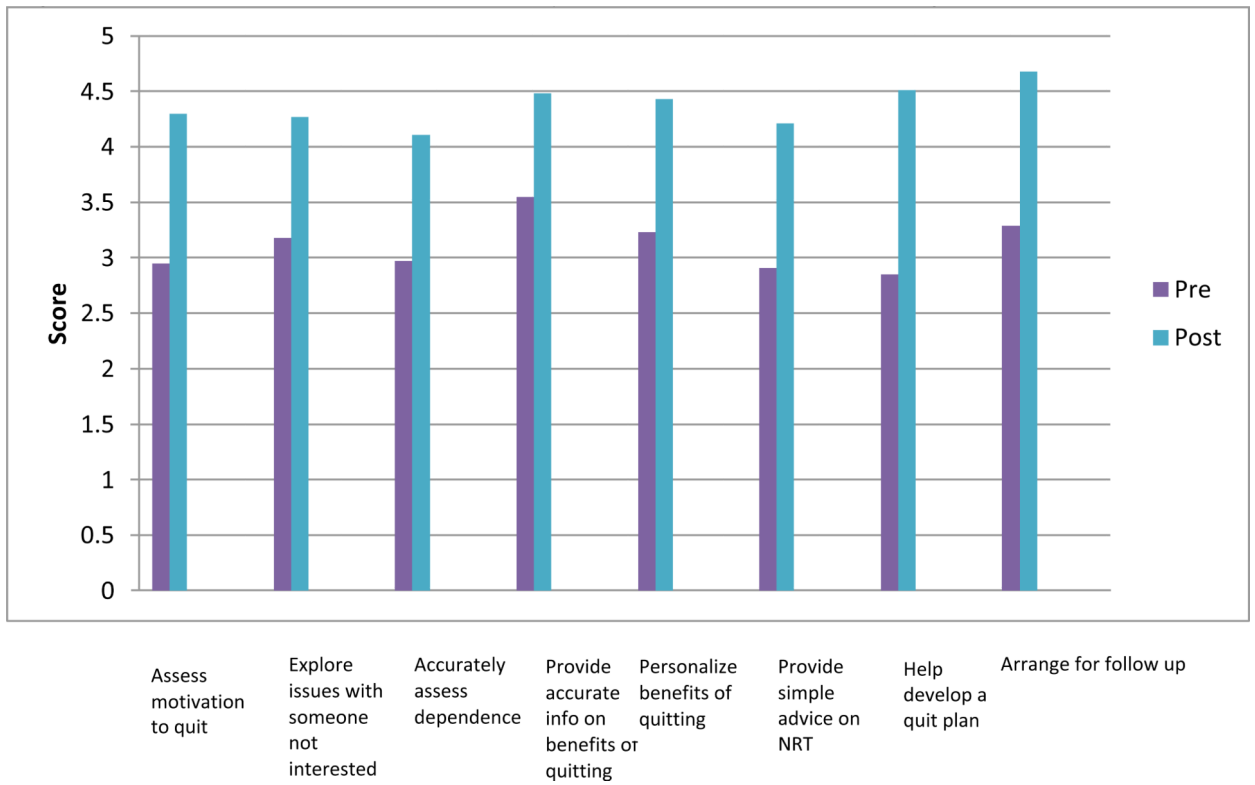


Figure 1.
Pre and post assessment survey results across all 4 training sites

Table 1

Quality improvement survey results

Indicator	n	Mean	SD
The educational objectives were well met.	67	4.73	0.44
The instructor(s) demonstrated a thorough knowledge of the subject matter.	67	4.78	0.45
The presentation content related appropriately to the objectives.	67	4.76	0.46
I would recommend this program to my colleagues.	67	4.82	0.49
The content reflected current issues.	67	4.62	0.58
The instructor(s) applied the material covered to the practice setting.	67	4.69	0.66
I attended this program because the content was relevant to my practice.	67	4.63	0.54
My objectives for this program were well met.	67	4.7	0.49
The instructor(s) did not demonstrate product bias during the presentation.	65	4.37	1.04
The Basic Skills curriculum was excellent.	67	4.76	0.42
The Basic Skills instructor was excellent.	67	4.74	0.57
The length of the class was too long.	66	3.14	1.50
The Basic Skills course was valuable.	67	4.75	0.50
There was ample time for discussion.	67	4.6	0.63
The Basic Skills course maintained my interest.	67	4.61	0.60
The level of information presented during the course was too advanced.	66	3.19	1.40
How much of the information presented in this course was professionally relevant to you?	68	4.55	0.59