Best Practices User Guides

Health Equity

in Tobacco Prevention and Control

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Purpose

The Centers for Disease Control and Prevention's (CDC) Office on Smoking and Health and the Center for Public Health Systems Science at Washington University in St. Louis are developing a set of user guides for the ***Best Practices for Comprehensive Tobacco Control Programs—2014*** *(Best Practices)*.[1]

The purpose of the user guides is to help tobacco control staff and partners implement evidence-based best practices by translating research into practical guidance. The user guides will focus on strategies (*e.g.*, programs and interventions) that have shown strong or promising evidence of effectiveness.

Content

This user guide focuses on how comprehensive tobacco control programs can work to achieve health equity in tobacco prevention and control. *Best Practices* recommends that "Identifying and eliminating tobacco-related disparities among population groups" be a primary goal of every state tobacco control program, along with preventing initiation among youth and young adults, promoting quitting among adults and youth, and eliminating exposure to secondhand smoke.[1] To further reduce overall tobacco use and secondhand smoke exposure, tobacco use must be reduced in population groups with the greatest burden of tobacco use and secondhand smoke exposure. Because tobacco control policies take a population-based approach to improving health, policies have the potential to reach groups most affected by tobacco and reduce disparities. This guide offers tobacco control program staff and partners information on how to work toward achieving health equity when planning, implementing, and enforcing tobacco control policies.

Note to the Reader

Each instance of italicized, bolded ***blue text*** in the guide indicates a link to an additional resource or a page within the guide itself with more information. Website addresses for all of the blue resources noted throughout the guide are also included in the Resources section.

Organization

- **Making the Case:** a brief overview of why tobacco control programs should work to achieve health equity
- **Brief History:** how health equity has become a main goal of tobacco prevention and control efforts
- **How to:** strategies to promote health equity and reduce tobacco-related disparities
- **Providing Support:** how tobacco control programs can support efforts to achieve health equity
- **In Action:** real-world examples of efforts to achieve health equity in tobacco prevention and control
- **Case for Investment:** information that can be used to gain support for tobacco control efforts that focus on health equity
- **Resources:** publications, toolkits, and websites to help in planning efforts

Best Practices for Comprehensive Tobacco Control Programs–2014[1]

The ***Best Practices for Comprehensive Tobacco Control Programs*** is an evidence-based guide to help states plan and establish comprehensive tobacco control programs. The report offers recommendations and supporting evidence for five essential components of effective tobacco control programs: state and community interventions, mass-reach health communication interventions, cessation interventions, surveillance and evaluation, and infrastructure, administration, and management.

Making the Case for Health Equity

In public health, health equity is the opportunity for everyone to reach their full health potential, regardless of any socially determined circumstance.[2] Health equity can be achieved in tobacco prevention and control by eliminating differences in tobacco use and exposure to secondhand smoke between certain groups. Well-enforced and comprehensive tobacco control policies (*i.e.*, those that do not include exceptions or unclear language that may leave some population groups unprotected) can reduce these disparities. Unlike traditional direct-service interventions that focus on individual behaviors, tobacco control policies focus on large-scale, population-level changes. They have the potential to influence and change social norms related to tobacco initiation, use, and secondhand smoke exposure.[1] Comprehensive tobacco control policies help achieve health equity by:

- **Reducing disparities among groups most affected by tobacco use and secondhand smoke exposure.**
  Multiple, coordinated efforts can reduce tobacco-related disparities among groups with the highest rates of use and secondhand smoke exposure.[1,3,4,5] These efforts can include implementing comprehensive smoke-free laws, increasing tobacco product prices, reducing targeted tobacco industry advertising, and offering comprehensive cessation services (*i.e.*, those that include all seven FDA-approved cessation medications along with individual, group, and telephone counseling). Comprehensive policies can reduce smoking initiation, tobacco use, and exposure to secondhand smoke.[1,6]

- **Addressing the factors that influence tobacco-related disparities.**
  Tobacco-related disparities are challenging problems created and affected by a complex mix of factors, including social determinants of health, tobacco industry influence, a changing U.S. population, and a lack of comprehensive tobacco control policies. These difficult problems do not have a single or simple solution.[7,8] Comprehensive, well-enforced policies help address these factors by changing social norms about tobacco use, increasing protections against exposure to secondhand smoke, and improving access to cessation resources among populations facing the greatest burden of tobacco use and exposure.[1,9]

- **Creating a return on investment.**
  Tobacco control policies are a cost-effective way to reduce the health care costs of tobacco use and secondhand smoke exposure.[6,10] Tobacco control programs can increase their return on investment when populations experiencing tobacco-related disparities are protected by comprehensive policies. Because populations experiencing health disparities make up a significant portion of health care costs, policies that focus on protecting these groups have the potential to significantly reduce overall health care costs.[11]

- **Building support for tobacco control among diverse parts of the community.**
  Policies are interventions that can have broad community support. Participation from a variety of stakeholders creates a powerful force that can work to eliminate tobacco-related disparities and achieve health equity. For example, coalition efforts can increase awareness of social and cultural differences, challenges facing specific populations, the harms of tobacco use, and the importance of comprehensive tobacco control programs. When developing, implementing, and enforcing tobacco control policies, coalitions can create the sustainable partnerships that are needed to reduce tobacco use and secondhand smoke exposure in these communities.

A Brief History

In the fifty years since the landmark 1964 Surgeon General's report, *Smoking and Health*, tobacco control policies have changed social norms and led to large declines in tobacco use.[12] Despite reductions among the general population, tobacco use and secondhand smoke exposure is still higher among some groups.[5] In the early to mid-20th century, smoking was considered a sign of prestige; now tobacco use and secondhand smoke exposure represents the marginalization of certain groups.[13]

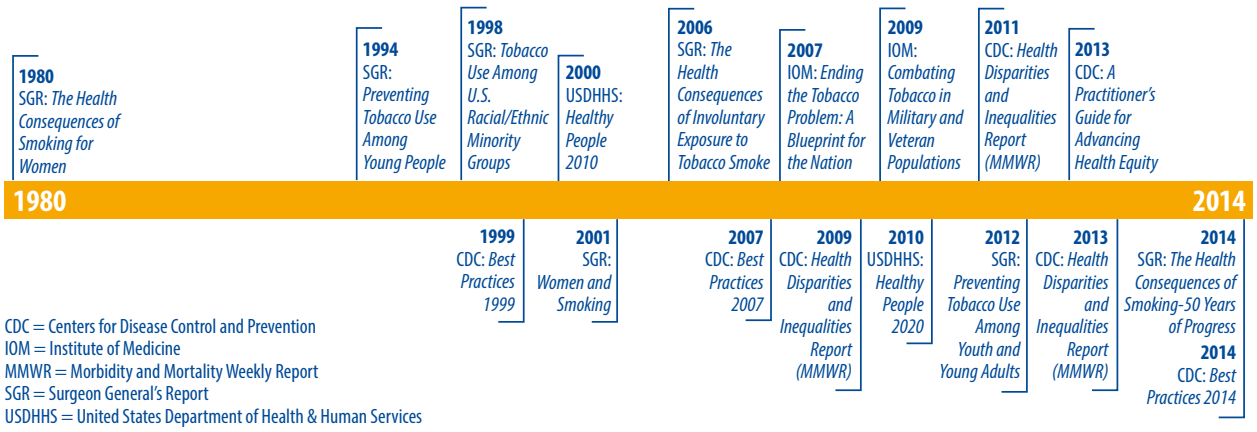
As awareness of tobacco-related disparities has grown, the need to address these differences has become a focus of the national public health agenda. Eighteen national reports on the differential effects of tobacco use among specific populations have been published since 1980, with a notable increase in the past ten years. The 1980 Surgeon General's report, *The Health Consequences of Smoking for Women*, was the first to discuss a specific population group.[14]

The 1998 Surgeon General's report, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups*, discussed four major racial/ethnic groups and explained that tobacco use results from a complex interaction of factors (*e.g.*, socioeconomic status, social and cultural characteristics, targeted advertising, and tobacco product pricing).[15] The 1999 *Best Practices* broadened the definition of disparities to include any group differently impacted by tobacco use and secondhand smoke exposure, not just particular racial or ethnic groups.[16] In 2001, the Surgeon General's report, *Women and Smoking*, made the first mention of smoking disparities by sexual orientation.[17]

In 2008, CDC began funding National Networks for Tobacco Control and Prevention to reduce tobacco-related disparities. In 2013, the CDC expanded this effort to include cancer-related disparities.[18] Organizations funded from 2013-2018 focus on the following groups: American Indians/Alaska Natives; Hispanics/Latinos; African Americans; Asian Americans; lesbian, gay, bisexual, and transgender (LGBT) individuals; people with low socioeconomic status; geographically defined populations; and people with mental health disorders or substance abuse conditions.[18]

Eliminating tobacco-related disparities continues to be a focus of recent national reports. *Healthy People 2020* includes eliminating health disparities as one of four overarching goals of the initiative.[19] The persistence of tobacco-related disparities was also one major conclusion of the 2014 Surgeon General's report, *The Health Consequences of Smoking—50 Years of Progress*.[12] The 2014 *Best Practices* added more evidence and recommendations that states can follow to eliminate these disparities.[1] The CDC report, *A Practitioner's Guide for Advancing Health Equity*, also offers strategies to achieve health equity in tobacco use, access to healthy food and beverages, and active living opportunities.[7] These reports, along with increased funding for health equity initiatives, more data on tobacco use and secondhand smoke exposure among specific populations, and a growing evidence base for the effectiveness of population-based policies, have accelerated efforts to eliminate tobacco-related disparities.

National Reports on Tobacco-Related Disparities



How To Work Toward Health Equity

What is Health Equity in Tobacco Prevention and Control?

In public health, health equity is the opportunity for everyone to reach their "full health potential."[2] No one is prevented "from achieving this potential because of their social position or other socially determined circumstance."[2] Health equity in tobacco prevention and control is the opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability. Tobacco control programs can work toward health equity by focusing efforts on decreasing the prevalence of tobacco use and secondhand smoke exposure and improving access to tobacco control resources among populations experiencing greater tobacco-related health and economic burdens.[1]

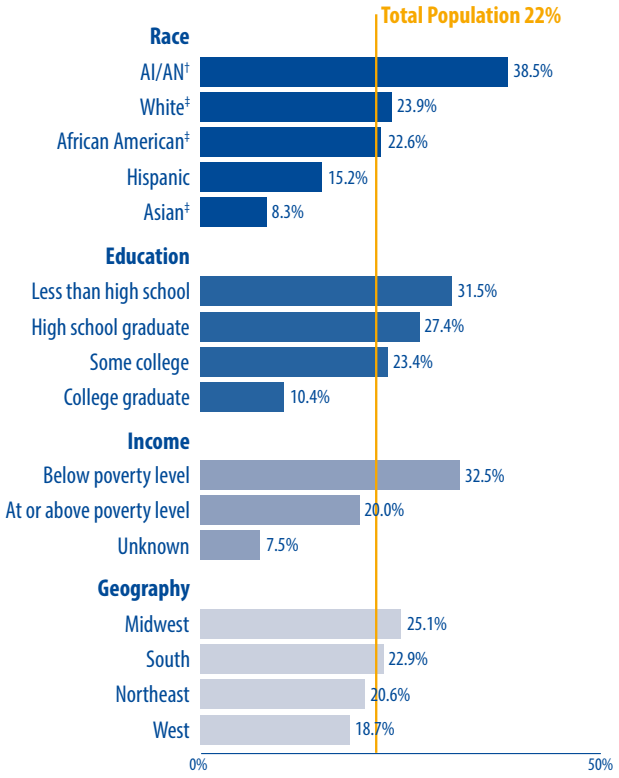
Understanding Tobacco-Related Disparities

Health disparities are differences in health outcomes between population groups based on characteristics like income, race, or geography.[20] CDC's *Best Practices* defines tobacco-related disparities as: "Differences that exist among population groups with regard to key tobacco-related indicators, including patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness; and capacity, infrastructure, and access to resources; and secondhand smoke exposure."[1]

Tobacco-related disparities affect many different population groups based on socially determined circumstances and characteristics like age, disability, education, income, occupation, geographic location, race, ethnicity, sex, sexual orientation, gender identity, mental health status, substance abuse, and military status.[1,21] These groups have a higher prevalence of tobacco use (*i.e.*, the proportion of a population group that uses tobacco), lower cessation rates, and poorer health outcomes.[1,12] Tobacco-related disparities have also been reported among people who are homeless and those who are incarcerated.[22,23]

Cigarette smoking prevalence is one example of these disparities. Despite overall declines in smoking prevalence in the U.S., large differences still exist among population subgroups. Higher smoking prevalence has been reported in the LGBT community and among populations living in poverty, those with mental health disorders and substance abuse conditions, and those living in the South and Midwest.[12,24,25] Other geographic differences also exist. For instance, rural populations have a higher smoking prevalence than urban

Current Cigarette Smoking Prevalence among Adults 18 and Older*



Source: The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General[12]
**Current cigarette smoking is defined as smoking in the 30 days before the survey and having used 100 cigarettes or more in lifetime.*
† American Indian/Alaska Native, non-Hispanic
‡ Non-Hispanic

A Note about Data on Disparities

Tobacco use and secondhand smoke exposure rates included in this guide are mainly reported from peer-reviewed articles and national reports like the ***National Survey on Drug Use and Health*** and the ***National Health Interview Survey***. These data have been adjusted for a variety of demographic characteristics. Adjusting rates is a way to make fairer comparisons between groups with different demographic distributions.[26] For example, one ethnic group might have more young people. If youth smoking prevalence is high, it will result in a higher smoking prevalence among the entire group, preventing a fair comparison with other groups. The adjusted characteristics vary by survey but most commonly include age, sex, or race/ethnicity. Surveys also use different estimates of these characteristics to make adjustments (*e.g.*, 2000 Census data or 2010 Census data). Because of these differences, prevalence rates from different data sources should not be directly compared. For more information on how a specific rate was calculated, please review the source.

Many national surveys also do not include people who are incarcerated, military personnel, or people who are homeless. Surveys also may only be offered in some languages and may include fewer responses from people that do not speak those languages. As a result, all data reported in this guide may not be generalizable to these groups.

populations.[27] The American Indian and Alaska Native population has a higher smoking prevalence than any other racial or ethnic group.[12] The graph on ***page 4*** illustrates differences in cigarette smoking prevalence by race, education, income, and geographic location. The table beginning on ***page 8*** describes smoking prevalence and other tobacco-related disparities among different populations in more detail and includes links to resources for working with specific groups.

Factors Influencing Tobacco-Related Disparities

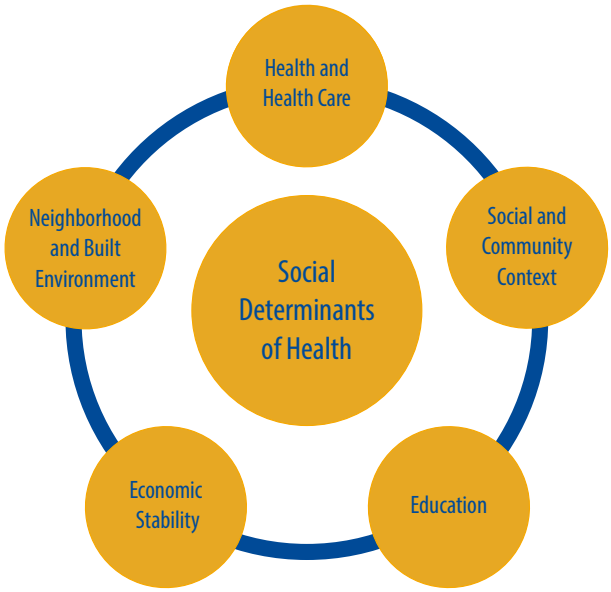
Tobacco-related disparities are created and affected by a complex mix of factors. Social determinants of health, tobacco industry influence, a lack of comprehensive tobacco control policies, and a changing U.S. population can contribute to and maintain tobacco-related disparities.

Social Determinants of Health

Social determinants of health are the conditions in which people are born, grow, live, work, and age.[28] *Healthy People 2020*, a set of national objectives for health promotion and disease prevention, describes five key areas of social determinants that affect health:[29]

- Economic stability;
- Education;
- Neighborhood and built environment (*i.e.*, the housing, environmental conditions, and safety of a person's neighborhood);
- Health and health care; and
- Social and community context (*i.e.*, family structure, community civic participation, and perceptions of discrimination and equality).

Social determinants within each of these broad areas, such as poverty, housing, social support, discrimination, quality of schools, health care access, and transportation,[29] influence tobacco-related disparities. For example, people that lack quality housing may be at greater risk of exposure to secondhand smoke, and people with limited health care access may lack information about the dangers of tobacco use and available cessation options. For more information on how public health programs can address social determinants of health, see the CDC workbook, ***Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health***.[30]



Source: Healthy People 2020[29]

Together, social determinants of health and tobacco use also affect other chronic disease health outcomes. Tobacco use combined with other risk factors like an inactive lifestyle, poor diet, and diabetes poses a greater combined risk and poorer prognosis for many chronic diseases than the sum of each individual risk.[1] Learn more about the connections between tobacco and other priority areas on ***page 26***.

Tobacco Industry Influence

The tobacco industry heavily markets its products to populations affected by tobacco-related disparities.[15,31] Marketing, advertising, and promotional strategies are often directed at low-income, minority, and young adult populations.[31-33] Historically, the industry has also funded groups that work with communities affected by tobacco-related disparities, such as LGBT organizations. For example, in the mid-1990s, an R.J. Reynolds marketing campaign known as *Project SCUM* (Sub-Culture Urban Marketing) was designed to target LGBT and homeless populations.[34] The tobacco industry made donations to AIDS research and supported programs for people with AIDS, sponsored and distributed free cigarettes at LGBT pride events, and paid for smoking lounges at GLAAD (formerly the Gay & Lesbian Alliance Against Defamation) events.[35] Industry funding and support may have contributed to a lack of awareness among the LGBT community about the dangers of tobacco. The industry also developed relationships with organizations that worked with homeless populations and those with mental illness by making financial and other contributions.[36] In 1994, Philip Morris donated 7,000 "Merit" cigarette brand blankets to New York City homeless shelters.[36]

Lack of Comprehensive Policies

Inconsistent adoption and enforcement of tobacco control policies create disparities in protections from secondhand smoke exposure and support for cessation. For example, geographic tobacco-related disparities exist in the South and Midwest,[12,24] regions with fewer comprehensive smoke-free laws, lower tobacco taxes, and limited tobacco control funding.[37] Some of the greatest disparities in lung cancer and coronary heart disease rates are found in these same regions.[38,39]

Service and hospitality workers experience some of the greatest disparities in protection from secondhand smoke. For example, casinos often do not have smoke-free policies. Some states exempt casinos from statewide smoke-free laws, and others allow casinos to have smoking areas, exposing their employees to high levels of secondhand smoke.[40] One study found casino workers were exposed to air pollution from tobacco smoke that was 4 to 6 times that of outdoor levels.[41] Many casinos operated by American Indian and Alaska Native tribes are also exempt from smoke-free laws. Because federal law recognizes these tribes as sovereign nations, tribes can choose to exempt the casinos and gaming facilities they run from statewide smoke-free laws.

Changing U.S. Population

The U.S. population is growing and changing. From 2007 to 2013, the poverty rate for American households increased from 12.5% to 14.5%.[42] Income inequality has also increased. Some subgroups have fared worse than others. For instance, since the 1960s, the poverty rate among adults with less than a high school education has increased from 15% to 34%.[43] Other population characteristics are also changing. By 2050, more than half of the U.S. population will come from racially and ethnically diverse backgrounds.[44]

These changes have the potential to worsen health disparities, including those that are tobacco-related. Poverty has fundamental associations with overall health status, mental health status, and risk factors for poor health. The population of adults living in poverty is more likely to forego needed medical care, experience psychological distress like hopelessness and anxiety, and smoke cigarettes.[12,43] They are also less likely to quit tobacco use, even though most express interest in quitting.[12] Understanding and monitoring the shift to a more diverse American population will be important in determining how to achieve health equity for all groups.

A CLOSER LOOK: Disparities in Other Tobacco Product (OTP) Use

Patterns of tobacco use are changing. People are now smoking cigarettes less often and increasingly using other tobacco products (OTPs).[12] Also known as "non-cigarette tobacco products," OTPs are all products other than cigarettes that contain nicotine.[45] Often milder-tasting or sweetened, these products include combustible products that burn tobacco when smoked (*e.g.*, cigars, pipes, and hookah), non-combustible products like smokeless tobacco (*e.g.*, chew, dip, snuff, and snus) and dissolvables (*e.g.*, orbs, strips, and sticks), and electronic nicotine delivery systems (ENDS) (*e.g.*, e-cigarettes, e-cigars, e-hookahs, and others).[46,47] Despite research linking some of these products to cancers and oral health problems, they are less regulated.[47] Many of these products also have strong youth appeal; for young people, the mild flavors may encourage them to try tobacco.[47] Youth and adults also use OTPs while continuing to smoke traditional cigarettes, a practice commonly known as "dual use."[12]

Disparities in the use and promotion of OTPs mirror trends in cigarette use and marketing. The American Indian and Alaska Native population has the highest prevalence of smokeless tobacco and cigar use of any racial or ethnic group.[12] This population is also most likely to use multiple tobacco products.[12] Other populations that have a high prevalence of multiple product use include young adults, those with less than a high school education, and those living in poverty.[12] Additionally, African Americans and young adults see more advertising and lower prices for OTPs in their neighborhoods.[48]

Data has shown recent increases in the use of ENDS, including e-cigarettes, which typically contain nicotine that is derived from tobacco. E-cigarette use increased among adults from 3% in 2010 to 8.5% in 2013.[49] Among current cigarette smokers, e-cigarette use increased from 10% to 36.5%.[49] From 2011-2012, e-cigarette use nearly doubled among middle and high school students.[12] National surveillance data on the awareness and use of e-cigarettes is still limited.[12,49] Collecting data on emerging electronic products and other tobacco products will help capture changing tobacco use patterns. Tobacco control programs and partners can use information on OTPs to implement policies that protect populations against all forms of tobacco use, regardless of whether the products are combustible, non-combustible, or electronic.

Tobacco-Related Disparities & Helpful Resources

POPULATION CHARACTERISTIC*	TOBACCO CONTROL RESOURCE
Age Most established smokers begin smoking during youth.[50] Among adults who smoke daily, 87% tried their first cigarette before age 18.[12] Young people also have a high prevalence of OTP use. Despite declines in cigarette use among youth, e-cigarette use is on the rise, use of smokeless tobacco has remained steady, and the decline in cigar use has slowed.[12,51] The population of adults aged 65 and older is less likely to try to quit than other age groups.[52]	• ***Quitting Smoking for Older Adults***, National Institutes of Health • ***Youth Resources***, Campaign for Tobacco-Free Kids
Disability/limitation The population living with disabilities has a higher cigarette smoking prevalence (23%) than those without disabilities (17%).[25] Although more likely to receive tobacco cessation information than smokers without disabilities, more than 40% of smokers with disabilities still lacked information about cessation options.[53]	• ***Smoking Cessation Resources***, American Association on Health and Disability
Education Groups with less education have higher cigarette smoking prevalence than groups with more education.[12] For example, 32% of adults who did not complete high school smoke, compared to only 10% of people with at least a college degree.[12] Groups with more education are also more likely to try and succeed in quitting.[12]	• ***How Schools Can Help Students Stay Tobacco-Free***, Campaign for Tobacco-Free Kids
Income Populations living below the poverty level have a much higher prevalence of cigarette smoking and OTP use than other income groups.[12,25] Low-income populations are less likely to successfully quit and more likely to not have access to affordable cessation support.[7,12]	• **SelfMade Health Network**† • ***Tobacco Cessation and the Affordable Care Act***, American Lung Association
Geographic location Total cigarette smoking prevalence varies dramatically within and between[24] communities, states, and regions. Populations in the South and Midwest, and places with large American Indian or Alaska Native populations, have a high smoking prevalence.[24] Rural populations also have higher smoking prevalence (26%) than urban populations (18%), and they use smokeless tobacco at twice the rate of urban populations.[27,54]	• **Geographic Health Equity Alliance**† • ***Prevent Tobacco Use: A CADCA Toolkit***, Community Anti-Drug Coalitions of America • ***Cutting Tobacco's Rural Roots***, American Lung Association
Mental health disorders The population of adults with mental illness is twice as likely to smoke cigarettes as the general population.[55] This population also smokes more cigarettes per month and is less likely to quit smoking.[1]	• ***DIMENSIONS: Tobacco-Free Toolkit for Healthcare Providers***, University of Colorado • **National Behavioral Health Network for Tobacco and Cancer**†
Occupation There are large differences in cigarette smoking across occupational groups. In 2011, smoking prevalence ranged from less than 9% among adults who worked in education to over 30% among adults who worked in construction.[56] Smoking prevalence is also high among workers in occupations like food preparation and serving (30%) and transportation (29%).[56]	• ***Workplace Health Promotion: Tobacco-Use Cessation***, CDC • ***Guide to Safe & Healthy Workplaces***, American Lung Association

*This table describes tobacco-related disparities for certain population groups. This list may not be exhaustive, and disparities may vary by community.
† CDC-funded National Network from 2013-2018.

Tobacco-Related Disparities & Helpful Resources

POPULATION CHARACTERISTIC*	TOBACCO CONTROL RESOURCE
Race and ethnicity Tobacco use disparities exist among racial and ethnic populations. The American Indian and Alaska Native population has the highest cigarette smoking prevalence compared to other racial and ethnic groups (38.5%).[12] This group also has the highest prevalence of cigar smoking, smokeless tobacco use, and use of multiple tobacco products.[12] There is also a high prevalence of cigar smoking among the African American population, particularly among young adults.[12] Some racial and ethnic groups suffer from higher rates of smoking-related diseases like cancer, are more likely to be exposed to secondhand smoke, and are less likely to successfully quit than the general population.[12,37,57]	• **National African American Tobacco Prevention Network**† • **National Native Network**† • **Nuestras Voces**† • **The RAISE Network**†
Sex Cigarette smoking prevalence is higher among males than among females across all racial and ethnic groups, though the gap is decreasing (only a 3% difference in 2012, compared to 5% in 1996).[12,24] Differences are greatest among Asian populations, where the smoking ratio is about three males to every one female.[12] Although females have a lower overall smoking prevalence, the tobacco industry uses targeted marketing strategies designed for female smokers. These strategies use themes like weight control, style, and sophistication to appeal to female consumers.[58]	• ***Resources for Health Professionals***, Smokefreewomen.gov • ***Tobacco Use and Pregnancy: Resources***, CDC
Sexual orientation and gender identity Tobacco use is higher among LGBT populations (38.5%) than among heterosexual/straight populations (25%).[59] The population of LGBT youth and young adults also have a very high prevalence of tobacco use compared to the heterosexual population.[60]	• **LGBT HealthLink**† • ***MPOWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control***, LGBT HealthLink
Substance abuse conditions The population who enters treatment for substance abuse is more likely to use tobacco than the general population, and tobacco use kills more people who seek substance abuse treatment than the alcohol or drug use that brings them there.[61] A long-term study that tracked people who had been in treatment for an addiction found that 51% of their deaths were caused by tobacco-related conditions.[61]	• ***Tobacco Use Cessation During Substance Abuse Treatment Counseling***, Substance Abuse and Mental Health Services Administration
Veteran and military status Active duty military personnel and veteran populations have a dramatically higher cigarette smoking prevalence than the general population. A 2011 Department of Defense study found that almost half of all military service members used a nicotine product in the past year.[62] Military personnel deployed to combat since September 11, 2001, have a higher prevalence of current and heavy smoking than other military members not combat-deployed.[62]	• ***Quit Tobacco – Make Everyone Proud***, U.S. Department of Defense • ***Tobacco and Health***, U.S. Department of Veterans Affairs

* This table describes tobacco-related disparities for certain population groups. This list may not be exhaustive, and disparities may vary by community.
† CDC-funded National Network from 2013-2018.

Policy Interventions to Promote Health Equity

Tobacco control policy interventions are the cornerstone of state and local tobacco control efforts.[12] Because tobacco control policies take a population-based approach to improving health, they have the potential to reach more people and can be particularly effective at reducing tobacco-related disparities.[3] Like most issues addressed by tobacco control policies, tobacco-related disparities are complex problems that do not have a single cause or solution.[7,8] Reducing tobacco-related disparities will take multiple, coordinated efforts.[1] Policies that focus on adolescence and young adulthood, a time when most people begin using tobacco, will be especially important to reduce tobacco-related disparities.[63] Policies to reduce tobacco-related disparities should focus on the following goals:[1,5,12]

- Increasing the number of people covered by comprehensive smoke-free laws;
- Increasing the price of tobacco products;
- Reducing exposure to targeted tobacco industry advertising, promotions, and sponsorship; and
- Improving the availability, accessibility, and effectiveness of cessation services for populations affected by tobacco-related disparities.

Create Smoke-Free Environments

Comprehensive smoke-free laws can benefit people from all socioeconomic, educational, and racial/ethnic backgrounds equally by increasing places where people are protected from tobacco smoke.[3,4] Smoke-free laws are comprehensive when they prohibit smoking in all indoor areas of workplaces, restaurants, and bars.[64] These laws are the most effective way to protect all workers from secondhand smoke exposure in the workplace. They can also reduce the social acceptability of smoking, which can motivate smokers to quit.[1] Although great progress toward creating smoke-free environments has been made in recent years, several groups and many regions of the country are not yet covered by comprehensive smoke-free laws. About 25% of nonsmokers and 40% of children ages 3-11 are still exposed to secondhand smoke.[65] Geographic,

occupational, and demographic disparities still exist. For instance, people with lower socioeconomic status, living in states without comprehensive smoke-free laws, or that work in service and hospitality jobs have the greatest disparities in exposure to secondhand smoke.[12] Tobacco control programs and partners should focus on implementing comprehensive smoke-free laws that protect these populations.

Tobacco control programs and partners should also encourage smoke-free policies in multi-unit housing, which can pose other secondhand smoke dangers. Even in units where residents do not allow smoking, secondhand smoke can enter through shared ventilation systems and hallways. Research has shown that children are 3 to 4 times as likely as adults to be exposed to secondhand smoke in the home.[12] African Americans are most likely to be exposed to secondhand smoke at home, and low-income families are three times as likely to be exposed as wealthier families.[12] Secondhand smoke may particularly affect low-income residents of multi-unit subsidized public housing who may not be able to afford to move.[7] Owners of multi-unit housing may be hesitant to adopt smoke-free policies because of the mistaken belief that restricting residents' smoking is against the law. In fact, state and federal courts have ruled that smokers are not a protected class under fair housing laws, and smoking is not a protected activity under the U.S. Constitution or state constitutions.[66] Prohibiting smoking may actually reduce landlords' legal liability and maintenance costs.[66]

A CLOSER LOOK: Tobacco Use in Rural Communities[54]

Tobacco use is firmly established in many rural communities. Rural populations are more likely to use tobacco products, start smoking at a younger age, smoke more heavily, and be exposed to secondhand smoke than urban populations. Smokeless tobacco use is also twice as common in rural areas. Rural residents do not smoke more just because they live in rural areas. Lower incomes, higher unemployment, and lower education levels also contribute to higher smoking prevalence among rural populations. For many rural communities, growing tobacco has also been a source of income, and as a result, tobacco use has been perceived as more acceptable.

The tobacco industry has a long history of targeting rural populations, particularly young men, with images showing cowboys, hunters, and race car drivers using tobacco. This advertising has been very successful; a study found that boys and men in rural Ohio consider smokeless tobacco use as a key to acceptance into male social networks and as a "rite of passage" into manhood. These beliefs often reduce the demand for policy change. States and local governments in rural areas are also less likely to implement policies that encourage cessation, like raising the price of tobacco products and enacting comprehensive smoke-free laws. Youth living in rural areas are less likely to hear anti-tobacco messages in the media, and rural populations who want to quit tobacco have fewer resources available to help them.

Though tobacco use continues to be a complex issue in rural communities, policy approaches that recognize that rural communities have unique needs and strengths are more likely to be successful. Tobacco control programs and partners can work to reduce tobacco use in rural areas by:

- Collecting data on tobacco use and secondhand smoke exposure in rural communities;
- Working with rural community members to select tobacco control policies and messages that will resonate with the community;
- Finding a community champion who is committed and willing to tackle the status quo of tobacco culture, especially in communities located near tobacco-producing areas;
- Buying spots in media markets that reach rural areas;
- Using e-learning and mobile technologies that can reach people in rural areas to promote tobacco control efforts; and
- Implementing media and education campaigns about the dangers of smokeless tobacco use.

Increase the Price of Tobacco Products

Strong evidence shows that increasing the price of tobacco products is effective in reducing tobacco use and preventing initiation.[1,10] It also prevents relapse among people who have quit.[45] Evidence also shows that increasing the price of tobacco products can reduce tobacco-related disparities among different income groups and may reduce disparities among different racial and ethnic groups.[10]

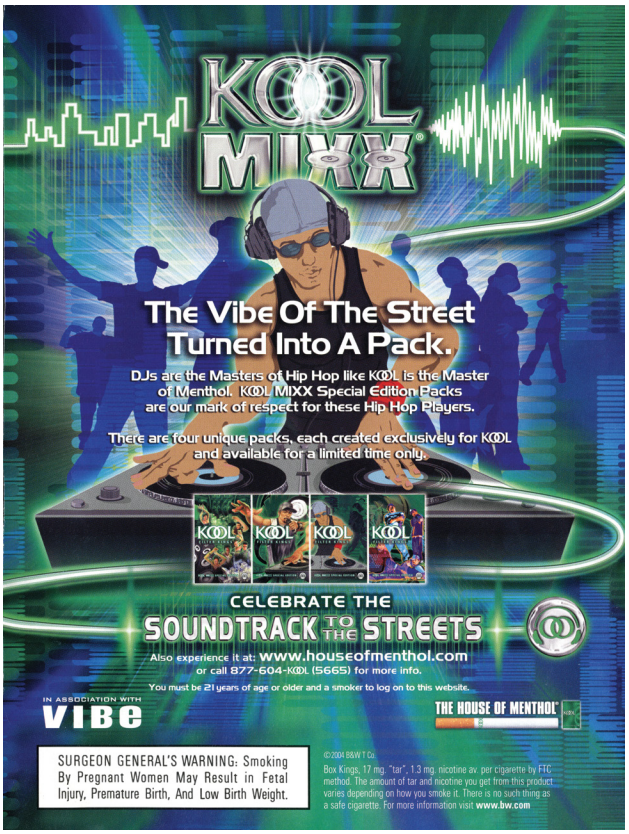
Studies have found that sensitivity to tobacco prices is highest among Hispanics, followed by African Americans and whites (regardless of differences in income).[10] Low-income smokers, certain lower-income occupational groups, and youth are also more responsive to price increases.[67] After tobacco price increases have gone into effect, tobacco use has decreased among low-income groups.[10]

Increasing the price of tobacco products through excise taxes on the manufacture, sale, or use of tobacco products can create large revenues for states.[45,68] When tax increases are not feasible, states can also raise the price of tobacco products through other policies, like banning price discounting or implementing (or strengthening) minimum price laws. To prevent tobacco users from using loopholes like switching to other tobacco products or discount brands, tobacco control partners should work to craft price increases that do not have product exceptions.[45] Increasing tax rates on tobacco products and dedicating part of the resulting revenue to cessation services for low-income populations can be an effective way to increase cessation and reduce tobacco-related disparities.[1,45] Because low-income smokers often have limited access to cessation services, price increases can be combined with evidence-based cessation services to have the greatest impact on tobacco use. Learn more about promoting cessation on ***page 15***.

Tobacco control programs should also work with tribal governments to make sure prices for tobacco products are comparable to state sales prices. Tribes have the right to exempt tobacco products sold to members of their tribe from state tobacco taxes.[45] However, other smokers visit American Indian reservations to purchase these cheaper, tax-free tobacco products. Some states have entered into special agreements with reservations where the tribe agrees to collect state tobacco taxes on all tobacco product sales.[45] In exchange, the tribes may keep this revenue.

Reduce Exposure to Targeted Tobacco Industry Advertising, Promotion, and Sponsorship

Decades of tobacco industry targeting have overwhelmed minority and low-income communities with tobacco advertising, promotion, and sponsorship.[15,31] Before the 1998 Master Settlement Agreement banned and restricted many forms of sponsorship and advertising, messages were often delivered through magazines, billboards, and product giveaways.[1,12] As advertising restrictions have tightened, the industry has become more covert and strategic in its approach, often using philanthropy to improve its image among target populations. For example, the tobacco industry has sponsored social and cultural events and made financial contributions to colleges, elected officials, and community organizations that serve these populations.[15,69] With limited budgets, community groups have welcomed tobacco industry funding and sponsorship. These factors may have reduced the capacity and will of some populations to advocate for the changes needed to rid their communities of the tobacco industry's strong influence.



Advertisement from Brown & Williamson 2004 promotional campaign

A CLOSER LOOK: Regulation of Menthol Cigarettes

As part of the 2009 Family Smoking Prevention and Tobacco Control Act, the U.S. Food and Drug Administration (FDA) banned cigarettes with characteristic flavors other than tobacco. Menthol-flavored cigarettes, which have accounted for at least 25% of cigarettes sold in the U.S. since 1973, were also excluded from the ban.[70] Menthol is produced from the peppermint plant and adds a minty flavor and a cooling sensation that masks the tobacco taste and throat irritation associated with smoking.[71,72] In 2010, there were an estimated 20 million menthol cigarette smokers in the U.S., the majority of whom were African Americans and young adults.[73]

From 2008 to 2010, 57% of youth smokers (ages 12-17) and 45% of young adult smokers (ages 18-25) used menthol cigarettes.[74] Although the overall cigarette smoking prevalence rate declined in recent years, prevalence of menthol cigarette use increased among young adults and remained stable among youth between 2004 and 2010.[73] Research studies have linked menthol with smoking initiation and dependence among youth.[75,76] Because most adult smokers begin smoking before age 18,[50] the link between menthol cigarettes and youth initiation is particularly concerning. Tobacco industry documents suggest that the industry has increased both the amount of menthol in cigarettes and targeted marketing of menthol products to youth and young adults to get them to start smoking and increase dependence.[77]

Menthol cigarette use is also high among other groups, including adult women, those living in the Northeast, and low-income populations.[78] Research studies and tobacco industry documents have shown the industry's targeted marketing of menthol cigarettes to racial and ethnic groups, including African Americans and Hispanics/Latinos.[79] From 2004 to 2008, almost 85% of African Americans who smoked used menthols, compared to only 27% of white smokers.[80]

The effects of menthol on tobacco use initiation, dependence, and cessation have been the focus of intense scientific study. To estimate the effect that a menthol ban could have on smoking-related deaths, researchers modeled three scenarios in which menthol smoking initiation decreased and cessation increased by 10%, 20%, and 30% each.[81] They found that if these assumed effects were to occur, between 323,000 and 633,000 menthol smoking-related deaths could be avoided.[81] Almost one-third of the prevented deaths would be African Americans.[81] A national survey also found that over half of all Americans would support a menthol ban.[82]

In July 2013, the FDA released for public comment an independent preliminary scientific review of the impact of menthol in cigarettes. The analysis supported the conclusion that "…menthol use is likely associated with increased smoking initiation by youth and young adults. Further, the data indicate that menthol in cigarettes is likely associated with greater addiction."[83] The number of menthol smokers is projected to increase if smoking initiation and cessation rates remain steady.[81]

Also in July 2013, the FDA issued an Advanced Notice of Proposed Rulemaking (ANPRM), a request for more information from the public and the research community on specific questions, to help FDA officials make informed decisions about menthol.[84] As of September 2015, the FDA is reviewing comments submitted in response to the ANPRM.

Tobacco industry spending on marketing is on the rise. In 2011, cigarette companies spent $23 million every day to market their products in the U.S.[85] That is nearly $1 million per hour. Increasingly, tobacco companies spend more of these dollars on promotions and sponsorship in stores than in any other venue. In 2011, payments to cigarette retailers and wholesalers to secure retailer cooperation for product placement and promotion accounted for nearly 93% of total industry cigarette marketing and promotional spending.[85] Tobacco industry advertising is greater in low-income and minority communities.[31-33,86] Youth cigarette smoking prevalence is also higher in communities with more tobacco retailers and advertising.[87] Tobacco industry price promotions like discounts and multi-pack coupons are most often used by women, young adults, and African Americans, regardless of income.[88] Smokers of menthol cigarettes and Camel brand cigarettes, most of whom are African Americans and young adults, are more likely to take advantage of discounts than users of other cigarettes.[88]

Tobacco control programs can combat these trends by implementing policies to reduce targeted marketing and sponsorship of tobacco products among vulnerable populations, including policies that:[33]

- Refuse tobacco industry money and sponsorship for events;

A CLOSER LOOK: Jóvenes de Salud Successfully Advocates for a Cinco de Mayo Free of Tobacco Industry Money

Just weeks before the 2010 Cinco de Mayo Fiesta in St. Paul, Minnesota, event promoters announced they would not accept tobacco industry funds. This decision came at the prompting of a group of high school students from Jóvenes de Salud, a Latino youth program. Jóvenes de Salud offered bilingual educational health outreach to peers, family members, and community members.[89] Made up of 50 members from four schools in St. Paul, the group was a program of the Association of Non-Smokers Minnesota and was supported by Comunidades Latinas Unidas En Servicio (CLUES), a Latino community-based health organization.

Jóvenes de Salud marches in tobacco-free Cinco de Mayo parade

The students from Jóvenes de Salud convinced event promoter Riverview Economic Development Association (REDA) to refuse $9,000 from a tobacco company, even though finding sponsors for the event had become difficult. If REDA had accepted the tobacco money, industry representatives would have been able to distribute promotional items and coupons to the over 100,000 people at the festival, the largest Latino event in Minnesota.[90] Youth from Jóvenes de Salud explained to REDA leadership the benefits of an event free from tobacco industry influence: Cinco de Mayo would be a more positive and family-friendly environment and would promote health and wellness in the Latino community.[91] Jóvenes also committed to help obtain funds equaling those offered by the tobacco industry. The group received $5,500 from UCare, a Minnesota health care provider and resolved to raise the rest of the funds for the event through shoe shining, tamale sales, and sales of "Cinco de Mayo" buttons. Their efforts raised another $700, and Jóvenes de Salud pledged to keep fundraising throughout the year.[90]

Tobacco industry price discounting

- Increase the cost of tobacco products through non-tax approaches (*e.g.*, prohibit price discounting);
- Reduce or restrict the number, location, density and types of tobacco retailers (*e.g.*, prohibit the sale of tobacco products at certain types of stores);
- Implement prevention and cessation messaging (*e.g.*, require the posting of quitline information at retail stores);
- Restrict point-of-sale advertising (*e.g.*, restrict all advertising in store windows regardless of the content);
- Restrict product placement (*e.g.*, prohibit self-service access to other tobacco products like cigars); and
- Implement other point-of-sale strategies (*e.g.*, prohibit the sale of flavored non-cigarette tobacco products like little cigars).

Promote Cessation

The majority of smokers want to quit, but some groups are less likely to be successful. For example, African American adults are more likely to express interest in quitting and more likely to have tried to quit than white adults, but they are less likely to use proven treatments and succeed in quitting.[1] Low-income adults also show interest in quitting but are less likely to receive cessation assistance and more likely to receive Medicaid than adults in other income groups.[1] A greater proportion of Medicaid recipients smoke, and they are also less likely to succeed at quitting than people with private insurance.[1] Interventions that combine individual or group counseling with medication are the most effective cessation interventions, but these may not be accessible to all groups because of language or geographical barriers.[12]

Because of the high prevalence of tobacco use among low-income populations, providing comprehensive Medicaid coverage of cessation treatments is one of the most important steps a state can take to increase cessation and reduce tobacco use.[1] The 2010 Affordable Care Act made several changes to cessation coverage, including expanding state Medicaid coverage of tobacco cessation treatment and requiring most private insurance plans to offer cessation as no-cost preventative health care.[92,93] Even with these changes, widespread barriers for Medicaid recipients seeking cessation coverage still exist. Many states still place limits on the number and duration of treatments, charge copayments, and require referrals from a patient's doctor.[94] Some recipients may simply be unaware that cessation is covered by Medicaid. Comprehensive cessation coverage means offering free-of-charge individual, group, and telephone counseling and offering all seven FDA-approved cessation medications (*e.g.*, bupropion, varenicline, and five forms of nicotine replacement therapy, including the patch, gum, lozenge, nasal spray, and inhaler).[1] Comprehensive coverage also means getting rid of any other barriers to services and promoting coverage so that smokers are aware of the options available to help them quit.[1,95]

Tobacco control programs and partners can use policy approaches to improve access to affordable, accessible, and culturally competent cessation services by:

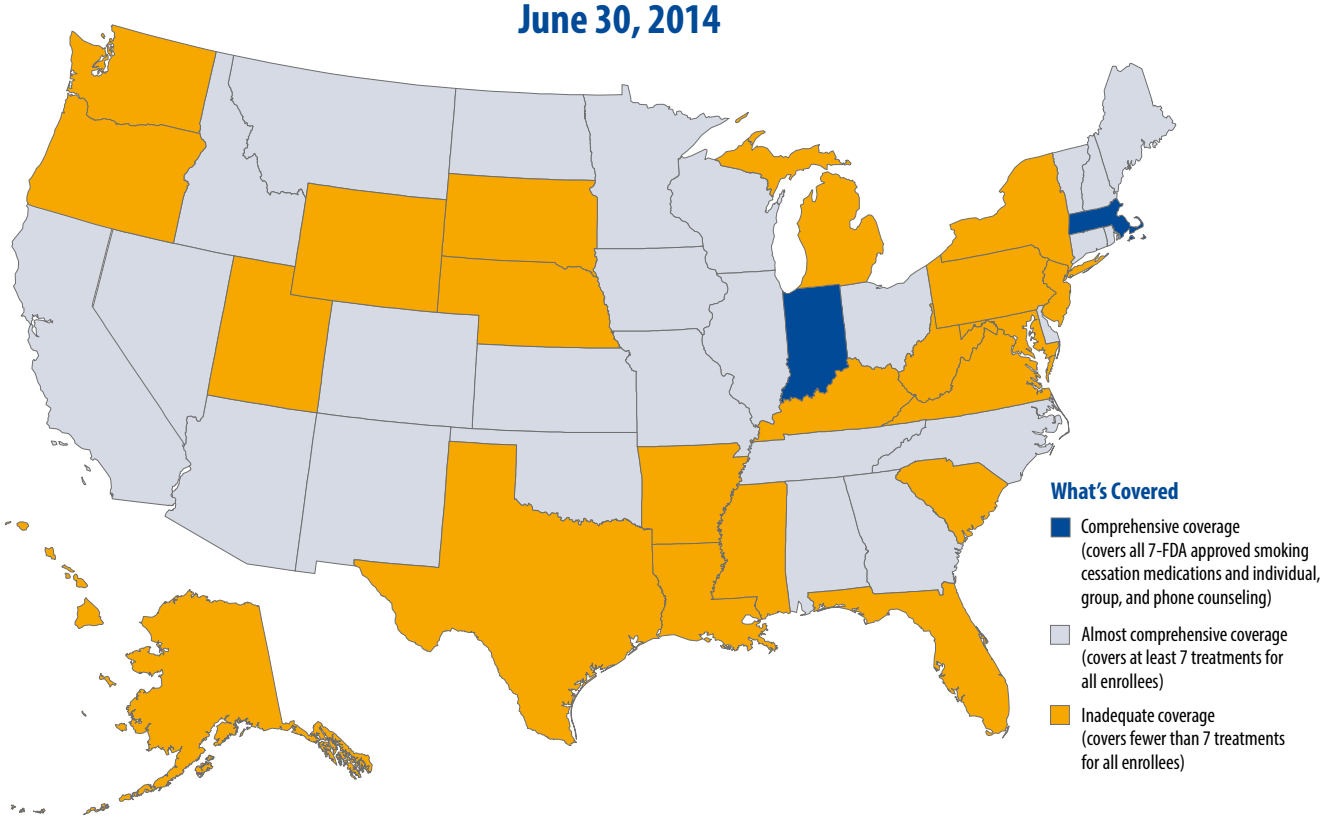
- Working with private health insurers, state Medicaid programs, state employee health plans, and large employers to offer comprehensive cessation coverage;[1]
- Reducing barriers to cessation treatments, including language and cost barriers;[1,95]
- Dedicating part of program resources to cessation, including funds from increases in the price of tobacco products;[1]

- Supplying health care providers with cessation materials that are tailored to their clients' cultures, literacy levels, native languages, and ages;[96]
- Making tobacco use screening and cessation a standard part of all medical care by training staff and offering cessation services in community health clinics;[1,96]
- Promoting and monitoring use of state Medicaid cessation coverage;[1]
- Requiring private health insurers to offer comprehensive cessation coverage;[1] and
- Monitoring implementation of the Affordable Care Act provisions related to cessation coverage.[1]

State quitlines are also effective in reaching African American populations, those who predominantly speak Asian languages, and low-income smokers.[1] Quitlines offer counseling, information on how to quit and, in some instances, FDA-approved cessation medication. Quitlines can help reach broader audiences because they are easily accessible from any phone line in any location. Programs should promote quitlines among populations affected by tobacco-related disparities through policies and activities that:

- Increase the state quitline's reach to populations with high smoking prevalence, including promoting the national Spanish-language and Asian-language Quitlines;[1]
- Expand quitline services by creating partnerships where health plans and employers reimburse the state quitline for services offered to their members/employees or offer their own quitline services;[1]

Smoking Cessation Medicaid Coverage
June 30, 2014



Source: Adapted from Helping Smokers Quit: Tobacco Cessation Coverage 2014, American Lung Association[97]

CDC Asian-language Quitline posters in Chinese, Vietnamese, and Korean

- Implement e-referrals to the quitline from patient electronic health records;[1]
- Integrate quitline services with text messaging like the SmokefreeTXT program that offers encouragement to people trying to quit;[1]
- Train quitline staff in cultural competence;
- Make sure that counseling is offered in the most commonly used local languages; and
- Seek community input during the policy process to make sure cessation services effectively reach the population.

Culturally competent cessation services should be planned to overlap with the implementation of comprehensive smoke-free laws. Even if offering comprehensive cessation services is not possible, cessation support is a critical part of all tobacco control policies.

Selecting Policy Interventions

Some states and communities may have considerable experience implementing tobacco control policies, while others are just beginning to explore policy options. A community's capacity to implement certain policies and the need for particular policies will vary depending on the community's current policy landscape. For example, comprehensive smoke-free air policies should be given highest priority, particularly in regions where these policies are weak. In states and communities that already have comprehensive smoke-free laws, tobacco control staff and partners should evaluate the effects of these policies on reducing tobacco-related disparities. Programs and partners should focus on filling gaps in existing policies and pursuing policies to further reduce disparities, such as those that increase the price of tobacco products or create smoke-free multi-unit housing.[1] For more guidance on planning tobacco control policy efforts, see ***Policy Strategies: A Tobacco Control Guide***.[9]

Implementing Policies to Promote Health Equity

Policies are more effective when pursued as part of a comprehensive tobacco control program.[1] Policies supported by complementary community assessments, partnerships, health communication interventions, infrastructure, and evaluation have the best chance of successfully changing population-level behaviors.[1,98] Comprehensive tobacco control programs are effective at reducing tobacco use across diverse racial and ethnic groups and groups with different education and income levels.[98] But without thoughtful design and implementation, even the most comprehensive tobacco control efforts could actually widen disparities.[7] For example, unintended consequences of policies can sustain existing or create new disparities. Implementation barriers like the cost of and limited access to cessation services can reduce the effectiveness of tobacco control efforts. Tobacco control staff and partners can use the following strategies to make sure policies reach those most affected by tobacco-related disparities:

- Review existing data and, if necessary, conduct a thorough community assessment;
- Partner with members of the population(s);

What is Cultural Competence and Why is it Important?

Working to reduce tobacco-related disparities requires cultural competence—an organizational and personal commitment to diversity and inclusion. It is often used in combination with "linguistic competence," or the ability to share information that is easily understood by diverse groups.[99] Other terms similar to cultural competence are "cultural fluency" and "community competence." Tobacco control programs can make cultural competence a priority by:

- Broadening their definition of culture beyond traditional racial or ethnic groups to include other demographic characteristics or aspects of a person's identity;[44]
- Making sure materials, resources, policies, procedures, and training and professional development of tobacco control program staff reflect an understanding of the people being served;[99]
- Asking tobacco control staff to complete cultural self-assessments of their own values, attitudes, and communication styles so they are prepared to be responsive and sensitive;[100]
- Researching the values, attitudes, communication styles, language, literacy levels, histories, cultures, and social, economic, and physical environments of the people they serve;[101]
- Making sure activities are sensitive to diverse cultural health beliefs and practices, preferred languages, and levels of health literacy;[44] and
- Communicating the program's commitment to and progress toward cultural competence to stakeholders.[44]

When fully integrated into a tobacco control program, cultural competence increases a program's ability to develop, implement, and evaluate policies to reduce tobacco-related disparities. Cultural competence adds to the strength and credibility of tobacco control programs by:[99,101]

- Involving people affected by tobacco-related disparities;
- Preventing stereotypes or overgeneralizations about a population's beliefs or practices; and
- Reducing conflict among coalition members and unintended consequences of policies.

- Design program infrastructure to promote health equity;
- Implement mass-reach health communication interventions that support policy work;
- Make connections between tobacco control and other priority issues; and
- Monitor tobacco-related disparities and evaluate the effects of policies on specific populations.

Conduct a Community Assessment

Community assessments can help tobacco control programs understand and describe the impact of tobacco on a specific community. Communities can be defined by geographic boundaries or other characteristics shared by a group of people.[102] For example, a program might do a community assessment of a city or county, the LGBT community, or the African American community.[102] Tobacco control programs can use assessments to decide which policy changes are most needed. Assessing past policy efforts can also help programs learn what worked and what did not in earlier policy change initiatives.[7] Additionally, community assessments can:[8,102-104]

- Evaluate a community's readiness for policy change;
- Identify existing resources and potential partners;
- Collect information that programs can use to decide where to focus resources and interventions, including information about community members' tobacco use and secondhand smoke exposure, and the community's assets, needs, and culture;
- Educate community leaders and media outlets about how tobacco policies affect other public health issues like chronic disease prevention;
- Share data to help partners understand the relationships between social determinants of health and tobacco use and secondhand smoke exposure;
- Improve the cost-effectiveness of programs; and
- Help design, plan, and implement policies that maximize community benefits and increase the likelihood of reducing tobacco-related disparities.

What Populations are Affected by Tobacco Use in Your Community?

During the community assessment, think beyond the groups facing tobacco-related disparities that you know exist in the population. California added military members as a separate priority group because there is a unique military culture in the state and the military population is targeted by the tobacco industry.[105]

Tobacco control programs can approach community assessments in different ways. Depending on the amount of time and resources available, programs can use interviews, focus groups, surveys, observations, and opinion polls to gather information from members or representatives of the population.[8,106] The Community Tool Box toolkit, ***Assessing Community Needs and Resources***, discusses possible data sources for community assessments.[106] Current census data and tools like Geographic Information Systems (GIS) software can also help visualize the demographic makeup of communities, identify areas of highest need, and tailor policy work. For example, Community Commons is a free online mapping tool that can overlay data on tobacco use with other indicators about the social, health, and environmental conditions of a community.[107] The following questions can help guide community assessments:[7,8,103,108]

"Who" questions:

- Who is in the population(s)?

"What" questions:

- What are the rates of cigarette smoking and secondhand smoke exposure among the population? What are the rates of other tobacco product use (*e.g.*, cigars, smokeless tobacco, or other tobacco products)?

- What are the rates of tobacco initiation and cessation?
- What infrastructure exists to support tobacco prevention and control efforts?
- What does the population view as the main issue, and what should be done about it? What other issues are also important to the community?
- What policies have been tried before? What worked and what did not?
- What policies will most effectively protect the population from tobacco use and secondhand smoke exposure (*e.g.*, workplace, multi-unit housing, or tobacco retailer policies)?
- What tobacco control messages resonate with the community, and what media venues are best to communicate those messages?
- What barriers or competing issues make it difficult to make tobacco control a priority in the community?

"How" questions:

- How does the tobacco industry target the population?
- How can tobacco control programs identify and reach out to community leaders and partners?
- How can tobacco control messages be most relevant to the population?

Partner with the Population(s)

Most issues addressed by tobacco policies are complicated problems that do not have a single cause or solution.[7,8] A variety of perspectives and skills is necessary to plan, implement, and evaluate policies that tackle these tough issues.[8] Strong relationships with people from diverse parts of the community can be a tobacco control program's greatest asset. In return, tobacco control programs can support local communities by helping them build the capacity and momentum needed to implement policies. Partnering with people affected by tobacco-related disparities and the organizations that serve them throughout the policy process also makes sure that policies take into account the needs, values, and culture of the population.[7]

St. Louis, Missouri, Develops Community Partnerships[7]

As part of the CDC's *Communities Putting Prevention to Work* program, the St. Louis Department of Health partnered with trusted community-based organizations to deliver cessation services to three populations with high local smoking prevalence. The department worked with local health clinic Casa de Salud, LGBT advocacy group SAGE Metro St. Louis, and the St. Louis Christian Chinese Community Service Center to reach priority populations. Because the organizations had experience serving these groups, they were able to use strategies that resonated with community members. For example, the St. Louis Christian Chinese Community Service Center used traditional Chinese puppet shows to educate community members about cessation, reaching over 500 people.

A collaborative policy process can support efforts to reduce tobacco-related disparities by:[8]

- Developing the community's sense of ownership of policy efforts because its members help create and implement policies;
- Bringing together different skill sets that may lead to breakthroughs when problems occur;
- Engaging community leaders who can bring credibility to tobacco control policies;
- Bridging language and cultural differences to communicate tobacco control messages that can be understood by diverse audiences;
- Increasing the likelihood that community members and groups will hear and respond to campaign messages;
- Mobilizing and empowering the community through involvement and decision making; and
- Making sure that all populations are included as active participants in discussions and decision making.

A CLOSER LOOK: Supporting Tobacco Control Policy Work in American Indian and Alaska Native Communities

National survey data shows that the American Indian and Alaska Native population has the highest cigarette smoking prevalence of any major U.S. racial or ethnic group (38.5%).[12] This population also has the highest rates of smokeless tobacco use, cigar use, and use of more than one tobacco product.[12] In fact, data from tribe-specific surveys show that commercial tobacco use may be as high as 63% among certain tribes.[109] Learn more about the difference between commercial and traditional tobacco on ***page 22***.

Federal law recognizes many American Indian and Alaska Native tribes as sovereign nations. This status gives tribes the right to self-govern and exempts them from many laws when on tribal land, including some statewide tobacco control policies. To achieve the goal of eliminating health disparities in the over 550 federally recognized tribes in the U.S., tobacco control programs must work closely with tribes and encourage them to make tobacco control a priority in their communities.

To reduce tobacco-related disparities, tribes also need access to valid and reliable data on commercial tobacco use by their members. The ***American Indian Adult Tobacco Survey*** and ***Alaska Native Adult Tobacco Survey*** are useful tools for measuring baseline rates of tobacco use, monitoring changes in tobacco use, developing culturally appropriate interventions, and gathering information to select policy interventions.[109,110]

States, partners, and others working with tribes should recognize that tribal populations vary greatly in geographic location, government, language, culture, and tobacco use. They also have different capacities to carry out tobacco control strategies and have made varying progress toward policy change. Some are in need of basic tobacco education, others are ready for policy development, while still others already have smoke-free policies in place and are considering smoke-free regulations in casinos. Understanding community dynamics and the community's capacity for policy work is important when working with any specific community or population.

State programs and partners can support tribes in implementing tobacco control policies by:

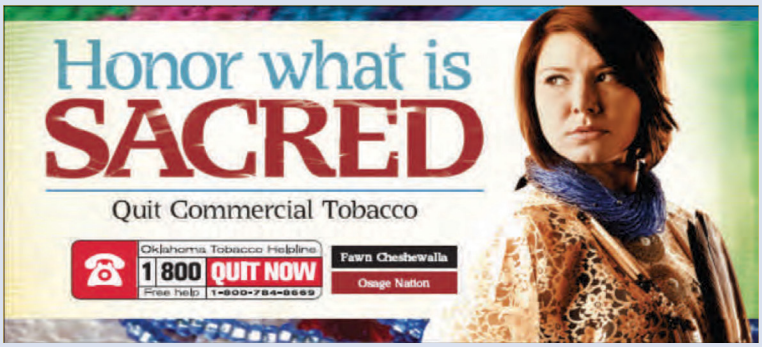
- Making a contact with someone in the tribal community, like a respected tribal elder or a health service provider already working in the community;
- Recognizing that the needs of specific tribal communities may differ from state needs, especially when developing funding opportunities;
- Helping tribal communities gather information about existing policies in their communities;
- Tailoring messages to acknowledge the importance of ceremonial tobacco use in some tribes;
- Recognizing that other health issues and social conditions may affect tribal communities, such as high rates of youth suicide, diabetes, heart disease, poverty, unemployment, and low levels of education;
- Educating tribal partners about how tobacco use can worsen other health issues affecting their communities; and
- Supporting tribal communities in creating policies that are developed, implemented, and enforced from within the communities.

Ceremonial vs. Commercial Tobacco

Many American Indian and Alaska Native tribes have traditional practices for using tobacco and other plants that are considered sacred. Use of the word "tobacco" in these practices can be confusing, because "tobacco" has become a generic term for several plants that are ceremonially smoked or burned, many of which are unrelated to the tobacco plant (*i.e.*, Nicotiana).

Traditional tobacco, in its many forms, continues to be used by some tribes for ceremonial purposes. Tribes that use tobacco ceremonially consider it a sacred medicine provided by the Creator.[111] Ceremonial tobacco is most often a blend of plants, which may or may not contain Nicotiana.[112] Commercial tobacco is manufactured tobacco that is sold for recreational use. It includes brands like *Camel*, *Marlboro*, *Natural American Spirit*, *Top*, and *Redman*. Commercial tobacco is highly addictive, contains harmful chemicals, and causes many health problems. In some cases, commercial tobacco is used for ceremonial purposes.[113]

Respecting ceremonial tobacco use while encouraging cessation of commercial tobacco can help tobacco control messages resonate with tribal communities. For example, using *Communities Putting Prevention to Work* funds, the Oklahoma State Department of Health worked with six Southern Plains tribes to develop the *Honor What is Sacred* campaign.[114] Tribal leaders delivered messages on honoring traditions and the body by emphasizing the difference between ceremonial and commercial tobacco use.[114] Messages were placed in tribal newspapers, promoted on billboards on tribal lands, and broadcast on tribal radio stations.[114]



Billboard from Oklahoma State Department of Health's "Honor What is Sacred" campaign

Tobacco control programs should work with members of the population to select a policy intervention(s) to pursue and develop a plan to guide the policy process. The plan should be part of the program's broader strategic plan and should include goals and objectives related to the policy intervention, identify who will carry out activities, give a timeframe to complete activities, and describe how the program will assess progress and outcomes.[30] Learn more about evaluating policies to reduce tobacco-related disparities on ***page 26***. For more information on developing an action plan, refer to the CDC resource, ***Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health***.[30]

Design Infrastructure to Promote Health Equity

Funding, staffing, and planning decisions all affect a tobacco control program's capacity to serve populations affected by tobacco use and secondhand smoke exposure. These decisions include who is hired, which populations are served, and how strategies are implemented.[7] Considering health equity goals when making infrastructure decisions can help develop culturally competent, equitable policies.

Programs can design infrastructure to promote health equity by:

- Including health equity goals in mission statements and strategic plans;[1,7]

- Distributing resources to organizations that work with specific populations, like tribal health departments;[1]
- Hiring staff with experience working with populations affected by tobacco-related disparities;[7]
- Training staff on cultural competence and health disparities;[7]
- Educating program leadership, partners, and decision makers about health disparities and the importance of reducing tobacco use among specific populations;[1] and
- Requiring funded organizations to implement similar practices.[7]

Implement Mass-Reach Health Communication Interventions

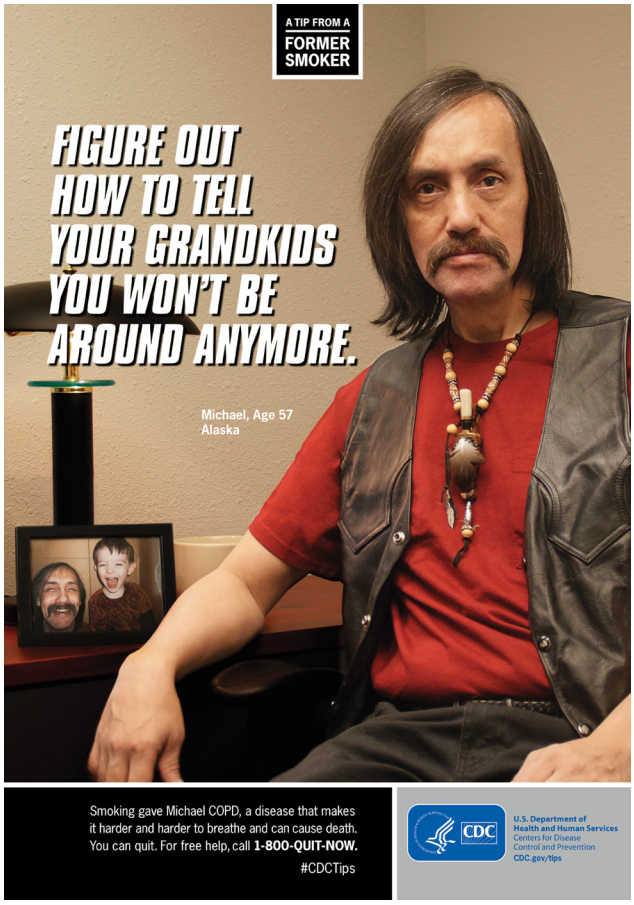
Health communication efforts can help partners build public support for policy interventions.[115] Communication efforts can also support policy goals by discouraging tobacco use initiation, promoting cessation, and shaping social norms among populations affected by tobacco-related disparities. Health communication interventions can take many forms, but to make population-level changes, approaches must reach large audiences.[1] Mass-reach strategies should include:[1]

- Paid media campaigns (*e.g.*, television, print, radio, digital, and out-of-home media like billboards);
- Media advocacy and earned media (*e.g.*, press releases and social media);
- Health promotion activities (*e.g.*, promoting quitlines); and
- Activities to reduce or replace tobacco industry advertising with cessation or health promotion messages (*e.g.*, posting the quitline at the point-of-sale).

Well-designed communications efforts can reach many people and capture the attention of decision makers. To achieve population-level change, efforts should promote policies and influence social norms, not just describe disparities.[7] Campaigns should also use community assessment findings on priorities, challenges, and values of the population to develop messages.[7]

Paid Media Campaigns

Effective paid media campaigns to support policy interventions and reduce tobacco-related disparities do not need to include unique messages for each audience.[1] General population campaigns resonate with diverse audiences when they include graphic, emotional testimonials about the negative consequences of smoking.[1] The ***Tips From Former Smokers*** *(Tips)* campaign, for example, includes personal stories from former smokers describing the effects of smoking on themselves and their loved ones in vivid detail. However, it is still important to incorporate audience diversity in campaigns. For example, the *Tips* campaign features people from population groups with high prevalence of tobacco use.[1]



"Tips" campaign ad featuring Michael, an Alaska Native former smoker

South Carolina Adapts *Tips* Campaign to Promote State Quitline Services[116]

The South Carolina Department of Health and Environmental Control compared Nielsen data on media preferences with health department data to plan media buys that would reach populations with high smoking prevalence. The department worked with the CDC to add the state quitline number to *Tips* campaign ads and coordinated the state's media buys with the CDC's national buys. During the campaign, South Carolina tracked quitline calls, adjusting ad placements and messaging weekly. The campaign tripled quitline call volume and increased the percentage of quitline callers without insurance by nearly 10%.

To be successful, campaigns also need to reach a large portion of the population and run enough times and for a sufficient duration.[12] In general, campaigns need to run for 3 to 6 months to create awareness of the message; 6 to 12 months to affect knowledge, attitudes, and beliefs; and 12 to 18 months to change behavior.[1]

Programs can tailor media buys to reach specific audiences and reduce campaign costs by adapting existing ads and strategically choosing where and when to place them. By researching the population's media habits and preferences, programs can select media outlets and times when the intended audience will be likely to see and hear the messages. For example, some audiences like to listen to the radio while at work; others watch cable news in the evenings. Other audiences walk or ride the bus to work and pass by bus shelters and billboards where ads can be placed. Tobacco control staff and partners can also work with minority-owned radio stations, newspapers, weekly publications, and TV stations that focus on a specific population. Adapting existing campaign materials like those available in the CDC's ***Media Campaign Resource Center*** database can save time and money.[1]

Earned Media & Media Advocacy

Earned media is a term used to describe news coverage earned by communicating with the press. Media advocacy includes all communications efforts to promote a policy intervention. Health communication interventions work best when they include paid media, earned media, and media advocacy in an overall health communication plan.[117] A well-thought-out plan can:[117]

- Help frame policy issues for the public;
- Keep issues alive in the media;
- Garner public support for the campaign and the policy issue; and
- Build credibility for paid media.

For example, secondhand smoke policy messages could frame protection from tobacco smoke as a social justice and workers' rights issue.

Important questions to answer when planning media advocacy efforts include:[117]

- What is the goal of the campaign?
- Who is the intended audience(s) (*e.g.*, community members or elected officials)?
- What action do you want the audience(s) to take?
- Is the message clear and understandable to audiences of all literacy levels?
- Who should deliver the message? Who are the people that can influence the audience(s)?
- What media channels are most effective to reach the intended audience(s)?

Earned media coverage can be an especially useful communication strategy when campaign funds are limited.[1] Low-cost activities include pitching stories to the media, training partners to become spokespersons, attending editorial board meetings, writing letters to the editor, holding press conferences and other media events, and drafting press releases.

Recently, tobacco control partners have effectively used digital media platforms (*e.g.*, dedicated websites, Facebook, and Twitter) to alert supporters to important events. As a cost-effective way to quickly reach a large audience, digital media platforms can be used to collect information, share resources, and expand the campaign's reach as intended audiences share messages among

How to Design a Media Campaign[1,117]

- **Identify the population(s) most affected by tobacco use**
  Analyze existing tobacco use data or conduct a needs assessment to identify the groups most affected by tobacco use and secondhand smoke exposure, and carefully select the intended audience(s) for the campaign. The campaign may need to be designed for multiple audiences (*e.g.*, English-speaking and Spanish-speaking audiences).

- **Include representatives from the intended audience in the campaign's development**
  Consult with credible people or groups who represent the diversity among the intended audience about how to encourage participation by audience members. Recruit members of the population for formative research and gain insights to determine what messages, activities, and communication channels would be most effective. Involve native speakers in writing communications or translating materials.

- **Develop cultural competence**
  Develop an organizational commitment to cultural competence. Learn about local groups affected by tobacco-related disparities, paying careful attention to subgroups, tobacco use, and social norms.

- **Use messages that resonate with the audience**
  Use culturally competent language and images, including personal stories from people with backgrounds that are similar to the intended audience. To be effective, messages should offer the audience a benefit they value, reach the audience enough times, and engage the audience in a way that makes them feel understood.

- **Place messages where and when the audience is most receptive**
  Study media use patterns and qualitative data about the audience's knowledge, beliefs, and attitudes, to decide what form of marketing to use and when and where to place ads to most effectively reach the intended audience.

- **Test the campaign**
  Test messages with representatives of the intended audience to make sure the messages are understood and accepted. Collect qualitative data, like responses from interviews or focus groups, along with quantitative data, like survey responses. Collecting both kinds of information can help capture meaningful feedback and decrease the chance of overlooking important issues. Testing helps make sure that messages are clear, relevant, persuasive, and not offensive to the intended audience.

- **Continue the campaign after the policy goes into effect**
  Continue the media campaign after the policy is implemented to focus the attention of the audience and media on making sure the policy is fully and fairly implemented for all populations. If policies are not implemented equally, certain groups may be protected while others continue to be harmed.

- **Evaluate the effects of the media campaign on the population**
  Evaluate the media campaign to assess how successful it was in changing the population's awareness, knowledge, attitudes, beliefs, and behaviors. Evaluation can also help identify changes to make to increase the effectiveness of future media campaigns focusing on the population.

their social circles. Social media messages are most likely to be shared by the audience when they relate to a topic of interest to the group.[118] Campaigns can tie tobacco control messages to particular hobbies, useful tips, upcoming holidays or major sporting events, information about a specific region or community, or content that interests a specific audience (*e.g.*, pregnant women). The CDC publication, ***CDC's Guide to Writing for Social Media***, offers guidelines and sample messages for Facebook, Twitter, and text messaging.[118]

Ways to communicate messages are continually changing as new media platforms appear and existing platforms fall out of use. Digital media platforms vary in required staff time, cost, and effectiveness at engaging audiences.[119] Although a promising new way to reach audiences, social media should complement paid and earned media, not replace them entirely.[1] Tobacco control staff and partners should evaluate new media efforts and share their findings to help understand what works best for specific audiences.[1]

Connect with Other Priority Issues

Tobacco control staff should seek opportunities to create partnerships with groups working on other community and public health issues. Communities whose members are most affected by tobacco use and secondhand smoke exposure often face other challenging issues like poverty, violence, and limited affordable housing. Community members may assign higher priority to problems like cardiovascular disease, diabetes, cancer, asthma, and substance abuse than to tobacco use and secondhand smoke exposure. Highlighting tobacco use as a key risk factor for other chronic conditions can bring new partners to the table who have existing connections and extensive policy experience. These new partnerships can help programs share tobacco control messages with a wider audience and mobilize support for policy changes.[1]

Low-cost ways tobacco control programs can connect to other priority issues include:

- Crafting joint messages;
- Educating partners about opportunities to promote cessation; and
- Working together to implement comprehensive smoke-free laws.

"Tips" campaign ad featuring Bill, a former smoker with diabetes

The table beginning on ***page 28*** describes the connections between community priorities and tobacco use and offers ways tobacco control staff and partners can work with other groups to support tobacco control efforts.

Monitor Tobacco-Related Disparities and Evaluate Policies

Surveillance, or the continuous monitoring of attitudes, behaviors, and health outcomes over time, and evaluation are crucial to identifying and understanding tobacco-related disparities. Because populations change over time, collecting current, disaggregated data for specific populations can help tobacco control programs maintain an accurate picture of which groups have the highest tobacco use and secondhand smoke exposure. Programs can track tobacco use, secondhand smoke exposure, disease and death due to tobacco

New Mexico Links Secondhand Smoke and Diabetes[120]

The New Mexico Department of Health used awareness of diabetes among Navajo communities to educate members on the less well-known dangers of secondhand smoke. With funding from *Communities Putting Prevention to Work*, the department created a single message about the harmful environment secondhand smoke creates for everyone, especially people with diabetes. The *Have a Heart* campaign used artwork by local artists, placed ads in English and the local tribal language on Navajo radio stations, and aired messages in Navajo Indian Health Service clinic waiting rooms.

use, and tobacco industry advertising, marketing, and promotional activities.[121] Collected data can help determine where tobacco control policies are needed and build support for stronger policies.

States and communities adopt new tobacco control policies every day. Monitoring how new policies are implemented and enforced can identify which groups are protected (or not protected) by tobacco control policies. Evaluations can also help determine how effective strategies are so that future policies, programs, and services can be improved.

Designing Evaluations to Promote Health Equity

Evaluations of efforts to reduce disparities assess what works, for whom, and under what conditions.[7] They also determine whether disparities have decreased, increased, or stayed the same.[7] Tobacco control programs should include questions in evaluation plans about how activities affect disparities, even when reducing disparities is not the main focus or goal. Designing all evaluations to capture effects on specific populations makes sure that unintended effects on these groups are not overlooked.[7] When designing evaluations, tobacco control staff and partners should:[1,7]

- Include questions relevant to the program and the needs of the population;
- Choose evaluation methods that take into account the population's language needs, their literacy levels, and who they would be most comfortable speaking with;
- Combine qualitative (*e.g.*, interviews and focus groups) and quantitative data collection methods (*e.g.*, surveys) to fully capture the effects of a policy on the population;
- Collect data before and after implementing a policy, extending the time frame of the evaluation as needed; and
- Design samples so that analysis can be conducted for subgroups of the population.

Collecting Data about Specific Populations

When collecting population-specific data, program staff and partners can start with existing data sources like state-level surveys or local data collected by health departments, universities, or hospitals.[7] Partners can adapt tobacco surveys, including the *Adult Tobacco Survey*, the *Youth Tobacco Survey*, and the *Behavioral Risk Factor Surveillance System*, to include other questions of interest.[122,123] Although these data collection tools are useful, they have limitations. For example, most surveys do not include sexual orientation and gender identity questions, and some lump ethnicities into one large group, missing important differences between groups.[124]

Program staff and partners may want to design their own data collection tools when existing measures are not available for a population or when they want to collect information about the effects of specific policies. New tools should take into account staff skills and available time for data collection, answer the evaluation questions, and be culturally competent.[125]

Links Between Tobacco Control and Other Priority Issues

COMMUNITY PRIORITY	LINK TO TOBACCO CONTROL	WAYS TO SUPPORT TOBACCO CONTROL
Asthma	Childhood and adult asthma attacks can be triggered by secondhand smoke. Racial and ethnic minority groups, low-income populations, and children living in inner cities visit the emergency room, are hospitalized, and die from asthma more often than the general population.[126] Comprehensive smoke-free laws protect workers with asthma and reduce hospital admissions.[12]	• Educate parent organizations and asthma advocacy groups on the link between secondhand smoke and asthma, especially among children • Encourage these groups to support smoke-free workplace and multi-unit housing policies[8]
Cancer	In 2015, smoking will cause an estimated 30% of all cancer deaths.[127] One study found that secondhand smoke also caused about 7,300 lung cancer deaths in one year.[12]	• Work with advocacy groups to support cessation and comprehensive smoke-free laws as part of their efforts • Work with health care providers to screen for tobacco use and promote cessation
Cardiovascular disease	Cigarette smoking is responsible for more than 151,000 deaths from cardiovascular diseases each year.[12] Secondhand smoke exposure also increases the risk of cardiovascular disease, stroke, and coronary heart disease.[12,128] Implementing comprehensive smoke-free laws reduces hospitalizations for heart attacks, stroke, and other coronary events, especially in younger people.[12,129]	• Work with advocacy groups to support cessation and comprehensive smoke-free laws as part of their efforts • Encourage health care providers to screen for tobacco use among patients who are at risk for or suffer from cardiovascular disease
Diabetes	Research has shown cigarette smoking to be a cause of diabetes.[12] The risk of developing diabetes is 30-40% higher for smokers than nonsmokers, and the danger increases with the number of cigarettes smoked.[12] Smokers with diabetes also have greater risk of cardiovascular disease.[12]	• Encourage health care providers to promote cessation for patients with diabetes • Encourage health care providers to screen for diabetes among patients who are known smokers
HIV	Compared to the general population, the HIV-positive population is 2 to 3 times more likely to smoke.[130] Smoking while HIV-positive increases the risk of developing infections and long-term side effects of HIV disease and treatment.[131] It is also linked with a higher rate of death.[131]	• Work with advocacy groups to support comprehensive smoke-free laws as part of their efforts • Work with health care providers serving people with HIV to screen for tobacco use and promote cessation • Educate organizations that support people with HIV
Mental health and substance abuse disorders	People with mental health disorders or substance abuse conditions make up 25% of the total population, but smoke 40% of all cigarettes.[132] Treatment program staff often incorrectly assume tobacco is not as harmful as other substances, or that tobacco cessation would be too stressful or prevent treating other addictions.[133] Only half of substance abuse treatment centers screen for tobacco use, and only 34% offer cessation counseling.[134]	• Clarify misunderstandings about tobacco cessation for people with substance abuse conditions or mental health disorders • Encourage treatment centers to screen for tobacco use, promote cessation, implement smoke-free policies, and encourage staff to quit[135]

Links Between Tobacco Control and Other Priority Issues

COMMUNITY PRIORITY	LINK TO TOBACCO CONTROL	WAYS TO SUPPORT TOBACCO CONTROL
Obesity	Overweight smokers have a shorter average life expectancy than nonsmokers.[136] The risk for obesity increases as the number of cigarettes smoked each day increases, especially for men.[137]	• Partner with healthy and active living advocates to develop policies that increase access to healthy foods and reduce access to tobacco products • Encourage health care providers to screen for tobacco use when screening for obesity
Oral health	Tobacco use increases the risk for oral cancer and periodontal disease.[138] Smokers have four times the risk of developing gum disease compared to nonsmokers, and smokeless tobacco increases the risk of tooth decay.[139]	• Encourage dentists to screen for tobacco use and promote cessation[140]
Prenatal and child health	Smoking during pregnancy increases the risk for early delivery and low-birthweight babies.[128] Infants' exposure to secondhand smoke increases the risk for sudden infant death syndrome, respiratory illnesses, respiratory and ear infections, and asthma.[128,141]	• Work with health care providers serving pregnant women and families to promote cessation • Encourage secondhand smoke protections in homes and cars
Poverty	Low-income populations are more likely to smoke cigarettes and less likely to quit.[12,25] Low-income smokers are less likely to receive cessation assistance and are more likely to be uninsured.[1] Low-income households with smokers spend more of their income on smoking.[142]	• Promote smoke-free housing policies • Promote comprehensive insurance coverage for cessation, especially for Medicaid recipients[1] • Work with social service agencies to increase access to cessation • Educate family support services about how tobacco control can help protect health and limited family budgets
Quality housing	Secondhand smoke can spread between apartments in multi-unit housing and harm residents in nonsmoking apartments. Children living in multi-unit housing are at particular risk. They experience greater secondhand smoke exposure than children in single-family homes.[143] Smoking can also damage property and cause fires. It is the leading cause of fire deaths in multi-unit housing, killing both smokers and other residents.[144]	• Educate tenants and rental property owners about how smoke-free housing policies can improve living environments and lower maintenance and liability costs[8] • Work with quality housing and child health advocates to support smoke-free multi-unit housing policies
Youth violence prevention	Youth who smoke are more likely to seriously consider suicide, engage in physical fights, and carry a weapon than youth who do not smoke.[31]	• Educate youth employment and resiliency programs on the link between tobacco and youth violence • Encourage programs to promote cessation by increasing youth's abilities to make healthy choices, including the choice not to use tobacco[8]

Program staff and partners should be aware that different subgroups of the population may have different social norms around tobacco use and can be affected differently by tobacco control policies. For certain cultural groups, it may be important to survey multiple generations. First, second, and third generation immigrants may view and use tobacco differently. Hard-to-reach subgroups that might be excluded from surveys, like youth who have dropped out of high school, also have some of the highest rates of tobacco use and secondhand smoke exposure.[5] It is important to collect data about these subgroups. Program staff and partners should ask participants about their specific tribes, racial groups, gender identities, or other characteristics early in data collection, and carefully select sites and participants so that samples represent these groups.[7]

Tobacco control staff and partners should also collect data use of other tobacco products (OTPs) and exposure to tobacco advertising among specific groups. For example, the American Indian and Alaska Native population has the highest rate of smokeless tobacco use, cigar use, and use of more than one tobacco product of any racial or ethnic group.[12] Menthol cigarettes are the main tobacco product used by African Americans and are popular among youth.[12] These groups also see more advertising and lower prices for other tobacco products in their neighborhoods.[48] By collecting data on OTPs, programs and partners can make sure that all tobacco use and exposure patterns are captured.

Evaluating Policy Implementation and Enforcement

Evaluating how policies are implemented and enforced can help tobacco control programs understand what works to reduce disparities and respond to possible challenges to successful implementation. To determine if the policy is reaching the population, programs and partners can collect data about what and where activities take place, who is using services, and what barriers to accessing services are encountered by the community.[7] For example, an evaluation of a smoke-free multi-unit housing policy could assess which apartment buildings are enforcing the policy (and which are not). The evaluation could also examine if cessation support is offered to tenants affected by the policy and if tenants experience problems accessing these services, such as high costs or inconvenient location. Programs can use this information to adjust strategies and develop future policies.

Designing Inclusive Evaluations[145]

- Include people from populations affected by tobacco-related disparities in the evaluation process.
- Train data collection staff in cultural competence and, when possible, have members of the population help collect data (*e.g.*, store assessments).
- Test surveys and instruments before use—members of different populations may not respond in the same way to certain questions.
- Have members of populations affected by tobacco-related disparities review data, decide on key findings, and share results.

Helpful Evaluation Resources

The CDC has developed a comprehensive set of resources to help tobacco control programs monitor and evaluate tobacco use.[146] Tobacco control programs can consult these workbooks for guidance on planning and implementing evaluations, selecting data sources and measures, and sharing and disseminating evaluation findings. The workbooks include:

- ***Introduction to Program Evaluation for Comprehensive Tobacco Control Programs***;[147]
- ***Developing an Effective Evaluation Plan***;[148]
- ***Surveillance and Evaluation Data Resources for Comprehensive Tobacco Control Programs***;[149]
- ***Preventing Initiation of Tobacco Use: Outcomes Indicators for Comprehensive Tobacco Control Programs***;[150]
- ***Developing an Effective Evaluation Report***;[151] and
- ***Impact and Value: Telling Your Program's Story***.[152]

Overcoming Unintended Policy Consequences and Barriers to Success

Tobacco control policies play a key role in changing social norms around tobacco use, but implementation barriers and unintended consequences of policies may limit their effectiveness or even worsen tobacco-related disparities.[7,13] For example, policies implemented in high-income countries in the 1960s-1980s reduced smoking prevalence faster among groups with higher socioeconomic status, increasing disparities in tobacco use and secondhand smoke exposure over time.[13]

Communities may lack the resources to fully implement and enforce policies. Policies that are limited, underfunded, not fully or consistently implemented, or that ignore the social, cultural, and economic environments that influence tobacco use, may lead to unintended consequences that preserve or even increase tobacco-related disparities. For example, exempting casinos from smoke-free laws maintains workplace disparities in secondhand smoke exposure.[153] Often, tobacco control policies do not have the same effects for all groups because they are not equally enforced. For instance, policies limiting youth access to tobacco products have been enforced more often for white youth than for African American and Latino youth.[154]

To make sure that tobacco control policies do not result in unintended consequences, tobacco control programs and partners can work to fully and equitably implement strong and comprehensive policies. Tobacco control policies are most effective when they:

- Exclude exemptions;[6]
- Protect all populations;[7,6]
- Identify the partners responsible for enforcement;[12,134]
- Include resources for countermarketing campaigns and cessation services;[1] and
- Include adequate fees, penalties, or both.[12]

Barriers like language, cost, transportation, or health literacy can all prevent community members from fully benefiting from a policy.[7] For example, cessation information may not be available in community members' native languages, or they may not have the capacity to understand and act on the information.[7] If someone from the community was not involved in policy development, community members may not be aware of the policy or it may not align with their cultural beliefs or customs.[7] During policy development, programs can brainstorm potential barriers and make a plan to overcome them.

Simply pushing for comprehensive tobacco control policies and planning for potential barriers is not enough. To avoid unintended consequences and overcome barriers, groups that have been historically excluded should be part of the policy process. Coalitions can help bring together people from a variety of backgrounds, represent diverse perspectives, and promote community buy-in for tobacco control policies.[8] Having community members help select, implement, and evaluate strategies also reduces the likelihood of unexpected effects or problems.

To avoid potential unintended consequences, programs can:[7]

- Educate community members about the policy and its benefits;
- Find champions from the community to ease concerns and build support for policy efforts;
- Assess knowledge gaps among partners and offer training and technical assistance where needed;
- Implement complementary strategies that work together to reduce disparities (*e.g.*, combine increases in tobacco product prices with cessation services);
- Monitor changes in tobacco use and secondhand smoke exposure to look for widening or new disparities;
- Evaluate policy implementation and enforcement to look for problems or barriers (*e.g.*, conduct compliance checks to make sure policies are being implemented consistently in low-income communities); and
- Share findings on tobacco industry targeted marketing and tobacco-related disparities with the affected populations to empower them to continue work to reduce disparities.

A CLOSER LOOK: Jefferson County, Alabama, Adopts Comprehensive Smoke-Free Laws

A smoke-free law now covers restaurants and bars in Birmingham, AL

With a *Communities Putting Prevention to Work* grant received in 2010, the Jefferson County Department of Health (JCDH) and the Health Action Partnership (HAP), a coalition of over 80 diverse organizations, worked to reduce disparities in smoke-free protections in Jefferson County, Alabama.[155,156] The state's most populated county and home to its largest city, Jefferson County has nearly 700,000 residents. JCDH and HAP conducted community assessments, built community partnerships, and implemented health communication interventions to promote comprehensive smoke-free laws.

JCDH and HAP began policy work by conducting community assessments and using GIS mapping to determine where the need for secondhand smoke protections was greatest.[7] By overlaying maps of low-income areas on maps of smoking, heart attack, and cancer rates, they were able to focus resources where they could have the greatest impact.[7]

After deciding where to concentrate their efforts, JCDH and HAP interviewed community members to identify champions and organizations that would be critical partners to reach these populations.[7] Through partnerships with local organizations and faith-based leaders, they educated community members on the dangers of secondhand smoke and the need for comprehensive smoke-free laws. For example, they hosted a Smoke-Free Worship Weekend that reached nearly 500 congregations.[156] Another partner, The Friends of West End, educated 100 neighborhood association presidents on the need for smoke-free policies.[7] The association presidents then shared the information with their communities. JCDH and HAP also developed a culturally competent media campaign about the need for smoke-free protections. JCDH created a radio soap opera called *Live Well Camberwell* that aired on radio stations with large African American audiences.[7]

As of 2012, six cities including Birmingham had passed comprehensive smoke-free laws.[155] Together, the policies protect nearly 300,000 people.[155] To avoid problems that might limit the effectiveness of the policies and ensure compliance with the new laws, HAP offered technical assistance to the communities before and after laws went into effect.[7]

How Can Tobacco Control Programs Support Health Equity?

A comprehensive tobacco control program requires coordinated efforts by state and community partners to provide education and support for policies that work to reduce and eliminate disparities. Although work toward achieving health equity may look different in each tobacco control program, staff and partners should use the following best practices as a guide:

Commitment to Cultural Competence

- Offer culturally competent technical assistance and training to grantees and partners.
- Develop health communication materials in multiple languages and with culturally relevant themes.
- Make sure that quitline services are culturally sensitive and have adequate reach to meet the needs of specific populations.

Administrative & Evaluation Support

- Conduct surveillance and evaluation activities to help understand the burden of tobacco-related disparities and guide policy development and implementation.
- Share and disseminate data on targeted marketing and other industry practices with communities that experience tobacco-related disparities.
- Develop accountability measures and take steps to make sure tobacco control policies are fully and consistently enforced.

Coordination & Collaboration

- Include diverse leaders from specific population groups, tribes, and community-based organizations in all phases of policy planning, implementation, and evaluation. Their experiences will help naturally tailor efforts to priority populations.
- Distribute resources to organizations that can effectively reach and mobilize specific populations.
- Work with representatives from community organizations to make sure that health equity issues are included in tobacco control strategic plans.

Case Study #1: San Francisco, California

California Department of Public Health supports LGBT Partnership's work to reduce tobacco-related disparities through first U.S. tobacco-free pharmacy policy.

State program funds community grantee's work to reduce tobacco use in priority population

In 2003, the California Department of Public Health/ Tobacco Control Section funded the California LGBT Tobacco Education Partnership's (the Partnership) work to reduce tobacco-related disparities among LGBT populations. Research has shown that tobacco use in LGBT communities is high and that the LGBT population is targeted by tobacco industry marketing.[12,60,157] The Partnership educates LGBT communities and partners about policies limiting tobacco industry donations and reducing the availability of tobacco products. Led by project director Bob Gordon, the group began exploring tobacco product sales in San Francisco pharmacies in 2007.

Different sales policies at two Castro district Walgreens spark idea for policy change

The idea for the pharmacy ban came from observations made by the Partnership about two Walgreens pharmacies in the Castro district of San Francisco, one of the nation's largest LGBT communities. A traditional Walgreens store located at the busy corner of 18th and Castro sold medications and other products, including tobacco. At one time, this store was known to have the highest revenue of the chain. Gordon worried that this high sales revenue translated to a high volume of cigarette sales to community members. A second Walgreens, located just half a block away, was a "specialty pharmacy" that sold only medications—no greeting cards, food items, office supplies—and no cigarettes. The difference in sales practices of the two stores prompted the Partnership to consider whether community members could have a say about what items are sold in their neighborhoods and particularly in their pharmacies. Because the state of California already encouraged grantees to work on increasing the number of tobacco-free pharmacies, the Partnership decided to begin formally working on this policy.

State program guides academic, health, and community partners' work to increase awareness of tobacco-free pharmacy issue

The Partnership began work by developing a three-year plan required by the state program that described a set of activities leading to a policy change goal. When

Ad promoting the "Cigarettes & Pharmacies Don't Mix" awareness campaign

asked about the state's guidance, Gordon said, "Having a detailed plan of where you are going to go and how you are going to get there, and having a measurable policy change at the end, is extremely helpful."

The Partnership's original goal was to have the Board of Supervisors pass a non-binding resolution (*i.e.*, a written motion that cannot progress into a law) that would help create awareness of the tobacco pharmacy sales issue. However, the Partnership quickly discovered that other stakeholders (faculty and students at University of San Francisco School of Pharmacy, the San Francisco Department of Public Health, community advocates, and the mayor's and city attorney's offices) were also interested in the issue. The Partnership surveyed over 400 community members at the October 2007 Castro Street Fair and found that 86% supported tobacco-free pharmacies in their neighborhoods. During the first year of the plan, it was announced that the mayor wanted to sponsor a tobacco-free pharmacy ordinance. Bob Gordon commented, "It all came together in the summer of 2008…that's when the policy work really took off…and we all worked together."

> "Having a detailed plan of where you are going to go and how you are going to get there, and having a measurable policy change at the end, is extremely helpful."
>
> – Bob Gordon

Media awareness campaign, earned media efforts, and vocal community support contribute to policy success

The Partnership used several media strategies to move the process along. They launched the *Cigarettes & Pharmacies Don't Mix* awareness campaign, posting ads on buses and inside historic trolley cars. Their goal was not to push for a specific ordinance but rather to spread awareness of the tobacco-free pharmacy issue. They also distributed flyers to pharmacies and other local businesses, trained advocates to educate the Board of Supervisors, wrote editorial pieces, and encouraged a position statement from a local university. Partners also asked independent pharmacists throughout San Francisco who were already not selling cigarettes to write letters of support. Hearing these stories was compelling to decision makers as they considered passing the ordinance.

First tobacco-free pharmacy ordinance passes quickly with strong partner support

Because of the strength of the broad tobacco control partnership, the mayor's support, and great timing, the ordinance passed quickly in July 2008. Opposition came primarily from Walgreens representatives, individual rights advocates, and some retailer associations. The ordinance added an amendment to the San Francisco Health Code that prevented pharmacies from being issued tobacco retailer licenses after October 1, 2008. The ordinance was later broadened to remove an exemption for pharmacies housed within big-box (*e.g.*, superstores or supercenters) and grocery stores.

San Francisco policy serves as model for other communities

What began as a single health equity policy education initiative by the Partnership in San Francisco has become a national tobacco control movement. The San Francisco ordinance spurred similar policies in other California and Massachusetts communities.[158,159] On February 5, 2014, CVS Health announced that its stores will stop selling all tobacco products, including cigarettes and cigars, by October 2014. In a statement explaining the change, CVS Health President Larry J. Merlo said, "We came to the decision that cigarettes and providing health care just don't go together in the same setting."[160] Advocates continue to encourage other communities and pharmacy chains to follow suit.

Case Study #2: Utah

Utah Tobacco Prevention and Control Program implements tobacco-free policies in mental health and substance abuse treatment centers.

Data reveal two different stories of tobacco use

Utah consistently has some of the lowest smoking prevalence rates in the nation. In 2009, only about 10% of Utah residents smoked, the lowest prevalence of any state.[161] However, data on smoking among people with mental health disorders and substance abuse conditions painted a very different picture of tobacco use among these groups. Over 65% of Utah substance abuse treatment center clients smoked, and national data suggested similar prevalence rates among people with mental illness.[162-164] To the Utah Tobacco Prevention and Control Program (TPCP) and the Division of Substance Abuse and Mental Health (DSAMH), these numbers stood out in stark contrast to smoking prevalence among all Utah adults.[165] Dave Felt, Director of DSAMH said, "We realized that the smoking percentage of our population was way above the state norm. We also took a look at the fact that tobacco kills more individuals than all of the other substances combined, and we said it was time that we stop ignoring the elephant in the room and start addressing this very serious health problem."[165] This realization, coupled with evidence that tobacco control efforts work in these populations,[162] prompted the partners to create the *Recovery Plus* initiative. With funding from the *Communities Putting Prevention to Work* program, the initiative aimed to make all publicly funded mental health and substance abuse treatment centers in the state tobacco-free.

Coalition develops three-phase plan to go tobacco-free

The two departments launched the initiative by forming a leadership team that included TPCP, DSAMH, local health departments, local mental health and substance abuse treatment centers, treatment center clients, advocacy groups, and the Department of Corrections. By engaging partners from treatment center clients to state agencies, TPCP and DSAMH developed leadership and buy-in at all levels of the initiative. Building on Utah State Hospital's 2007 tobacco-free policy and using New York's model for tobacco-free treatment facilities as a guide, the partners created a three-phase plan to reach the goal of 100% tobacco-free treatment centers. The plan was designed to first gather data about the current treatment center environment and to then use the information to inform policy design and implementation. This step-by-step process helped the team recognize barriers to successful policy implementation and adapt strategies as needed.

> "We took a look at the fact that tobacco kills more individuals than all of the other substances combined, and we said it was time that we stop ignoring the elephant in the room and start addressing this very serious health problem."
>
> – Dave Felt

Phase 1: Needs assessments inform policy process

In Phase 1 of the plan, partners conducted a needs assessment of publicly funded substance abuse and mental health treatment centers. They examined current tobacco use by clients and staff and asked about their attitudes toward tobacco cessation. The needs assessment confirmed high smoking prevalence among treatment center clients (60-68%) and revealed a culture where smoking was acceptable. For example, smoking was sometimes seen as a reward for clients or as a secondary concern to treating clients' other addictions. The assessment also revealed that, while clients were aware of the benefits of smoking cessation, staff needed education on how quitting could help clients fight their addictions and more training on how to help them quit.

Phase 2: Systems changes help treatment center staff promote tobacco cessation

TPCP and partners used the information gathered during the needs assessment to make sure that clinical staff had the necessary training, resources, and systems in place to support tobacco cessation among their clients. The team developed a new intake form to integrate tobacco use screening into the existing admissions process. They also worked with the state quitline to create a protocol to contact treatment center staff when clients called the quitline to request nicotine replacement therapy (NRT). The treatment center staff then distributed the NRT to the client and made a note in the client's medical chart, so that it could be monitored along with other treatments. Both quitline and treatment center staff received training and resources on promoting cessation among people with mental health or substance abuse disorders. For example, TPCP developed a series of educational materials called *Fighting Myths* to dispel misunderstandings among treatment center staff about clients' tobacco use.

Phase 3: Mental health and substance abuse treatment centers implement tobacco-free policies

On July 1, 2012, tobacco-free policies went into effect at all 155 publicly funded mental health and substance abuse treatment centers, reaching over 17,000 clients. The policies prohibited tobacco use on campus by staff or clients and included tobacco cessation in screening, treatment, and discharge protocols.

Since the policies went into effect, TPCP has seen an increase in the number of people with mental health and substance abuse disorders using cessation services. For treatment center clients, the policies helped them accomplish a goal they never thought they could achieve. One client said of the program, "If I wasn't coming in to a treatment facility to learn about my addictive behaviors, I probably would have never quit smoking. It seemed impossible."[165] TPCP Program Manager Janae Duncan says, "That's what is important to us, that we're improving the quantity and quality of life for people with mental health and substance abuse issues."[165]

Recovery Plus continues to improve and expand services

The *Recovery Plus* leadership team's work has not stopped since the policies went into effect. DSAMH reviews the policies annually during site visits with treatments centers, looking for ways to improve policy implementation and identifying technical assistance needs. The program will also continue to track tobacco use by clients and use of cessation services as they enter and leave treatment centers. In the future, *Recovery Plus* hopes to expand services to include other risk factors and chronic diseases affecting people with mental health and substance abuse disorders.

Case Study adapted from:

Centers for Disease Control and Prevention. *Recovery PLUS: Utah's Plan to Integrate Comprehensive Tobacco Policies into Mental Health and Substance Abuse Treatment*. Atlanta, GA: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; n.d.

Why Invest in Health Equity?

Reducing tobacco-related disparities is an essential part of all comprehensive tobacco control programs. Comprehensive, fully enforced policies can provide equal protection to everyone, regardless of their gender, job, age, race or ethnicity, sexual orientation, gender identity, where they live, or other factors. Tobacco control programs and partners can use the information in this section to educate decision makers and other leaders about how policies can reduce tobacco-related disparities and work to achieve health equity.

History and Adoption

For over 30 years, public health officials have recognized that tobacco use and secondhand smoke exposure affects some populations more than others. From the 1980 release of the Surgeon General's report, *The Health Consequences of Smoking for Women*,[14] until the most recent Surgeon General's report, *The Health Consequences of Smoking–50 Years of Progress*,[12] data on tobacco use among specific populations have been used to illustrate the need for tobacco control policies that promote health equity.

The release of tobacco industry documents and the Surgeon General's report, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups*, in 1998 revealed that tobacco use among groups experiencing tobacco-related disparities does not have a single cause.[15] Instead, tobacco use among these populations results from a complex interaction of factors (*e.g.*, socioeconomic status, social and cultural characteristics, targeted advertising, and tobacco product pricing).[15]

Eliminating tobacco-related disparities continues to be a focus of recent major national reports, including *Healthy People 2020* and the 2014 *Best Practices*.[1,19] These reports, along with greater understanding of tobacco-related disparities, growing evidence of the effectiveness of population-based policies, and emerging promising practices for high-risk groups have helped build momentum to reduce these disparities through policy.

Scientific Evidence

Tobacco control efforts have changed social norms and reduced tobacco use and exposure to secondhand smoke among the general population.[12] Despite these overall declines, higher tobacco use prevalence, lower cessation rates, and poorer health outcomes have been reported among some populations. For example, certain racial or ethnic groups, the LGBT community, women, Southern and Midwestern populations, and groups with less education or lower incomes experience tobacco-related disparities.[1,12,24]

To decrease overall tobacco use and secondhand smoke exposure, tobacco use must be reduced among these groups. Population-based policy interventions like creating smoke-free environments,[4,6,7] increasing the price of tobacco products,[1,10,12] reducing exposure to tobacco industry advertising,[7,33,87] and improving access to cessation services[1,7,166,167] can reduce tobacco-related disparities. Comprehensive smoke-free laws in particular have been consistently linked to improved health outcomes, including fewer hospital admissions for strokes, heart attacks, and respiratory diseases like asthma.[6,12,168]

Research has also shown that policies are more effective when pursued as part of a comprehensive tobacco control program.[1] Comprehensive tobacco control programs are effective at reducing tobacco use across diverse racial and ethnic groups and groups with different education and income levels.[98]

Cost

Populations experiencing health disparities make up a significant portion of health care costs.[11] For example, a 2009 study estimated that poorer health outcomes for African Americans, Asian Americans, and Hispanics added $229.4 billion in direct health care costs between 2003 and 2006.[11] Estimated indirect costs of poorer health outcomes among these groups amounted to more than one trillion dollars over the same period.[11] As the leading cause of preventable disease and death in the U.S., tobacco use and secondhand smoke exposure resulted in $175.9 billion in direct health care costs in 2013 and an additional $150.7 billion in annual productivity losses.[12] An estimated 480,000 premature deaths each year are caused by cigarette smoking and exposure to secondhand smoke.[12] Working toward health equity in tobacco control is a powerful way to help eliminate tobacco-related disparities and decrease health care costs.

Policies to reduce tobacco-related disparities have already proven to be cost-effective ways to lower the health care costs of smoking.[6,10] When Massachusetts expanded its Medicaid cessation benefit in 2006 to include comprehensive cessation coverage, smoking prevalence decreased from 38% to 28% among Medicaid recipients.[1] Hospitalizations for cardiovascular conditions were cut in half, saving $3.12 for every dollar spent on the benefit.[1] Annual smoking-related medical costs to states range from $258 million (Wyoming) to $13.3 billion (California).[1] Policies that reduce these costs would result in significant savings for states.

Policy efforts supported by well-funded, comprehensive tobacco control programs can have even greater returns on a program's investment. California's comprehensive tobacco control program combines policy approaches with media campaigns and technical assistance. The program cost $2.4 billion over ten years, but saved $134 billion in health care costs.[1] Washington's tobacco control program implemented a statewide comprehensive smoke-free law, along with price increases, quitline services, a media campaign, and community programs. From 2000 to 2009, the program achieved a $5 savings in health care costs for every $1 spent on the program.[169]

Sustainability

By investing in policy efforts to reduce tobacco-related disparities, tobacco control programs can have a lasting effect on tobacco use and secondhand smoke exposure. Tobacco control policies change social norms around tobacco use and create systems to help people live a tobacco-free lifestyle.[1] Interventions that change social norms are the most effective way to sustain behavior change.[1]

Working on policies to reduce tobacco-related disparities also helps develop infrastructure and partnerships that support program sustainability. Policy efforts increase political will and public support for tobacco control programs by educating decision makers and engaging communities. Involving communities that have traditionally had a limited voice in shaping policy can help sustain the program by strengthening ties to those communities. Through training and technical assistance, tobacco control policy efforts build the capacity of communities to continue working on tobacco-related disparities on their own.[1,7]

Policy efforts also help spread tobacco control messages to a wider audience. Media advocacy helps to educate the population about the harms of tobacco use, the value of strong policies, and the importance of comprehensive tobacco control programs. Linking tobacco control messages to other community and public health issues can increase awareness of the program and create partnerships that may lead to new funding opportunities. After a policy is passed, tobacco control partners can continue to educate decision makers about the importance of sustained funding for efforts to reduce tobacco-related disparities. Lessons learned from health equity policy efforts can inform future policy work and increase the effectiveness of tobacco control programs.[7]

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CDC, Smoking and Tobacco Use Surveillance and Evaluation
http://bit.ly/cdc_tobaccoeval

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http://bit.ly/cdc_cppwinaction

Community Commons
http://www.communitycommons.org

Community Health Needs Assessment
http://bit.ly/cc_healthneeds

Community Tool Box, Toolkits
http://ctb.ku.edu/en/toolkits

Healthy People 2020, Disparities
http://bit.ly/hp2020_disparities

Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services in Health and Health Care
http://bit.ly/minorityhealth_clas

Smokefree.gov, Resources for Health Care Professionals
http://bit.ly/smokefree_healthcare

Tobacco Technical Assistance Consortium, Culturally Competent Coalitions
http://bit.ly/culturalcomptence

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Population-Specific Resources

Age

Campaign for Tobacco-Free Kids, Youth Resources
http://bit.ly/ctfk_youth

CDC, Youth Tobacco Prevention
http://bit.ly/cdc_youth

Clear Horizons, National Cancer Institute
http://bit.ly/clearhorizons

National Institutes of Health, Quitting Smoking for Older Adults
http://bit.ly/nih_seniorhealth

Smokefree Teen, Resources for Health Professionals
http://bit.ly/smokefreeteen_hp

Disability/limitation

American Association on Health and Disability, Smoking Cessation Resources
http://bit.ly/aahd_cessation

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Veteran and military status

SmokefreeVET
http://smokefree.gov/vet

U.S. Department of Defense, Quit Tobacco – Make Everyone Proud
http://www.ucanquit2.org

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