Tobacco Control in Rural America
Legacy’s Commitment to Dissemination

The American Legacy Foundation® (Legacy) is committed to building a world where young people reject tobacco and anyone can quit. To further this mission, Legacy has engaged in a comprehensive dissemination effort to share information about the replicable, sustainable tobacco control projects being implemented around the nation with the assistance of Legacy funding.

*Tobacco Control in Rural America* is the seventh in Legacy's series of dissemination publications and is intended to highlight the issue of tobacco-related disparities facing rural areas in the United States. This publication examines the unique challenges to tobacco control and prevention efforts in these areas and ways in which organizations can overcome them. It includes examples of promising strategies implemented by some of our grantees to demonstrate how organizations are addressing the issue of tobacco use in rural communities across America.

This publication may include certain grantee activities beyond the scope of Legacy's grants. Some of our grantees' tobacco control activities have multiple funders, and it is essential to examine the full range of program activities to explore various ways organizations are implementing tobacco control and prevention efforts in rural areas. No Legacy funds were used for lobbying or other political activities.

Grassroots community-based organizations, state and local tobacco control offices, and other public health groups often look for successful interventions that address tobacco-related disparities in rural communities; this publication helps to support that purpose. Policy makers and practitioners in foundations and nonprofits in general also will benefit from the case studies and discussion in this publication.

[Legacy recognizes and honors the fact that tobacco has a sacred cultural place in American Indian life in parts of North America. Many Native American tribes use tobacco for spiritual, ceremonial and medicinal purposes. Legacy, therefore, distinguishes traditional, cultural and medicinal use of tobacco from its commercial use. Legacy promotes tobacco control efforts that are not geared toward targeting traditional tobacco. Legacy only supports programs and activities designed to address the issue of manufactured, commercial tobacco use in communities including Native American communities in the United States.]
This publication takes a closer look at tobacco control efforts under way outside of metropolitan areas, where tobacco use is higher than in urban centers. From the outset, this report establishes a working definition of “rural” beyond demographics and population density, with an eye toward cultural distinctions. A one-size-fits-all approach to tobacco control can be problematic, and one must also account for vast diversity within rural areas. We explore “place-based” policy in this publication and conclude that a flexible and dynamic approach to tobacco control is particularly important when targeting the specific challenges of priority population groups in rural America.

The publication examines:

- Tobacco-related disparities facing rural areas;
- Socioeconomic and cultural conditions that cause these disparities in these areas;
- Challenges to tobacco control and prevention efforts in rural areas; and
- Unique assets or opportunities in rural areas for effective tobacco control interventions.

A series of case studies explores effective strategies that have shown measurable outcomes in rural communities in very different parts of the country. Place matters: What works in southeast Ohio may not be a good fit for communities in southeast Arizona. Despite the differences among the communities presented in this publication, a broad set of promising practices has emerged.

Each of the highlighted projects spends a great deal of time determining specific and endemic contributing factors to tobacco use. Each strives to broaden its interventions and research beyond a strictly clinical approach and aims to establish nontraditional collaborations. Each takes a creative approach to facilitating the enforcement of tobacco-free policies, reshaping norms and public opinion around tobacco use, or connecting rural tobacco users with cessation services.

The U.S.-Mexico border area has high concentrations of poverty and low literacy, making the farm worker population susceptible to dramatic tobacco-related health disparities. In our first case study, we see how Campesinos Sin Fronteras (CSF) employs a truly grassroots approach to addressing tobacco usage in that community. The borderland is a unique place for tobacco control efforts, with a transient population that is influenced by messages from both sides of the fence, but it occupies a subculture of its own. We highlight how CSF relies on well-established relationships, trust, and deep local knowledge to effectively promote tobacco-free policies on farm buses and encourage cessation in the fields.

Smokeless tobacco usage is a far greater cause for concern in rural areas than in metropolitan areas, and chew usage often comes with a higher degree of acceptance outside of urban centers. Even in rural states and counties, many public health workers find that smokeless tobacco control has not been given adequate attention. Two programs highlighted in this report investigate the promising practices of projects in Colorado and Ohio, each taking aim at the entrenched, multigenerational tradition of smokeless tobacco use.

Our second case study looks at the tobacco control program of Selby General Hospital in Appalachia’s Mid-Ohio Valley. Selby focuses on both cigarettes and smokeless products in a community with a high
level of acceptance for tobacco usage. The Mid-Ohio Valley has high poverty, low levels of education, and degraded air quality from decades of toxic heavy-industry emissions. Selby takes its services directly to the population, interfacing with clients in check-cashing stores, tattoo parlors, and even gathering places for deer hunters.

The Colorado Chew Tobacco Collaborative Initiative’s far-reaching, community-based participatory research is our third case study. This project aims to uncover the norms surrounding acceptance of smokeless tobacco throughout the rural counties of that state, using a large-scale, collaborative, ethnographic approach. Here, community members are enlisted to fan out and photograph “what chew tobacco looks like in your life,” thus compiling a prismatic view of this looming public health crisis. These photos—showcasing a wide variety of places, from the boys’ locker room to the homemaker’s purse—are then used as prompts to begin a community dialogue around the dangers of smokeless tobacco and approach a community policy consensus.

The fourth case study looks at the work of the La Crosse County Health Department (LCHD) in Wisconsin, focusing on the dual challenges of tobacco use and alcohol dependence. La Crosse County has one of the highest binge drinking rates in the country and an unusually high concentration of bars and taverns. Heavy drinking tends to go hand in hand with tobacco use, and one-third of Wisconsin residents between the ages of 25 and 44 without a high school diploma are tobacco users. LCHD works with employers of this population to provide targeted and tailored cessation support. This project also focuses on La Crosse residents in alcohol recovery programs, under the premise that quitting smoking helps in maintaining sobriety. Dismantling the tobacco acceptance characteristic of support group culture is a particular challenge, but LCHD is beginning to see some results.

The fifth and final case study is a departure from the “boots on the ground” approach to tobacco control. The University of Maine’s Tobacco Access Portal aims to improve the accessibility of web-based tobacco education resources to rural Mainers. The vast majority of these websites, the researchers found, failed to meet the basic guidelines of accessibility. This portal distills and simplifies, on a phrase-by-phrase and word-by-word basis, the language of tobacco education websites to be readable by tobacco users with a wide range of literacy, from high school dropouts to highly educated immigrants with limited English facility. Dismantling literacy barriers to tobacco information, argue the researchers, is a human rights issue that has too long been overlooked.

We hope the wide geographic and cultural spread of these case studies presents a broad snapshot of rural tobacco control efforts and patterns of common challenges faced, key lessons learned, and promising interventions developed.
CHAPTER ONE
TOBACCO-RELATED DISPARITIES IN RURAL AMERICA

Introduction
Organizations in the field of tobacco control and prevention generally recognize the importance of implementing culturally tailored programs to address the issue of tobacco use in high-risk populations. Some specific population groups—based on race or ethnicity, age, sex, socioeconomic status, sexual orientation, mental health, level of education, co-morbidities, and geographic location—experience disproportionate effects of tobacco use. Disparities exist among these groups in terms of prevalence of tobacco use, risk of illness, mortality, and economic consequences resulting from tobacco use. Research has established that there are also significant gaps among these groups in terms of tobacco control capacity and infrastructure, access to appropriate services and resources, and risk of exposure to secondhand smoke.

This publication is part of Legacy’s ongoing commitment to shine a spotlight on tobacco-related disparities.

Place Matters
This particular publication focuses on disparities across geographic regions or locations and highlights disproportionate effects of tobacco use in rural areas across America. In the following chapters, this report examines:

- Tobacco-related disparities facing rural areas;
- Factors or conditions that cause these disparities;
- Exceptional challenges to tobacco control and prevention efforts in rural areas;
- Unique assets or opportunities in rural areas for effective interventions; and
- Examples of promising interventions implemented by five Legacy grantees to address the unique tobacco control needs of their rural constituents.

This publication seeks to further define tobacco-related disparities in rural America, adding to the knowledge of unique rural factors or conditions that contribute to these disparities. Legacy’s ultimate goal is to encourage organizations to further examine these and identify unique rural factors and challenges so that they are better positioned to implement effective interventions in their communities.

“Rural”: A Common Word with Many Definitions
The word “rural” is generally used to describe some unique social, economic, geographic, demographic, and cultural characteristics or conditions of people and places. But there is no single, common or universal definition of the word. What are the characteristics of a rural area? Is it the population size of a geographical region? Is it the density of population of an area? Is it a particular set of economic, social, and cultural features of a place? Should the relative geographical isolation of a community from a metropolitan area be the sole defining criterion? Apart from population size, population density, and distance from the nearest metro area, what other conditions make an area rural? Do all rural areas have similar conditions? Answers to these questions do not usually lead to a precise and clear-cut definition. Many regions in America are not clearly rural or urban, irrespective of what specific criteria are being used to define them. They
fall somewhere along an urban-rural continuum. For example, even a county that is commonly defined as an urban or metropolitan area based on its population usually has large pockets of rural communities.

Rurality may be best understood as a relative term that indicates a very complex range of possible urban-rural variations. Instead of following a common measure to define the rurality of a place, organizations should consider the context of a particular programmatic effort to determine, based on different rurality factors, whether their target area or population group is rural; how relatively rural the area is; and, most importantly, what rural conditions or challenges are relevant to their programs.

Even within the federal government, multiple definitions of “rural” exist. Often, these definitions do not lead to the identification of similar regions as rural. As the U.S. Department of Agriculture (USDA)’s Economic Research Service argues, “Researchers and policymakers share the task of choosing appropriately from among the more than two dozen rural definitions currently used by Federal agencies.” Furthermore, “The share of the U.S. population considered rural ranges from 17 to 49 percent depending on the definition used.”

Describing the importance of identifying a particular set of rural factors that are relevant to health and health care, Eric H. Larson and L. Gary Hart write, Tobacco control programs can better identify and target a very specific at-risk population group by incorporating the most relevant economic, social, cultural, and tobacco-related conditions into the definition of a rural community.

“Definitions of rurality are limited and approximate. Rurality is multidimensional, with many sociologic, demographic, economic, and geographic facets. The various rural concepts are often imprecise and occasionally contradictory. Sometimes, rurality is usefully understood as a continuum. Other times, it is better understood as a dichotomy. To choose a definition of rurality that helps the health policy maker or health researcher make useful distinctions between rural and urban, or within rural areas, it is important to understand which aspects of rurality matter for health, health workforce, and the delivery of health services to rural populations.”

Rural areas in the United States are diverse and represent a wide range of factors that contribute to the rurality of an area. According to the Institute of Medicine, “Rural communities are heterogeneous in other ways as well, differing in population density,
remoteness from urban areas, and economic and social characteristics.”

Rural areas in West Virginia are different from those in Texas. Similarly, the conditions that can be characterized as rural in Northern California are greatly different from rural areas in Arizona or Alaska.

Rural communities along the U.S.-Mexico border represent a unique set of rurality factors. Most of these communities are predominantly Hispanic or Latino and are made up of recent immigrants with strong social and cultural roots on both sides of the border.

These immigrants usually cross the border in both directions on a regular basis. As Joel Rodríguez-Saldaña writes, “The communities along the border are economically and socially interdependent, with more than 1 million legal northbound crossings every day.”

Most importantly, compared to their counterparts in metropolitan areas, people living in the rural areas along the border are often extremely disadvantaged, economically and educationally, much more so than people living in other parts of the country.

According to the Pan American Health Organization, “Four of the seven poorest cities and five of the poorest counties in the United States are located in Texas along the Mexican border. Generally, counties on the U.S. side have experienced an increase in unemployment and a decrease in per capita income over the past 30 years. For example, in the city of El Paso, Texas, poverty is twice the national average and average income is one-third the national figure. The educational level of the population in U.S. border counties also is lower than elsewhere in the country.”

A single, uniform definition or scheme cannot capture or represent each and every rural area of the nation. Therefore, every tobacco control intervention should be tailored to a specific set of rural conditions of a community to effectively meet its unique tobacco-related challenges. Highlighting the significance of a place-specific approach, Lawrence C. Hamilton, et al., at Carsey Institute, University of New Hampshire, write in their report, “Place Matters: Challenges and Opportunities in Four Rural Americas”:

“Policy must become more ‘place-based, not simply in terms of geographic location, but also with awareness of social, cultural, economic, environmental, and political characteristics. Each of the CERA [Community and Environment in Rural America] study regions is struggling with its own place-specific issues and problems, which call for different policies and solutions. However, some needs appear common across all regions, such as advanced telecommunications technology, access to good education at all levels, affordable and accessible healthcare, and forward-looking transportation systems.”

In the context of public health and tobacco control, specific criteria to create a rural-urban definition of an area should be based on desired program goals and outcomes. The most prudent approach for organizations is to ask what specific rurality conditions give rise to unique tobacco-related disparities in a particular region or place and what programmatic actions they need to take to best address those disparities.

“County Type” Definition Adopted by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

In this report, for the purpose of analyzing the data on the prevalence of tobacco use in rural areas and highlighting how this issue has a disproportionate impact on these areas, we use the rural-urban definition developed by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies.
Racial and Ethnic Diversity in Rural Areas

The racial and ethnic landscape of rural America is changing rapidly. Today’s rural areas are much more racially and ethnically diverse than they were in the past. Besides Whites, Blacks, and Native Americans, a growing number of Hispanics/Latinos, Asians, and Pacific Islanders constitute the rural population. Although the population in rural America is still predominantly White, these other groups now have a strong presence not only in border regions of the Southwest but also in communities in the Midwest and Southeast.

According to USDA’s Economic Research Center, “Hispanics and Asians are the fastest growing minority groups in the United States as a whole and in nonmetro areas. Blacks, concentrated in the South, remain the largest minority group in nonmetro areas, making up 8.4 percent of all nonmetro residents in 2006. This figure has hardly changed since 1980. In contrast, the Hispanic proportion grew from 3.1 percent in 1980 to 6.4 percent by 2006.” The Economic Research Center further notes, “Racial and ethnic minorities now make up 18.3 percent of nonmetro residents and are geographically dispersed throughout the nation.”

Arguing that rural America will be even more diverse in the future, Kenneth Johnson at the Carsey Institute, University of New Hampshire, notes, “Data on the rates of population growth among the various racial and ethnic groups in rural America suggest that diversity is likely to increase in the future.” Organizations need to recognize this changing racial and ethnic mix in rural communities and implement culturally tailored programs that can address the unique tobacco control needs of different minority groups.

In the following sections, this publication focuses on the disproportionate impact of commercial tobacco use on rural areas, the unique set of challenges facing tobacco control efforts in these areas, and ways to address these challenges.

High Prevalence of Smoking and Tobacco Use

Cigarette smoking is more prevalent in rural communities compared to large and small metropolitan areas. According to the Centers for Disease Control and Prevention (CDC)’s 2006 National Health Interview Survey, current cigarette smoking among persons 18 and older varied significantly by geographic regions. The smoking rate was highest among individuals living outside of a MSA and lowest among people who were living in a large metro area.

As presented in Figure 1 below, among people not living in metropolitan statistical areas, the smoking rate was 25.1 percent, compared to 18.5 percent among people in large metro areas and 22.1 percent in small metro areas.

FIGURE 1

AGE ADJUSTED PERCENT DISTRIBUTIONS (WITH STANDARD ERRORS) OF CURRENT CIGARETTE SMOKING STATUS AMONG PERSONS 18 YEARS OF AGE AND OVER, BY PLACE OF RESIDENCE: UNITED STATES, 2006

High Prevalence of Smokeless Tobacco Use in Rural Settings

Use of smokeless tobacco is most common in rural areas. Various national surveys have clearly shown that the use of smokeless tobacco is undeniably high in rural areas versus small and large metropolitan areas. According to the 2006 and 2007 National Survey on Drug Use and Health, the use of smokeless tobacco is two to three times higher in less urbanized and completely rural areas of the country (see Figure 3, page 11) compared to large and small metropolitan areas. Combined 2002 to 2007 data also indicate that past-month smokeless tobacco use is highest among persons who live in completely rural and less urbanized counties in nonmetropolitan areas and lowest among persons who live in large metropolitan areas. Smokeless tobacco use is entrenched in the social and cultural norms and practices of many rural communities. Moreover, the manufacturers of smokeless tobacco products have exploited these social and cultural aspects of tobacco use and targeted these rural areas with persistent marketing campaigns to promote smokeless tobacco products. Tobacco companies’ sponsorships of rural sporting events such as rodeos demonstrate this kind of culturally targeted marketing campaign.

Disproportionate Exposure of Children to Secondhand Smoke

Exposure to secondhand smoke is hazardous to human health. Studies have shown that children are highly vulnerable to the negative effects of secondhand smoke including acute respiratory infections, ear problems, and more severe asthma. According to the CDC, exposure...
to secondhand smoke is associated with higher rates of sudden infant death syndrome, asthma, bronchitis, and pneumonia in young children. 21

Since smoking is more common in rural areas, children in rural America are more often exposed to secondhand smoke in the household. Based on the National Survey of Children’s Health conducted by the National Center for Health Statistics, 22 38.1 percent of children in small rural areas and 37 percent of children in large rural areas live with a smoker, compared to 27.5 percent in metropolitan areas. Among children in rural areas, in general, older children, children with lower family income, and White and American Indian/Alaska Native children are most likely to be exposed to smoking in the household. 23 In terms of race and ethnicity, 46.5 percent of American Indian/Alaska Native children in small rural areas live with a smoker, compared to 30.4 percent of urban White, 27.7 percent urban Black, and 20.6 percent urban Hispanic children. 24

By implementing community-based, culturally tailored programs to address these disparities, organizations can close the gaps in prevalence of tobacco use, increase access to evidence-based prevention and cessation services, and minimize the disproportionate impacts of tobacco use on the health of people living in rural areas of the country.

### Challenges to Tobacco Control and Prevention Efforts in Rural Settings

In addition to a very high prevalence of tobacco use, rural communities face a number of challenges to tobacco control efforts. These challenges consist of the following:

- Lack of appropriate tobacco control programs and services 25, 26
- Lack of or very limited transportation 27, 28, 29
- Low income 30, 31
- Lower rates of insurance coverage 32, 33, 34
- Minimal access to tobacco cessation 35, 36
- Limited access to health care services 37
- Proximity to tobacco growers 38
- Limited media resources on tobacco prevention 39, 40
- Inadequate enforcement of laws against tobacco sales to minors 41, 42
- Lack of effective compliance of smoke-free policies 43
- Limited research on the question of how different rural conditions lead to higher tobacco use in rural areas 44
- Culturally and socially entrenched use of tobacco products 45, 46
Rural Areas and Disproportionate Burden of Tobacco Use

As highlighted in the previous sections, tobacco has a disproportionate impact on rural areas because of their unique geographic, cultural, social, and economic conditions. In addition, many rural areas lack adequate access to an effective, evidence-based tobacco prevention and cessation infrastructure. Many national and state surveys have shown that rural areas generally have higher tobacco prevalence. Individuals living in these areas have limited access to appropriate, effective services compared to their counterparts living in metropolitan areas of America. To address this tobacco-related disparity, organizations need to identify rural areas and understand the unique public health and tobacco control challenges they face in order to implement comprehensive, systemic tobacco control programs that address the underlying social, economic, cultural, and geographic conditions of these areas. The following sections highlight some unique ways to address tobacco-related disparities in rural America.

Assets and Opportunities in Rural America

Rural areas offer unique assets and opportunities that organizations can leverage to implement tobacco control programs. Generally, rural areas are made up of closely knit communities and strong families. They demonstrate a sense of social trust and neighborliness. Many residents in rural areas are involved in local faith-based and other community-based organizations. These organizations play an important role in all aspects of people’s day-to-day lives in these communities.

By examining the data gathered in 2007 from a representative survey of 8,000 rural Americans selected from nine clusters of 19 rural counties across the United States, Lawrence C. Hamilton, et al., of the Carsey Institute at the University of New Hampshire found that more than 75 percent of the residents in these communities agreed with the statements “People around here are willing to help their neighbors”; “People in this community generally trust one another and get along”; and “If this community were faced with a local issue such as the pollution of a river or the possible closure of a school, people here could be counted on to work together to address it.”47 The Carsey Institute’s survey also showed that residents’ participation in local organizations was high.48 These informal social networks and institutions offer unique opportunities for organizations to enhance the impact of their tobacco control programs. By tapping into the robust social capital in rural areas, organizations can earn the trust of the community, mobilize and gain support of local stakeholders, and expand the reach of their initiatives.

KEY STRATEGIES TO ADDRESS TOBACCO-RELATED DISPARITIES IN RURAL AMERICA

Identify and adapt to specific rural factors or conditions of a region.

A wide variety of conditions contributes to the exceptionally high prevalence of tobacco use in a rural area. As discussed above, rural communities vary in terms of their social, economic, cultural, and geographic characteristics. In addition, each community has a specific combination of factors that may give rise to the high prevalence of tobacco use and/or create barriers to effective tobacco control and prevention efforts. Organizations need to identify specific conditions that contribute to the problem of tobacco use in their target communities. In order to create strategies to match these conditions, organizations need to examine them in depth and thereby gain a practical understanding. In this way, organizations can create a community-based, culturally tailored approach to tobacco control and prevention that both fits the specific set of rural conditions and meets the unique challenges facing their communities.

Foster broad-based collaboration to engage multiple stakeholders.

Organizations may fail to address a host of challenges to tobacco control in a rural area without first engaging diverse, local stakeholders in their interventions. Tobacco use is a culturally entrenched behavior in rural populations. Without long-term and comprehensive interventions, organizations cannot successfully address the issue of tobacco use in a rural setting. Moreover, designing and implementing a holistic, multifaceted intervention to address diverse systems-level issues—deriving from a lack of transportation, communications, smoke-free policies, and education—requires a significant amount of resources and broad-based collaboration among all major decision makers and resource holders in the community. A mere clinical approach, focused exclusively on helping individuals quit without multipronged, community-wide engagement, cannot address the exceptionally high rate of tobacco use in rural populations.
**Enact and enforce smoke-free policies.**

Many small rural areas lack smoke-free policies that not only protect nonsmokers from secondhand smoke but also help reinforce smoke-free social norms in a community. Where such policies exist, enforcement is not always very effective. According to Stacy Stevens, et al., “While the number of community prevention policies has increased in the past decade, rural communities do not necessarily comply with these policies.” Illegal tobacco sales, especially to minors, are more prevalent in rural settings. Small businesses, farms, and other places of employment in rural areas often either are not covered by a robust policy or they do not effectively comply with such policies that may already exist. Therefore, both enactment and enforcement of robust smoke-free policies is fundamental to addressing tobacco-related disparities in rural settings.

**Implement public awareness campaigns targeting smokeless tobacco in rural settings.**

As presented earlier, the use of smokeless tobacco is exceptionally high in rural areas. Over the years, it has become an inherent part of rural culture and social norms. Even though cultural or social use of tobacco is decreasing in rural communities, in many areas, the cultures of mainstream rodeos, ranching, and farming still galvanize tobacco use. Smokeless tobacco companies target this population through aggressive marketing of their products. Through sponsorships of rural sporting events and various forms of targeted messaging, these companies try to reinforce the culture of smokeless tobacco use. Culturally tailored public education campaigns are needed to counter the tobacco industry’s marketing strategies and to promote a new, smoke-free culture in rural America.

**Create alternative ways to provide affordable, accessible tobacco treatment and counseling.**

Organizations need to develop program strategies to make tobacco cessation services more affordable and accessible to individuals who live in rural areas. Interventions proven to be effective in metropolitan areas may not be effective in rural areas, if implemented in the exact same format. These interventions can be tailored to meet the unique needs of the people in rural areas. Specific outreach, enrollment, retention, follow-up, and relapse prevention techniques grounded in rural settings are key to effective tobacco cessation programming.

**Case Studies**

This publication highlights five case studies that demonstrate how organizations across America are addressing the issue of tobacco use in rural communities. These case studies reflect a broad range of tobacco control, prevention, and cessation programs implemented by Legacy grantees to deal with the tobacco-related disparities facing their rural communities. Through these case examples, Legacy seeks to highlight the unique barriers to tobacco control and prevention efforts in rural areas and ways in which organizations can address those challenges. These examples show that by creating program interventions tailored to the specific rural conditions and tobacco control needs of a rural community, organizations can provide effective, accessible tobacco control and prevention services for people living in rural areas. Legacy hopes that other organizations involved in tobacco control and prevention will learn from these case examples, identify unique rural conditions that create tobacco-related disparities and challenges, and develop program strategies to achieve effective and sustainable tobacco control and prevention outcomes for their rural communities.
CHAPTER TWO

CASE STUDIES

No. 1
Campesinos Sin Fronteras: Futuro Claro
Grassroots Tobacco Education in the Borderland

No. 2
Selby General Hospital
Creative Outreach for a Marginalized Rural Community

No. 3
Colorado Chew Tobacco Collaborative Initiative
Targeting Chew Tobacco with Community-Based Participatory Research

No. 4
La Crosse County Health Department
Western Wisconsin Tobacco and Alcohol Reduction Project
Addressing the Dual Challenges of Tobacco and Alcohol Used

No. 5
University of Maine: Tobacco Access Portal
Dismantling Literacy Barriers to Tobacco Information
Campesinos Sin Fronteras: Futuro Claro
Grassroots Tobacco Education in the Borderland

Program Overview

Campesinos Sin Fronteras (CSF) has built a reputation as a trusted one-stop shop for migrant farm workers seeking health, education, and economic services in South Yuma County, Arizona, an agricultural region that hugs the U.S.-Mexico border. Founded by former farm workers in 1997, CSF connects campesinos (migrant farm workers), a dramatically marginalized community, with everything from reproductive services and domestic abuse counseling to housing advocacy. They began tobacco education work in 2001.

The U.S.-Mexico border region has culture, norms, and language distinct from both Mexico and the United States. Awareness of these differences is crucial to building an effective public health initiative. If treated as the 51st state, the border areas (excluding San Diego County, California) would be dead last in per capita income and last in terms of access to primary medical care. In this region, 43.2 percent of the total population living in poverty is between 0 and 17 years old compared to only 34.8 percent in non-border regions. Border counties would be ranked 50th in insurance coverage for adults and children. Not considering the economies of San Diego and Pima, in 2004, the unemployment rate for the remaining 22 border counties was more than double the rate of the rest of the United States.

According to Flor Redondo, director of CSF, South Yuma County imports over 10,000 farm workers daily from November to April. In the winter, the area becomes the lettuce-producing capital of the world, with more than 50,000 farm workers picking the greens that become the nation’s salads. “We don’t have the resources to serve the population that lives here year round, and imagine in the winter when it triples,” Redondo says. “We cannot respond to all the needs.”
“They call us “pochos.” For us in the border area, “pocho” means half-Mexican/half-American. People see you as a mix of both. It suggests that we are not really a part of the Mexican culture. We learned Spanish when we were young and then we came to the U.S. and learned English, but we don’t master any language at all. But we speak Spanglish usually, the border language.”

Flor Redondo, CSF Programs Director

The borderland receives tobacco messages from both sides of the fence. Mexican television broadcasts its telenovelas and films 50 miles deep into South Yuma County. Television programs that normalize and glamorize tobacco use are popular with campesinos. The ubiquity of the population compounds the challenges of effective tobacco control. “We can do all the prevention and referrals to the quitline, but at the end of the day they come from Mexico, and they may have a home there to return to every weekend,” Redondo says. “It’s cheap and easy to buy tobacco there and bring it back for the week. It can be really challenging to get a program going with these kinds of barriers. But despite these challenges, our program has been successful in reaching our target group,” Redondo says.

Farm Buses: A Secondhand Smoke Frontier

Thousands of migrant workers start gathering in San Luis, Arizona, at 3 a.m. every morning to board one of approximately 300 old school buses, which transport them to the fields. In the winter, all the windows are closed because there is no heat in these buses. Each bus carries 30 to 40 campesinos to their job sites. These buses are often thick with smoke for the four to five hours of transportation each day, even though only a few riders may be smokers. For years, CSF has received reports of chronic respiratory diseases from the campesinos. A grant from Legacy allowed them to begin to address this serious public health concern.

Redondo remembers a decade ago, when she rode those buses to pick lettuce in the field. “Everybody smoked,” she says. “It was really hard for us who didn’t [smoke], but it was just part of life. You didn’t even think of the possibility of asking people not to smoke.” But Arizona smoking laws make that illegal now, and CSF aims to educate both the campesinos and their bosses that smoke-filled buses are detrimental to workers’ health. Despite new signs in the buses, awareness and enforcement of the smoking regulations are slow to trickle down.

Rosario Sanchez, also a former farm worker and now lead promotora (peer health counselor) for CSF, often heads out into the cold, dark night to give informal tobacco education to campesinos at the San Luis bus stop. “People ask me if I am afraid to go here at 3 a.m. all by myself,” she says. “I’m not afraid, because they know me and respect me, and that opens a lot of doors.” Sanchez also makes regular rounds in the fields promoting smoking cessation and referring any identifiable smokers to the Arizona state quitline (ASHLine).

The promotora model employs community members to transmit health education to underserved, low-income Spanish speakers. “We can talk to them at their educational and professional level,” says Luis Vazquez, CSF Tobacco Use Prevention Program Coordinator. “We may encounter people at the stores
“About 55,000 farm workers labor in Yuma County between October and March, the peak season for lettuce,” said Janine Duron, supervisor of the Migrant and Seasonal Farm Worker Program for the Arizona Department of Economic Security.”


**Tobacco Control in Rural America**

or church or the park and we talk to them about their smoking. Even on a Saturday or Sunday we are providing education.” This truly grassroots approach has generated positive results in many communities, including South Yuma County, Arizona. Campesinos still light up cigarettes from time to time on the farm buses, but far less than just a few years ago.

**Juan Perez: 58-Year-Old Farm Worker, 30-Year Smoker**

Juan Perez has been smoke-free for two months. Vazquez convinced him to call the state quitline and come to a CSF cessation support group where 15 other farm workers gather weekly to give each other a pat on the back for putting down the cigarettes. Perez has been telling all his friends in the fields that they should come to the group, too. “The support group is providing the human touch through this hard quitting process,” Vazquez says. “I’m so glad to see Juan quitting.”

Juan’s four daughters are grateful that he has stopped smoking. “It’s helped me change the way I think about my health,” he says. “I’ve learned how to keep my mind busy with other positive things rather than smoking. Some people get off the bus to smoke, and some people get off the bus to get away from the smokers. That’s what I do.”
border. Hundreds of young people came across the border and joined the local kids to hear the music. “Some of the kids were smoking,” Redondo says. “Many of them came from the Mexican side, where it’s part of the culture to be chic and smoke.”

Carlos Sanchez has been a peer counselor in the Futuro Claro project team for two years. He noticed that farm workers are in the fields as young as 17 years old. He, too, worked in the local citrus groves in the summers when he was in high school, picking fruit. “It’s really hard work,” he says. “I understand how difficult it is. It took me like four hours to do three trees.” He realized he wasn’t cut out for picking in the hot sun, but he did have a knack for talking to people and helping them improve their lives.

“The problem is they just don’t know what’s out there for health services,” he says. “With tobacco, a lot of people don’t know the health impacts. I’ve talked to lots of young women who have chronic asthma or have lost babies to premature birth. One time this young husband started crying, because they had lost a child, and he said he used to smoke in the house all the time. He just didn’t know. He had no idea.”

Carlos says it is important to have promotoras of both genders. “They often want to ask questions about pregnancy, but they don’t want to ask me,” he says. “They want to talk to a woman of their own age.”

“If a person wants to smoke in the buses now, the other workers tell them ‘get out of here, ’cause we know about the law and we have the right not to have smoke in here.’ Our information is really making a difference.”

Flor Redondo, CSF Programs Director

Currently the Futuro Claro team is working on a “photonovela,” a comic strip-like book intended to ease comprehension of tobacco education. These photonovelas are a series of photos featuring actors telling a story about tobacco cessation. CSF has used this strategy for diabetes and HIV education. “It is a useful tool for our population,” Redondo says.

Rural Roadblocks and Borderland Barriers

Since the time of the Bracero program in the 1940s, through the formation of the United Farm Workers, the needs of these laborers who toil in the shadows have been long overlooked. We rely on migrant
“ Somehow you think that with a cigarette you can get things done faster and it makes the tiredness go away, but it’s not true. Your body will give in either way. People smoke when they are tired or happy. People think if they smoke when they are angry it will go away. It’s not true.”

Juan Perez, Farm Worker, South Yuma County

Lessons Learned

- The borderland has its own culture, separate from both the United States and Mexico, but is influenced by messaging from both sides.
- The borderland has seasonal population surges that affect basic healthcare resources.
- Smoking on farm buses is not legal, but it is common, and a cause for genuine concern.
- The promotor model of counseling should include counselors of both genders.
- Awareness of the health risks of tobacco use can be alarmingly low among farm workers.
- Social awareness campaigns must be tailored to the literacy level of the target population.
Program Overview

Selby General Hospital is in Washington County, Ohio, which sits near the state’s border with West Virginia, in a rural part of Appalachia called the Mid-Ohio Valley. The population is overwhelmingly poor, with a lower per capita income than the state at large, and the education level is also low. Among residents 25 years and over in the county, 15.5 percent have less than a high school degree. Farmers in Ohio still grow government-subsidized tobacco, and high school students in the Future Farmers of America in this part of southeast Ohio are still taught how to cultivate this cash crop. Conventional wisdom here says that chew tobacco is a safer alternative to cigarettes. “There is a lot of resistance here, and change is difficult until [something] hits them personally,” says Stephanie Davis, Tobacco Prevention Program Director at Selby General Hospital.

Selby General has only 25 beds, and patients have come to trust the personal nature of its care. The other hospital in town has 1,000 beds. “The rural people like our hospital because they can park out front,” Davis says. “They’re not a number, and the big factor is getting over their fear of an establishment.”

Smoking prevalence rates in Washington County are very high, with use among 18- to 24-year-olds and 35- to 44-year-olds topping 40 percent and over 60 percent of Selby General’s inpatients identifying themselves as tobacco users. Decades of heavy industry—plastic production and carbon processing—have produced chronically toxic air quality. The obesity and cancer rates are all astoundingly high in Washington County. “Many people around here have a fatalistic view of life,” Davis says. “Generationally, there is not much hope to succeed or better yourself.” The cycle of poverty, low education, and diminished health has a firm grip on the rural residents of the Mid-Ohio Valley, and the idea of preventive healthcare has little traction.
In April 2009, the impact of tobacco use hit this population where it hurts most—the wallet. After the increase in federal tobacco tax, the tax per pack of cigarettes in Ohio increased to over two dollars.13

“Some people will have the worst health on the planet, but it’s not until it’s personal—the money—that they think about quitting,” Davis says. Selby General normally runs two cessation classes each month with about a dozen participants in each class. After the tax increase, 100 people came looking for help in just a few weeks.

Creative Marketing: From Check-Cashing Stores to Opening Day of Hunting Season

According to Davis, this population is reluctant to seek help and reluctant to go into a government building or a hospital. They are hesitant to call the Ohio Quitline. “If they call the quitline, it’s routed through a national hotline out of a different state, and they say, ‘Heck, I don’t want to talk to you. You don’t know anything about me, and you’re not going to understand,’” Davis says. She acknowledges that some aspects of the Appalachian culture present a serious public health challenge.

“Only 30 percent of the population has cable television, and the majority of [the area’s] target population does not read the local daily paper, the Marietta Times,” Davis says. So purchasing advertising in these outlets is not really practical for the Selby General Tobacco Prevention Program. Instead, they turned to a collection of alternative forms of marketing. “We’ve tried the backs of register receipts, the outside of pharmacy bags—we’ve done the gamut,” Davis says.

The “Bulletin Board,” a local publication of buy, sell, and trade ads, is popular with their target audience of low-income residents with low education. Most folks in the Mid-Ohio Valley call this circular “The Bible” and use it to find good deals on livestock and farm equipment or to look for a yard sale. They are also likely to see an advertisement for one of Selby General’s cessation classes. Demographically targeted direct mail has also proven useful: Classes doubled in size after the mailings. “We’d advertise on bus lines, if we had any,” Davis says. “It took us a while, but we finally figured out a good way of communicating.”

Davis and her Lead Tobacco Educator, Joellen Masten, have assembled a diverse collection of places to interface with their target demographic outside the hospital. They regularly leave their stickers, brochures, and freebies, such as branded toothpick dispensers, at laundromats, tattoo parlors, and barber shops.

“They are very accepting of things that aren’t necessarily healthy. It’s generational—grandpas who take their grandkids out fishing when they’re seven and give them chew. Moms buying their kids cigarettes. We’ve seen them as young as third grade.”

Stephanie Davis, Tobacco Prevention Program Director, Selby General Hospital

Washington County also has the highest number of check-cashing establishments per capita in Ohio, since West Virginia has stricter regulations on these payday lenders. Customers of check-cashing places tend to fall into Selby General’s target demographic. Masten and Davis have found these businesses to be an ideal place to reach their patients.

Perhaps Selby General’s most innovative community location is the deer checking stations. Davis and Masten have distributed over 70 “Quit Kits” to deer hunters at the places where they check in with the Fish and Game Department after a day’s hunt. They set up an outreach booth on opening day and other high-traffic days and give out information on chew tobacco cessation and herbal snuff. Some hunters mix the herbal chew with their Copenhagen to wean themselves off gradually.

The Transportation Barrier: Taking Hospital Services Directly to the Community

Davis and Masten get many referrals from within the hospital, since most of their inpatients are tobacco users. Anyone who indicates tobacco use can expect a visit. “We’ve got them barred up in a hospital, and sometimes they’re not so happy to see us,” Davis says. “Hopefully, if they can be tobacco-free for a few days in the hospital, they can turn that into a few more days.” But Davis and Masten have found that, by and large, their target population requires pursuit.

Due to the high poverty in Washington County, many residents have limited access to transportation. Selby General holds two monthly classes concurrently, rotating through all the major communities in southeast Ohio, and actively refers about 100 tobacco users to the quitline every week since the tax increase.
Selby’s outreach booth for hunters.

“You can’t smoke in the woods because the deer will smell you. So we see a huge number of chew users there. We’ve had them put the herbal chew in their Copenhagen can because they don’t want to tell their friends they quit.”

Joellen Masten, Lead Tobacco Educator, Selby General Hospital

“We are taking the services to them on a regular basis, because it eliminates the excuse factor,” Masten says. Free nicotine replacement therapy is also a major incentive. “That initial purchase is the worst part for them,” Davis says. “They can come up with $5 for a pack of cigarettes, but it’s difficult to come up with $50 for NRT [nicotine replacement therapy].”

They also frequent health fairs, where the big draw is useful, free products. “They come for the raffles and the Wal-Mart gift cards or the bicycle helmets and car seats,” Davis says. “This is where our population connects with local organizations.”

They set a goal for their Legacy grant of helping 200 women quit cigarettes and 50 men to quit chew tobacco. They have found that women are more likely to participate in cessation support and men are more likely to rely on an anonymous quitline. Since July of 2007, they have counseled 375 smokers and 63 smokeless tobacco users, with an average end-of-class quit rate of 43 percent. Since the program’s inception in 2003, Masten and Davis have helped over 1,000 people.

David Howell: The Story of One Less Mid-Ohio Valley Tobacco User

David lives in Marietta, Ohio, and works in telecommunications. He was a pack-and-a-half-a-day smoker for 36 years and found Selby General’s services in a different way compared with most of Davis and Masten’s patients: He Googled it. He dropped in on one of their tobacco use open houses and started a support class right away. Now Howell has gone 112 days without lighting up. “That’s 3,330 cigarettes I haven’t smoked, and $882 I’ve saved,” he says. “And I’ve given myself 18 more days of life.”

These days he breathes a lot easier and he doesn’t snore nearly as much. “My spouse likes that, because I used to not want to encroach on her space too much, but [it can be hard on a relationship] when you’re in separate rooms,” he says. “I’ve gotten my brain on the other side.
of the process now, and I’m looking at all the good things that have happened since I stopped smoking.

Howell says he had to get mad at himself and his habit and had to admit that he is an addict. “My whole life was driven by when I was going to have that next smoke,” he says. Driving his car was like passing a constant stream of messages encouraging him to smoke. “I’d pass a certain street sign, I’d light a cigarette. The odometer clicks another 30 miles, I’d light a cigarette. I’d pass the city limits, I’d light a cigarette.” He had to change his daily patterns and literally take different paths. He still avoids convenience stores, because that is where his strongest cravings emerge. “I pay at the pump so I don’t have to go in those places,” he says.

He has channeled the nervous energy into his work and an impressive array of home restoration projects. “I’ve accomplished more in the last three months than I have in the last three years,” he says. “I think of all the time I save. Assuming it takes eight minutes to smoke a cigarette, that’s over two hours a day, per pack. That’s frightening.”

“We have them do the math. A pack a day at six dollars a day—over a year, that’s a house payment or a car payment. And if you’ve got two people smoking in the house, well, think about the cost.”

Joellen Masten, Lead Tobacco Educator, Selby General Hospital

Lessons Learned

- Smaller hospitals can be better positioned to serve rural communities.
- Preventive healthcare is less common in marginalized rural communities.
- The financial impact of a tobacco habit may be an effective incentive for quitting.
- Take the services directly to the target population, whether they’re in a tattoo parlor or in the woods hunting.
- Eliminate the transportation barrier by holding regular group sessions in dispersed communities.
- The hospital itself is an opportunity to conduct outreach to the target population among inpatients.
Colorado Chew Tobacco Collaborative, University of Colorado Health Center
Targeting Chew Tobacco with Community-Based Participatory Research

Program Overview

Chew tobacco use rates nationally tend to be lower than smoking rates, but while chew tobacco does not have the same secondhand exposure issues pervasive in tobacco smoking, it is a looming public health crisis, particularly in rural communities. The tobacco industry continues to develop smokeless products that may entice younger and nontraditional users, as well as hold a firm grip on longtime users. Some public health officials and doctors actually suggest smokeless tobacco as a harm reduction method, even though recent research has indicated this to be ineffective in the United States.

Colorado Chew Tobacco Collaborative Initiative (CCTCI) Project Coordinator Erin Seedorf comes from a ranching family in Northern Colorado and married into a family of farmers from the northeastern Colorado plains. Chew tobacco use is prevalent in her family, and some relatives have suffered the health effects of decades of chew tobacco use. “It’s very prevalent in these rural communities,” Seedorf says. “Everyone you know chew.” Chewing is a rite of passage here, an “adult activity” play acted by children, and a cultural fixture deeply entrenched in multiple generations.

Seedorf brought her perspective on chew tobacco use to Legacy and was awarded an Innovative Grant to form the first statewide program in Colorado focusing on smokeless tobacco. According to Seedorf, some rural Colorado communities have chew tobacco rates far higher than rates of cigarette smoking. Chew tobacco use in Colorado metropolitan areas is not quite as prevalent, but Seedorf fears new products will drive those rates up. Statewide, says Seedorf, it remains to be seen if smoke-free ordinances and an increase in the marketing of smokeless products will lead to an increase in chew tobacco use.

CCTCI aimed to begin dismantling this cultural rural prevalence with an innovative research approach called Community-Based Participatory Research (CBPR).
Meera Viswanathan, et al., define CBPR as “a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.” Based on this theoretical framework, CCTCI implemented a unique community engagement strategy that empowers communities to collect qualitative data—in the form of photographs and oral histories—to assemble a grassroots account of what chew tobacco use actually looks like, and what challenges exist in cessation. “Barriers in rural tobacco control often actually have benefits attached,” Seedorf says. “These are communities within a community, and that can be hard because of the social acceptance of things. But the benefit is that they really do support each other, and if you get the right person in the right situation to start to make change, it can affect the whole area really quickly.”

### Implementing the Methodology: Photovoice and Story Circle

The research design of CCTCI is based on ethnographic documentation, a way of effectively and unobtrusively constructing surveillance of chew tobacco use in these communities. Seendorf and her partners trained participants to go out and take pictures and collect stories with a general question in mind: “What does chew tobacco look like in your life?” In the Photovoice technique, participants take pictures in their local communities and use them as prompts for a written account, a story describing just what those images were intended to illustrate. The Story Circle technique is similar, giving participants an opportunity to create and share their own personal stories. Participants then share these stories and pictures with the group, creating a wider dialogue and, ideally, isolating the major community concerns. Finally, participants are asked for solutions to the concerns. This approach is intended not just as an educational project but also to inform policy makers to create change around the community concerns.

Participants shot hundreds of photographs. They include countless images of the “telltale ring” in the back pocket of a pair of blue jeans of a longtime chew user, dozens of close-up shots of fat, snuff-engorged lips, and brown-spit-filled bottles, and then the unexpected purse with a chew can inside. “We’ve gotten lots of pictures of what chew actually looks like in the community and the impact it can have. One of the interesting observations was the enforcement of the Colorado Tobacco-Free Schools Law as it relates to chew,” Seedorf says. “We are hearing and seeing in our research that while it is being enforced with cigarette use on school campuses, chew tobacco is being completely overlooked. We see this as an exciting possibility to address statewide change.”

The individual communities each own the research. Seedorf returns all the photos, stories, and transcriptions for partners to share with the community and continue the process of solution building.

### Forming a Statewide Rural Coalition for Data Collection

Health department officials and academics from research institutions can sometimes be seen as community partners in rural areas, but often the cultural distance can be an insurmountable barrier. Seedorf knew that as a “Denver person,” access to rural communities would be difficult. She set out to form a project steering committee and discovered an ad hoc group of county public health workers who were informally meeting to strategize about smokeless tobacco issues in their communities.

“A lot of our rural communities have long been aware that chew tobacco is the major tobacco issue in their area,” Seedorf says. “But there has not been any funding or initiative statewide for them to look at it. These folks were already meeting to see...
“We all associate chew with the agricultural landscape and the cowboy, but the reasons for it were very different from what I expected. It’s not just a culture; it’s a critical tool, some might say a drug to stay awake. We have moms who use because their husbands keep it around, and it’s a way to keep themselves awake as they fulfill their roles as a wife or a mother. They were hiding their use and nobody knew it.”

Erin Seedorf, Program Manager, Cancer Center, University of Colorado; Director, Colorado Chew Tobacco Collaborative Initiative

what other people were doing and talking about how to try to convince the state to start looking at spit tobacco seriously.” She also pulled in some nontraditional partners outside of the county health departments and nursing services. For example, she contacted someone in a home visitation program who conducts parenting classes in seven counties in northeast Colorado. Seedorf also engaged partners who work with the collegiate rodeo program and partners in the tobacco prevention youth advocacy movement GET REAL (Resist! Expose Advertising Lies, getrealcolorado.com). From this outreach, a statewide steering committee, Partners Accessing Chew Tobacco (PACT), was formed for the project.

The steering committee brimmed with ideas for data collection sites. Each member was tasked with assembling a list of possible sites, ranging from a rural vocational technical high school and a church youth group to an Air Force base and a group of student athletes. In the first year of the grant period, Seedorf directed the group to pick the low-hanging fruit—the groups known to have a high use rate, a culture associated with chew, or groups with a strong desire to participate. In the pilot year of the data collection process, 18 groups including youth, college, adults, and military participated.

Preliminary Findings: A Prismatic View of Chew Tobacco

Seedorf and her team amassed piles and piles of data. One of the benefits of widely dispersed CBPR is volume. Taken as a whole, a statewide picture of spit tobacco use begins to emerge. Much of the data
underscored the cultural currency that chew enjoys in these rural communities. One photo that struck a chord with Seedorf was that of the at bed of a pick-up truck, completely covered with Copenhagen lids nailed directly into the wood slats. Another photograph showed old can lids nailed along a doorframe. “I know that with people who chew, there is an image associated with it,” Seedorf says. “But I’ve been working in tobacco for eight years, and I’ve never heard of anyone nailing cigarette packages into something. It really showed how people go to great lengths to use this product as an identity piece.”

Officially, female chew prevalence is low, but the photos and stories that came back from the group data collections told a different story. One photograph captured a massive can of chew inside a tiny clutch purse with bright pink polka dots. Another photograph showed a whole line of spit bottles next to a curling iron. Several discussions centered on the point that it is not just something men or boys do, but that girls and women are using chew as well. Though it lacks the quantitative statistical significance, this research methodology begins to get past the challenges of quantitative surveys.

Many community members took photos of chew tobacco displays in convenience stores. In these areas, smokeless products completely overshadow cigarettes. “They say they can’t even find the cigarettes in the store,” Seedorf says. “But the chew is on the counter where it’s all self-serve, and the posters are all over the place.”

This process allowed Seedorf and her partners to see common themes across the state. For instance, despite the tobacco-free schools policy, photos from all corners of Colorado showed evidence of chew in the schools: spit-stained carpets, spit-filled water fountains, and empty cans in lockers. Now CCTCI is collaborating with a tobacco control group working with schools to explore and educate Coloradans about the school policy, to better train staff and inform both students and parents.

Preliminary Solutions: Working Toward a Community Action Plan

PACT, the statewide steering committee, met in the spring of 2009 to begin the next phase — helping each community distill the massive amount of data down to a plan of action to confront chew prevalence and begin to dismantle the culture of acceptance. This process will enable each community to look at its data and begin to create policy directives to affect change. Otero and Crowley counties, for example, collected data with the 4-H clubs, and the presence of smokeless tobacco products at the rodeo emerged as a huge concern. With the help of the CCTCI data collection, concerned citizens have set a goal to encourage the local rodeo committee to adopt a tobacco-free policy and in the future build on that momentum to advocate for a city ordinance.

To some extent, the movement toward building a community action plan already began in the story-sharing sessions all over the state. “Once they start

“One girl came from a family of smokers, and she thought that was a nasty habit, so she started chewing. ‘It helps me balance with the stress,’ she said. ‘Why should it be any different for the girls?’ One of the guys was a rodeo rider, so he got as much as he wanted for free and he said he used it to stay awake on long trips.”

Lori Gittings, CCTCI Steering Committee Member, Prowers County, Colorado

“This basic social acceptance and bonding dynamic that happens between parents and their kids around chew tobacco is a powerfully strong norm. These folks always have chew in the fridge in the kitchen or out in the shed. Here, if you’re a kid, it’s fine. If you’re a grandma, it’s fine. You can’t put that on a graph, but now we have people from the ninth grade all the way up to guys in their seventies actually having a conversation about all this.”

Edward Ellis, CCTCI Steering Committee Member, Jefferson County, Colorado
talking about chew, you hear all these perspectives on acceptance and the social contract,” says steering committee member Edward Ellis. “They even brainstormed some practical solutions: Start talking about this in school more often, get cessation services in schools, do something about the tobacco displays, and boost the tobacco taxes.”

CCTCI took a novel approach to studying—and beginning to chip away at—one of the most overlooked health crises in rural communities. A dialogue is under way now in these communities, but there is much work still to be done. “Chew tobacco is so prevalent that you just ignore it here—you don’t even see it,” says steering committee member Lori Gitings. “But things are starting to change now; the Colorado Rockies [baseball] team doesn’t allow it.”

Lessons Learned

- Chew tobacco acceptance is generationally and geographically rooted, and intervention must be similarly oriented.
- New smokeless products may entice nontraditional users.
- Rural communities may be resistant to change, but once initiated, change can spread rapidly.
- Look for community partners already working toward the same goal.
- Community-Based Participatory Research initiates community dialogue, a necessary precursor to culture shift.
La Crosse County Health Department: Western Wisconsin Tobacco and Alcohol Reduction Project
Addressing the Dual Challenges of Tobacco and Alcohol Use

Program Overview

La Crosse, Wisconsin, a city of just over 50,000, has roughly 250 bars and taverns, making their bar-to-resident ratio one of the highest in the country. Two universities and one college all sit within a short walk of the pub-congested downtown area. Breweries and drinking establishments have long been a primary engine of the economy in this part of the Midwest, and particularly in La Crosse County. For example, La Crosse is home to the world’s largest six-pack, located at the City Brewery downtown.

Wisconsin leads the country in binge drinking, according to the 2008 Behavioral Risk Factor Surveillance System. Binge drinking is defined by the Centers for Disease Control and Prevention as having five or more drinks on one occasion within the past 30 days for males, four or more drinks for females. In 2008, 22.8 percent adults in Wisconsin reported binge drinking in the last 30 days. This is the highest rate of binge drinking in the United States. La Crosse County is near the top of the list for the state.

The alarming alcohol abuse rate also goes hand in hand with high prevalence of tobacco use. Nearly one-third of adults aged 25 to 44 with less than a high school education in Wisconsin are current smokers. Al Bliss and the La Crosse County Health Department (LCHD) set out to break the strong correlation between a culture of alcohol abuse and a high smoking rate among residents with less than a college education. They turned to Legacy for project funding to launch their Tobacco and Alcohol Reduction Program to address this problem of co-morbidity of tobacco use with alcohol abuse.

LCHD decided to target both active binge drinkers and people in recovery programs for aggressive cessation education. Up to 75 percent of patients in treatment for alcoholism are tobacco-dependent and about half of them are heavy smokers, according
Approximately 75,766 alcohol-attributable deaths and 2.3 million years of potential life lost, or approximately 30 years of life lost on average per alcohol-attributable death, were attributable to excessive alcohol use in 2001 in the United States.

Alcohol-Attributable Deaths and Years of Potential Life Lost—United States, 2001, MMWR, September 24, 2004 / 53(37); 866-870.

to the National Institute on Alcohol Abuse and Alcoholism. These rates are nearly as high as the rates for the co-occurrence of tobacco dependence and serious mental illnesses.

De-normalizing Smoking at Recovery Centers and 12-Step Meetings

LCHD’s initial outreach strategy was to access the recovery client’s interest in quitting; provide motivation through free nicotine patches, gum, or lozenges; and provide evidence on the serious health risks of heavy drinking and tobacco dependence. While interacting with the participants at the recovery centers, Al Bliss talked about the co-morbidities and the higher rates of cancer. Many of his clients are unemployed or underemployed. “Many people in substance abuse programs are stressed out and without employment and a permanent residence, and it exacerbates the problems of addiction,” Bliss says.

“The smoking rate in Wisconsin just dipped below 20 percent,” he says. “So people recognize that the smoking rate in the general population has dropped, but what they don’t realize is the great disparity in the other population, particularly the population we are working with.” Up to 80 percent of people in recovery programs express interest in quitting smoking, but Bliss does not believe that implementing a smoke-free policy before assisting tobacco users interested in quitting would be effective. “Staff of recovery centers have a great fear that their clients would not attend treatment and get the help that they need if a complete smoking ban was in place,” Bliss says. “We start with educating the staff themselves, some of whom are smokers. We provide the training and technical assistance to help them quit. We are finding that the socialization associated with smoking is a big part of it.”

A large part of the support culture of people in recovery involves gathering before and after meetings for a chat and a smoke. Studies have shown that...
alcoholics who quit smoking have a better chance of maintaining their long-term sobriety, and that encouraging cessation does not threaten the priority of sobriety. The recovery centers try to integrate smoke-free activities into the daily routine.

One of the regular stops on LCHD’s recovery center rotation is the Coulee Council on Addictions (CCA), located a short distance from downtown La Crosse. CCA implements the entire spectrum of addiction support, from preventive to end-stage substance abuse. CCA has a drop-in center for anyone looking for help, a meal, and some support with their addictions. Bliss is often on hand to offer free nicotine replacement therapy (NRT) and cessation support.

“We’ve got to dispel that myth that you should quit alcohol first and then just keep smoking,” says Pat Ruda, the Executive Director of CCA. “That’s old thinking. We need to help people become healthy in all aspects.”

“Equal access to an array of services that promote wellness and recovery” is the LCHD mission statement. “There is a tremendous amount of work that could be done in cost savings for local health departments to provide and integrate tobacco treatment in their services, particularly in mental illness, clinical services, and economic support,” Bliss says.

Targeting the Binge-Drinking Population at Workplaces and in jail

Another part of LCHD’s Tobacco and Alcohol Reduction Program focuses on area businesses. To access the employed, binge-drinking segment of the local population with less than a college degree, LCHD works directly with local employers and human resource managers. Bliss has developed relationships with a diverse array of employers, from car dealerships to telemarketing companies. “It’s amazing how many HR managers and employees are not aware of their cessation and tobacco treatment coverage for medications,” Bliss says. “It might be in a 30-page book, and you’ve never read it.” Now, many businesses promote this benefit regularly and offer the opportunity for LCHD staff to meet with smokers one-on-one to develop an individualized quit plan and select appropriate medication.

LCHD surveys workers to identify the binge drinkers but does not disqualify workers who are not binge drinkers. “It’s not that difficult to identify them based on our intake survey,” Bliss says. “Well over half of the individuals that we reach through businesses can be identified this way, and most of these adults we talk to do not identify themselves as binge drinkers or heavy drinkers. For example, employees might believe that binging is having more than 10 drinks during an evening.”

LCHD’s goal for the term of the Legacy grant is to enroll 320 total participants, with a little over one-third

“Alcohol and nicotine are triggers for each other. There are a couple of schools of thought on this, but some treatment centers say to hit them all at once. If you’re going into recovery for alcoholism, you might as well go for the nicotine as well. We just put it out there, and kind of meet them where they’re at.”

Pat Ruda, Executive Director, Coulee Council on Addictions
“Many people feel that it is too much to ask someone to quit tobacco at the same time they are quitting drugs and alcohol. I tell them if you want to participate in our program once you have some of your finances worked out, your housing in place, and your initial treatment done, then maybe there is a better time to do this. We may not catch them at the right time, but maybe a couple months later, they’re ready to think about quitting.”

Al Bliss, LCHD, Health Educator

coming from recovery centers and the rest via local businesses. At 18 months in, over 300 individuals have been enrolled. LCHD offers both one-to-one and group cessation support classes in La Crosse and four surrounding rural counties where tobacco cessation efforts are few and far between. Bliss considers two of the biggest barriers to cessation to be fear of quitting tobacco use while in recovery and lack of affordability of the seven approved FDA medications. “There is a myth that quitting smoking costs too much—that it costs more than smoking,” Bliss says. LCHD makes free starter “quit kits” available, which include nicotine patches, gum, or lozenges, and refers participants to the Wisconsin Tobacco Quitline for additional free NRT.

Most of the employers with whom Bliss works have indoor smoke-free policies, which help to diminish tobacco use. But he finds that businesses are often hesitant to offer cessation classes during work time, though they are not as reluctant to allow individual meetings of a half hour for a brief intervention and NRT dispersal. Besides a healthier workforce, another incentive for employers is a more productive staff with fewer sick days and less disability leave.

Bliss also sought his target demographic within the inmate population, successfully counseling 27 prisoners, many of whom were serving sentences for alcohol-related offenses. Unfortunately, Bliss cannot provide inmates with NRT without violating prison contraband policies. He conceded the follow-up could be challenging. “The first thing they want to do when released is to light up,” he says. “But we are at least reaching out to them, and that has been another area of opportunity for us and could be for many health departments.”

Wisconsin Governor Jim Doyle signed a smoking ban on May 18, 2009, making the state the 27th to clear the air for employees in all public spaces and patrons of eating and drinking establishments. Wisconsin will not be “the ashtray of the Midwest,” and if past is prologue, the prevalence of tobacco use will begin to diminish.

Lessons Learned

- Binge drinking is culturally endemic to La Crosse County, Wisconsin.
- Binge drinkers are much more likely to smoke than the average population and are an overlooked group for tobacco cessation.
- Providing free nicotine replacement therapy increases the cessation rates among clients.
- Educating smokers on the financial benefits of quitting is effective.
- Breaking the socialization of recovery around smoking is necessary.
- Intervention services must come to the client rather than vice versa.
- Quitting tobacco increases the likelihood of maintaining sobriety.
Maine leads the states in tobacco control funding, but smoking rates remain at crisis levels for certain segments of the population, raising the concern that tobacco cessation information is not trickling down to its residents effectively or equally. Data show that 17.5 percent of Maine women smoke while pregnant. Of those, 83.3 percent receive MaineCare or Medicaid assistance. Maine also has a high number of residents with disabilities—a population both more likely to use tobacco and less likely to quit. Twice as many Mainers earning less than $25,000 use tobacco compared to residents who earn over $50,000, and three times as many of those with a high school degree use tobacco compared to those with a college degree. For people with literacy barriers, reading a text on the web—a dynamic multimedia platform—is more difficult than reading a text in printed materials. Because reading is further complicated on the Internet, those with reading challenges are at greater risk of prolonged tobacco use and its consequences, as they are not able to access important information on cessation techniques.

Alarming statistics such as these encouraged Drs. Stephen Gilson and Liz DePoy to apply for a grant from Legacy. Gilson and DePoy are co-directors of the Prevention Center of Excellence located in the Center for Community Inclusion and Disability Studies (CCIDS) at the University of Maine and have built considerable capacity for improving health information access for diverse populations. The original idea came from their intent to develop a web-based tool that renders text from tobacco information websites into readable information for mostly rural Mainers with limited literacy and English proficiency. When they tested the top ten Google search results found by using the key words “quit smoking,” they found only one—the Centers for Disease Control and Prevention.
“Maine is a poor rural state. It’s a border state, where many people speak Acadian French as their first language. Low literacy here in a rural area is an issue for different reasons than it is in, say, New York, where an immigrant might come to the city and never learn to speak English. That’s different than if you never went to school or you went to a one-room schoolhouse, which is still the case here in a lot of places.”

Liz DePoy, Developer and Researcher, University of Maine Tobacco Access Portal

website—that met basic accessibility guidelines.

The idea for the prototype Tobacco Access Portal (TAP) was born from DePoy’s personal experience, when she became sick with encephalitis and had temporarily lost her eyesight. “Walking into the doctor’s office and not being able to read anything,” she says, led to her interest in developing tools for people with limited access to print information. While TAP addresses visual challenges, it also includes 47 percent of American adults who have trouble reading English in the dynamic and often distracting web-based format.

While taking into account that individuals access and comprehend information in a variety of ways, Gilson and DePoy aimed to build a bridge to tobacco cessation information for those who do not use the web in standardized ways. “It’s ludicrous,” DePoy says. “The people who need the information the most—those who tend to be lower in literacy—can’t access it. From a human rights perspective it just makes perfect sense that something should be written at a literacy level that can be both read and orally rendered.”

Building the Portal Word by Word

Software like Babel Fish is designed to translate blocks of text from one language to another, but a web portal capable of distilling and simplifying language to a literacy level below its original had not been developed until the University of Maine created the TAP project. Existing tools such as English language “parsers” and “thesauruses” work toward this aim, but no existing software could filter a health-based website to be readable to a low-literacy population. A particular challenge is that many topical areas, such as tobacco control, have specialized lexicons that do not lend themselves to easy translation.

Initially, the process was a labor-intensive, line-by-line, word-by-word tinkering with the language. Gilson and DePoy worked with a handful of graduate students who developed a matrix to check and double-check each word as the portal was being built and improved. “What do you do when the title of a website says ‘smoking cessation’?” asked Gilson. “We had to develop a program that differentiated between formal names and text describing quitting smoking.” The process uncovered kinks in their software that produced problematic translations of some phrases. For instance, “people with special needs” became “special people” in an early iteration of the portal.

The current version of TAP translates the six major tobacco prevention sites serving the state of Maine. “This has never been a project with the intention of doing an ‘I gotcha’ against the designers of these websites,” Gilson says. “We just ipped our brains and started thinking differently. Web authors and designers didn’t write those sites to exclude people.”

A local journalist interviewed Gilson and DePoy soon after they received the Legacy grant. The journalist went and pulled up those six sites and told them he couldn’t see how the information was difficult to understand. “He was reading through a lens of someone with a

“We thought that low literacy was low literacy. It never dawned on us that there would be differences in the nature of literacy even at the same level. If somebody speaks English as a second language but is very literate in his/her first language, that was a very different picture than someone who never learned to read in the first place.”

Liz DePoy, Developer and Researcher, University of Maine Tobacco Access Portal
master’s degree, and those words seemed common to him,” Gilson says. It is easy for most members of the population to take their basic literacy for granted.

Accounting for a Low-Literacy Population That Is Not Homogeneous

In the rural communities of Maine, low literacy takes many forms. Roughly 25% of Mainers are of French or French-Canadian ancestry. This population grows up speaking “Franglais,” much like the residents of the U.S.-Mexico border are fluent in “Spanglish.” The Chinese immigrant population is on the rise in Maine, particularly in and around Bangor, as is the Spanish-speaking population in the agricultural areas. Gilson and DePoy had not anticipated their tool becoming useful for the English-as-a-second-language (ESL) population until they entered the testing phase.

“That was a big ‘a-ha’ for us that we hadn’t considered,” DePoy says. “So we began looking at the differences between what people want from a website, how they read it, and ultimately how they can learn from it. We really had to look at the multiple explanations of why they don’t read well and what that means for the development of a web portal.” In other words, the conceptualization and learning process for an immigrant highly educated in his or her native language may be quite different from that of a “Franglais” speaker or a high school dropout.

“It would be a dream come true if this could be an overlay for any sort of website. It’s really easy to see the potential of making the Internet accessible. We see people all the time who simply can’t understand the health information that many of us take for granted, and it’s clear that low literacy translates into low health.”

Mary Lyon, Executive Director, Literacy Volunteers of Bangor

Testing the Portal and Building Creative Partnerships

Gilson and DePoy had a TAP testing site in place through the Literacy Volunteers of Bangor (LVB) even before they submitted their grant application. LVB’s goal is to reduce the disparity of access to social, economic, and educational resources for adults with identifiable low literacy skills. Mary Lyon, the LVB executive director, and her staff serve roughly 200 people every year, mostly within a 25-mile radius of Bangor. The population served at LVB is roughly 40-percent native English speakers and 60-percent ESL.
Gilson and DePoy arranged for a testing group of 20 at LVB to receive stipends for their participation and also donated a set of PCs to the center for ongoing assistance. “Our students would have done it even without the stipends, because they are all so appreciative of what we do,” Lyon says. “It is a forgotten population, and this helps to remove barriers and level the playing field.” The testing process helped Gilson and DePoy polish the portal by honing in on some language that remained difficult or unfamiliar and moved the prototype to a level where it could be unveiled.

At the time of this publication, the Maine Adult Education Association has developed a growing interest in implementing the portal for a wider audience. After a presentation at the American Public Health Association annual conference in 2008, immigrant service providers in New York have expressed interest. “This has sparked something for us,” Gilson says. “We had originally conceived of this as a tool for folks with some sort of diagnostic circumstance for why they are not reading, people who are in rural areas with problematic access, or for people who had schooling curtailed.”

**Looking Forward with a Sustainable Initiative**

Gilson and DePoy are now looking to broaden the geographic reach of their innovative tool. They are developing a version that will filter the tobacco education sites in any state. “We started with Maine as a framework to figure out the issues in development of this portal,” Gilson says. “Now we’re ready to have it work anywhere. Whether you’re urban or rural, in North Carolina, Wyoming, or Los Angeles, you’ll be able to plug in a cessation site and have it do the translation. I am really excited about this next phase that will allow us to extend beyond the boundaries of Maine.”

Gilson and DePoy see a paradigm shift on the horizon. As the chair-elect of the Disability Section of the American Public Health Association, Gilson feels that the conversation around web-based information access is gaining traction. “That is part of how policy thinking takes place,” Gilson says. “It gets on people’s radar, and they begin looking at it and thinking differently.”

**Lessons Learned**

- Maine’s adult smoking rate and literacy rate made it an ideal testing ground for the Tobacco Access Portal.
- Those who can least understand text-based health information are often the ones who most need it.
- A tool like TAP requires many rounds of patient, diligent revision to distill language and simplify specialized language while retaining accuracy.
- Vast differences in the nature of literacy exist (even at the same level), and must be accounted for: regional dialects, ESL populations, and differences of conceptual ability.
- The TAP model could be widely applied to improve literacy access for a range of sites across geographic boundaries.
- Innovative projects require creative partnerships.
NEW IMMIGRATION POPULATION CHANGE:
NON-METRO COUNTIES IN THE U.S.

APPENDIX B

ENDNOTES


15. Ibid.

16. USDHHS, Substance Abuse & Mental Health Administration (SAMHSA), Office of Applied Studies, “Results from the 2007 National Survey on Drug Use and Health: Detailed Tables,” SAMHSA, Table 2,49B, 80402, http://oas.samhsa.gov/NSDUH/2k7NSDUH/tabs/Sect2peTabs47to51.pdf [accessed May 28, 2009].


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Ibid.


Stevens, Colwell, and Hutchison.
ENDNOTES, CONTINUED


48 Ibid.


50 Ibid.


53 Stevens, Colwell, and Hutchison.

54 The Family Smoking Prevention and Tobacco Control Act gives new authority to the Food and Drug Administration (FDA) to put restrictions on the sponsorships of athletic or other entertainment events by tobacco product manufacturers, distributors, or retailers. The specific restrictions on sponsorships and other areas will be determined through the regulations process.


57 Ibid., “Income,” Chapter 4.


The terms “spit,” “chew,” and “smokeless” tobacco are often used interchangeably.


73 John R. Hughes, Treating Smokers with Current or Past Alcohol Dependence, American Journal of Health Behavior 20, [1996].


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The American Legacy Foundation® is dedicated to building a world where young people reject tobacco and anyone can quit. Located in Washington, D.C., the Foundation develops programs that address the health effects of tobacco use — with focus on vulnerable populations disproportionately affected by the toll of tobacco — through grants, technical assistance and training, partnerships, youth activism, and counter-marketing and grassroots marketing campaigns. The Foundation's programs include: truth®, a national youth smoking prevention campaign cited for its contributions to significant declines in youth smoking; EX®, an innovative public health program designed to speak to smokers in their own language and change the way they approach quitting; research initiatives that explore the causes, consequences, and approaches to reducing tobacco use; and a nationally-renowned outreach program to priority populations. The American Legacy Foundation was created as a result of the November 1998 Master Settlement Agreement reached among attorneys general from 46 states, five U.S. territories and the tobacco industry. For more information about the foundation please visit www.americanlegacy.org.

Acknowledgements

We acknowledge and thank the five grantees whose work has been featured in this publication. We are grateful to them for providing information about their initiatives and reviewing manuscript drafts. Kabi Pokhrel is the principal architect and author of this publication. We are grateful to Zachary Slobig, who created the case studies. Legacy staff colleagues Amber Hardy Thornton, Laura Hamasaka, Katherine Wilson, Michael Wood, Benjamin Frey, Robin Scott, and Alesia Brody contributed to this publication and served as reviewers. Kaye Placeres directed the graphic design of this publication.

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