Community and Policy Interventions Breakout Session

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Overview

The Impact of Policy Interventions

Policy interventions are now a well-recognized component of tobacco control and prevention efforts. In the United States, early Federal policy-making efforts focused on cigarette advertising and promotion. In the 1970s and 1980s, nonsmokers' rights organizations began pressing for policies to protect nonsmokers from environmental tobacco smoke (ETS) and, later, for other policy measures (1). Over time, the success of these and other policy-focused efforts has helped establish public policy as an important component of tobacco control and prevention.

Research now demonstrates the effectiveness of policy interventions to prevent and decrease tobacco use. Among the most powerful interventions is increasing tobacco excise taxes. As noted in *Reducing Tobacco Use: A Report of the Surgeon General*, "Increases in cigarette prices lead to substantial reductions in cigarette smoking by deterring smoking initiation among youth, promoting smoking cessation among adults, and reducing the average cigarette consumption among continuing smokers" (2). The impact of price increases is not limited to the United States; the World Bank reports that, on average, a price increase of 10 percent per pack would reduce demand for cigarettes by about 4 percent in higher-income countries and by about 8 percent in lower- and middle-income countries (3).

Policies to restrict smoking in indoor locations such as workplaces and public areas ("clean indoor air" laws) are effective in reducing nonsmokers' exposure to ETS. These policies are also credited with increasing the rate at which smokers attempt to quit, increasing the success rates of these attempts, and reducing the number of cigarettes smoked per day by those who continue to smoke (4, 5). In addition, a recent study suggests that the broad decline in the percentage of children exposed to ETS in the home is due, in part, to efforts to decrease ETS in worksites and public places (6). The laws and the effort required to enact them may have helped change social norms, including the attitudes of parents who smoke toward exposing their children to ETS in the home. In addition, many countries have either banned or severely restricted tobacco advertising and promotion in response to its impact on youth and adults (7).

Community-Level Programs and Policies

Community-level intervention research has contributed greatly to our understanding of effective state- and community-level programs and policies. The North Karelia Project (Finland) and the Stanford Three-Community Study (United States) were key early community-level intervention trials aimed at preventing cardiovascular disease (8). These studies, which demonstrated the potential impact of community-level interventions, were followed by others, including many aimed specifically at reducing tobacco use (9). The potential of community-based interventions to provide persistent and inescapable messages to quit smoking formed the basis for the NCI Community Intervention Trial for Smoking Cessation (COMMIT), begun in September 1986 (10). Its successor, the American Stop Smoking Intervention Study (ASSIST), which began in October 1991, focused on changing policy to alter the social, cultural, economic, and environmental factors that promote smoking (11). More recently, increased emphasis has been placed on conducting research that is truly "community centered" or "community based"—defined as a "collaborative approach to research

that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process" (12). Community intervention and community-based research have helped make state- and community-level interventions, both programmatic and policy, an important part of efforts to reduce tobacco use (13, 14).

Community activism and advocacy, including media advocacy, are a critical part of efforts to implement effective tobacco control and prevention policies. Community activism can be effective even when legislation is not enacted; the process of community activism serves to educate the community and change social norms and, on occasion, results in changes in private policy. For example, many large businesses, including several nationwide restaurant chains, have implemented 100 percent smoke-free policies in the absence of laws requiring them to do so.

Reducing Women's Risk

Lung cancer has been the leading cause of cancer death in women for many years, having overtaken breast cancer death in white women in 1986 and in black women in 1990 (15). However, while awareness of the risk of breast cancer is widespread, research suggests that few women are aware of the grave danger they face from lung cancer. For example, a January 2001 survey conducted by the American Legacy Foundation found that 80 percent of women believed that breast cancer is the leading cause of cancer death among U.S. women (16). Few women's and girls' organizations are involved in tobacco control and prevention, and this issue is rarely visible on the agenda of the women's advocacy community.

Certain groups of women are at increased risk for tobacco use and tobacco-related disease. Overall, in 2002, 20 percent of women aged 18 and older were current smokers; however, prevalence varied sharply by level of educational attainment, race/ethnicity, and economic status. Women with a graduate degree had the lowest smoking prevalence (6 percent). In sharp contrast, women with low levels of education had the highest prevalence: 31 percent of women with 9-11 years of education and 37 percent of women with a GED smoked. Women at or above the poverty level were much less likely to smoke than those living below the poverty level (20 percent vs. 30 percent, respectively) (17). Lastly, a recent study documented enormous variation in cigarette smoking among different racial and ethnic groups. In 1999-2001, the prevalence of cigarette smoking was 40 percent among American Indian/Alaska Native women, 26 percent among white women, 22 percent among black women, 17 percent among Hispanic women, and 9 percent among Asian women. Variation among different Hispanic and Asian subgroups was also demonstrated (18).

Data on tobacco use by American Indian/Alaska Native women have some significant limitations; for example, the National Health Interview Study did not identify American Indian/Alaska Native respondents until 1978. Despite this, it is clear that American Indian/Alaska Native men and women have had significantly higher smoking rates than any other group for many years. Furthermore, the overall figure masks significant variation among tribal groups. For example, a threefold variation in prevalence was observed among American Indian/Alaska Native women of different geographic regions: 14 percent of women in the Southwest were current smokers, compared with 38 percent of women in the Northern Plains (1988-1992 aggregate data). Cigarette smoking by American Indian/Alaska Native women of reproductive age remained at 36 to 44 percent between 1978 and 1995, and even higher rates were observed among American Indian/Alaska Native women of reproductive age with less than a high school education (47 to 82 percent). Relatively little quitting behavior has been found in this population (19), and some data also indicate high rates of smokeless tobacco use among specific groups of American Indian/Alaska Native women (20, 21).

Many challenges exist in reducing tobacco use by American Indian/Alaska Native women. These include the community's enormous diversity, poverty, and deprivation and the fact that conventional service organizations often do not operate on Indian reservations. Interventions will need to be tailored to the specific community served; partnering with organizations that already operate on Indian reservations, especially American Indian/Alaska Native organizations, may be particularly valuable.

Research Barriers, Gaps, and Opportunities

Numerous barriers to research on effective community and policy interventions exist, including insufficient resources, capacity, infrastructure, leadership, and researchers capable of conducting community-based research. In addition, research on effective community and policy interventions is often not amenable to the use of randomized controlled trials, generally considered the "gold standard" of research (22). For this and other reasons, community-based researchers often have greater difficulty than their more traditional counterparts in securing funding for their work (12).

Important gaps in this area include the need for a better understanding of differences in smoking prevalence among ethnic groups and the cultural and gender-specific factors that influence exposure to ETS. Often, research fails to consider culture; as a result, many "best practices" are not especially effective in reaching priority populations. Segmented, targeted social marketing research is especially needed to counter the extensive qualitative and quantitative research conducted by the tobacco industry. Research is also needed to determine the effects of tobacco control and prevention policies implemented at technical schools and other institutions that serve young women who do not attend college.

Important community and policy research opportunities exist in many areas, including lessons learned from changes in societal attitudes toward tobacco use; factors that motivate policy makers to support tobacco control policies; successful strategies to convey smoking cessation messages to subpopulations characterized by isolation, low socioeconomic status, and/or low literacy; Internet sales of tax-free or low-tax tobacco products by Indian reservations; the impact of smoking bans in bars, casinos, and other venues; and whether analysis of existing surveillance data can identify gaps in knowledge about gender, ethnicity, and culturally specific issues related to tobacco use. Past research has rarely studied the impact of policies and interventions on women; gender-specific research represents an important opportunity for future work.

Recommendations

Research

*1. Encourage funding organizations to embrace participatory research.

New funding mechanisms are needed to support culturally relevant community-based participatory research. Funding organizations should increase their commitment to support institutions and organizations that are committed to forging research partnerships with community organizations. True partnerships are bidirectional—community-based collaborators receive training in research methodology while academic researchers receive training in culturally and community-tailored interventions—and require a commitment to joint decision making and shared ownership of the project. The breakout group recommends increased funding for collaborative research projects, including applied research and "community action research," to encourage partnerships between community-based organizations and academic researchers.

California's Tobacco-Related Disease Research Program's Participatory Research Awards may be a useful model for other research funding organizations to consider. These awards (Community-Academic Research Awards and School-Academic Research Awards) are designed to stimulate and support collaborations between academic investigators and community-based organizations, local tobacco control initiatives, and schools to perform scientifically rigorous research.

Because other health conditions are prominent among smokers, NCI should consider partnering with other National Institutes of Health (NIH) Institutes to study such issues as tobacco use in people with diabetes and hypertension or the interaction of alcohol and tobacco policies. To counter discrimination based on race and ethnicity, gender, and social class, research subjects—people who smoke, community-based organizations, communities of color, and other groups—should have a voice in determining future research funding.

Impact

Within 5 years, an increased level of active participatory research will be under way.

*2. Develop funding mechanisms that foster partnerships between research institutions and organizations that serve high-risk populations.

At present, funding mechanisms do not often facilitate partnerships with community organizations; at times, they even create barriers to these partnerships. Partnerships are especially needed with organizations serving populations at high risk for tobacco use. American Indians/Alaska Natives are a particular focus, given the magnitude and persistence of the problem of tobacco use in this population. Tribal colleges, tribal health departments, and other institutions that serve these communities should be especially targeted for research partnerships.

Impact

Within 2 years, funding mechanisms will incorporate culturally competent approaches and language to facilitate greater involvement by culturally diverse organizations and researchers.

* Recommendations with an asterisk are those identified by the breakout groups as their top three (or four) recommendations.

*3. Fund strategic policy research to increase our knowledge of the impact of public and private tobacco control policies on women and girls.

Despite the well-recognized role of policy interventions in tobacco control and prevention, relatively little research has focused on the differential impact of policies, if any, on women and girls. A better gender-based understanding of the impact of current policies (at the community, state, national, and international levels) on attitudes, behaviors, and health effects is needed. Gender-based analyses of newer policy efforts, such as the impact of family and home-based policies and policies related to health systems change, are needed as well. Research can also provide and test models to understand how various policies alter social norms and behaviors, clarify the policy development process, and offer an understanding of how best to communicate and collaborate with policy makers to enact and enforce effective policy measures.

Impact

Within 5 years, research findings will be analyzed and published that will guide the development of evidence-based tobacco control policy and its impact on gender differences.

*4. Support research to identify messages and strategies to engage women's and girls' organizations and their constituents in tobacco control and prevention efforts.

Long-term, sustained, and coordinated strategies are needed to engage women's and girls' organizations in tobacco issues and to incorporate the issue of tobacco into the women's health agenda. Women's and girls' organizations are appropriate partners to determine how best to communicate to women the enormity and importance of the problem of tobacco use and their potential role in addressing this problem.

Impact

Within 3 years, a functional, operative network will exist, will have established relationships with key women's and girls' organizations, and will support a growing constituent base.

5. Consider replicating the applied research model used for NCI's American Stop Smoking Intervention Study (ASSIST).

ASSIST was a public-private partnership between NCI and the American Cancer Society aimed at using policy strategies to change the social, cultural, economic, and environmental factors that promote smoking. ASSIST demonstrated that strong tobacco control programs and effective policies lower smoking rates (11). Lessons learned from the ASSIST project could be applied to the development of public-private partnerships to decrease women's tobacco use. For example, the NIH Office of Research on Women's Health, the U.S. Department of Agriculture's Women, Infants, and Children (WIC) program, and a foundation that focuses on women's or health issues could work together to design and implement programs and policies at WIC clinics to assist women to quit smoking and reduce children's ETS exposure. Successful projects could then be considered for nationwide dissemination. Research and demonstration projects are also needed to understand how to convert broad community support—especially women's and girls' support—for tobacco control policies into active community involvement in their development and enforcement.

References

1. Bloch MH. Tobacco control and prevention. In: Brobeck S, ed. *Encyclopedia of the Consumer Movement*. Santa Barbara, CA: ABC-CLIO; 1997: 564-8.
2. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2000.
3. Jha P, Chaloupka FJ. *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Washington, DC: World Bank; 1999.
4. Hopkins DP, Briss, PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine*. 2001;20(2S):16-66.
5. National Cancer Institute. *Population-Based Smoking Cessation: Proceedings of a Conference on What Works to Influence Cessation in the General Population*. Smoking and Tobacco Control Monograph No. 12. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; November 2000. NIH Pub. No. 00-4892.
6. Soliman S, Pollack HA, Warner KE. Decrease in the prevalence of environmental tobacco smoke exposure in the home during the 1990s in families with children. *American Journal of Preventive Medicine*. 2004;94:314-20.

7. Roemer R. *Legislative Action to Combat the World Tobacco Epidemic*. 2nd ed. Geneva: World Health Organization; 1993.
8. Sorensen G, Emmons K, Hunt MK, et al. Implications of the results of community intervention trials. *Annual Review of Public Health*. 1998;19:379-416.
9. Hymowitz N. Community and clinical trials of disease prevention: Effects on cigarette smoking. *Public Health Reviews*. 1987;15:45-81.
10. National Cancer Institute. *Community-Based Interventions for Smokers: The COMMIT Field Experience*. Smoking and Tobacco Control Monograph No. 6. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute; August 1995. NIH Pub. No. 95-4028.
11. Stillman FA, Hartman AM, Graubard BI, Gilpin EA, Murray DM, Gibson JT. Evaluation of the American Stop Smoking Intervention Study (ASSIST): A report of outcomes. *Journal of the National Cancer Institute*. 2003;95:1681-91.
12. Israel BA, Schulz AJ, Parker EA. Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*. 1998;19:173-202.
13. Siegel M. The effectiveness of state-level tobacco control interventions: A review of program implementation and behavioral outcomes. *Annual Review of Public Health*. 2002;23:45-71.
14. Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs–August 1999*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; August 1999.
15. Mortality trends for selected smoking-related cancers and breast cancer—U.S., 1950-1990. *Morbidity and Mortality Weekly Report*. 1993;42:857,863-66.
16. American Legacy Foundation. *Women and Lung Cancer Survey*. Washington, DC: American Legacy Foundation; January 2001.
17. Centers for Disease Control and Prevention. Cigarette smoking among adults—U.S., 2002. *Morbidity and Mortality Weekly Report*. 2004;53:427-31.
18. Centers for Disease Control and Prevention. Prevalence of cigarette use among 14 racial/ethnic populations—U.S., 1999-2001. *Morbidity and Mortality Weekly Report*. 2004;53:49-52.
19. U.S. Department of Health and Human Services. *Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 1998.
20. Kaplan SK, Lanier AP, Merrit RK, et al. Prevalence of tobacco use among Alaska Natives: A review. *Preventive Medicine*. 1997;26:460-5.
21. Spangler JG, Case LD, Bell RA, et al. Tobacco use in a tri-ethnic population of older women in southern North Carolina. *Ethnicity & Disease*. 2003;13:226-32.
22. Sackett DL, Rosenberg WMC, Muir Gray JA, Hanyes RB, Richardson WS. Evidence based medicine: What it is and what it isn't. *British Medical Journal*. 1996;312:71-2.