COMPREHENSIVE SMOKE-FREE POLICIES

COMPREHENSIVE SMOKE-FREE POLICIES MAY INCLUDE STATE OR LOCAL LAWS OR REGULATIONS THAT PROHIBIT SMOKING IN ALL INDOOR AREAS OF WORKSITES AND PUBLIC PLACES, INCLUDING RESTAURANTS AND BARS.[33,34]

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for comprehensive smoke-free policies that advance health equity:

- **Differential Policy Coverage in Workplaces Employing Vulnerable Populations:** Comprehensive smoke-free policies are the most effective means to fully protect all workers from secondhand smoke exposure in workplaces.[33] In contrast, policies that exempt venues, such as restaurants, bars, hotels, casinos, and factories, may exclude many blue-collar and service sector workers from smoke-free protections and create disparities in secondhand smoke exposure.[35,36] These workers—many of whom are racial or ethnic minorities, immigrants, and individuals with limited education and low incomes—may have disproportionate exposure to secondhand smoke in the workplace.[37,38]

- **Lack of Enforcement and Compliance with Existing Smoke-Free Policies in Some Communities:** Even when a comprehensive smoke-free policy exists, some groups may not fully benefit from the policy due to inconsistent education and enforcement regarding the policy.[35,39,40] Lack of community engagement or culturally appropriate efforts to inform these groups about policies and failure to provide these populations with cessation services may also influence who benefits from the policy.

- **Challenges with Adopting Comprehensive Smoke-free Policies in Rural Areas and Tribes:** Some rural areas or tribes may be resistant to smoke-free policies as indicated by higher smoking rates in these areas.[30,41] Others may be resistant because the economy may rely on tobacco production or use.[42-44] Additionally, in many American Indian and Alaska Native tribes, barriers to such policies may arise if cultural and historical norms regarding ceremonial or traditional tobacco practices are not considered when adopting and implementing smoke-free policies.[44] Considering the cultural and social norms in communities is critical for the development of successful, smoke-free strategies.

Design and Implement with Health Equity in Mind

To maximize health impact and advance health equity, consider these factors and others when designing, implementing, and evaluating comprehensive smoke-free policies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
COMMUNITY AWARENESS & INVOLVEMENT Engage communities to understand and shift social norms around smoking and secondhand smoke	Some communities, particularly those with high rates of smoking, may be reluctant to implement comprehensive smoke-free policies. In other communities, tobacco control interventions may not be a priority.	• Understand the social norms around smoking and secondhand smoke in underserved communities. • Work with organizations that serve population groups experiencing inequities to engage the community. • Use culturally appropriate media and education efforts to build awareness of the health effects of smoking and secondhand smoke exposure in the underserved communities.
CAPACITY & INFRASTRUCTURE Build community capacity and infrastructure to support implementation of comprehensive smoke-free policies	Limited capacity and infrastructure among agencies serving populations experiencing inequities may be a challenge to implementing comprehensive smoke-free policies.[44] Additionally, some of these organizations may receive financial and other supports from the tobacco industry.[45-47]	• Prioritize inclusion of organizations serving or working with populations experiencing inequities in tobacco control coalitions. • Identify community leaders and train them to educate stakeholders about the disparities that result when policies are not prioritized in underserved communities. • Use partnerships to leverage resources. Explore funding opportunities to support organizations that want to join smoke-free implementation efforts.
ACCESS TO CESSATION SERVICES Integrate cessation support as part of a comprehensive approach	Given existing inequities in access to and quality of health care,[48] access to cessation supports and services may vary.[49,50]	• Incorporate free or low-cost cessation services before and during policy implementation to help motivated individuals quit. • See strategy on Tobacco Cessation Services for more information.
LACK OF SUPPORTIVE DATA Identify and track health inequities	Lack of timely and comprehensive data that fully explore health inequities may be a barrier to tobacco control efforts[49] (e.g., data examining inequities in secondhand smoke exposure among different groups).	• Improve collection and use of standardized data across population groups (e.g., geography, occupation, sexual orientation) to assess inequities in secondhand smoke exposure and policy coverage. • Use findings to identify where interventions are needed, monitor effects of an intervention, and track progress in addressing health inequities.
VARIABILITY IN IMPLEMENTATION & ENFORCEMENT Expand smoke-free policies and institutional practices	State and local smoking restrictions may not cover all settings, including certain worksites (e.g., bars and casinos), outdoor public spaces (e.g., dining areas, construction sites), and institutions (e.g., mental health and substance abuse treatment facilities).	• Eliminate exemptions in existing smoking restrictions. • Prioritize efforts in institutions with high rates of secondhand smoke exposure when local or state policies do not cover these settings. • Use media to address the health benefits of smoke-free policies and any misperceptions about these policies. • Develop appropriate enforcement mechanisms to support policy implementation.

Build the Team: Partnership for Success

Successful efforts to implement comprehensive smoke-free policies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Area Agencies on Aging
- Cessation support services
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Employee rights groups
- Health care systems, hospitals, community clinics, and health care providers
- Leaders and community champions from multiple sectors
- Local businesses
- Mental health and substance abuse treatment facilities
- Organizations serving populations experiencing health inequities
- Parks and recreation department
- Public health agencies
- School districts, universities, and community colleges
- State tobacco control programs
- Tobacco control groups
- Youth, the elderly, and people with disabilities

HEALTH EQUITY IN ACTION

Native American Tribes Adopt Tobacco Protections for Tribal Members and Future Generations

Montana

In Montana, 43% of Native American adults self-report cigarette smoking.[51] These high rates of commercial tobacco products use contributes to high rates of disease and premature death among Montana's Native Americans.[52] To address the commercial use of tobacco in their communities, the Blackfeet and Fort Peck tribes worked together to implement comprehensive smoke-free indoor protections. These protections also safeguard casino visitors and employees from secondhand smoke.

Respect for cultural traditions of tobacco use was instrumental in the development and implementation of strategies to create smoke-free environments. Several years earlier, the Native American Tobacco Coalition of Montana approached tribal elders to ask if they would support the creation of smoke-free environments. Initially, the elders were not supportive, because they believed this could potentially hinder traditional uses of tobacco, which are rooted in spiritual beliefs and medicinal practices. The elders engaged in a four-year process of teaching the historical and ceremonial practices of traditional tobacco use, including spiritual offerings. In turn, the coalition educated elders about the impact of commercial tobacco use and secondhand smoke exposure on tribal youth and future generations.

With support from the elders, the coalition educated the tribal members about the distinction between the sacred use of tobacco and the use of commercial tobacco. Community engagement activities included commercial tobacco-free celebrations, health fairs, youth-focused events, and trainings. By conducting extensive educational initiatives for tribal members and elders, the Blackfeet and Fort Peck Tribal Nations were able to create smoke-free indoor environments that included casinos. As a result, other tribes have created smoke-free environments in most tribal facilities. The coalition learned a valuable lesson: to be successful, smoke-free strategies need to be true to the people and rooted in cultural tradition.

Smokefree table tent at Birmingham, AL restaurant. Photo courtesy of the JCDH and the HAP.

Partnerships and Educational Initiatives Lead to Smoke-Free Air Protections

Birmingham, AL

Jefferson County Department of Health (JCDH) and the Health Action Partnership (HAP) are helping to implement smoke-free protections in Birmingham—impacting approximately 356,000 Jefferson County residents and commuters. With support from CDC's *Communities Putting Prevention to Work* program, the health department conducted community needs assessments and used geographic information systems (GIS) mapping to track rates of smoking, heart attack, and cancer to identify communities with the highest need for smoke-free protections. Then they overlaid those maps with maps of low-income areas.

After identifying high-need communities, JCDH and HAP conducted evaluation interviews in these areas to assess the key organizations and community champions that could become a conduit for educating residents on secondhand smoke issues. Working with a variety of local organizations, faith-based leaders, and the media, the community was able to successfully educate and increase community awareness about the benefits of smoke-free environments. The Friends of West End, a local organization with strong ties to the targeted communities, educated nearly 100 neighborhood association presidents. The presidents then educated their respective communities while local pastors did the same among their congregations. JCDH's understanding of culturally appropriate educational media led to a well-received radio soap opera, *Live Well Camberwell*. The educational radio program and health expert interviews were aired on stations with largely African American audiences.

All of these educational initiatives contributed to increasing awareness around the health effects of secondhand smoke exposure in indoor places of employment including restaurants, bars, and hotels. When smoke-free protections were put in place, the HAP provided technical assistance to ensure proper implementation of and compliance with the smoke-free protections.