A PRACTITIONER'S GUIDE FOR

ADVANCING HEALTH EQUITY

Community Strategies for Preventing Chronic Disease

TOBACCO-FREE LIVING STRATEGIES

National Center for Chronic Disease Prevention and Health Promotion
Division of Community Health

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WWW.CDC.GOV/HEALTHEQUITYGUIDE

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Additionally, *A Practitioner's Guide for Advancing Health Equity* is not intended to serve as step-by-step instructions, as there is no one-size-fits all approach to advancing health equity. Although this document discusses a variety of evidence- and practice-based strategies, it is not exhaustive. Strategies included may not be appropriate for every organization's situation. Communities must decide what is appropriate for their local context. Therefore, strategies and examples in this guide should be considered in accordance with an organization's and, where applicable, its funder's established protocols and regulations.

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LETTER FROM THE DIVISION OF COMMUNITY HEALTH

PUBLIC HEALTH PRACTITIONER,

There is a growing body of literature exploring how environments in this nation shape our health. To address this issue, public health practitioners are implementing chronic disease policy, systems, and environmental improvements where people live, learn, work, and play. Practitioners are also considering how to ensure such improvements are designed to reverse the negative trends of chronic health conditions among vulnerable population groups. In response to the mounting needs of practitioners seeking reliable tools to advance health equity, the Centers for Disease Control and Prevention (CDC) developed *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease (Health Equity Guide)*.

The purpose of the *Health Equity Guide* is to assist practitioners with addressing the well-documented disparities in chronic disease health outcomes. This resource offers lessons learned from practitioners on the front lines of local, state, and tribal organizations that are working to promote health and prevent chronic disease health disparities. It provides a collection of health equity considerations for several policy, systems, and environmental improvement strategies focused on tobacco-free living, healthy food and beverages, and active living. Additionally, the *Health Equity Guide* will assist practitioners with integrating the concept of health equity into local practices such as building organizational capacity, engaging the community, developing partnerships, identifying health inequities, and conducting evaluations. The *Health Equity Guide* is designed for the novice interested in the concept of health equity, as well as the skillful practitioner tackling health inequities.

We encourage you to visit **WWW.CDC.GOV/HEALTHEQUITYGUIDE** for additional tools and resources that promote health and the integration of health equity into everyday practice. We hope you find the information and examples provided to be useful and an impetus in your efforts to reduce health disparities and advance health equity.

Sincerely,

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INTRODUCTION

Heart disease, cancer, diabetes, and stroke are the most common causes of illness, disability, and death affecting a growing number of Americans.[4] Many of these chronic conditions tend to be more common, diagnosed later, and result in worse outcomes for particular individuals,[5-7] such as people of color, people in low-income neighborhoods, and others whose life conditions place them at risk for poor health.

(See Appendix A for list of population groups experiencing chronic disease disparities.)

Despite decades of efforts to reduce and eliminate health disparities, they persist—and in some cases, they are widening among some population groups.[8-11] Such disparities do not have a single cause. They are created and maintained through multiple, interconnected, and complex pathways. Some of the factors influencing health and contributing to health disparities include the following:[12,13]

- **Root causes or social determinants of health** such as poverty, lack of education, racism, discrimination, and stigma.
- **Environment and community conditions** such as how a community looks (e.g., property neglect), what residents are exposed to (e.g., advertising, violence), and what resources are available there (e.g., transportation, grocery stores).
- **Behavioral factors** such as diet, tobacco use, and engagement in physical activity.
- **Medical services** such as the availability and quality of medical services.

INTRODUCTION (Continued)

HEALTH EQUITY MEANS THAT EVERY PERSON HAS AN OPPORTUNITY TO ACHIEVE OPTIMAL HEALTH REGARDLESS OF:

- THE COLOR OF THEIR SKIN
- LEVEL OF EDUCATION
- GENDER IDENTITY
- SEXUAL ORIENTATION
- THE JOB THEY HAVE
- THE NEIGHBORHOOD THEY LIVE IN
- WHETHER OR NOT THEY HAVE A DISABILITY[3]

While health disparities can be addressed at multiple levels, this resource focuses on **policy, systems, and environmental improvement strategies** designed to improve the places where people live, learn, work, and play. Many of the 20th and 21st century's greatest public health achievements (e.g., water fluoridation, motor vehicle safety, food safety) have relied on the use of laws, regulations, and environmental improvement strategies.[14,15] Health practitioners play an important role in these improvements by engaging the community, identifying needs, conducting analyses, developing partnerships, as well as implementing and evaluating evidence-based interventions.

These intervention approaches are briefly described below:

- **Policy improvements** may include "a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions."[16]
  Example: A voluntary school wellness policy that ensures food and beverage offerings meet certain standards.

- **Systems improvements** may include a "change that impacts all elements, including social norms of an organization, institution, or system."[17]
  Example: The integration of tobacco screening and referral protocols into a hospital system.

- **Environmental improvements** may include changes to the physical, social, or economic environment.[17]
  Example: A change to street infrastructure that enhances connectivity and promotes physical activity.

Such interventions have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address root causes, ensuring the greatest possible health impact is achieved over time. **However, without careful design and implementation, such interventions may inadvertently widen health inequities.** To maximize the health effects for all and reduce health inequities, it is important to consider the following:

- Different strategies require varying levels of individual or community effort and resources, which may affect who benefits and at what rate.
- Certain population groups may face barriers to or negative unintended consequences from certain strategies (see Appendix B for a list of common barriers). Such barriers can limit the strategy's effect and worsen the disparity.
- Population groups experiencing health disparities have further to go to attain their full health potential, so even with equitable implementation, health effects may vary.
- Health equity should not only be considered when designing interventions. To help advance the goal, health equity should be considered in other aspects of public health practice (e.g., organizational capacity, partnerships, evaluation).

A Practitioner's Guide to Advancing Health Equity provides lessons learned and practices from the field, as well as from the existing evidence-base. This resource offers ideas on how to maximize the effects of several policy, systems, and environmental improvement strategies with a goal to reduce health inequities and advance health equity. Additionally, the resource will help communities incorporate the concept of health equity into core components of public health practice such as organizational capacity, partnerships, community engagement, identifying health inequities, and evaluation.

This resource has four major sections:

- Incorporating Health Equity into **Foundational Skills** of Public Health
- Maximizing **Tobacco-Free Living** Strategies to Advance Health Equity
- Maximizing **Healthy Food and Beverage** Strategies to Advance Health Equity
- Maximizing **Active Living** Strategies to Advance Health Equity

TERMINOLOGY

A clear understanding of definitions is important. The following definitions are offered as a starting place as you think through this issue and review this resource:

Health equity: Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[12]

Health disparities: Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.[7]

Health inequalities: Health inequalities is a term sometimes used interchangeably with the term health disparities. It is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity).[7]

Health inequities: Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.[7,18,19]

Social determinants of health: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[20]

SECTION 2 Maximizing Tobacco-Free Living Strategies to Advance Health Equity

USE THE CONTENT TO:

- FOSTER DIALOGUE ON HEALTH EQUITY CONCERNS WITHIN A COMMUNITY.
- TRAIN STAFF AND PARTNERS ON EQUITY ISSUES SURROUNDING TOBACCO-FREE LIVING STRATEGIES.
- IDENTIFY WAYS TO ADDRESS HEALTH EQUITY IN THE DESIGN AND IMPLEMENTATION OF STRATEGIES.
- DEVELOP YOUR OWN APPROACH FOR ENSURING EFFORTS ARE ADDRESSING HEALTH INEQUITIES.

Despite overall declines in cigarette smoking, some population groups have disproportionately higher rates of smoking. These groups include certain racial/ethnic minority groups, particularly American Indians/Alaska Natives; those with low socioeconomic status; those with mental health and substance abuse conditions; those in the lesbian, gay, bisexual, and transgender communities;[30] and those with disabilities.[31] Identifying and eliminating tobacco-related health inequities among population groups is an important component of tobacco control efforts.[32]

The Tobacco-Free Living section of *A Practitioner s Guide for Advancing Health Equity* provides equity-oriented considerations, key partners, and community examples related to the design and implementation of the following strategies:

- Comprehensive Smoke-Free Policies
- Smoke-Free Multi-Unit Housing Policies
- Tobacco Cessation Services
- Point-of-Sale Strategies to Address Access and Exposure to Tobacco Products

The content presented is not exhaustive and is not intended to act as a "how-to" guide. Rather, this section is devised to stimulate ideas for ensuring tobacco-free living strategies are designed to address the needs of populations experiencing health inequities. Please refer to the disclaimer on page iii when using this Section.

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.

SMOKE-FREE MULTI-UNIT HOUSING POLICIES

SMOKE-FREE MULTI-UNIT HOUSING POLICIES AIM TO PROTECT NONSMOKERS WHO LIVE IN, WORK, AND VISIT MULTI-UNIT RESIDENCES SUCH AS APARTMENTS, CONDOMINIUMS, TOWNHOUSES, DUPLEXES, AND AFFORDABLE HOUSING COMPLEXES FROM SECONDHAND SMOKE.

MAKE THE CASE:

Why Is This A Health Equity Issue?

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

- **Increased Secondhand Smoke Risks among Vulnerable Populations:** Low-income individuals generally have higher smoking rates,[30] which may result in increased exposure to secondhand smoke in affordable and public housing. Given that many residents living in these settings are vulnerable population groups (e.g., children, older adults, racial/ethnic minorities, and those with a disability),[53] secondhand smoke exposure is critical to address. For instance, many racial/ethnic minorities and low-income populations suffer higher rates of asthma and other tobacco-related health issues,[54] making them particularly vulnerable to the effects of secondhand smoke exposure. Children are also vulnerable to developing health effects from secondhand smoke exposure.[55]

- **Residents Who are Being Exposed to Secondhand Smoke May Have Limited Alternative Housing Options:** Even when residents of multi-unit housing do not allow smoking in their unit, secondhand smoke can enter their unit from other units or common areas through shared ventilation systems, air spaces, windows, and hallways, putting residents at risk.[54,56,57] Low-income residents in affordable or public housing complexes who are being involuntarily exposed to secondhand smoke in their homes in this manner may have limited alternative housing options or be unable to move.

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 smoke-free multi-unit housing policies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
MISPERCEPTIONS Clarify intent and address misperceptions about smoke-free multi-unit housing strategies	Organizations that work on behalf of low-income residents (e.g., residents' rights organizations, affordable housing groups) may have misconceptions about the intent or effects of smoke-free multi-unit housing strategies.	• Ensure residents and owners understand that the smoke-free policy is designed to promote a healthy home environment and reduce secondhand smoke exposure—not to remove smokers or prevent new smokers from moving in, as long as they comply with the policy. • Consider working across different types of multi-unit housing (e.g., public, affordable, and market-rate) to show everyone deserves clean air and prevent concerns about discrimination.
STAKEHOLDER SUPPORT Address concerns and build support among housing providers	If landlords are unaware of resident support for smoke-free policies, they may have concerns that such a policy will lead to reduced occupancy or will be difficult to enforce.	• Alleviate concerns of stakeholders (e.g., landlords, apartment owners) by educating them on the business, health, and safety benefits of smoke-free policies. • Provide tools and training on how to gather resident feedback, navigate the implementation process, develop monitoring mechanisms, and address noncompliance.
COMMUNITY INVOLVEMENT & AWARENESS Engage residents in strategy development and implementation	Strategies developed without resident input may negatively affect strategy implementation and enforcement.	• Identify residents to serve as champions and involve them throughout the development and implementation process. • Gather input through resident surveys and forums, and collaborate with resident associations to develop the strategy. • Establish mechanisms to ensure that residents are aware of the policy and its benefits (e.g., culturally appropriate education initiatives, resident forums).
ACCESS Increase access to free or low-cost cessation services	Residents without access to cessation supports may not comply with smoke-free policies, placing other residents at risk for secondhand smoke exposure.	• Provide smokers with free access to evidence-based cessation treatments to ease the transition to a smoke-free environment, increase compliance, prevent smokers from feeling stigmatized, and help them quit smoking, thus maximizing the policy's health benefits. • Offer and promote cessation services in or near the complex at convenient times before and during policy implementation.
EQUITABLE IMPLEMENTATION Anticipate additional challenges to policy implementation	After policy implementation, smokers may tend to congregate in outdoor areas near buildings, exposing residents in outdoor or adjacent indoor areas to secondhand smoke, which may enter the building through doors, windows, or vents.	• Make the entire property smoke-free or restrict smoking to a few designated outdoor areas located far enough away from entrances and exits to prevent secondhand smoke from infiltrating indoor areas. • Improve compliance by conducting tailored resident engagement, education, and cessation efforts. • In supportive housing settings, (e.g., homeless shelters, mental health and substance abuse treatment facilities), work with staff to find tailored, context-specific approaches.

Build the Team: Partnership for Success

Successful efforts to implement smoke-free multi-unit housing 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)
- Condominium owners
- Faith-based organizations
- Housing industry organizations, local housing authorities, and nonprofit housing associations
- Immigrants and refugees
- Low-income residents
- Organizations serving populations experiencing health inequities
- Real estate developers
- Residential property owners, management companies
- State tobacco control programs
- Residents' rights/fair housing organizations
- Youth, the elderly, and people with disabilities

HEALTH EQUITY IN ACTION

Creating Healthy Environments through Smoke-Free Multi-Unit Housing Policies

San Antonio, TX

Everyone has the right to breathe clean air, especially in their own home. Yet in many San Antonio multi-unit housing complexes, residents were being exposed to secondhand smoke infiltrating their units from neighboring units. To address this issue, the San Antonio Metropolitan Health District (SAMHD) worked with the San Antonio Housing Authority (SAHA) to implement a smoke-free multi-unit housing policy for all 70 of its housing sites. These efforts were made possible with support from a combination of state and local funds.

SAMHD focused on making multi-unit housing smoke-free with a strategy that covered all indoor areas, since a comprehensive policy would have a greater impact on health equity for all SAHA residents and staff. Both organizations recognized the importance of community engagement to ensure policy success. They worked closely with residents and staff in mini-community centers associated with each housing campus. Engaging the residents through the community centers—a resource that residents were already turning to for information—was key to the success of this approach.

SAMHD bolstered its outreach and education efforts through a partnership with the American Cancer Society (ACS). ACS educated community center staff on how to answer questions about the new policy, to refer residents to the state quitline, and to discuss options for obtaining nicotine replacement therapy (e.g. nicotine patches). All materials were printed in both English and Spanish, and staff in many centers were able to communicate the benefit of smoke-free air protections to residents in their own language.

ACS and SAHA also helped organize town hall meetings to educate residents and discuss the benefits of smoke-free protections in an open forum. As a result of the policy, nearly 16,000 residents (many of them low-income immigrants and racial/ethnic minorities) now have access to cleaner air in their homes.

Housing Authority and Public Health Commission Partner on Smoke-Free Housing

Boston, MA

Building relationships with the Boston Housing Authority, other city agencies, and community-based organizations, the Boston Public Health Commission (BPHC), with support from the CDC's *Communities Putting Prevention to Work* program, educated housing providers about the voluntary adoption of smoke-free multi-unit housing policies. The Commission has also successfully leveraged support for smoke-free housing among residents in all market sectors (e.g., market rate, public housing), as well as used data to identify disparities in health outcomes across residents of different types of housing. The goal is to ensure that residents, particularly those most vulnerable to secondhand smoke exposure, have clean air to breathe in their homes. Smoke-free protections in public housing, affordable housing, and market-rate housing have the potential to provide protection for populations with high exposure to secondhand smoke, including low-income families, children with asthma, immigrants, elderly residents, and persons with chronic diseases or disabilities.

The BPHC has taken a series of steps to increase smoke-free protections in and around multi-unit housing complexes. One key to the success of the BPHC's policy was its approach of working closely with stakeholders such as the Boston Housing Authority and landlords, property management companies, and community development corporations. Input from residents in policy development was critical, and mini-grants to community development corporations supported community engagement. The BPHC also worked strategically with a variety of community partners to make the case to landlords and housing agencies that a majority of residents wanted smoke-free housing, and that going smoke-free would benefit all stakeholders. The BPHC provided technical assistance in developing and implementing a smoke-free multi-unit housing policy. Because Massachusetts has relatively good coverage of smoking cessation treatments, many smokers in the state can access affordable cessation services.

The BPHC approach led to some notable early successes. The Boston Housing Authority portfolio became 100% smoke-free in September 2012, assuring a healthier environment for the 23,000 residents living in their 12,000 units. Community development corporations have transitioned over 600 units to smoke-free status, and continue to bring additional units on line as smoke-free. There are now 6,600 non-public smoke-free units and the BPHC sees this as just the beginning. As Margaret Reid, Director of the Division of Healthy Homes and Community Supports at the BPHC, says, "We are supporting smoke-free policies and awareness so that smoke-free becomes the norm in Boston multi-unit housing, whether it is public, subsidized, or market-rate."

TOBACCO CESSATION SERVICES

TOBACCO CESSATION STRATEGIES HELP PEOPLE QUIT SMOKING OR USING OTHER FORMS OF TOBACCO. THESE STRATEGIES MAY INCLUDE CLINICAL SCREENING AND REFERRAL SYSTEMS, QUIT LINES, BEHAVIORAL COUNSELING, AND CESSATION MEDICATIONS.[58]

MAKE THE CASE:

Why Is This A Health Equity Issue?

The issues below highlight the need for tobacco cessation strategies that advance health equity:

- **Varying Rates of Smoking and Cessation among Different Communities:** In the United States, certain population groups stand out as having higher-than-average smoking rates, lower-than-average cessation rates, or higher-than-average rates of tobacco-related diseases.[49,59,60] For example, population groups with disproportionately high rates of smoking include American Indian and Alaska Natives,[7,60] the lesbian, gay, bisexual, and transgender (LGBT) communities,[61-63] people with mental illness[64] and substance abuse conditions,[7] and people with disabilities.[65] African American adults have been found to be more likely to express interest in quitting and more likely to have tried to quit in the past year than white adults, but are less likely to use proven treatments (e.g., counseling and/or medications) and are less likely to succeed in quitting.[59] Adults aged 65 or older have also been found to be less likely to attempt smoking cessation compared to younger adults.[59,66] Additionally, low-income populations are more likely to smoke, less likely to quit, and often lack access to affordable cessation support.[49,60,67]

- **Barriers to Accessing Cessation Resources:** Differential access and quality of health care may present barriers to quitting.[50] For example, uninsured smokers may be less likely to receive quitting advice or other forms of cessation treatment from health care providers.[50] Additionally, certain population groups, including African Americans and Hispanics, are less likely to be screened for tobacco use or receive smoking cessation interventions.[59,68-70]

- **Challenges to the Widespread Use of Evidence-Based Cessation Interventions:** There is limited research on effective approaches for promoting and increasing utilization of cessation interventions among population groups experiencing health disparities.[71,72] A lack of sensitivity to social norms and cultural traditions in developing cessation interventions may influence intervention use and ultimate effectiveness.

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 tobacco cessation strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
ACCESS Increase access to cessation services by integrating them into health systems and making them convenient	Certain population groups are less likely to be screened for tobacco use or receive tobacco cessation counseling.[69,70] Additionally, cessation services may be underused because of limited knowledge, awareness, and cultural beliefs.[73,74]	• Prioritize integration of tobacco screening and provision of/referral for evidence-based cessation treatments into institutions that are already serving vulnerable populations (e.g., community health centers, Federally Qualified Health Centers, rural health clinics, mental health and substance abuse treatment facilities). • Prioritize the promotion of existing cessation services including tobacco quitlines and Web sites to populations experiencing health disparities. • Integrate cessation programs and support into community institutions located in places where people already go (e.g., public housing, faith-based settings, social service agencies). • Train community health outreach workers to provide cessation services during home visits.
COST Remove/reduce cost and insurance barriers	Costs associated with cessation services, which may result from lack of/inadequate health insurance coverage pose particularly significant barriers for low-income populations.[75-77]	• Develop relationships with private and public health insurers and health care systems, including state Medicaid programs, to expand insurance coverage of cessation services. • Consider ways to eliminate or minimize cost and other barriers (e.g., co-pays, prior authorization requirements) to accessing cessation treatments.
DIVERSE NORMS AND CUSTOMS Ensure that cessation services are culturally relevant and appropriate	Limited research on effective approaches to promote cessation services interventions across different groups may hinder the utilization of such interventions.[49,71,78] For example, tobacco quitlines may be accessed less by groups with cultural norms that avoid seeking counseling from strangers.	• Evaluate the effectiveness of cessation interventions across different population groups. • Ensure that underserved populations have access to and are aware of cessation services (e.g., promote services through culturally appropriate communication channels). • If such populations are still not using, or are unsatisfied with, existing cessation services, partner with relevant organizations to increase culturally relevant training of providers or to tailor these services to meet the populations' needs.

Build the Team: Partnership for Success

Successful efforts to implement tobacco cessation strategies depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Academic institutions
- Cessation support services
- Community-based organizations
- Community health centers, including Federally Qualified Health Centers and rural health clinics
- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Employers
- Health care systems
- Health insurers
- Lay health providers/promotoras
- Leaders and community champions from multiple sectors
- Media
- Mental health and substance abuse treatment facilities
- National culturally specific cessation guidance organizations
- Public health agencies
- State quitline providers
- State tobacco control programs
- Tobacco control groups
- Workplace wellness organizations

HEALTH EQUITY IN ACTION

Expanding Cessation Services in Marginalized Communities

St. Louis, MO

With the goal of reducing tobacco-related health disparities, the St. Louis County Department of Health (DOH), with support from CDC's *Communities Putting Prevention to Work* program, set out to increase access to cessation services among populations with high smoking rates. "Being in their neighborhood and speaking their language" was a critical strategy for helping people most in need of cessation resources, noted Barry Freedman, Project Manager for the *Communities Putting Prevention to Work* program at the DOH. DOH partnered with three trusted organizations that had strong ties in the community to provide free and low-cost services and culturally competent care. Each partnership is briefly described below.

Casa de Salud, a local health clinic, provides cessation services to low-income and limited-English-speaking Hispanic populations, including onsite one-on-one cessation counseling and nicotine replacement therapy (NRT), such as nicotine patches. All of this is done using culturally appropriate materials in an environment where clients can feel safe.

SAGE Metro St. Louis works with the lesbian, gay, bisexual, and transgender (LGBT) communities and offers cessation counseling services and NRT free of charge. SAGE also provides education on the techniques the tobacco industry has used to target LGBT communities. Having a presence at the city's three major gay pride events proved an effective outreach and education approach.

The St. Louis Christian Chinese Community Service Center worked to provide cessation services, including individual counseling, support, and other resources, to Asian-American restaurant employees with high rates of smoking. Because of limited health literacy in the communities they serve, the Center conducted traditional Chinese puppet shows to encourage cessation and provided health information to over 500 Chinese Americans. The shows are especially powerful because they respect Chinese cultural norms while conveying important health messages to multiple generations.

In addition to these partnerships, the DOH is helping support low-income and uninsured community clinic clients. DOH is training providers in those clinics to facilitate a free cessation program, and is offering a free three-month supply of NRT products to smokers who want to quit.

Using Partnerships to Increase Access to Cessation Services

Santa Clara County, CA

"A one-stop shop [is] more likely to work than having people go to different places for [tobacco cessation] services," noted Kris Vantornhout, Program Manager for the *Communities Putting Prevention to Work* program at the Santa Clara County Public Health Department (SCCPHD). With this in mind, Santa Clara County's Tobacco Prevention Program strategically partnered with established community-based organizations (CBOs) throughout the county. These CBOs were poised to implement cessation services in neighborhoods with high numbers of smokers. At times, securing diverse community leadership involvement was challenging, but focused efforts were successful in finding champions to lead the way.

SCCPHD awarded twenty-seven mini-grants to CBOs to expand cessation counseling, referrals, and access to nicotine replacement therapy (NRT). These grants supported organizations working with the Vietnamese, African American, Latino, and Lesbian, Gay, Bisexual, and Transgender (LGBT) communities, and engaged diverse partners. Efforts also focused on improving cessation services and referral systems in mental health facilities, health care clinics, and college campuses.

CBOs integrated cessation services into organizational practice by implementing the "ask, advise, refer" model during intake processes and, as appropriate, referring patients or students to trained staff for cessation assistance. Providing culturally and linguistically relevant messaging around secondhand smoke exposure was also important for increasing the uptake of cessation services. Tobacco-free messaging and cessation information were shared onsite, as well as at outreach events such as the San Jose LGBT Pride Celebration, the annual Martin Luther King Luncheon, and the Holiday Fair.

As a result of the Tobacco Prevention Program's partnership efforts, cessation services are now available to some of the most vulnerable populations in the county. Thirty health facilities, 8 colleges, and 11 CBOs now have staff or clinicians using the "ask, advise, refer" model to reach over 544,000 residents. Approximately 8,000 units of NRT were distributed through these networks within less than two years, and post-intervention surveys have shown an overall 39% quit success rate, with an amazing 50% quit rate within the Vietnamese community.

Smoke-free sign on medical center campus in Santa Clara County, CA. Photo courtesy of Breathe California.

POINT-OF-SALE STRATEGIES TO ADDRESS ACCESS AND EXPOSURE TO TOBACCO PRODUCTS

POINT-OF-SALE (POS) STRATEGIES TO REDUCE THE AVAILABILITY AND APPEAL OF TOBACCO PRODUCTS MAY INCLUDE ADDRESSING THE MARKETING AND AFFORDABILITY OF THESE PRODUCTS THROUGH RESTRICTIONS ON THE POINT-OF-SALE TOBACCO ADVERTISING, PROMOTION (INCLUDING PRICE PROMOTIONS), DISPLAYS, AND PLACEMENT; THE SALES OF SPECIFIC TYPES OF TOBACCO PRODUCTS (E.G., FLAVORED PRODUCTS); AND TOBACCO RETAILER LOCATION AND DENSITY.[79-81,*]

MAKE THE CASE:

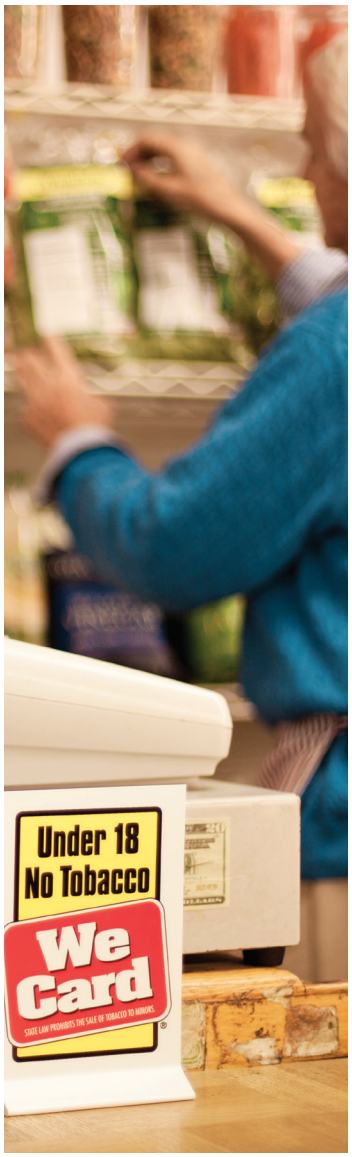
Why Is This A Health Equity Issue?

The issues below highlight the need for POS strategies that advance health equity:

- **Different Exposure to POS Advertising and Targeted Marketing:** Studies have consistently shown that low-income communities[82] and communities of color are more heavily exposed to POS tobacco advertising than other communities.[83,84] Additionally, such advertising may be targeted to or disproportionately impact certain population groups. For instance, the messaging used in marketing menthol cigarettes has been culturally tailored and targeted toward communities of color, especially Africans Americans.[85]

- **Placement of and Price Discounts on Tobacco Products:** Tobacco companies have used a variety of point-of-sale strategies to place tobacco products prominently in the retail environment and keep these products affordable.[86] For example, in 2011, the tobacco industry spent an estimated $8 billion, or nearly $23 million per day, on cigarette advertising and promotional expenses in the United States alone. Approximately 84% (or nearly $7 billion) of this expenditure was spent on price discounts to cigarette retailers or wholesalers to reduce the price of cigarettes to consumers.[87] A placement strategy may include placing tobacco products (e.g., cigarillos, cigars) next to candy or within the view of children and youth.[88] Additionally, tobacco companies may deeply discount their products in stores in lower-income communities and require targeted placement of signs advertising lower prices in these stores.[89] Youth and low-income individuals may be particularly sensitive to prominently placed, inexpensive tobacco products.[79,90]

- **Greater Density of Tobacco Retailers in Underserved Communities:** Research has shown that tobacco retail outlets are more heavily concentrated in low-income communities and communities of color than in higher income communities.[91-94] This makes tobacco products more readily accessible, potentially increasing consumption.[94]



*Note: The Tobacco Control Act preserves the authority of state, local, and tribal governments to regulate tobacco products in certain specific respects. It also prohibits, with certain exceptions, state and local requirements that are different from, or in addition to, requirements under the provisions of the FDCA relating to specified areas.

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 POS strategies:

KEY FACTORS	BARRIERS OR UNINTENDED CONSEQUENCES	OPPORTUNITIES TO MAXIMIZE IMPACT
RESOURCE & FUNDING LIMITATIONS Prioritize and prepare resources for communities in greatest need	Underserved communities may have fewer resources to implement POS strategies. Additionally, such communities may have other priorities that make it difficult to implement tobacco control initiatives.	• Conduct assessments to examine tobacco retail density, the amount of POS advertising, and tobacco-related health disparities. • Prioritize intervention efforts to address areas with greatest need. • Engage partners who can provide technical assistance to identify viable POS strategies and overcome barriers. • Participate in community coalitions and events in order to understand community priorities, align POS efforts with those priorities, and educate and mobilize the community around these efforts.
ECONOMIC STABILITY Support retailers when implementing POS strategies	Underserved communities, which can have disproportionately high concentrations of tobacco retailers, may oppose POS strategies due to concerns about the potential financial effects on local businesses.	• Find creative mechanisms to support retailers that are implementing POS strategies. • Establish programs that may help retailers transition from relying on sales of tobacco product to selling healthier products (e.g., Healthy Food Financing,[95] healthy corner store initiatives[96]).
COMMUNITY AWARENESS Build community awareness and skills to counter tobacco advertising	Tobacco product displays and POS advertising may distort perceptions of the pervasiveness of tobacco use among adolescents,[97] increase the likelihood of youth smoking initiation,[97,98] and may prompt impulse buys (e.g., among smokers who are trying to quit).[99]	• Increase community awareness of industry marketing tactics to help people critically assess the advertising they see around them. • Work with media outlets serving specific population groups to reinforce positive messaging and to counter any negative effects of tobacco marketing.
VARIABLE IMPLEMENTATION & ENFORCEMENT Support Implementation and Enforcement of POS Strategies, particularly in communities with tobacco-related inequities.	Disparities may increase if POS strategies are not fully implemented or enforced in communities with high smoking rates or social norms that support tobacco use.	• Consider developing implementation plans to support consistent and equitable policy compliance. • Consider establishing processes for accountability and gathering feedback from all communities affected by the policy.

Build the Team: Partnership for Success

Successful efforts to implement POS strategies in communities with tobacco-related disparities depend on bringing a diverse set of partners to the table early, consistently, and authentically. These partners may include the following:

- Community members (of diverse abilities, ages, cultures, gender, income levels, race/ethnicity, and sexual orientation)
- Healthy food retail groups
- Leaders and community champions from multiple sectors
- Local governments
- Local store owners
- Public health agencies
- Public Works Department
- School districts, universities, and community colleges
- Senior Centers
- State tobacco control programs
- Tobacco control groups (including groups representing populations experiencing health disparities)
- Youth volunteers/coalitions
- Zoning and Planning organizations

HEALTH EQUITY IN ACTION

Citywide Restrictions Tackle Flavored Tobacco Products

New York, NY

"The price point for entry into the world of tobacco is one dollar." Kevin Schroth, Senior Legal Counsel for Policy, at New York City's (NYC) Department of Health and Mental Hygiene was describing sales of single, flavored cigarillos and little cigars. These inexpensive alternatives to cigarettes are heavily marketed in stores in low-income and minority urban neighborhoods. These products are often flavored, come in brightly colored packages, and are prominently placed in stores next to gum and candy—all features that make them appealing to children and youth.

"Kids spend twice as much time in convenience stores as adults," said Schroth. "It's not a coincidence that these flavored tobacco products look similar to other products marketed to kids." The point-of-sale marketing of these products contribute to perceptions among youth that these products are easily accessible and that their use is acceptable and cool.

The health department partnered with the New York City Coalition for a Smoke-Free City and community-based organizations such as Korean Community Services, which serves an Asian population with high smoking rates. Together, with support from state and city funds, they educated community stakeholders about the health risks associated with flavored non-cigarette tobacco products. In 2009, the NYC City Council passed a law that restricted the sale of flavored non-cigarette tobacco products, with the exception of menthol, mint, wintergreen, and tobacco-flavored products, in stores throughout the city, with the exception of tobacco bars. The strategy is part of a comprehensive approach to protect all residents, especially impressionable youth, in all New York City communities from tobacco industry marketing. The example has motivated other local jurisdictions, such as nearby Providence, Rhode Island, to implement similar measures.

Tobacco-Free Pharmacies Promote Health for All

San Francisco, CA

Many people go to pharmacies to purchase medications and other items to improve their health. Why then do many major pharmacy chains and independent pharmacies sell tobacco products which contribute to severe health effects? The California LGBT Tobacco Education Partnership (the Partnership) saw this discrepancy as an opportunity to decrease the widespread availability of tobacco products.

With the high rates of smoking within the LGBT population, the Castro District (historically considered the center of San Francisco's LGBT communities) was the Partnership's priority location in its attempt to eliminate tobacco sales in pharmacies. The Partnership strategically engaged independent pharmacies that were already tobacco-free, acknowledging them with certificates. These pharmacies also educated community stakeholders on the benefits of tobacco-free pharmacies. In addition, a public opinion survey of smokers and nonsmokers assessed the need for tobacco-free pharmacies.

To ensure that every San Francisco resident, not only those living in the Castro District, has access to tobacco-free pharmacies, the Partnership, with support from the California Department of Public Health, Tobacco Control Program and others, implemented a citywide strategy. Working with diverse partners, including the San Francisco Tobacco-Free Coalition, the University of California at San Francisco School of Pharmacy, and the Board of Supervisors, the Partnership made a compelling research-supported argument that pharmacies should be hubs for health, and that this role was inconsistent with selling tobacco products. Even in the face of opposition from some local media outlets and national retailers, the Partnership remained focused on the message that health for all should be the priority.

On October 1, 2008, San Francisco became the first city in the United States to eliminate the sale of tobacco products in its pharmacies (through changes to the Health Code), affecting an estimated 100 pharmacies and all 805,000 city residents. The policy's success has inspired similar efforts in cities from nearby Richmond, CA to Boston, MA. As Bob Gordon of the Partnership stated, the policy has "changed a social norm around the availability and accessibility of tobacco products in San Francisco. That alone is an amazing outcome."

APPENDICES

APPENDIX A
Health Disparities in Chronic Disease Risk Factors by Population Group

APPENDIX B
Considerations for Health Equity-Oriented Strategy Selection, Design, and Implementation

APPENDIX C
Example Resources for Identifying and Understanding Health Inequities

APPENDIX D
Health Equity Checklist: Considering Health Equity in the Strategy Development Process

APPENDIX A

HEALTH DISPARITIES IN CHRONIC DISEASE RISK FACTORS BY POPULATION GROUP

Despite decades of effort to reduce and eliminate health disparities, they have largely persisted—and in some cases are widening.[9-11] Specifically related to chronic diseases, there is a concentrated, disproportionate burden of chronic disease in many underserved populations and communities. The table below describes disparities in chronic disease risk factors by various population groups.

PEOPLE OF COLOR (RACIAL/ETHNIC MINORITIES)	According to the 2010 Census, approximately 16% of Americans identified themselves as Hispanic or Latino, 13% as Black, 5% as Asian, 1% as American Indian and Alaska Native, and 0.2% as Native Hawaiian and other Pacific Islander.[231] On a variety of health indicators, significant disparities among these racial and ethnic minorities continue to exist.[7,232] For example, adult obesity rates in the U.S. are higher among non-Hispanic African Americans (50%) and Mexican Americans (40%) than among non-Hispanic Whites (35%), and they are highest among African American women, at 59%.[233] In 2011, cigarette smoking among adults was highest among American Indian/Alaska Native populations (32%), compared to other racial/ethnic groups.[234]
PEOPLE WITH MENTAL OR SUBSTANCE USE DISORDERS	In the United States, adults with mental or substance use disorders comprise approximately 25% of the population. However, this population accounts for an estimated 40% of all cigarettes smoked resulting in a disproportionate burden from the health consequences of smoking.[235]
PEOPLE LIVING IN RURAL COMMUNITIES	Approximately 19%, or 60 million Americans, live in rural areas.[236] Rural residents are more likely to be elderly, in poverty, in fair or poor health, and to have chronic health conditions.[48] For example, the prevalence of obesity is higher in rural adults (40%) than urban adults (33%).[237] Adults living in non-metropolitan counties also have a higher average annual percentage of smoking (27%) than adults living in large metropolitan counties (18%).[238]
PEOPLE WITH DISABILITIES	Approximately 20% of U.S. adults have a disability.[239] Approximately 28% of adults with disabilities smoke, compared to 16% of those without a disability.[31] Adults with disabilities are more likely to be physically inactive (22%) than are adults without disabilities (10%).[240] Obesity is also higher among adults with a disability (38%) compared to those without a disability (24%), according to self-reported data.[241]

PEOPLE WITH LOW-INCOME AND THOSE EXPERIENCING POVERTY

In 2011, an estimated 15% of the U.S. population lived below the federal poverty level.[152] Poverty is correlated with perceived and actual poor health outcomes. People living in poverty are five times more likely to report their health as "poor" compared to high-income individuals.[242] People with a household income below the poverty line (29%) have a much higher prevalence of smoking compared to people with household incomes at or above the poverty line (18%).[234] Healthy eating (specifically fruit and vegetable consumption) is also lower among low-income populations compared to higher income populations.[243]

PEOPLE WITH LESS THAN A HIGH SCHOOL EDUCATION

Approximately 15 % of Americans 25 years old and older have not earned a high school diploma.[244] Those with undergraduate degrees have a lower prevalence of smoking (9%), compared to those with less than a high school education (25%) or only a high school diploma (24%).[234] Additionally, those with a GED have the highest prevalence of smoking (45%). Regarding obesity, college graduates or above had the lowest rate of obesity (28%) in 2009-2010, compared to those with less than a high school education (38%).[245]

OLDER ADULTS

The proportion of our nation's population aged 65 years and older is expected to increase from approximately 13% of the population in 2010 to an estimated 19% in 2030.[246] In 2009–2010, 45% of adults aged 65 and over were diagnosed with two or more chronic conditions.[247] Regarding inequities, older adults living in poverty and isolation may be particularly vulnerable.[248]

PEOPLE WHO IDENTIFY AS LESBIAN, GAY, BISEXUAL, OR TRANSGENDER (LGBT)

The lesbian, gay, or bisexual population is estimated at 3.5% in the United States, with an additional 0.3% identifying as transgender.[249] Regarding sexual orientation, use of any tobacco products have been found to be higher among lesbian, gay, bisexual, and transgender populations (38.5%) compared to the heterosexual/straight population (25.3%).[61] Obesity prevalence has also been noted among the LGBT community, particularly among lesbians who have been shown to have a higher prevalence of being overweight and obese than heterosexual women who are overweight and obese.[250]

NOTE: This list is not exhaustive and the groups are not mutually exclusive; individuals may belong to more than one population group.

APPENDIX B

CONSIDERATIONS FOR HEALTH EQUITY-ORIENTED STRATEGY SELECTION, DESIGN, AND IMPLEMENTATION

Policy, systems, and environmental improvement strategies have great potential to prevent and reduce health inequities, affect a large portion of a population, and can also be leveraged to address the underlying social determinants of health. **However, without careful design and implementation, such interventions may inadvertently widen health inequities.** Collaborate with partners and community members, including those experiencing health inequities, to identify possible barriers or negative unintended consequences that may limit a strategy's effectiveness. Then, account for identified challenges in strategy development to maximize the health effects for all and reduce health inequities. Consider the following barriers, unintended consequences, and questions when selecting, designing, and implementing equity-oriented strategies:

1 LIMITED COMMUNITY CAPACITY AND RESOURCES

Variability in community capacity and resources can influence decisions about which communities and community organizations to partner with, especially if resources are limited. While there are benefits to funding and collaborating with partners that can "hit the ground running," it is also important to build the capacity of other groups through training and additional support.

- Has lack of capacity or resources kept critical partners away?
- What training opportunities can build the capacity of residents or organizations to make community improvements?
- Are the same organizations repeatedly benefiting from funds distributed in the community? What steps can you take to engage other organizations?

2 VARIABILITY IN HEALTH LITERACY

Addressing health literacy means ensuring that all members of the community have the capacity to access and understand the information they need to engage in health improvement strategies or reap their health benefits.

- Will the improvements be understood by all community members?
- Is training needed to support and sustain the improvements?
- How will language, culture, and other differences be accommodated?

3 LACK OF COMMUNITY ENGAGEMENT, AWARENESS, AND PARTICIPATION

A well-designed effort may fail to reach its full potential if residents are unaware of the improvements or were not invited to participate in the planning and implementation process. Community residents and stakeholders should be consulted and engaged from the very start, and this engagement should be sustained throughout the process.

- How will stakeholders representative of the community's diversity be engaged?
- What steps will be taken to engage community members in planning, implementation, and evaluation?

4 **COST, RESOURCES, AND OTHER FISCAL CONSIDERATIONS**	There may be costs related to strategy implementation, either for the institutions making the improvements, or for the people who are the intended beneficiaries of these improvements. Examine how budget constraints may hinder implementation or uptake in underserved communities.	• Will costs prevent underserved populations from fully benefitting from the strategy? How can affordability be ensured for all? • Which partners might be able to help provide required resources (e.g., funding, materials, staff, other assets) to implement the strategy?
5 **TRANSPORTATION CHALLENGES**	Lack of personal transportation, unaffordable or unreliable public transportation, or inadequate infrastructure may reduce access to goods, services, or environmental improvements, including tobacco cessation services and other health care services. Explore whether transportation issues such as access, cost, and proximity exist.	• Is lack of transportation a problem for the intended beneficiaries of the strategy? • Are the locations where services are provided too distant, inconvenient, inaccessible, or unsafe?
6 **POTENTIAL DISPLACEMENT EFFECTS**	Changing community conditions may contribute to cycles of displacement. It is important to ensure that improvements will benefit residents rather than create conditions that displace them. Identify factors that may drive displacement and protections that can prevent it.	• How might community improvement strategies lead to displacement in the future? • What protections can be put in place to preserve affordable housing and prevent displacement? • How might concerns about displacement prevent residents from engaging in community improvements?
7 **VARIABILITY IN IMPLEMENTATION**	Uneven implementation of a policy or systems improvement may worsen inequities. Explore the factors (including those listed in this table) that might prevent consistent implementation of a strategy and develop solutions early in the planning process.	• Once your strategy is adopted or implemented, what steps will ensure proper implementation? • How will you ensure implementation occurs where it's needed most? • Which institutions need additional support to implement the improvements?
8 **CRIME/SAFETY INFLUENCES (BOTH REAL AND PERCEIVED)**	Even if effective strategies are put in place, fear of crime at locations where the intervention or service is being delivered may keep residents from using the new resources. Assess safety conditions and residents' perceptions of these conditions, and, if necessary, take steps to ensure participants' safety.	• How might concerns about safety prevent the community from benefitting from the strategy? • Are there visible signs of crime and violence?
9 **LACK OF AWARENESS OF DIVERSE NORMS AND CUSTOMS**	Understanding the diversity in culture, norms, and customs among population groups can ensure that strategies are designed to be inclusive. Institutions also have their own customs and norms, and these should also be considered, as they might affect decision making.	• How will community members with different norms and customs be engaged in strategy design? • Are differences in culture and norms understood in ways that result in respectful strategy development?

APPENDIX C

EXAMPLE RESOURCES FOR IDENTIFYING AND UNDERSTANDING HEALTH INEQUITIES

This table describes several online resources that you may be able to use to identify and understand health inequities in your area. This list is not exhaustive and you should determine what best fits your local needs.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)[251]	A state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury.
CENSUS DATA[252]	A database that provides demographic information on income, education, race/ethnicity, housing, and other factors that are viewable at multiple levels: national, state, county, and smaller geographic areas. Interactive features also allow cross tabulation of indicators and population groups.
COMMUNITY COMMONS[253]	An online interactive mapping tool that provides free geographic information systems (GIS) data from the state level to the block group level. The Commons is linked to the National Prevention Strategy and provides a peer learning network and other resources.
COMMUNITY HEALTH ASSESSMENT & GROUP EVALUATION (CHANGE): BUILDING A FOUNDATION OF KNOWLEDGE TO PRIORITIZE COMMUNITY NEEDS[17]	A tool to help community teams develop a community action plan. This tool provides steps for community team members to use in an assessment process. It also helps define and prioritize possible areas of improvement to address the root causes of chronic diseases, as well as related risk factors.
COUNTY HEALTH RANKINGS: MOBILIZING ACTION TOWARD COMMUNITY HEALTH[254]	A ranking of counties in each of the 50 states according to summaries of a variety of health measures. Summary measures include health outcomes (mortality and morbidity) and health factors (health behaviors, clinical care, social and economic aspects, and physical environment).

COMMUNITY HEALTH STATUS INDICATORS (CHSI)[255]	A report that contains over 200 measures for each of the 3,141 U.S. counties. The report presents indicators for deaths due to heart disease and cancer as well as on behavioral factors such as tobacco use, diet, physical activity, alcohol and drug use, sexual behavior, and others that substantially contribute to these deaths.
DATA SET DIRECTORY OF SOCIAL DETERMINANTS OF HEALTH AT THE LOCAL LEVEL[256]	A directory that contains an extensive list of existing data sets that can be used to address social determinants of health. The data sets are organized according to 12 dimensions (broad categories) of the social environment.
HEALTHY COMMUNITIES NETWORK (HCN)[257]	A network that tracks over 200 health and quality-of-life indicators. It also provides guidance on 1,800-plus community-level interventions. Local information is collected and combined with other data.
HEALTH DISPARITIES CALCULATOR[258]	Statistical software from the National Cancer Institute that imports population-based health data and calculates different disparity measurements.
HEALTH EQUITY INDEX[259]	An online tool created by the Connecticut Association of Directors of Health that outlines and measures the social determinants of health with specific health outcomes. The index produces scores as well as GIS maps.
HEALTH INDICATORS WAREHOUSE[260]	A Web site maintained by CDC's National Center for Health Statistics. This resource provides data on communities' health status as well as different determinants. There are over 1,000 indicators that can be categorized by geography, initiative, or topic.
THE TOOL FOR HEALTH AND RESILIENCE IN VULNERABLE ENVIRONMENTS (THRIVE)[261]	A tool intended to help people understand and prioritize the factors within their own communities in order to improve health and safety. The tool identifies key factors around equitable opportunity, people, and place, and allows users to rate how important each factor might be in their community.

APPENDIX D

HEALTH EQUITY CHECKLIST: CONSIDERING HEALTH EQUITY IN THE STRATEGY DEVELOPMENT PROCESS

The Health Equity Checklist provides questions for consideration when designing a strategy to ensure health equity remains central to all aspects of an initiative.

STEP 1: IDENTIFY

Clearly identify health inequities and protective factors in both health outcomes and community conditions across population groups and geographic areas through the use of existing data, community input, and environmental assessments.

STEP 2: ENGAGE

Include and meaningfully engage representatives of population(s)/area(s) defined in Step 1 in your partnerships, coalitions, or on leadership teams.

STEP 3: ANALYZE

Ensure the selection, design, and implementation of strategies are linked to the inequities identified in Step 1, and will work to advance health equity. Consider the following:

- Is the strategy TARGETED to a population group(s)/area(s) experiencing health inequities?
  - Is the outcome written in a way that allows you to measure the effect of efforts?
  - Is it culturally tailored to the unique needs of population group(s)/area(s) experiencing health inequities, and are potential barriers addressed?
- Does the strategy rely on SITE SELECTION (e.g., selecting X number of sites for smoke-free cessation services, creating X number of farmers' markets)?
  - Do selection criteria for sites reflect populations/areas with the highest burden?
  - If not, are selection criteria logical and justified?
  - Are there additional supports provided for selected sites that might require them to be successful?
- Is the strategy POPULATION-WIDE?
  - Have population(s)/area(s) experiencing health inequities been engaged in efforts to identify possible barriers and unintended consequences of the proposed strategy?
  - Are identified barriers regarding implementation and enforcement being addressed?
  - Have potential unintended consequences been considered and accounted for in proposed activities?

STEP 4: REVIEW

Review evaluation and monitoring plans to ensure health equity-related efforts will be measured. Additionally, ensure appropriate data will be collected to conduct sub-analyses. These data will help in assessing the differential effects of each strategy across population group(s)/area(s), as well as the overall impact of strategies on reducing health inequities.

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