Disparities In Lung Health Series

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Fighting for Air

Cutting Tobacco's Rural Roots

Tobacco Use In Rural Communities

Preface

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Tobacco use is the leading cause of preventable illness and death in the United States. It is the primary cause of many lung diseases including lung cancer (which causes more American deaths than any other cancer) and chronic obstructive pulmonary disease (COPD), the third leading cause of death in this country. In addition to the human toll, tobacco use costs the nation almost $200 billion annually in direct medical costs and lost productivity. While there has been great progress in reducing overall tobacco use over the past several decades, some parts of our society bear a disproportionate burden of tobacco use and tobacco related illness.

America's rural population is one group that is more heavily impacted by tobacco use. People living in rural communities are more likely to use tobacco and they have especially high rates of smokeless tobacco use. Rural Americans are also more likely to be exposed to secondhand smoke and less likely to have access to programs that help them quit smoking. The rural community clearly requires special attention if we hope to end the epidemic of tobacco use in this country.

The American Lung Association has chosen to highlight the issue of rural tobacco use because addressing this problem will require a multi-pronged approach. The federal government and state and local governments must take steps to ensure tobacco control efforts address and include people living in rural communities. School systems and health systems must take measures to promote smokefree air and tobacco cessation services. Lastly, everyone must do their part to change our culture and ensure that future generations have a healthy, tobacco-free future.

Working together, we can reduce and ultimately eliminate the burden of tobacco use on rural communities. Please join the American Lung Association in our fight to reduce lung health disparities, prevent lung disease and save lives.

Cutting Tobacco's Rural Roots

Tobacco Use in Rural Communities

Introduction

In the villages of New Hampshire, the mountains of Appalachia, the ranch lands of Oregon and all the tribal nations and rural communities in between, today's children are being cultivated to become tomorrow's tobacco users. Tobacco use remains the leading cause of death and disease in the United States, accounting for more than 440,000 deaths each year. In spite of years of effort by federal, state and local public health agencies and advocates, residents of rural communities are more likely to use tobacco products, to start at a younger age, to use more heavily and to be exposed to secondhand smoke at work and at home than their counterparts in cities and suburbs.

Tobacco use is deeply rooted in the social environment in many rural communities, not only harming the health and well-being of the current generation, but also perpetuating a cycle that threatens future generations. Many of the factors that are known to promote tobacco use among children and adults are at work in rural counties

and small towns. The tobacco industry has targeted young rural men, especially smokeless tobacco users, with appealing imagery of rugged individualism. State and local governments serving large segments of the rural population have been less likely to enact the kinds of policies that have reduced tobacco use elsewhere, such as increasing excise taxes and eliminating exposure to secondhand smoke in workplaces and other public venues. Rural youth are more likely to be surrounded by role models who are tobacco users, and are less likely to hear anti-tobacco messages in the media. And people living in rural areas who are ready to quit often find they have few resources available to help them.

The American Lung Association calls upon government agencies, the research and funding communities, health systems and insurers, community leaders, schools and families to take action now to cut tobacco's rural roots. State and local tobacco control programs should be adequately funded, and should focus resources on disparities in rural communities. Adults and children should be protected from exposure to secondhand smoke in workplaces, schools and homes. People who are ready to quit should be aware of and have access to cessation services by qualified providers, fully covered by their insurance. And most important, parents and other community members should refuse to accept the culture of tobacco use as part of life in their communities, and to expect that their children will have healthy, tobacco-free lives.

Understanding Rural Communities

Rural communities make up 90 percent of the land area in the United States, but only about 16 percent of the population. Rural areas vary considerably from place to place, depending on terrain, population density, racial and ethnic mix, distance from urban areas and availability of resources. The majority of rural residents are white, but there are many communities, especially in the south and west, where the majority population is African American, Hispanic or American Indian. While rural communities are diverse, many of them share similar challenges and assets that are useful to understand when examining the culture of tobacco use.

The beautiful landscapes, low population density and distance from urban centers that can make the American countryside so attractive can also mean fewer educational and employment opportunities for the people who live there. Unemployment rates are generally high, and rural residents as a whole are more likely than urban residents to have incomes below the poverty level.[1] In many places, limited opportunity has resulted in young people moving away, leaving behind aging populations and fewer economic resources to support much-needed public institutions like schools and health care.[2]

In many ways, the challenges of living in rural communities can be offset by the strengths of the residents, which have been forged over generations of working together with neighbors to overcome obstacles. Rural communities have strong traditions of self-reliance and individualism. Research has also shown that in most rural areas, residents have very high levels of trust and civic engagement.[3]

Rural, of course, is anything that is far off from city life. It does not necessarily have to be farm country. Small town USA, that kind of thing… You find rural communities all over the country.

Joan Myers, retired home health nurse, Clearfield, PA

DEFINING RURAL

What exactly is a rural community? According to the Department of Agriculture, the portion of the population that can be considered rural ranges from 17 to 49 percent, depending on the definition used.[4] While the multiple definitions can make it challenging to compare data and research findings, common factors include population size, population density, proximity to metropolitan areas and land use patterns.

In its analysis for this report, the American Lung Association used data from the 2009 National Survey on Drug Use and Health (NSDUH), the primary source of statistical information on the use of illegal drugs, alcohol and tobacco by the U.S. civilian, non-institutionalized population ages 12 and older.[5] Tobacco users were classified as either rural or urban based on the population size, density and the nature of commuting patterns in their county of residence. Rural counties were defined as those without an urban area of 10,000 or more residents, less than 25 percent of the residents with jobs working in a neighboring metropolitan county and less than 25 percent of the jobs in the county being filled by residents from a neighboring metropolitan county. We have also cited a number of research studies in the report, and it should be noted that they may have used different methods to define their study populations.

It is important to note that it can be challenging to get accurate information on rural communities. They are small communities that can differ greatly from one to the next, which makes it more difficult to collect meaningful and representative data and statistics.

An Epidemic of Tobacco Use in Rural Commmunties

The Marlboro Man as a symbol of rugged, independent country life may be history in the United States, but, sadly, the legacy of tobacco use (and addiction) he stood for lives on. Residents of rural communities are more likely to use tobacco products, to start at a younger age, to use more heavily and to be exposed to secondhand smoke at work and at home than their counterparts in cities and suburbs. These disparities perpetuate a culture of tobacco use that ultimately results in higher rates of tobacco-related illness and death among this population.

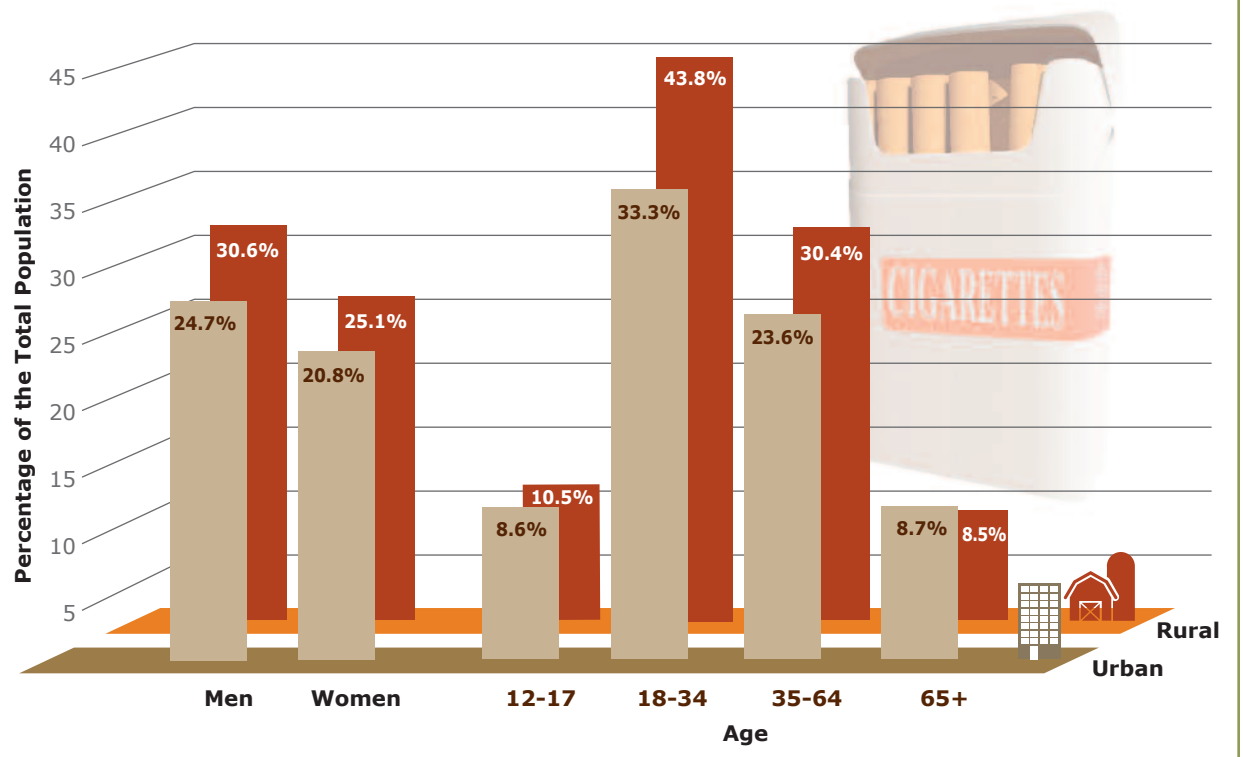
High Rates of Smoking and Smokeless Use

According to national survey data, 27.8 percent of rural residents smoke, compared to 22.7 percent of urban dwellers. This trend is consistent for both males and females up to age 64. Rural young adults ages 18 to 34 smoke at especially high rates, and are 27 percent more likely to smoke than their urban counterparts.

Smokeless tobacco use has long been linked with rural life in the public's mind, and indeed the difference in rates of its use by geography is dramatic. Men are far more likely to use smokeless tobacco and those from rural areas are more than twice as likely to use these products as those from metropolitan areas. When looked at by age, smokeless tobacco use was more than twice as common in rural areas for every age group.

While use of both cigarettes and smokeless tobacco, called dual use, was quite low overall at 1.4 percent, it was still twice as high in rural areas (2.5 versus 1.2 percent). However, a recent report from West Virginia finds that dual use is on the rise, and that smokeless tobacco is being marketed heavily as an alternative in situations

Current Cigarette Use by Geography, Gender and Age



Data from the National Survey on Drug Use and Health, 2010. Analysis performed by the American Lung Association

where one cannot smoke.[6]

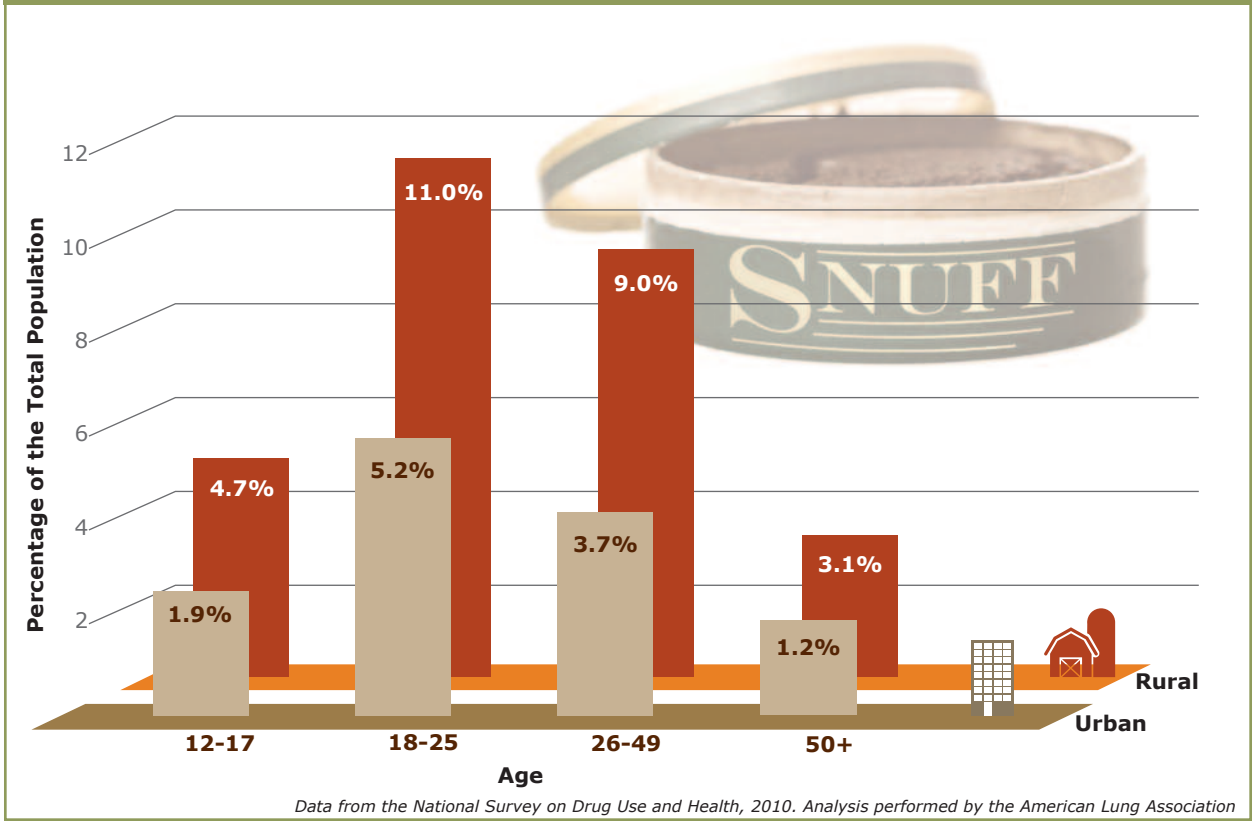
For the most part, differences between rural and urban tobacco users based on race and ethnicity are difficult to determine due to the small population size in rural communities. A notable exception is among American Indians, who since the 1980s have had higher smoking rates than any other racial/ethnic group. One study found that 45.2 percent of American Indians living in rural areas near metropolitan areas were regular tobacco users, which was higher than any other demographic group.[7]

Starting Young, Smoking More

The long-term impact of tobacco use is determined in part by how young a person is when they start, and how much they use over time. Both of these factors not only increase the body's exposure to the cancer-causing ingredients in tobacco products, but also make addiction more severe, making it harder to quit. This is like double jeopardy for the health of rural tobacco users. According to a recent study, youth who live in rural areas were three times as likely as both urban and suburban youth to smoke.[8] Among children living in rural areas, those who smoked a full cigarette before the age of 12 were twice as likely to become regular smokers as those who started experimenting at a later age. Overall, 37.4 percent of rural adolescents were considered regular, daily smokers, which was significantly higher than both suburban and urban adolescents.

An American Lung Association analysis shows that how heavily a person smokes is strikingly different between rural and urban areas. Rural smokers are less likely to consume fewer than six cigarettes daily and more likely to consume more than 15 cigarettes daily.[9]

Current Smokeless Tobacco Use by Geography and Age



Data from the National Survey on Drug Use and Health, 2010. Analysis performed by the American Lung Association

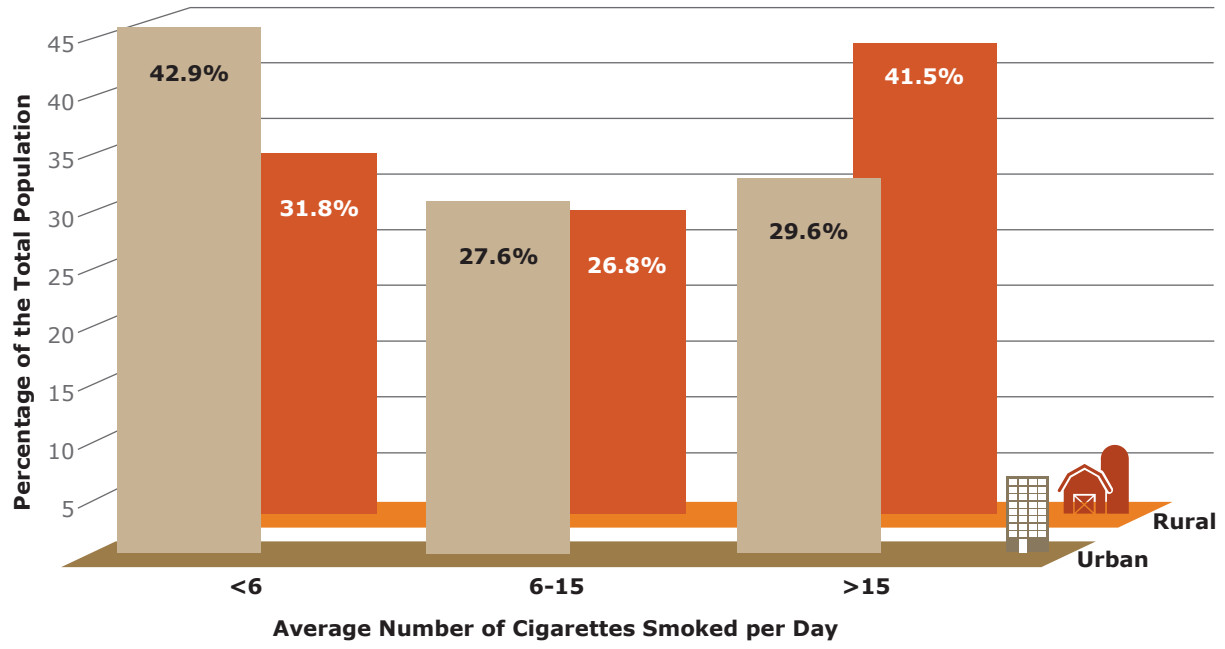
Smoking in Pregnancy

Children whose mothers smoke while pregnant are at a much greater risk for a range of health problems, including low birth weight, behavioral disorders like ADHD and lifelong breathing problems including asthma. They are also more likely to become smokers themselves.[10] Fortunately, public awareness of the dangers of smoking during pregnancy is high, and overall, women who are pregnant smoke at lower rates than those who are not. But according to an American Lung Association analysis of national survey data, 27.4 percent of pregnant women in rural communities smoke throughout their pregnancy, compared to 11.2 percent of their urban counterparts.[11] When accounting for contributing socioeconomic factors, pregnant women still were two times more likely to smoke if they lived in a rural area as compared to an urban area. In fact, rural women who were pregnant smoked at approximately the same rate as urban women who were not pregnant.

Exposure to Secondhand Smoke

Not surprisingly, communities with high rates of smoking also suffer from high rates of exposure to secondhand smoke, which threatens the health of all who live there, including children. According to the National Survey of Children's Health, the percentage of children who live in a household with a smoker is considerably higher in rural areas: 33.1 percent of children living in large rural areas, 35.0 percent of children in small rural areas, compared to 24.4 percent of urban children.[12] Residents of rural areas are more likely to allow smoking in the presence of children in their homes and family cars.[13] Adults are affected too, of course. In one recent survey, the percentage of rural respondents reporting that in the past week someone had smoked in their presence at work (16.2) and at home (20.5) was significantly higher than for urban respondents (11.0 and 14.1 percent, respectively).[14]

Cigarettes Smoked per Day by Geography

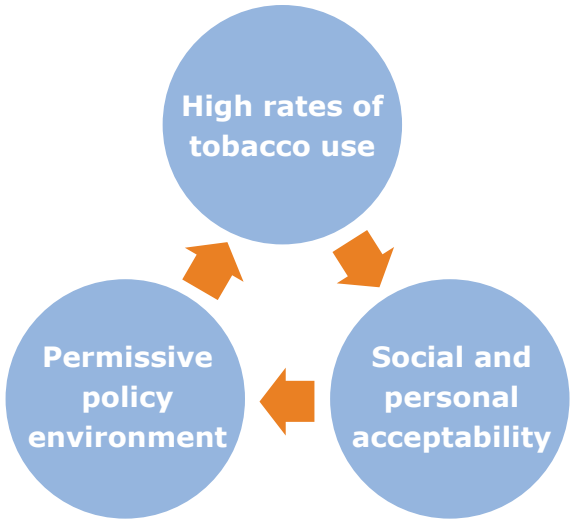


Data from the National Survey on Drug Use and Health, 2010. Analysis performed by the American Lung Association

Contributing Factors

Simply living in a rural community is not in and of itself the reason for the tobacco use differences seen between rural and urban communities. Much as the rural population itself is multifaceted and diverse, the reasons for the increased rates of tobacco use are complex. Some factors, such as poverty, stress and targeting by the tobacco industry, contribute to higher rates of tobacco use in specific populations throughout the country. Other factors are more specific to rural cultures and communities, like the economic dependence on tobacco growing and a greater level of social acceptance of smoking. The result is a self-perpetuating cycle of high rates of tobacco use, social and personal acceptance of tobacco use as the norm and a policy environment that does not discourage tobacco use.

Cycle of Rural Tobacco Use



Influence of Income and Education Level

It is well established that people with lower income and lower levels of education are more likely to use tobacco products. Analysis of national survey data by the Lung Association showed that income and education significantly contributed to higher levels of cigarette smoking in rural areas.[15] Also, as the amount of education and income increased, the rate of cigarette smoking decreased. Surprisingly, smokeless tobacco use across income or education in rural areas did not follow this pattern.

Although by no means are all rural communities poor, the average level of income is lower than in urban areas, and there are pockets of extreme persistent poverty in parts of Appalachia, the Deep South and tribal lands. Educational and job opportunities can be limited in some rural communities. Tragically, in rural America, people who report that they are unemployed are especially likely to smoke. One study found that nearly half of rural residents without jobs were current smokers.[16]

The reasons for the strong connection between lower incomes and education levels and tobacco use are not fully understood, and, in fact, may seem counterintuitive given the cost of tobacco products. But there is evidence that the perception that tobacco products relieve stress may play an important role, as the nicotine in tobacco can cause a calming effect on a user that is addicted already. In one study of a rural low-income community in Alabama, researchers found that residents who were unemployed or retired were 1.7 times more likely to smoke than those who were working.[17] Those who reported experiencing moderate levels of stress were more than twice as likely to smoke. This was especially true for women in the study.

Rural children, adolescents and adults present unique challenges in tobacco prevention and control. We need innovative, culturally sensitive prevention, cessation and policy interventions to address these underserved, high-risk groups.

Kimberly Horn, Ed.D., Associate Dean of Research,
The George Washington University School of Public Health and Health Services

The interaction among income, education and stress may also affect people's ability to quit smoking for good. A recent study of adults enrolled in a quit smoking program in Arkansas found that participants from across the socioeconomic spectrum quit at roughly the same rates. But six months after the end of the program, the poorest smokers were two-and-a-half times more likely to be smoking than the more affluent smokers. The author suggested that the higher rate of smoking in the poorest smokers could be attributed to higher stress levels.[18]

Tobacco Industry Marketing Tactics

Tobacco products are one of the most heavily marketed consumer goods in the United States. In 2008, tobacco companies spent $9.94 billion on the marketing of cigarettes and $547 million on the marketing of smokeless tobacco products.[19] In spite of persistent claims by the companies that they are only interested in getting current tobacco users to switch brands, research has clearly proven that tobacco marketing creates new users, especially among young people.[20] Promotional tactics, such as price discounts and coupons, increase not only the number of youth who try tobacco for the first time, but also the likelihood that they will progress from experimentation to daily smoking.[21]

For decades, the tobacco industry has done a masterful job of targeting the marketing of specific products to specific populations, including the blue collar and rural men who are some of their best customers. Ads depicting rugged "manly" images of cowboys, hunters and race car drivers are carefully placed in the media and retail outlets most likely to reach their audience.[22,23] Smokeless tobacco in particular has been targeted in this way, and it certainly seems to work. A recent study among boys and men in Appalachian Ohio found that the participants viewed smokeless tobacco use as a rite of passage in the development of their masculine identity, and a key to acceptance into male social networks.[24]

The recent implementation of the Food and Drug Administration's Tobacco Control Act has restricted marketing and promotional tactics for cigarettes and smokeless tobacco products. It seems that the tobacco industry has been taking advantage of the few loopholes that do exist as well as the generally lower price of smokeless tobacco products. Marketing of smokeless tobacco products has skyrocketed in the last couple of years, with expenditures more than doubling between 2005 and 2008, during which time the marketing budget for cigarettes slightly decreased.[25]

Tobacco Control Environment

After 50 years of effort by government agencies and public health advocacy organizations, there is a strong consensus on what policies and programs are effective in overcoming the power of the tobacco industry and reducing the toll of tobacco use on public health. According to the Centers for Disease Control and Prevention (CDC), strategies that have proven effective include: increasing the cost of tobacco products, implementing smokefree policies for worksites and public places, counter-marketing campaigns, providing insurance coverage of tobacco use treatments and limiting children's access to tobacco products.[26]

Although much progress has been made in some of these areas nationwide, rural communities as a whole lag behind in these efforts.

The economic pressures on low-income rural communities may make them especially sensitive to challenging a lucrative and powerful industry, especially in tobacco growing regions. Fears that state or local tobacco control policies to reduce tobacco use and secondhand smoke exposure will hurt local businesses are common but unfounded. Studies from Kentucky and Ohio showed there was no evidence that local or state smokefree legislation negatively influenced local economies in either rural or urban communities.[27]

About a week before my restaurant went smokefree, I had an angry customer tell me that what I was doing was wrong. He vowed never to come back. Guess who I saw sitting at the counter just six weeks later? Going smokefree didn't hurt my restaurant one bit!

Rommel Jones, former owner of Arts Café in Moose Lake, MN

SPECIAL CONCERNS IN TOBACCO GROWING REGIONS

Tobacco growing has been an important part of the economy and the culture of the southeastern United States since colonists started arriving in the 1600s. At the height of U.S. tobacco production in the 1950s, there were 512,000 mostly small family farms in 17 states covering 1.5 million acres.[28] The land and the livelihood passed from generation to generation, and tobacco use came to represent a way of life that meant stability, and even prosperity, in numerous small rural communities. It is not surprising that state legislators, community leaders and residents in tobacco-growing regions have traditionally resisted tobacco control efforts that are thought to be a threat to the local economy.[29] Using tobacco has been considered acceptable, and even supportive, of family and community.[30]

In recent years, changing farming practices, global competition and lower smoking rates in the United States have resulted in a dramatic reduction in the number of tobacco farms, now down to 16,234 farms covering 359,846 acres. Many farms have passed out of family ownership and are now controlled by large agribusiness corporations. Tobacco manufacturing employment, which is concentrated in North Carolina and Virginia, has also been shrinking, and makes up less than 2 percent of manufacturing jobs in those states.[31] Research is lacking on how the shifting role of tobacco in local economies is changing attitudes about tobacco use and tobacco control. But perhaps the time is right for community leaders to change the script and start talking about the true economic impact, including the cost of illness and premature death, of perpetuating the culture of tobacco use.

Tobacco control funding and efforts can't just be statewide — there needs to be a focus on making sure rural communities are included in the effort.

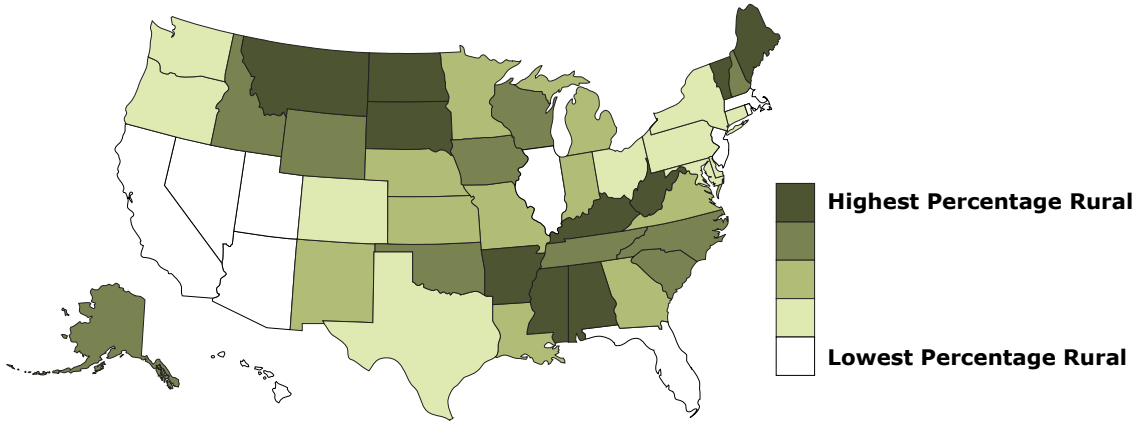
Chris Doster, Ringgold County (IA) Department of Public Health

Smokefree air policies

Secondhand smoke exposure both damages health and reinforces tolerance for or acceptance of tobacco use. Over the past 20 years, there have been successful efforts in many states and communities to put in place laws and policies that protect people from secondhand smoke in workplaces and other public venues. As of June 2012, 27 states and the District of Columbia have passed comprehensive smokefree laws. These laws provide significant health protection for roughly 50 percent of the U.S. population.[32,33]

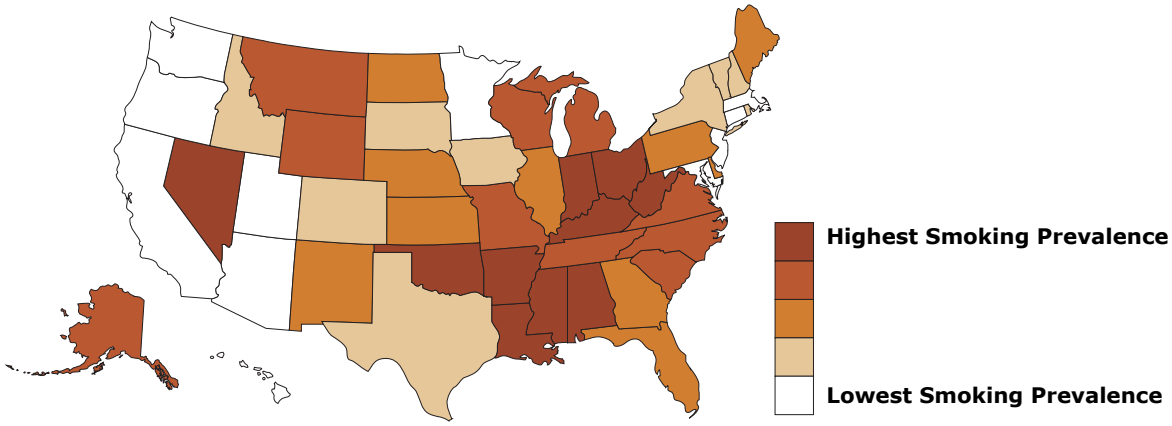
Unfortunately, comprehensive smokefree policies have yet to reach rural communities to the same degree as urban communities, especially in tobacco-growing states. Some states that do not have comprehensive statewide smokefree laws have significant local smokefree policy activity happening, but it is often concentrated in bigger cities or university/college towns, and does not touch the very rural areas of those states. One survey of counties in Kentucky found that rural communities have fewer smokefree laws and voluntary restrictions compared to urban communities, and larger rural communities were more likely to have strong protections in place than smaller rural communities.[34] In 2009, a review of local ordinances in six states in Appalachia found that few communities passed comprehensive clean indoor air ordinances that truly protect people from secondhand smoke. Although roughly half of the communities examined had passed some kind of law restricting smoking, fewer than 20 percent of communities had a comprehensive workplace, restaurant, or bar ordinance. Communities with higher education and income levels were more likely to have a comprehensive smokefree ordinance in place.[35]

Percentage of State Population Living in Rural Areas



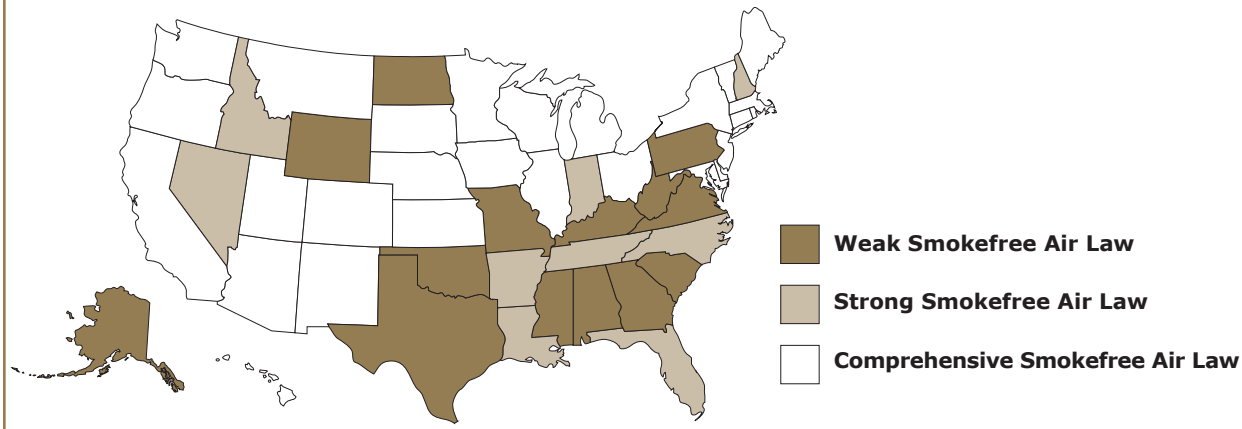
Source: Statistical Abstract of the United States 2012, U.S. Census Bureau

Adult Smoking Prevalence



Source: Behavioral Risk Factor Surveillance Survey 2010, U.S. Department of Health and Human Services

Strength of Smokefree Air Laws



Source: State Legislated Actions on Tobacco Issues 2012, American Lung Association

Having kids get involved was the key. It meant a lot when they stood up and said, "I want to be able to come back here someday and raise a family and I want to be able to say we have smokefree parks and be proud of this town."

Chris Doster, Ringgold County (IA) Department of Public Health

Tobacco-free schools

Because most tobacco users start as teenagers, the policies and programs that children are exposed to in school are an important part of a community's overall approach to tobacco control. While federal law requires all schools that receive federal funds to have smokefree indoor policies, the CDC recommends that all schools adopt and enforce a completely tobacco-free policy that prohibits the use of all tobacco products by anyone, including students, staff and visitors on school grounds or at school events at all times.[36] Here again, rural youth enjoy fewer protections than their urban counterparts. An analysis of data collected by the 2006 School Health Policies and Programs Study found that while 64 percent of schools surveyed reported a tobacco-free environment, rural schools, small schools and poorer schools were least likely to have tobacco-free policies and practices in place.[37]

An in-depth survey of school administrators in Kentucky, one of the largest tobacco growing states, found that only 20 percent of schools reported having comprehensive tobacco-free policies. Urban area schools were twice as likely to have a tobacco-free campus policy as schools in rural areas. Nearly all schools in the survey had a policy prohibiting smoking indoors by students and staff, but the schools without a comprehensive policy tended to allow teachers and other school personnel to smoke on school grounds during the day. The researchers suggested that by creating this environment, in which students feel surrounded by tobacco use, schools are actually promoting tobacco use among students.[38]

Awareness and counter-marketing campaigns

Comprehensive tobacco control programs include a health communication strategy called counter-marketing, which raises awareness of the dangers of tobacco use and exposes the false imagery peddled by the tobacco industry. Millions of dollars have been spent on these counter-marketing campaigns over the years, and there is evidence that well-designed campaigns using proven effective messaging have made a real difference in smoking behavior, especially among young people.[39] But major media markets are based in metropolitan areas, and rural residents may not see or hear as many messages discouraging tobacco use or encouraging people to quit. In one study comparing the responses to a mass media campaign among youth in different communities in Indiana, researchers found that suburban and urban youth were twice as likely to recall seeing or hearing messages about not using tobacco, compared to rural youth.[40]

The American Legacy Foundation, sponsor of the national "truth" campaign, became concerned when they realized that youth in rural areas were less aware of the campaign's anti-tobacco messages than other youth nationwide. Through targeted purchasing of airtime in local broadcast media, they were able to increase confirmed awareness of "truth" from 40 to 71 percent among rural youth in their study area. The majority of the youth reported being receptive to the messaging, and found it convincing.[41]

No mentorship exists for specialists in our small community. Young doctors do not see the local hospital as a way to learn to become a great specialist.

Joan Myers, retired home health nurse, Clearfield, PA

Access to Treatment

Rural tobacco users face a number of challenges that may limit their ability to quit when they are ready. Health care providers can play a vital role in encouraging and assisting quit attempts by their patients who use tobacco products. But geographical isolation can mean having to travel long distances to get any kind of health care, including services to quit tobacco use. In 2010, 1,505 of the 2,052 rural and frontier counties in the United States were designated as Medically Underserved Areas by the federal government, which means they have too few primary care doctors, high infant mortality rates, high poverty and/or high elderly populations.[42] There are also shortages in the public health workforce, which includes public health nurses and health educators. Health department budgets are usually stretched, hiring and retaining qualified personnel can be difficult, and there are few opportunities for specialized professional development, such as being trained in tobacco use treatment.[43]

Rural residents, especially those with lower income, are slightly more likely to be uninsured. In one study, even participants with health insurance reported that their out-of-pocket costs prevent them from seeking treatment except in emergencies. They recognized the importance of quit smoking medications for successful quit attempts, but described the cost as a significant barrier.[44]

Users of smokeless tobacco who are ready to quit have to deal with the additional problem that most of the proven-effective medications for smoking cessation do not work very well for smokeless tobacco products. For reasons that are not well understood, nicotine replacement products like patches and gum, as well as the medication bupropion, have not been shown to help people stop using smokeless tobacco products, although there is some evidence that the medication varenicline can be effective.[45]

Cessation programs tailored for rural audiences may need to consider topics like tobacco-growing economies, favorable tobacco environments, favorable norms about use, geographic isolation and lack of access to services, cultural and traditional values and customs, poverty and stress and coping.

Kimberly Horn, Ed.D., Associate Dean of Research, The George Washington University School of Public Health and Health Services

The barriers to tobacco cessation services from the health care system, and the lack of options for other types of community-based cessation programs could become less of concern with the emergence of new technologies for distance learning and digital interventions. More and more health information and education resources of all kinds are available online and via smartphone applications. Some interventions are being developed specifically to meet the needs of rural tobacco users.[46,47] However, rural communities still face the basic challenges of first finding out about the programs, and then accessing the technology. In a small study of rural smokers in the Midwest, participants talked about the difficulty of finding programs to quit tobacco use, and seemed to be unaware of the availability of state counseling services by phone and online resources.[48]

There is a gap between less educated, lower income individuals living in rural areas and the rest of the population in using the Internet to find health information.[49] This is not surprising considering the findings of the Pew Internet & American Life Project that the gap between rural and non-rural Americans' in-home Internet use is still significant, although it has been narrowing. The rise of the smartphone, which has caught on quickly in a range of communities with lower income and education, may be a key to accessing digital information, although service in remote areas is still under development.[50]

Social Attitudes and Personal Beliefs

Children's attitudes are shaped by their environment at an early age. In communities with high rates of tobacco use, children observe the adults around them smoking and dipping; they breathe the smoke-filled air in their homes and in public places; and before they get to adolescence they have become accustomed to and accepting of tobacco use as the social norm. This in turn increases the likelihood that they will become tobacco users themselves. Attitudes of acceptance also reduce the demand for policy change. When asked about smoking in the workplace, adults in rural communities were significantly less likely than those in metropolitan areas to believe that workplaces should be smokefree (60 versus 70 percent respectively).[51]

There is evidence that breaking the generational cycle of tobacco use can be successfully started at home. Like people everywhere, rural residents report a desire to set a good example and to protect their children from tobacco use.[52] Not allowing smoking in one's home has been shown to not only protect family members from exposure to secondhand smoke; it also lowers the levels of smoking by tobacco users in the family, and increases interest in and success with quitting.[53]

When I looked across the dining area, there was a thick haze from people's cigarettes. That's just the way things were back then. It was normal.

Romelle Jones, former owner of Arts Café in Moose Lake, MN

Solutions and Successes

In spite of the many challenges to reducing the tobacco epidemic in rural communities, there are places where people working together are making a difference. Below are just a few examples of the successful initiatives that are going on in counties, small towns and villages from coast to coast. The key features they have in common are committed individuals who are willing to tackle the status quo, and a place-based approach that recognizes that rural communities are all unique in their needs and in their strengths.

Place Matters: Taking a Community Health Approach

In 2010, the Department of Health and Human Services launched the Committees Putting Prevention to Work (CPPW) program to prevent tobacco and obesity-related chronic disease and improve health through place-based and community-driven initiatives. Led by the CDC, this successful two-year program supported 55 communities as they planned and implemented strategies based on their unique needs. As of March 2012, more than 18.4 million Americans in 20 CPPW communities were benefitting from policies in their communities that protect them from exposure to secondhand smoke in workplaces, restaurants, bars, multi-unit housing complexes, campuses, parks or beaches.[54]

One of the funded projects was in Ringgold County, Iowa, one of the poorest counties in the state, with fewer than 5,500 residents and a youth smoking rate of approximately 40 percent.[55] Ringgold County coalition members used CPPW funds to mobilize local resources and strengthen community capacity for tobacco control. After hearing from concerned groups, decision-makers in several Ringgold County communities adopted tobacco-free park policies. Ringgold coalition partners also successfully launched a media campaign to encourage tobacco cessation among women of reproductive age. Local health care providers have also been trained on how to work with their patients to encourage tobacco cessation and make referrals to more intensive cessation services. These efforts have begun to pay off. From June 2010 to December 2011 alone, three times as many Ringgold County tobacco users had contacted Quitline Iowa to end their addiction to nicotine as compared to any other 18 month period since 2007.

Ringgold County, Iowa, provides an example of how a well-funded comprehensive effort to address tobacco use and secondhand smoke exposure can have a real impact in a rural community. Citizens of this rural county are now much more supportive of smokefree air policies and the new smokefree park policies are evidence that social norms in this community are beginning to change. With increased referrals to accessible smoking cessation services such as Quitline Iowa and efforts to reach high-risk populations with counter-marketing efforts, Ringgold County should soon see the benefits from decreased tobacco use and ultimately from a lower burden of tobacco on this rural community.

Hospital Sets a Healthy Example

Northwestern Medical Center is a rural county hospital in St. Albans, Vermont, that had all but stopped enforcing its smokefree campus policies. Amy Brewer is a hospital employee and leads the Franklin Grand Isle Tobacco Prevention Coalition. About five years ago, Ms. Brewer decided it was time for the hospital to re-embrace its commitment to smokefree air.

Using an innovative approach, all hospital employees are responsible for enforcing the hospital's smokefree campus policy. Neither patients nor staff are allowed to smoke anywhere on the hospital's campus; smoke breaks are also prohibited. Patients who smoke are offered nicotine replacement therapy and bedside coaching to help with their efforts to quit. An employee wellness program was created to support hospital staff who want to quit smoking and it provides free smoking cessation medications and cash rewards for meeting key milestones over the course of each person's quitting process. Northwestern Medical Center set an example for the neighboring Northwestern Counseling & Support Services, which has since adopted its own smokefree policies.

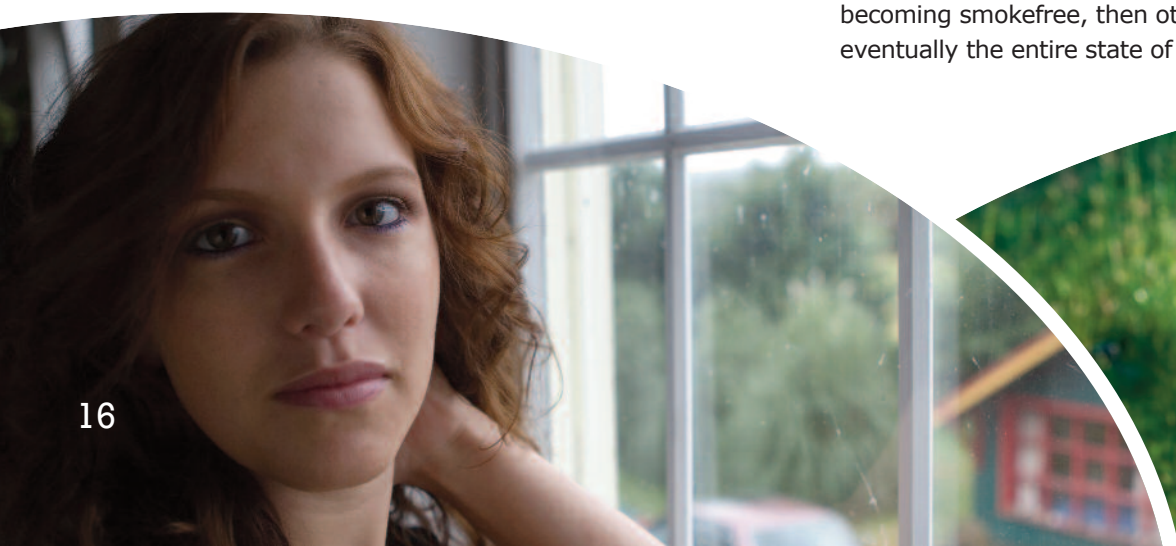
Ms. Brewer's work extends beyond the hospital setting and into other social service organizations, including a local women's shelter and a food bank. Priding herself on never taking no for an answer, she attributes her success on finding that common thread with potential partners to expand her community's smokefree movement one doorstep at a time. Having once spent two tireless years working to make a local park a designated smokefree area, Ms. Brewer doesn't give up easily and advises other advocates to do the same.

From Smoking Hub to Smokefree

Once known as the smokiest venue in town, the Arts Café has been the social hub of Moose Lake, Minnesota, for several generations. Romelle Jones inherited the family business after working alongside her parents for much of her young life. She vividly remembers working in the restaurant's kitchen as a young woman and looking out into the dining area and seeing a thick, cloudy haze of smoke. "That's just the way things were back then. It was normal," recalls Ms. Jones.

After both of Ms. Jones' parents died from lung cancer, she started to see things at the restaurant through a different lens and knew she wanted to make a difference. She saw an opportunity to make that difference when she received a call from the American Lung Association in Minnesota. The Lung Association asked her to support a local smokefree air ordinance by agreeing to make her restaurant smokefree and providing an example for other businesses in this rural area. Ms. Jones gave her support without hesitation, knowing her actions could prevent others from suffering the same tragic fate as her parents.

Leading up to the passage of Moose Lake's smokefree ordinance, Ms. Jones recalls people saying some "not very nice things" to her and warning her that the restaurant was sure to go out of business. She also happily recalls the many people who came in to thank her for taking a stand. She even noticed that old customers who had avoided the restaurant because of the smoke started to return. A few years later, Ms. Jones retired and sold her restaurant after enjoying its most profitable year ever. Proving smokefree laws are indeed good business, Ms. Jones' bold stand started a chain reaction that led first to her county becoming smokefree, then other counties, and eventually the entire state of Minnesota.



Tobacco control funding and efforts can't just be statewide, there needs to be a focus on making sure rural communities are included in the effort.

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Ms. Jones' experience is part of a larger and highly successful tobacco control movement in Minnesota that has helped to reduce the burden tobacco use places on the state. Since initial funding became available in 2000, youth tobacco use in Minnesota has dropped by 30 percent for high school students and 45 percent for middle school students. More recently, the Minnesota Department of Health's Tobacco-Free Communities in Minnesota (TFC) grant program awarded more than $3 million in 2010 and 2011 to support local grant efforts and American Indian tribes and organizations.[56] A total of 21 grantees throughout the state have been funded to reduce tobacco use and increase the number of tobacco-free environments in rural and urban settings throughout the state. The continued success of this movement shows that a well-planned and well-funded effort can reduce tobacco use and secondhand smoke exposure for both rural and urban populations.

Community Creates Unique American Indian Quit Smoking Program

The Americans with the highest smoking rates among all ethnic groups have been the least researched—and perhaps the least helped by smoking cessation efforts. It is a sobering situation—one that has challenged a team of tenacious experts to create a long-term public health strategy to help American Indians quit smoking, funded by the American Lung Association. Christine Makosky Daley, Ph.D. and Won Choi, Ph.D. of the University of Kansas worked through a number of barriers to create an effective smoking cessation program for American Indians, whose culture includes ceremonial use of tobacco as a sacred plant. Their program, All Nations Breath of Life (www.anbl.org), began with a request from patients at an Indian Health Service clinic who asked for a novel smoking cessation program that was culturally sensitive to American Indians.

American Indians, living throughout the United States in more than 500 tribes with unique customs, use traditional tobacco to welcome and honor guests, for blessings, as gifts, and as part of sacred ceremonies and powwows. The distinction between misuse of commercial tobacco and ceremonial use of traditional tobacco is just one of the cultural elements researchers must understand. "We realized right away that we couldn't modify existing smoking cessation programs for the general population or other cultures," explained Dr. Daley. "They all say 'don't use tobacco at all,' and we were working among a culture of tobacco. There is very little we know from a research perspective about that culture of tobacco, so we really needed to start at the beginning, understanding traditional use of tobacco as well as the fact that it is an economic mainstay on some reservations. We had to dive in and start something new."

Diving into that culture meant conducting community-based participatory research: including the community in all phases of research and program development, so that the program ultimately reflects the American Indians' culture and is a product of the community who will use it. After five years' research and pilot testing, All Nations Breath of Life presents a comprehensive smoking cessation program of group sessions, one-on-one phone counseling and pharmacotherapy of the individual's choice—all free of charge. The researchers are tracking the efficacy of the program and are learning about the personal impact on American Indians who have quit smoking. "One elderly gentleman had smoked for 40 years and would go to powwows but couldn't dance because he would get out of breath too quickly," said Dr. Daley. "After completing the program he could get out with his grandson and dance a two-day powwow without getting winded. Being able to get out there with his grandson was a huge event for him!"

Recommendations for Action

The disparities of tobacco use in rural communities not only harm the health and well-being of the current generation, but also perpetuate a culture that threatens future generations unless advocates for rural health and community members themselves demand that changes are made. The American Lung Association calls upon government agencies, the research and funding communities, health systems and insurers, community leaders, schools and families to take action now to cut tobacco's rural roots.

- The federal government should support programs such as those funded by the Prevention and Public Health Fund established by the Affordable Care Act, as a way of ensuring continuing progress in place-based community health in rural areas.
- States should dedicate funding for comprehensive tobacco control at levels recommended by the CDC, with a focus on resources allocated for reducing disparities, including in rural communities.
- State and local governments and employers should establish and enforce measures to protect the public from exposure to secondhand smoke.
- State and local governments and funders should invest in the public health workforce, including leadership development and specialized training on issues affecting rural health equity.
- The research community should focus attention and resources on identifying effective cessation treatments for smokeless tobacco use.
- Public and private insurers should include comprehensive cessation services with low copays or no copays as a covered benefit.
- Tobacco control coalitions and public health advocates should engage with the rural communities they serve to assess tobacco-related disparities, and plan and implement strategies to address them.
- School systems should adopt comprehensive tobacco-free policies that prohibit the use of all tobacco products by anyone, including students, staff, and visitors on school grounds or at school events, at all times.
- Families should protect their children's health by refusing to allow tobacco use in their homes and cars.
- Community leaders and families should reject the culture of tobacco use as part of life, and empower the next generation of their citizens to have healthy, tobacco-free futures.

This was always an issue about our children's health. It's a valuable lesson for anyone advocating for a tobacco-free community. How can anyone deny a child their fundamental right to live and play in an environment that does not threaten their health?

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Acknowledgments

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