community VOICES

Reducing Tobacco-Related Health Inequities

MDH | Minnesota Department *of* Health

Community Voices: Reducing Tobacco-Related Health Inequities

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Executive Summary

Minnesota has achieved significant success in tobacco prevention and control over the past two decades. Adult cigarette use is at a historic low rate and below the national average. However, certain Minnesota communities still suffer disproportionately from tobacco-related death and disease.

To address tobacco-related inequities, the Minnesota Department of Health (MDH) sought to identify tobacco prevention and control-related opportunities and priorities among groups most disparately impacted by commercial tobacco[1] use and secondhand smoke exposure. In coordination with partners, we facilitated a series of community-specific, in-person input sessions, interviews, and a stakeholder survey to learn about tobacco-related threats and how they may be addressed. These findings will provide insight for Minnesota's communities and tobacco control funders and partners and be integrated into statewide tobacco prevention and control efforts.

Key findings and opportunities for action

Tobacco use is a deeply embedded social norm in many communities. Often, tobacco products are widely available, easily accessible, and marketed to target specific communities.

When tobacco use is so prevalent, it is viewed by many to be a social norm rather than a significant problem. Tobacco use and smoking are social activities which create a place of belonging. Largely because of the social aspect of tobacco use, community members may find little support – or even active discouragement – from peers when they decide to quit, or even begin thinking about quitting.

OPPORTUNITIES FOR ACTION: Prioritize and intensify efforts among communities most impacted by the harms of tobacco use. Tobacco control work must address social norms and the underlying reasons why people use tobacco. Additional community-specific funding is needed to sustain the tobacco control successes made so far, as well as to reach the communities that have seen less progress.

Reduce the availability and accessibility of tobacco products, especially where youth and priority populations are being targeted. Incorporate initial and ongoing assessment into program efforts to identify areas of particular concern. Incorporate information about tobacco industry targeted marketing in outreach and educational efforts.

Tobacco use is often seen as a lesser threat compared to other issues that are reported as more serious or imminent.

Tobacco use is often seen as being a less serious problem than other stressors communities face, especially issues related to social determinants of health (e.g., structural racism, poverty). Smoking cigarettes is at times viewed as an immediate way to deal with the daily stress brought on by other concerns.

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[1] All references to "tobacco" refers to commercial tobacco products (cigarettes, cigars, chew, etc.) and not tobacco used for spiritual or ceremonial purposes.

OPPORTUNITIES FOR ACTION: Acknowledge how social determinants of health and other socioeconomic factors contribute to tobacco use. Improve communication between MDH and community members related to the unique social, cultural, and environmental factors that need to be considered in community-specific program efforts. Integrate ongoing community engagement into program efforts.

Increase opportunities for integrating tobacco-related activities with other high priority areas, existing services, and health initiatives. Meet community members where they currently engage with service providers and where they may be more receptive to receiving information.

Communities are best suited to identify and address their own tobacco-related needs and priorities.

Within each community, there are community-based organizations that represent the people they serve and are in tune with community needs. Many are embedded within the community but are not necessarily working in tobacco control; these organizations are in a unique position to address tobacco and cessation needs, but may not currently be working in tobacco.

OPPORTUNITIES FOR ACTION: Use asset-based approaches to leverage community strengths. Community members are best suited to identify and capitalize on their unique strengths and cultural contexts. Funders, working in partnership with community leaders and organizations, should build upon those strengths and provide the resources needed to capitalize on them.

Support and integrate advocacy and capacity building, especially within priority populations. Create opportunities to strengthen the leadership capacity of community-based organizations and community members to participate in and lead advocacy efforts.

When quitting, community members wish to use services that are provided by members of their own communities, which are not necessarily available.

Community members most often seek the support of family, friends, and faith communities when quitting. Barriers, such as a lack of health insurance, prevent healthcare providers from playing a greater role in cessation. Community members do not perceive quitlines to be culturally relevant. Culturally based community-based organizations are generally not involved in tobacco work. Because cessation services are often not provided in an appropriate language and cultural context, community members do not generally use them.

OPPORTUNITIES FOR ACTION: Work directly with community members to identify needed resources and services. Create opportunities for community members to identify what is needed, as well as how to promote existing services and resources in the most effective, appropriate manner.

Expand and integrate cessation activities into existing services and community networks. Identify opportunities for community-based organizations to provide linkages to cessation services. Community-based organizations and community leaders should be tapped into to create an infrastructure that can be used to promote and provide services within communities. Cessation efforts should be paired with other services that organizations are providing, and could be linked to more relevant or compelling areas of interest, such as addressing racism or feminism, when appropriate.

There is a shortage of culturally specific and language-appropriate tobacco-related outreach and education efforts and services, which contributes to misconceptions about tobacco. Culturally relevant and peer-to-peer messaging is most effective.

Resources developed for one community may not be relevant or culturally effective for others. In many cases, community members are not aware of the harms of tobacco, have misconceptions about its relative safety, or perceive tobacco to be not as impactful to their community as other, higher-priority issues.

OPPORTUNITIES FOR ACTION: Work directly with communities to develop and incorporate culturally relevant messaging and other communication strategies. Messaging efforts must be led by communities to ensure relevance. Community engagement, outreach, and education efforts should be sustained, ongoing, incorporated into all tobacco control efforts, and customized for unique communities.

Community-based organizations experience significant barriers in the grant process that funds much of Minnesota's tobacco work.

Participants suggested that current processes be adapted to be more user friendly for small organizations. Smaller organizations are positioned to have significant impact on the people they serve, but often lack the resources needed to secure funding.

OPPORTUNITIES FOR ACTION: Fund community-based organizations to work directly with community members and build community capacity. Develop grant criteria that allow community-based organizations to be competitive, and offer education and technical assistance to enhance competitiveness and strengthen capacity. Create longer-term funding opportunities for sustained efforts, and allow flexibility for grant program activities and outcomes.

Overarching conclusions and recommended actions

Upon completion of the community input process, the project's advisory committee reviewed the findings and developed a number of conclusions and recommendations:

- Use a health equity lens in all tobacco prevention and control work. This lens should include consistent use of several questions that address who is involved in advocacy and decision making.
- Tobacco prevention and control should be framed as a social justice issue, taking into consideration the continuum of tobacco use, as well as the multiple determinants of tobacco use.
- Relationships between MDH, other funders and community partners must be strengthened. These enhanced partnerships can promote mutual capacity building and opportunities to learn with, and from, each other. Sharing power with community-based organizations can provide them with the tools, training, and investment of resources needed to increase leadership and advocacy skills.
- There is also a need for both an increase in overall funding for tobacco prevention and control, as well as funding for community-based organizations to do the work within their own communities. Funding opportunities should provide flexibility for programs to be designed and implemented with input from communities that recognizes and maximizes their strengths.

Introduction

Minnesota has achieved significant success in tobacco prevention and control over the past two decades and adult cigarette use is now at a historic low rate of 14.4 percent, down from 16.1 percent in 2010 and 22.1 percent in 1999.[2] However, while the overall use rate has declined over these years for all populations, substantial tobacco-related health disparities and inequities remain.

The Minnesota Department of Health (MDH), as part of an intentional focus on achieving health equity, initiated this community input process to identify and address tobacco-related disparities and inequities in Minnesota.

Project purpose and goals

The purpose of this project was to identify tobacco prevention and control-related opportunities, priorities, and needs among groups most disparately impacted by commercial tobacco use and secondhand smoke exposure. These groups, hereafter referred to as *communities*, are defined by several unifying features, including geography, race and ethnicity, age, and sexual orientation and gender identity.

We heard directly from stakeholders working to improve community health to learn about:

- Strengths and opportunities in disparately impacted communities related to tobacco prevention and control;
- Community-specific tobacco-related challenges, issues, and concerns; and
- High-priority tobacco prevention and cessation strategies, especially for those who are disparately impacted.

In the context of this project, we use the terms *stakeholder* or *member* to include the individuals who are from or work closely with the disparately impacted communities, can speak to their unique and individual strengths, barriers, preferences, and needs, and are knowledgeable about tobacco prevention and control.

This input process will:

- Contribute to the Minnesota Comprehensive Tobacco Control Framework;
- Guide the direction of the Tobacco-Free Communities (TFC) grant program;
- Support long-term planning for the MDH's tobacco prevention and control work plan;
- Influence tobacco work as a part of the Statewide Health Improvement Program (SHIP) and other MDH tobacco-related initiatives; and
- Provide insights and information for communities, partners, and other funders.

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[2] 2014 Minnesota Adult Tobacco Survey

Note: the focus of this project was on commercial tobacco, including cigarettes, cigars and cigarillos, shisha, smokeless tobacco, and e-cigarettes, *not* traditional tobacco that is used for spiritual or ceremonial purposes.

Advancing health equity

The *2015 MDH Strategic Plan* identifies health equity as the central challenge facing state, local, and tribal health departments in Minnesota and across the nation and calls for the integration of three practices into all work being done by MDH:[3]

- Expanding our understanding of what creates health;
- Strengthening the capacity of communities to create their own healthy future; and
- Implementing a 'health in all policies' approach with health equity as the goal.

The purpose of this input process aligns with our overall goal of advancing health equity. Strategies for moving forward that include (1) changing systems, structures, and policies that perpetuate inequities and structural racism and (2) listen authentically to and partner with communities.[3]

This input process also builds upon the recommendations identified in *Advancing Health in Minnesota,* a 2014 report to the Minnesota Legislature, and supports our commitment to engage communities.

Building on previous engagement efforts

From 2013-2014, MDH conducted a community input process with the Minnesota American Indian Community for the purpose of listening to and identifying the needs of communities, and improving design of the grant making model for American Indians in Minnesota.

We used the recommendations from the Stakeholder Input Process American Indian Community (SIPAIC) Project to inform its grant making processes, which are aimed at implementing practice-based and culturally appropriate commercial tobacco prevention and cessation and obesity initiatives through the Tribal Tobacco and Tribal SHIP grants.

The SIPAIC Project laid the foundation for engaging, listening, and responding to the needs of communities by incorporating findings and recommendations from these processes into our programs and how we work with the communities we serve.

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[3] http://www.health.state.mn.us/about/strategicplan.pdf

Methodology

This project was directed by MDH staff and carried out by The Improve Group and DeYoung Consulting Services, in coordination with an advisory committee and the many participating community stakeholders.

Identifying disparately impacted communities

We used data to help identify populations with tobacco-related disparities and determine from which communities to gather information.

Tobacco-related disparities are based on characteristics that include, but are not limited to, race and ethnicity, sexual orientation and gender identity, income and education, age, geography, and mental health. The following communities were identified for participation in this process:

- African American
- American Indian
- Asian American, including Hmong, Lao, Karen, Vietnamese, and Cambodian
- East African
- Youth and adults residing in Greater Minnesota
- Hispanic or Latino
- Lesbian, gay, bisexual, transgender, and queer (LGBTQ)
- West African
- Youth and young adults residing in the Twin Cities metro area

Additional communities and data sources

While tobacco use disproportionately affects lower-income and less-educated communities, information was not gathered from these groups, in particular. However, stakeholders consistently identified the impact of income and poverty on tobacco use in their communities.

People with mental illness and people with substance use disorders are also disproportionately affected by tobacco. However, to avoid duplication of data collection efforts among these populations, they were not included in our community engagement efforts. Rather, findings from the October 2015 Minnesota State Leadership and Policy Academy Summit, which developed a state action plan to reduce smoking prevalence among people with mental illness and substance use disorders, are included in Appendix A.

Findings and recommendations from the SIPAIC Project[4] will be used in conjunction with American Indian-specific information collected as part of this project.

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[4] This project included nine American Indian Tribes in Minnesota, two urban Indian organizations, the Great Lakes Inter-Tribal Epidemiology Center, and MDH. To avoid duplication, our repot did not focus on individual Tribal communities.

Identifying stakeholders

A stakeholder analysis process was used as an inclusive and purposeful way to select participants; it helps identify individuals to include and provides a clearer understanding of their connection to tobacco prevention and control work. Additionally, a participatory process can help us further enhance an organizational culture that supports evaluative thinking and practice, while also engaging stakeholders in a meaningful way.

The key question driving the analysis process was: *Who are the individuals and organizations that have a stake or interest in, or power to influence, MDH's efforts to obtain input on tobacco prevention and control-related opportunities and priorities from communities disparately impacted by tobacco use?*

We joined several external partners in using a power and interest grid (shown in Appendix B) to identify stakeholders, their varying levels of interest and power to influence the project, and their motivation and capacity (resources, knowledge, or skills) that they bring to the issue.

The results were used to create our initial stakeholder contact list. Additional community stakeholders were identified on an ongoing basis throughout the project.

Creating an advisory committee

We established an advisory committee to offer guidance and subject matter expertise to inform this process and community engagement efforts. Committee members were knowledgeable about tobacco prevention and control, could offer perspectives on community engagement, health equity, and strategic approaches, and represented or served communities facing tobacco-related disparities. The advisory committee:

- Reviewed the stakeholder list and outreach plan and offered guidance for gathering community input that was inclusive, respectful, and as effective as possible;
- Assessed protocol questions for content, tone, and comprehensiveness; and
- Reviewed community stakeholder feedback and offered insights to help craft recommendations.

The advisory committee provided additional feedback and recommendations that were high-level and broader than could be directly tied to the input findings. These recommendations are highlighted separately at the end of the Findings Section.

Collecting input

Input was collected using several methods, including:

- Focus group-style regional grantee meetings.
- A series of in-person group sessions with community stakeholders and individuals working in tobacco prevention and control or community health.
- An online survey.
- Community stakeholder interviews.

Multiple forms of participation were used to expand our reach and allow all interested parties to participate, while also providing the depth and specificity of information needed to fulfill the goals of this project.

In-person group sessions and interviews

We used existing MDH-organized meetings with grantees from TFC, SHIP, and other grant programs. These meetings allowed us to gather input from local public health agencies and community-based organizations working in tobacco prevention and control in Greater Minnesota, as well as to pilot the project's protocol questions (see Appendix C). We conducted input sessions during four regional meetings in July 2015 and one in October 2015. In total, 62 participants contributed through these meetings.

Community-specific input

Upon completion of the stakeholder analysis and with the addition of stakeholders from our networks, select contacts from each stakeholder group were identified as potential partners. Partners helped coordinate and facilitate sessions, promoted the online survey, depending on the partners' needs and preferences, and extended invitations to participate to appropriate connections within their networks.

In total, 252 stakeholders participated in group input sessions, and 12 in phone interviews. Appendix D includes a full list of community-specific participants, by method. While the same protocol was used for interviews and input sessions, separate protocols were used for sessions that included adults and youth. Both protocols are available in Appendix C.

Twin Cities metro-based stakeholders, as well as those located within a reasonable traveling distance from greater Minnesota, were invited to participate in community-specific input sessions. To reduce the travel burden and accommodate for a lower geographic density of potential participants, all stakeholders who were too far to drive to an in-person input session were sent an invitation to participate in the online survey.

All participants were asked to help identify additional informants who could participate in upcoming input sessions or interviews. Interviews were conducted with community stakeholders who were identified as being particularly knowledgeable, but were unable to attend input sessions. Input from stakeholders of individual communities was pursued until connections had been exhausted.

Finding individuals who were able to speak about community-specific needs and considerations, while also having expertise in tobacco, was challenging. Accordingly, the number of individuals participating in input sessions varied by community; opportunities to include additional key informants through interviews were pursued, when available and if necessary, to gain additional community-specific input.

Online survey

The online survey presented the same questions as the in-person input sessions and interviews. The survey was accessible from the MDH website and its URL was shared with all project stakeholders and participants, and we encouraged all participants to further share the survey link to members of their

networks who could speak to tobacco-related issues and were interested in sharing feedback. The survey collected input from 88 respondents.

Analysis

Dedoose, qualitative analysis software, was used to code interview and group notes and survey responses by question topics and emerging themes. We analyzed data across all community groups and input sources, as well as for particular themes that emerged within individual community groups.

Reading this report

Findings in this report are organized by major topics including, community assets; social, cultural, and environmental factors; tobacco-related threats; barriers to reducing tobacco use and secondhand smoke exposure; strategies for reducing tobacco use and secondhand smoke exposure; culturally relevant cessation and community services; and cessation strategies: how community members seek help with quitting.

Findings are presented as statements, followed by a narrative summary of the evidence supporting each finding. In most cases, examples of participants' comments supporting the findings are provided following the narrative summary. Quotes are not necessarily verbatim, but written to reflect participants' words as closely as possible.

Opportunities for Action are identified following the supporting findings and were co-created by MDH staff, evaluators from DeYoung Consulting Services and The Improve Group, and the advisory committee. The *Opportunities for Action* are directed towards the Minnesota tobacco prevention and control community, including MDH, other funders, and organizations working towards reducing commercial tobacco use and secondhand smoke exposure in Minnesota.

A note on language

Input was collected through online surveys, phone interviews, and a series of focus group-style meetings with community members and people closely involved in tobacco work. Thus, community-specific findings may have come from one source, or a combination of sources. Accordingly, all participants, no matter the format in which they contribute, will be referred to as community *members* or *stakeholders*, unless further specificity is required.

To respect the American Indian use of traditional tobacco, all references to "tobacco" refers to commercial tobacco products (cigarettes, cigars, chew, etc.) and *not* tobacco used for spiritual or ceremonial purposes.

Findings

Community assets

In the broader discussion of health disparities and health equity, the focus often reverts to the gaps within communities. While it is important to understand what disparately impacted communities lack because of socioeconomic circumstances, it is also important to note that these communities have assets that can be leveraged to meet their own needs.

Proponents of an "asset-based" approach to community development Kretzmann and McKnight[5] suggest that outside resources, such as grants, can be used more effectively if the community is actively engaged in using their own skills, abilities, and resources to address the challenges they experience.

To that end, input session participants offered a number of community strengths that can be leveraged.

Communities are best suited to identify and address their own tobacco-related needs.

Within each community, there are community-based organizations that represent the people they serve and are in tune with community needs. Many are embedded within the community but are not necessarily working in tobacco control; these organizations could help design programs that fit the unique needs of the people they serve. As one Latino community stakeholder said, "the community knows more about themselves than anybody else can tell them about themselves." Representatives from these organizations may also be able to advocate for policy change more effectively or through different capacities than public health or healthcare agencies.

> *"Another community strength is [that] any nonprofit is run by [a] board. Board members have a lot of experience and are a lot more stable than program people. If we ever really wanted to, we could use some of the strengths of the boards that run the Urban League, or the Somali Confederation. We haven't tried that but it is doable. It's a strong part of any nonprofit organization. At least in the AA community, the history is ripe enough with organizations that have done interventions, it's not that they couldn't learn tobacco control." – African American Interviewee*

> *"Community assets – many non-profits are involved in the food deserts. If we add one more layer to the work already being done, it may be easier than creating something." – Latino Interviewee*

Additionally, each community has leaders, inside or outside of these organizations, who can serve as champions for the tobacco control cause. Asian American, American Indian, East African, and Latino community members talked specifically about the importance of engaging faith leaders in these efforts.

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[5] Kretzmann, John P. and McKnight, John L. 1993. Building Community from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets.

"Multiple avenues – one with executive directors that lead their own organizations within the Asian Pacific Islander group; there are multiple organizations that need to be involved. Second, the ethnic-specific churches – Hmong, Vietnamese churches and temples – they each have their own place of worship or community gathering and settings. That's where I can see an opportunity for engagement. Thinking about the Laotian community work on cancer, they gathered hundreds of community members to have the Masonic Cancer Center director gave a 101 about how it's impacting communities; it was so well attended. Sessions where people can ask questions on behalf of their families, it could be a similar model for tobacco. Not just reaching professionals, but ordinary folks and families." **– Asian American Session Participant**

"Community people have more influence – religious leaders, community activists. If you direct them, they will lead the community." **– LAAMPP Fellow[6] Session Participant**

"Another point, we learned having identifiable community people as messengers – having people within community that sort of become champions or spokespeople for whatever cause we're talking about has been critical. Messenger is a key component, having native people deliver messages to native community – but having them be respected within community is also key. Within, doesn't have to be an official position, official title of leadership – a lot of people that we call 'informal leaders' with respect." **– American Indian Session Participant**

> **OPPORTUNITY FOR ACTION**: Use asset-based approaches to leverage community strengths.
>
> Each community has its own unique strengths and cultural contexts; community members are best suited to identify and capitalize on those strengths. Funders, working in partnership with community leaders and organizations, should build upon those strengths and provide the resources (funding, training, and mentoring) needed to capitalize on them. Cultural context and social structures must be considered when engaging community leaders and community members.

Youth engagement is essential.

Community members noted that adults and elders can provide youth with the education they need about tobacco use, but youth were also identified as a community asset and can serve as educators for their peers. Youth are very influential with policymakers and community members, have peer-to-peer influence, and should be engaged in tobacco control efforts.

"Lots of tribes in Minneapolis, elders from different tribes that need to impact the children. Such important people that can come and teach the children, but they need money and availability to bring them in. Here in Minneapolis, so many tribes – not just Ojibwa and Dakota – need to teach the children. Tribes use sacred medicines differently; kids need to hear the oral history from the people, to be able to understand." **– American Indian Session Participant**

"Back to hiring on more youth too, to be youth-led, to show the faces of who we are trying to educate. Getting them jobs, to be youth led, see the faces that they're trying to show. Therefore,

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[6] In September 2015, MDH facilitated a discussion with ClearWay Minnesota's℠ Leadership and Advocacy Institute to Advance Minnesota's Parity for Priority Populations (LAAMPP) Fellows. This group of Fellows includes members of the African and African American, American Indian, Asian American and Pacific Islander, Latino, and LGBTQ communities.

you have to go into schools. Get the faces of who you're advertising to. Hire people, get the youth involved, they listen peer-to-peer. We can teach and preach, but youth listen to youth at the end of the day. They're the faces, they're the leaders." — **African American Session Participant**

"… youth are powerful messengers, too. Young people interested in arts and media, integrating those types of strategies for them to craft messages that have that skill, real opportunity right now. Combination, youth to youth and community leaders to youth. Having a conversation focused on health – state-wide community gathering, focused on generational connections, critical conversations between adults and youth, the generational knowledge transference, connection between elders and youth." — **American Indian Session Participant**

OPPORTUNITY FOR ACTION: Incorporate youth engagement in tobacco control efforts.

Peer-to-peer messaging models are particularly effective. As school-based tobacco education becomes more limited, additional efforts to continually engage and educate youth should be prioritized. Engaging and educating youth contributes to strengthening the capacity of the community. Youth can be influential with decision makers as well as family and peers.

Social, cultural, and environmental factors

Our convening of community-specific groups uncovered a number of shared social, cultural, and environmental factors that cut across communities. But the individual gatherings also provided an opportunity to discuss the unique characteristics of communities, and the individual factors that should be taken into consideration when doing tobacco work with them.

While communities share many common traits, needs of subgroups must be considered.

Culture, behavior, and needs of population subgroups can vary. Some communities (particularly Asian American and LGBTQ) emphasized the importance of acknowledging the subgroups within the broader cultural community and tailoring efforts, including cessation services, to each group's culture and tradition.

A key to understanding these differences and tailoring programs and services, is community-specific research. There is little to no data on the policies and programs that work for each community. Data that is collected should be collected in such a way that it can be disaggregated by population subgroup.

"I think it's going to take so many different strategies, which is the challenge for the American Pacific Islander community; we're so diverse in cultures and traditions. It's a great challenges." *we almost need studies in each specific group, to see what particularly is needed, who exactly are the smokers? May be different between ethnic groups."* — **Asian American Session Participant**

"The data needs to be improved; see how the health equity works out. With these interventions, we need more and better data so we understand the impact of these policies on different communities. The overall smoking rate doesn't acknowledge our communities." — **LAAMPP Fellows Session Participant**

Attention should be paid to cultural differences. For example, Asian American and East African community members talked about the role of women in the community and the stigma associated with smoking. Outreach and cessation efforts should consider this cultural nuance.

> *"… it was more culturally acceptable that men could smoke outside or indoors. Women smoking was kind of a taboo; they're the leaders of the house, nurturing, but also they have a high status in the community. For a woman, it was looked at more negatively if a woman is smoking. They're both bad, but for woman it may be more embarrassing. Things have shifted, so now women do smoke, but it's mostly not in public. It's indoors, in apartments, more private. That's bad because it'll be indoors, in apartments, in front of kids. That affects more people."* – **East African Session Participant**

> *"For the women that do smoke, who are Asian American, there is a stigma that women are not supposed to do this. Maybe offer cessation in ways that are safe and confidential, and that they know that it is confidential, would help. Many people smoke behind their spouse's backs. Reach out in a way they feel safe to come into a support group or whatever."* – **Asian American Session Participant**

Closely related, one Asian American session participant said that, given the hierarchical structure in their communities, particular attention must be paid to the example of male leaders.

> *"A lot of our cultures are still very patriarchal. The men still wear the pants. That's a huge barrier for many health aspects – not just tobacco, but breast exams, screenings, needing permission – going back to engaging community leaders and elders, many are men. Have the conversation with leaders; we haven't done that enough to create opportunity to engage people."* – **Asian American Session Participant**

Latino community interviewees talked specifically about adherence to traditional cultural values and the role these values play in youth tobacco influence.

> *"What we found in the curriculum is that previous research identified traditional culture and values as a protective resource. It is possible that children of parents whose adherence to traditional values is low would benefit from culturally grounded intervention."* – **Latino Interviewee**

OPPORTUNITY FOR ACTION: Customize outreach and education efforts for each unique community.

One-size-fits-all outreach and cessation efforts are not effective. Consideration should be given to the cultural contexts of specific groups, such as gender dynamics. Additionally, supporting programs that emphasize traditional cultural values may decrease the number of youth who start smoking.

OPPORTUNITY FOR ACTION: Collect community-specific data and incorporate findings into culturally appropriate program development and services.

Culturally appropriate programs and cessation services require culturally specific data. In partnership with community groups, more community-specific research is needed to inform tobacco prevention and control efforts. Data collected should be disaggregated by population subgroups whenever possible.

Culturally relevant and peer-to-peer messaging is important.

Community stakeholders emphasized the need for culturally relevant messaging. In order to ensure relevance, members of specific communities must be involved in crafting messaging and outreach strategies geared towards their own communities. While there was little consensus about the best approach for messaging (for example, what it should include, and how it should be delivered), a common thread between community members and across groups was self-creation and delivery.

Culturally relevant messaging should include messages that resonate with community members and reflect what each community is most affected by and cares about most. Most community stakeholders agreed that messaging that includes short-term tobacco concerns (for example, financial aspects, diabetes, or asthma) may be more relevant than those that focus solely on long-term effects (for example, lung cancer).

> *"Having people within [the] community that sort of become champions or spokespeople for whatever cause we're talking about has been critical. The messenger is a key component, having native people deliver messages to native community. But having them be respected within community is also key."* – American Indian Session Participant

Youth and young adults relate more to peers speaking candidly about their experiences, rather than fear-based media.

Youth explained that the anti-tobacco messages they have seen featuring older adults suffering through health consequences related to tobacco use are not effective; youth are too far removed from worrying about their health as an older adult, and resonate more closely with peer-to-peer discussions and candid conversations.

Multiple strategies should be used to reach youth at school, including school assemblies, health classes, and posters throughout the school. Youth also mentioned using other places where they congregate, such as sporting events or libraries. Several youth shared that having older high school students discuss tobacco use with younger students, including examples from their own lives, may make a lasting impression.

> *"Friends telling friends… that's where we learn all of our habits. Friends are the biggest peer pressure, that's why everyone starts smoking, and that's what they need to quit. You learn it from your friends, if they tell you not to, or older kids telling younger kids in the schools, what they've learned."* – American Indian Youth Participant

> *"[It would be] best to bring someone into a classroom or something, explain what happened to them, how they became addicted. Kids will ignore the commercials with an old man talking about what happened to him, but bring someone to talk about it, let them ask questions in school. [That] will have a bigger impact."* – Urban Youth Session Participant

> *"Encourage your friends not to use it. Stick it in their heads so they won't do it, just like a commercial. If you see a commercial a bunch, they won't do it. Friends telling friends it's cool not to smoke."* – American Indian Youth Session Participant

Social media may be an effective means of reaching youth, but is likely not as effective as face-to-face interaction.

Youth and young adults generally agreed that social media may be an effective way to message to youth. Most agreed that Facebook is not the best option due to infrequent usage among young people and the low likelihood that youth would stop and read the desired information. Youth suggested other social media options which may be more captivating; for example, including content in Snapchat stories, advertising on YouTube, or having celebrities such as pro athletes, musicians, or actors post on Instagram.

Overall, youth were confident that face-to-face interactions are more effective than social media.

> *"Facebook might not be that good. Like, if you see something that's not interesting or is boring, or about not smoking when you like to smoke, you would just scroll by it and not even read it."* **–**
> **Urban Youth Session Participant**

> *"Anti-tobacco ads right now are mostly serious, people don't pay attention. They don't want to see that, they tune it out. To get attention, it needs to be more appealing. If you see it on social media, you'll scroll right by if it doesn't look good. Needs to be more appealing to watch."* **–**
> **Urban Youth Session Participant**

OPPORTUNITY FOR ACTION: Work directly with communities to develop and incorporate culturally relevant messaging and other communication strategies.

Messaging efforts must be led by communities to ensure relevance. Community engagement and outreach efforts should be ongoing and embedded throughout program work. Community feedback should be collected and incorporated into messaging and messaging strategies.

OPPORTUNITY FOR ACTION: Incorporate peer-to-peer outreach and education into tobacco control work.

Tobacco-related threats

The health-related dangers of tobacco use and exposure have been, in most cases, largely studied and documented; on an individual level, these risks span culture and community. Accordingly, in community-specific conversations, we asked stakeholders to describe what they see to be the greatest tobacco-related threats specific to their communities. While many did discuss health consequences and overall high rates of tobacco use as threats, the following findings are related to the threats that are more specific to the communities included in this report.

Tobacco use is a deeply embedded social norm in many communities.

The communities included in this report are disproportionately impacted by tobacco use and secondhand smoke exposure; accordingly, many community members explained that because tobacco use is so prevalent, it is viewed by many to be a social norm, rather than a significant problem that needs to be mitigated. This is especially true in communities with the highest prevalence rates, including the American Indian and LGBTQ communities. Pervasiveness of tobacco use in communities leads to

increased opportunities for youth to access products, and an increased likelihood that parents, siblings, or other family members will allow youth to smoke and provide them with cigarettes.

"People see their families doing it. It becomes an addiction. Like if your parents drink coffee, you start drinking coffee. If you're around them smoking cigarettes, you'll start smoking cigarettes." **– American Indian Youth Session Participant**

"[Youth] prefer cigarettes because it's the norm, [and they] can get them from friends. It's easy access. Cigarettes are really common within the community in general [and] families." **– American Indian Youth Session Participant**

"A person's identity as LGBTQ is so wrapped up in their identity as a smoker and drinker. They came out as a smoker. People come up to us [when we are sharing information] at Pride, and they're really angry and say, 'all gay people smoke. Get over it!'" **– TFC Grantee Session Participant, Minneapolis**

Tobacco use and smoking are social activities which create a place of belonging.

Tobacco is often used for the social aspect of belonging and for the perceived stress relief. This is especially true in the LGBTQ Community, where stakeholders described smoking circles as being a place where queer people, especially youth, facing discrimination can find comfort and belonging. Additionally, many LGBTQ community-specific social events take place in bars and clubs, or are based around bar culture. These are places where outdoor smoking areas are readily available and tobacco use is socially acceptable; stepping outside to take a break and smoke a cigarette is seen as an opportunity to socialize, build relationships, and get to know peers.

Stakeholders explained that, largely because of the social aspect of tobacco use, community members may find little support – or even active discouragement – from peers when they decide to quit, or even begin thinking about quitting. Relatedly, community members reported that there is a reluctance to quit when friends and families also smoke, as they do not want to be excluded from smoking circles, or will miss the social time spent outside smoking.

"There's a loss of community when people try to quit. A lot of queer culture is based around bars, spaces where smoking is a social point… it's hard when you're already a person of a marginalized identity already to choose to isolate yourself further by removing yourself from the social situations where smoking is the norm." **– LGBTQ Session Participant**

"For queer kids, it's about finding a place where they can belong. Maybe [they are] separated and ostracized, discriminated against in the school… but they can go outdoors with anybody that smokes and have a cigarette and belong." **– LGBTQ Session Participant**

"As a non-smoker, there aren't areas to go to just [stand and have a conversation at clubs]. Or you can go and hang in the smoking area just for the social aspect, but you're exposed to secondhand smoke." **– LGBTQ Session Participant**

"In a group that I connect with, if someone says, 'I'm going to quit' the group will be suspicious. But if they say they are not trying to quit they will react in a more positive way." **– Latino Interviewee**

Community leaders and role models, especially in the LGBTQ and American Indian communities, often use tobacco themselves.

Stakeholders explained that community leaders and role models in their communities often smoke, which in turn facilitates normalization. While this may be true in all communities with persistently high rates of use, stakeholders in the American Indian and LGBTQ communities expressed this challenge specifically.

In American Indian communities, tribal leaders are visible and integral to community decision making; often, their use of commercial tobacco products reduces momentum for efforts to make community gatherings, celebrations, and powwows smoke free. Similarly, LGBTQ participants shared how mentor/mentee relationships are valued in the community and if mentors smoke, it may, in turn, influence mentees to smoke, as well.

> *"There seems to be this phenomenon of people doing work with youth and adults are themselves smokers, so it's a negative and positive role model in one; this person that I admire and aspire to be – an adult, who was once a LGBTQ youth like me – is also a smoker… it normalizes what it means to be an adult in the community, and that it is so pervasive is incredibly normalizing."* – LGBTQ Session Participant

> *"Denial among tribal leaders that we have a problem [is a threat]. Some of that is because they themselves are smokers. Frankly, six out of ten are smoking; it's not like in the majority community where it's two out of ten… and, it's easy to see the problem. If six out of ten are smoking, where do you even start?"* – American Indian Session Participant

> *"A lot of the leadership in tribal communities do use commercial tobacco, so policies aren't getting discussed, passed, or enacted. The tribal leaders don't want to keep hearing the negative."* – American Indian Session Participant

Many recent immigrant communities come from countries where smoking is prevalent and affordable.

Stakeholders from the Asian American and Latino communities, in particular, discussed how the prevalence of tobacco in their home countries contributes to persistent use and exposure in immigrant communities. In many cases, home countries lack tobacco control efforts; accordingly, tobacco products are much more readily available and affordable, and there are few limits on areas where smoking is permissible. In some cases, it is not uncommon to give cartons of cigarettes as gifts at birthdays, holiday events, or funerals.

> *"I see newer arrivals to Minnesota with a higher rate of smoking; they bring that culture of smoking back with them. For example, I lived in Korea for a year and it's so much more prevalent there – maybe 50% of males smoke – it's common to smoke in the office, there [are] no cessation [services]… I started getting into it because it was all around me. I brought it back to America, and it took me a while to stop smoking when I got back."* – Asian American Session Participant

"More on the cultural piece… in our countries there are not rules like there are here, for example, no smoking restaurants or building areas. That is not us… They don't care as much." — Asian American Session Participant

"For the adults the lack of social support is problematic. There is more negative support [to keep smoking]. The expectation of their peers is that we do it back home; we can do it here… One needs to go out of the way to quit." — Latino Interviewee

OPPORTUNITY FOR ACTION: Prioritize and intensify efforts among communities that are most impacted by the harms of tobacco use and secondhand smoke exposure.

Tobacco control work must address social norms and the underlying reasons why people use tobacco. Funding should be made available to address tobacco issues in these communities. Additional community-specific funding is needed to sustain the tobacco control successes made so far, as well as to reach the communities that have seen less progress.

High rates of tobacco use in communities increase exposure to secondhand smoke.

Smoking as a social norm, coupled with a lack of information related to the harms of secondhand smoke, increases community members' exposure to secondhand smoke. People are more likely to smoke in homes and vehicles, and in front of children and other community members.

"We see a lot of smoking in cars, smoking in houses, they think that smoke will damage your house, but if you stand next to a family member smoking, they don't see that as a problem. If they smoke next to you, they don't know it's a problem." — East African Interviewee

"Exposure to secondhand smoke [is a threat] because [if you have] relatives and parents that smoke you can't get away from them. Babies don't have a choice, young kids can't get away from it. Anyone can be exposed to it, even children." — Greater Minnesota Youth Session Participant

In Asian American communities, exposure to secondhand smoke is amplified by a reluctance to ask community members to smoke elsewhere.

Asian American community members shared that, in their communities, smoking is a regular social activity. However, what was described as the "culture of saving face" reduces the likelihood that nonsmokers will ask smokers to not smoke in front of them, or the likelihood that they will remove themselves from secondhand smoke in social situations.

"The culture of saving face – we don't tell people to leave the room, or if they smoke they have to step aside. People smoke, come into a circle of nonsmokers and you can't say a thing. The interaction for smokers and nonsmokers creates a tremendous impact for non-smokers and secondhand smoke." — Asian American Session Participant

"We love to be silent. That is the reason – why do we care about what they do? We care about ourselves, blame ourselves, because I do this, that's why it costs me almost my life." — Asian American Session Participant

East African communities are experiencing an increase in exposure to secondhand hookah smoke.

East African community members explained that hookah smoking has become a regular social activity for community members, but that community members do not necessarily understand the health consequences of smoking shisha, or exposure to the secondhand smoke from hookah. Misperceptions of the safety of hookah smoke are largely due to the fruit flavoring being seen as a healthy alternative to cigarettes, and a lack of hookah-specific education efforts. Community members regularly gather in homes and apartments to smoke hookah as a social activity, often times exposing children to secondhand smoke.

> *"Secondhand smoke for the children, people don't know not to smoke it in front of their children. They're in small, one or two bedroom apartments, it's a social activity involving hookah, a fun time when people come together, the kids go wherever and then just smoke in front of the kids."*
> **– East African Session Participant**

> *"Another [threat] that we see is shisha or hookah that people use, we see that a lot indoors, and that's hard. It's more harmful than cigarettes, and a lot of people don't think that… People think it's fruit and so it's an okay thing to do indoors, even if there's infants around, or small children. Because it has the fruit flavor, people think it's safer."* **– East African Interviewee**

> *"Education in the community is very effective… I used to do outreach and educate the Somali community, many think that the hookah is healthy, they think if they smoke hookah they will lose weight, or they're just smoking fruit. They need education, they need to understand that it is dangerous."* **– East African Interviewee**

OPPORTUNITY FOR ACTION: Prioritize efforts that address nonsmokers' secondhand smoke exposure wherever community members are being most exposed.

Collaborate with community members to identify where and how, specifically, they are most exposed to secondhand smoke, and how exposure can be most appropriately addressed.

Tobacco products are widely available in community stores and easily accessible, especially by youth.

Community members expressed concern with the availability of tobacco products, especially in lower-income neighborhoods where gas stations, corner stores, and other tobacco retailers are more heavily concentrated. Specifically, stakeholders from the African American, Latino, West African, and American Indian community groups named prevalence of retailers and products as being particularly concerning. With a higher concentration of retailers comes a higher concentration of in-store displays and advertisements for tobacco products, and an increase in opportunities for youth access to products.

> *"Stores in our communities are not the same as in Lakeville or Apple Valley – I really want to see the north side community be treated the same as Eden Prairie, for example. I'm ready to see results for the black community."* **– African American Session Participant**

> *"The marketing is a big one. You walk into the store, you see the register, and what do you see? A whole wall of cigarettes. Packaging looks just like candy – ice breakers or stuff like that – like*

*candy with fruit on it. Kids walk up to it, adults, they take a look and think it's the new…
whatever you call it, and grab it."* — African American Session Participant

*"The easy access to [tobacco products] is a problem. There are a lot of little stores around,
especially in low-income neighborhoods, that I don't know if they sell to minors, but probably… it
shouldn't be that easy to access."* — Latino Interviewee

*"I'm from the urban community, and I knew what stores I could go into to get tobacco as a
youth. In communities where they know you, you know them. I used to be able to buy single
cigarettes."* — American Indian Session Participant

OPPORTUNITY FOR ACTION: Reduce the availability and accessibility of tobacco products, especially
where youth and priority populations are being targeted.

Incorporate initial and ongoing assessment into program efforts to identify areas of particular concern.
Increase point of sale changes that limit youth access and exposure to tobacco products.

Tobacco industry marketing targets specific communities.

Community members shared concerns about the tobacco industry's resources and ability to adapt
products, flavors, and advertising campaigns to stay ahead of tobacco prevention work. As one youth
participant from the Twin Cities explained, "Advertisements are always changing; no one can keep up.
Think about e-cigarettes – no one even knew they existed a few years ago." While many community
members expressed concerns about tobacco displays and advertisements in the retail environment,
stakeholders from the LGBTQ, African American, and American Indian communities expressed particular
concern for marketing from tobacco industries targeted directly at their communities.

The LGBTQ Community and Bar Culture

*"The media around LGBTQ communities are filled with images around bar culture – smoking,
drinking, [and] dancing. Often times, queer youth who are exploring their identities, who think
that's who they are, thinking 'how do I join this community, and be accepted?' They emulate the
images, do what they think is normal for LGBTQ community, which can mean using tobacco."* –
LGBTQ Session Participant

*"It's interesting to look at the history of tobacco in the community… There was a shift… with the
tobacco industry struggling to look for new communities and sources of revenue, and they
identified the LGBTQ community as being rebellious and a potential fit. In the beginning, people
were skeptical… but took on at a pretty incredible rate."* — LGBTQ Interviewee

The African American Community and Menthol Cigarettes

*"When we think about menthol, we've got a fight against the industry. Eighty-two percent of
African American's [who smoke] smoke menthol. That's very high, everyone I know of color,
they're smoking Newports. That's the community, these are high market products that [tobacco
companies] are really strategic about marketing to communities."* — African American Session
Participant

"Menthol, they've targeted us and we don't even know we're under attack. I remember as a kid wanting Kool because Kool was cool. It had menthol in it. They were trying to addict us to these cigarettes but the same thing was not happening in other communities." – African American Interviewee

American Indian Use of Traditional versus Commercial Tobacco

"Native communities, native-owned [tobacco] companies, have partnerships with tribal governments to sell their products within reservation communities… and craft more specific advertising [about being] a native-owned company and native-owned brands." – American Indian Interviewee

"An aspect within native communities that people have to have an awareness of [is that] we're talking about commercial tobacco, but there's also the cultural use of tobacco within communities. Within the cultural aspect, we've seen an infiltration of commercial tobacco industry within ceremony where it's hard to harvest traditional plants. There's been awesome efforts within last decade to revitalize those practices, but we're coming through a time where there's an infiltration from industry." – American Indian Session Participant

> **OPPORTUNITY FOR ACTION**: Incorporate information about tobacco industry targeted marketing in outreach and educational efforts.
>
> **OPPORTUNITY FOR ACTION**: All training and education should include the difference between traditional versus commercial tobacco.

Barriers to reducing tobacco use and secondhand smoke exposure

Communities with disproportionately high rates of tobacco use and secondhand smoke exposure face various unique and overlapping barriers to reduction. Accordingly, a focus of the conversations that informed this report was to explore those particular barriers, and the extent to which they can be alleviated.

Tobacco use is often seen as a lesser threat compared to other issues that are reported as more serious or imminent.

Across community groups, stakeholders consistently shared concerns that tobacco use is often viewed as being a less serious problem than many of the other stressors in their communities. Many of the competing priorities that were shared – including feeding one's family, addressing immigration concerns, facing discrimination or structural racism, finding safe and stable housing, and the use or abuse of other chemical substances – are social determinants of health largely found in communities with low socio-economic status. Compared to these daily stressors, participants shared that the harms of tobacco use and exposure are not highly prioritized.

Additionally, smoking cigarettes is at times viewed as a quick and immediate way to deal with the daily stress brought on by other concerns. Smoking is also less expensive in the short term than going to

therapy or seeking mental health services for people without health insurance. These social, cultural, and environmental factors should be taken into consideration as a part of tobacco-related efforts.

> *"It's cheaper to get a 99 cent burger and a pack of cigarettes than to deal with the stress that you're facing if you're making less than $40,000 per year."* **– American Indian Session Participant**

> *"People are more concerned about having a job and place to stay, things to eat, and feeding kids... They think 'I'm stressed out, I need this cigarette.' I see they're worried about how they're going to live day to day."* **– African American Session Participant**

> *"It's not just quick but it's also cheap. If you're looking at counseling, well, that costs a lot. Or you might not have access to insurance, but cigarettes are a few bucks a pack. People will say 'I'm not going to that counselor, I'll have this cigarette and feel better'."* **– LGBTQ Session Participant**

> *"Another thing, this is all similar across all cultures, people really smoke because they're stressed, there's so much going on in their lives, they want some relief from their everyday lives... The stress relief is so immediate."* **– East African Interviewee**

OPPORTUNITY FOR ACTION: Increase opportunities for integrating tobacco-related activities with other high priority areas and health initiatives.

Tobacco reduction efforts should be linked to existing services to reach more community members and help meet them where they currently engage with service providers and may be more receptive to receiving information. Suggestions included linking tobacco work to housing and employment supports, existing health care services, faith-based supports and services, and WIC and other nutrition programs. This will help to "meet people where they are at" and help to create more cultural relevance in tobacco work.

OPPORTUNITY FOR ACTION: Acknowledge how social determinants of health and other socioeconomic factors contribute to tobacco use.

An opportunity exists to improve communication between MDH and community members related to the unique social, cultural, and environmental factors that need to be considered in community-specific program efforts. Ongoing community engagement must be integrated into program efforts.

In some areas, there is a lack of political will and buy-in from policy makers to regulate tobacco product use or availability, especially among communities in Greater Minnesota.

Community stakeholders, particularly in Greater Minnesota, explained that many of the tobacco control efforts they support are limited due to the local political environment. Pressure from private businesses, concerns about negatively affecting small businesses, competing priorities, and political views that favor limiting government interventions can result in fewer local tobacco control efforts. This may be especially pronounced in Greater Minnesota, as tobacco retailers may more often be privately owned and locally based small businesses.

"Changing political landscape – there's a lot of re-education and change that comes in as school boards and county commissions turn over. Is there anything that [we can do] to keep the stability that has been built?" — **Greater Minnesota Session Participant**

"Concerns about negatively affecting small businesses by increased restrictions - bordering a tribe with a casino causes long standing resentment about losing business related to smoking in the casino. Bordering South Dakota causes long standing resentment about losing smoking customers to South Dakota bars." — **Survey Response, Greater Minnesota**

"This community values free enterprise and limited government involvement. Elected officials are reluctant to adopt or expand policies that restrict individual business choices and interfere in what they believe are parental responsibilities." — **Survey Response, Greater Minnesota**

OPPORTUNITY FOR ACTION: Support and integrate advocacy and capacity building, especially within priority populations.

Opportunities must be created and offered to strengthen the leadership capacity of community-based organizations and community members to participate in and lead advocacy efforts.

An emphasis must be placed on collaboration and partnerships to build the mutual capacity of community-based organizations and public health agencies to learn with each other and from each other. Non-traditional partnership opportunities should be identified and created (for example, businesses, social service or health-related organizations).

Cessation services are less accessible in rural areas.

Additional barriers to accessing cessation services exist in less densely-populated areas, where cessation and other related services, including mental and physical health resources, may be concentrated in local hubs. In these cases, services, particularly those offered in-person or onsite, are less accessible to those who live further away. These barriers may be related to having reliable, affordable transportation options, the extra time for travel, or access to information about the available services.

"[From a] cessation perspective, what we offer… is here in the hub at Duluth. The others are left out, there's no cessation resources beside a referral form. Unless you're uninsured or underinsured, we can't use quit plan... Resources are central to Duluth, but not where the smoking rates are higher." — **Greater Minnesota Session Participant**

"Transportation, location, time of day, and facilitators that offer the tobacco reduction/help services. They can all make an impact." — **Survey Respondent, Greater Minnesota**

There is a shortage of culturally specific and language-appropriate tobacco-related information and services.

Stakeholders consistently explained that their communities experience a lack of community-specific resources – including cessation and prevention services, educational materials, and information about what services and resources are available.

For non-English speaking communities, part of the need includes having resources in their own languages; however, beyond translation, community members expressed that resources developed for one community may not be relevant or culturally effective for others. Across all community groups, stakeholders emphasized that they are the experts of their own communities, and therefore need to be the ones creating culturally relevant resources. The need for cultural-specificity in tobacco work is a far-reaching theme that touches on many topics covered in this report, and will be discussed further in the Culturally Relevant Cessation and Community Services section.

> *"I think the big barriers are we don't have – many organizations or programs to work with the Latino community in prevention, or in cessation; the big barrier is the economic resources to help the people when they want to quit."* – Latino Interviewee

> *"The lack of outreach and education in the community is a threat, because there is none."* – African American Session Participant

OPPORTUNITY FOR ACTION: Work directly with community members to identify needed resources and services.

Community members can best identify what is needed, as well as how to promote existing services and resources in the most effective, appropriate manner.

A lack of cultural and language-specific outreach and education efforts contribute to misconceptions about tobacco.

All communities identified increasing culturally relevant outreach and education as a strategy for bridging tobacco-related information gaps. Community stakeholders explained that, in many cases, community members are not aware of the harms of tobacco, have misconceptions about its relative safety, or perceive tobacco to be not as impactful to their community as other, higher-priority issues (as described previously). A significant reason for this knowledge gap is the lack of sustained, culturally and language-appropriate education and outreach efforts.

Stakeholders shared that the limited efforts that have been made to educate specific communities are funded on a short-term basis, which limits reach and reduces effectiveness. This point was illustrated by American Indian stakeholders, who described their experiences with short-term funding for culturally appropriate tobacco campaigns; the funding quickly ran out, resulting in a single remaining billboard. They compared this to the successful media and education campaigns that have been geared towards the mainstream community, which are far-reaching, long-lasting, and use multiple forms of traditional media.

Commonly reported information gaps include: misconceptions about tobacco such as the perceived safety of non-cigarette products (for example, e-cigarettes, shisha, and chewing tobacco); misinformation about the harms of secondhand smoke; and a lack of awareness of the disproportionately high rates of community use and exposure, and tobacco marketing targeted towards specific communities.

> *"Thinking about communities of color, we are on the high end of health disparities when it comes to lung cancer and tobacco-related deaths. A lot of communities of color don't know that."* – African American Session Participant

"People [smoke hookah] for fun. It's an activity to do when people come together to socialize… they don't see it as a habit … [and] don't consider themselves to be smokers. I hear that doing outreach, and it amazes me when people say 'I don't smoke, only hookah.' [When I] tell them that it's even more dangerous, and the chemicals in [shisha], they say 'oh, really, I didn't know this,' and they're very surprised." – **East African Interviewee**

"The education and understanding is not there. The understanding that cigarette smoke is toxic." – **American Indian Session Participant**

"A lot of adults in our community chew tobacco. They don't think it is unhealthy because there's no smoke, just to chew, [and] no smell." – **Asian American Session Participant**

New immigrant communities are particularly disadvantaged by the lack of sustained, ongoing, and culturally appropriate education efforts.

With new immigrant populations, in particular, there is a need for consistent education about the harms of tobacco use and exposure to secondhand smoke. Many home countries do not have tobacco education efforts, and new community members are always joining, creating a continual need for ongoing education.

"Each new [immigrant] group needs to be educated on the harms of commercial tobacco; groups that are always changing." – **LAAMPP Fellow Session Participant**

"Education, a lot of Minnesotans take it for granted, since there has been a long time educating main stream communities about the health risks. It's assumed that it's understood at the same level by a lot of communities, but what we learned is that it's transient. A lot of community members come and go, so we can't assume people are at the same understanding level… you can't assume people understand the harms of the bat." – **Asian American Session Participant**

> **OPPORTUNITY FOR ACTION**: Support sustained, culturally specific education and awareness-raising efforts.
>
> Education and awareness-raising efforts should be ongoing, long-lasting, and relevant to community concerns. To ensure relevance, work directly with community-based organizations and community members. Communication plans and messaging campaigns should be incorporated into all tobacco control efforts.

Community-based organizations experience significant barriers in the grant process that funds much of Minnesota's tobacco work.

Some community members connected continuing tobacco-related disparities to a lack of community-specific organizations doing the work. They offered suggestions for funders related to the grant review, selection, and funding process. For example, participants suggested that funders should remember that a grant writer's "literacy" is not the same as their "awareness" of community needs; being an English Language Learner can be a barrier to successfully completing grant proposals. One West African session participant suggested that "similar to MNsure community specialists, [grantors could go] to communities to visit organizations and help them to go through difficult areas of grants."

Additionally participants suggested that current processes be adapted to be more user friendly for small organizations. The current review process favors larger, more established organizations rather than grassroots ones that are embedded in the community, and lacks transparency. Smaller organizations are positioned to have significant impact on the people they serve, but often lack the resources needed (such as grant writers) to secure funding. Also, the funding they do receive is often short term. Providing continuous and long-term investment and resources to communities is needed to see meaningful change. Once funding is received, MDH's grant implementation rules are often rigid, and do not allow the organization to define "success" and adapt the program to the needs of individual communities.

"Something I see is RFPs that come out are for a large dollar amount as a minimum, which requires the certain percentage of the budget be a percentage of your overall budget, as a guideline. An AA owned organization is normally a smaller nonprofit with not that large of a budget. So you can be a sub-grantee to the Caucasians who get the grant or whatever, when it's you guys that know who lives in the community and you can't keep letting that happen. We need the money ourselves, we need to be able to say where it needs to go and where it should be spent, rather than the admin costs for the regular grantee and we get nickel and dimed as the sub-grantee." – **African American Session Participant**

"[There's a lack of transparency for grant giving [criteria used)]." – **West African Session Participant**

Some who did receive grants talked about the perceived rigid guidelines they had to adhere to during implementation. They would prefer that communities have the flexibility to design their own programs.

"More culturally relevant cessation is important, but to be able to design your own prevention intervention based on program. My grant experience, we designed it ourselves, but it had to be within three boxes. We had to pick a box – it didn't reflect our priorities that we thought we wanted to work on, or what we though the community found important. Flexibility for communities to decide the priorities they want to address." – **Asian American Session Participant**

Sustained funding should also include ongoing capacity building for organizations doing the work, such as training and skill building.

"Also build the capacity of the org, too, for the long run. Not 1 year and done, then start another thing." – **Asian American Session Participant**

"Basic training for community leaders who will be sending out a message; capacity building for community leaders to be well-positioned to access to information and going through training to impact our community; building the local capacity " – **West African Session Participant**

"Organizational capacity to meet with political leaders at city and state level. It's a process to get comfortable with that. Making that transition is not easy. Community engagement makes it successful; supporters who are willing to stand up for what they believe in." - **SHIP, TFC Grantee Session Participant, Minneapolis**

Some community members talked about the need for culturally specific funding; some suggested that, to effectively address disparities, money should be divided based on need.

"You do have to prioritize and rank but I'm not sure how the state ranks that. How do you rank racial ethnic minorities? In the past, unlike [organizations], when they did have money to spend, they did not go by population. They did not say, "Whites are 80% of the population and say they get 80% of resources." They at least tried to do double. Then they supported the ancillary services the organizations needed. (This was back in the 90's) They said we're going to spend more to provide technical assistance for invoicing, grant requirement, recruitment, etc. Those were wise things the Heath Department did and they were unable to continue. You can't treat everyone the same. If you're going to address disparities this is what you have to do." **– African American Interviewee**

"There's not enough cultural specific funding – not enough in general – but of that that is available, less than 10% is for specific communities. Now we're starting to see it, the disparities." **– Asian American Session Participant**

OPPORTUNITY FOR ACTION: Fund community-based organizations to work directly with community members and build community capacity.

OPPORTUNITY FOR ACTION: Develop grant criteria that allow community-based organizations to be competitive.

Many community-based organizations are excluded from or are unable to compete competitively with larger, more established organizations for tobacco-related funding. Barriers include, but are not limited to: organizational status, network size, limitations in language and/or writing skill level, or financial requirements. Community-based organizations find that, when they are able to work in tobacco control, it is often as a sub-grantee of a larger organization, which limits their ability to apply community expertise.

OPPORTUNITY FOR ACTION: Allow flexibility with grant program activities and outcomes.

Community stakeholders provided strong evidence for why community-based organizations are best suited to address their communities' needs. However, even when funding is available, there are limitations to how fully they can apply their expertise and community-specific knowledge. Largely, these limitations come in the form of pre-selected, allowable activities, which often will not adequately address community needs. Funding should allow for flexibility, and be open to communities suggesting alternative approaches. Similarly, communities need to be allowed to define what success will look like.

OPPORTUNITY FOR ACTION: Offer education and technical assistance to enhance competitiveness and strengthen capacity.

Smaller, grassroots organizations, while well-suited to address their communities' unique needs, may need help securing grants and effectively implementing funded programs. Additional technical assistance, such as a train the trainer model for educating community leaders on the harms of tobacco and assistance in understanding granting criteria is needed.

OPPORTUNITY FOR ACTION: Create long-term opportunities for funding to support sustained efforts.

Many funding opportunities are limited to two years or less. As organizations pursue their work plans, they are able to make modifications to expand upon what they see as working particularly well, and stop

pursuing strategies with more limited results. However, the short-term funding cycles limit institutional learning and impact.

Strategies for reducing tobacco use and secondhand smoke exposure

To gather information about reducing tobacco use and exposure, in-person input session attendees, interviewees, and survey participants were presented with a list of twelve (non-exclusive) policy, systems, and environmental strategies that reduce tobacco use and secondhand smoke exposure (see Appendix C). Strategies generally fell into four major categories:

- Improving the tobacco retail environment;
- Increasing the price of tobacco;
- Limiting exposure to secondhand smoke; and
- Increasing access to culturally relevant cessation services

From the list, participants were asked to identify and discuss the two or three that would have the greatest impact on reducing tobacco in their communities. Participants were also able to make other suggestions outside of those listed. The following findings are largely drawn from conversations generated by this question and list of suggested strategies, and also include ideas related to strategies from discussions about tobacco-related threats.

Suggested strategies for reducing tobacco use varied among community groups, depending on community priorities and particular threats.

Community stakeholders did not pick a single, best strategy for reducing tobacco use and exposure. Rather, they recognized that each tobacco reduction strategy has potential strengths and weaknesses, and will work well for some but not others. While stakeholders discussed the relative positives and negatives of tobacco reduction strategies, many conversations concluded that all of the potential options are best used in combination.

> "All of the options on the list here, there are some with a point, [and] some that work for E. African or Somali, there are some for Native American or African American. We need a lot of these, because they work with different communities." — East African Session Participant

> "All [of these strategies] have an impact… All are important. The question isn't 'what is most important?' but 'how do we do all of them?' We don't hold the State and policy makers to all of these." — LAAMPP Fellow Session Participant

OPPORTUNITY FOR ACTION: Allow flexibility and consider community priorities and particular threats when designing and implementing strategies.

Population-based strategies are essential for reducing tobacco use and secondhand smoke exposure, but effectiveness depends on community priorities and particular threats. Tobacco-related threats vary by community; for example, low-income urban communities are particularly concerned about the number of tobacco retailers and advertisements in their communities, while this is less of a concern in

rural areas. Accordingly, a mix of strategies should be pursued, with particular consideration for community-specific concerns.

Increasing the cost of tobacco products is essential, but should be considered as one piece of broader efforts.

Increasing the cost of tobacco, particularly through increased taxes, was discussed in nearly every in-person input session and was the top-selected tobacco-reduction strategy by survey participants (as chosen by 38 percent of all respondents). Other strategies for increasing prices, including prohibiting coupon redemption or requiring minimum pack sizes, were discussed positively, though not as frequently. Stakeholders shared that this strategy may be most effective for youth, who have less income.

While most think that tobacco products should be more expensive, there were concerns about the financial impact for those who do not quit; as many discussed, a large number of community members have continued to use tobacco through the price increases that Minnesota has already implemented, further stretching family household budgets. Because of the increased financial burden, price increases must not be done in isolation, but be coupled with increased access to cessation services.

> *"Increasing the cost of cigarettes – it's hard but it is the reality. Income is very limited in [many] families. If you have to pay a ton for cigarettes or choose other things for your family you may have to stop."* **– Latino Interviewee**

> *"Increasing the tobacco tax really helps young people not to start. It's a tax on a lot of people who have to pay more, [who are] addicted, which is bad, but then with the coupons and stuff that come out to negate the tax. The fact, they're trying to undermine anything that the other side does to try to get people to quit."* **– Greater Minnesota Session Participant**

> *"Increase taxation because it can dedicate money for support services. People will find a way to buy it; if we tax for prevention, at least we get that money to use."* **– LAAMPP Fellow Session Participant**

Improving the tobacco retail environment, in general, is crucial in urban areas.

As explained in the Tobacco-Related Threats section of this report, stakeholders from urban areas shared particular concerns related to the availability of tobacco products in their neighborhoods, largely due to the high density of tobacco retailers. Accordingly, members of these communities shared that improving tobacco retail environments has the potential to greatly impact tobacco use and exposure in their communities.

In particular, community members supported limiting the number of retailers near each other and near youth-oriented places (such as schools and parks), and restricting advertising and tobacco displays where tobacco is sold. Community members also discussed limiting the sale of flavored tobacco products, including menthol, as an important strategy. Stakeholders noted that these products are being targeted towards youth and, accordingly, restricting the sale of these products to adult-only tobacco retailers will limit youth exposure.

"Limiting number of retailers near each other – if there are more places to get it, you're going to use more, it's just easier to get. If every other store sells, especially by schools, students can sit there and wait for someone to come out and buy some cigarettes." – African American Session Participant

"If tobacco products could be in only tobacco shops, not convenience stores that would really help the communities." – African American Session Participant

"Retail environment would be a really great point of impact for youth, in particular – exposure to marketing there is critical." – American Indian Interviewee

"Restricting advertising and tobacco product placement. This is really hard to get at because they are so pervasive and the messaging is well done. How can one decrease that? It's so appealing." – Latino interviewee

Increasing the legal purchase age from 18 to 21 years old may help to restrict youth access, though may be most effective in communities where tobacco use is not a norm.

Some community stakeholders expressed that raising the legal age to purchase tobacco products from 18 to 21 will be very effective in limiting youth access to tobacco; this strategy was also one of the most commonly selected by survey participants, with one-third identifying it as one of the greatest impact strategies for tobacco reduction in their communities. Community members explained that if the age were raised, underage youth, especially high schoolers, would be less likely to have friends to purchase tobacco for them, and may delay starting until they are able to purchase for themselves. Equally as important, community members believe raising the purchase age will send a strong message to youth and communities about the importance of reducing tobacco use, especially by youth.

Conversely, stakeholders, especially in the American Indian and African American communities, expressed doubt that an increased age would reduce tobacco in communities where tobacco is most persistently a norm. In these communities, especially, youth are easily able to access tobacco products from friends and family members; sharing these products with underage youth is not perceived to be a significant problem. Stakeholders also felt strongly that the policy should be structured so that penalties only apply to retailers and not for use or possession for 18 to 21 year olds. Many expressed the fear that if the policy was not directed specifically to retailers, it could potentially create a problem of targeting or possible harassment for use or possession of tobacco.

"The legal age to buy cigarettes should not be 18. It should be 21 or 23. The brains of adolescents are not fully developed until 26. If we can delay the decision-making thing, it could help… I don't know if it is the most effective but could help a little bit." – Latino Interviewee

"Increase age, I know it's supported by public opinion. It would send the message of how serious this is and how much we love our young people… that this is important." – African American Session Participant

"Putting the age up won't [help]. People can still find a way to get it - they'll know someone of age, or their mom will go in there for them. The community you're in, whether your parents

smoke cigarettes, whether they smoked in front of you, it's up to you to break the cycle." **– American Indian Youth Session Participant**

Increasing the availability of tobacco- and smoke-free environments is important, but enforcement and reach are concerns.

In general, tobacco-free environments were not mentioned as the highest priority strategy, but may be needed to address the broader norms of use; when discussed, smoke-free housing was the most commonly supported smoke-free policy. There is a need for tobacco-free efforts to include places where the highest users live and work (for example, low-income housing, and production or labor worksites). Stakeholders expressed concern related to enforcement of smoke-free housing policies, as neighbors are often reluctant to report each other. Community stakeholders recognized that many smoke-free workplace efforts that have been put in place in Minnesota are in professional settings; often, in production, labor, and service positions, workers are further incentivized to continue smoking, as breaking for cigarettes may be the only acceptable break allowed in those positions.

> *"Smoke-free multi-unit housing [because] we need to make sure that we are protecting ourselves and other people from second hand smoke. We should make sure that …there [are] ordinances that you cannot smoke in that type of environment when there are other people around. You are affecting my ability to maintain a healthy life."* **– African American Session Participant**

> *"Some polices are there but they're not enforced. If there's policies they say that they need something to do to enforce it. People worry about reporting, and think even if I go report, they won't do much about it…They don't want to snitch on their neighbors, or have their neighbors get kicked out."* **– East African Interviewee**

> *"The workplace efforts that I've seen are focused on office spaces. So many in our community don't work in that venue. If you're working production and the only way for you to get a break is for it to be a union sanctioned break or to have a smoke break, then you're going to smoke so you can get that extra time where your coworker will fill in for you. It's completely accepted in these types of jobs, where that's the extra break you get. Workplace efforts for cessation have not been at production level, where there is a much more engrained smoking culture."* **– Asian American Session Participant**

For all strategies, strong enforcement is important, but should not focus on criminalizing the user.

Community members recognized that strategies to reduce tobacco use and exposure, which require policy changes and increased regulation, will entail strong enforcement to be effective. A shared concern, though, is that stronger enforcement will have serious consequences for tobacco users; in particular, stakeholders from the African American and American Indian communities expressed concerns about the criminalization of tobacco and racial discrimination in enforcement, communities of color being unfairly targeted, and having tobacco be a pathway into the criminal justice system for youth.

Culturally relevant cessation and community services

Across community groups, participants said that increasing access to culturally relevant cessation services is the top priority. While the elements of cultural relevance differed for each community, all stressed that efforts should involve the community-based organizations that represent the communities they serve, and resources and services should be offered and promoted among community leaders and organizations that understand and reflect the community.

Community members wish to use services that are provided by members of their own communities, which are not necessarily available.

Community members are more likely to use services that are referred to them by, and provided by, members of their own community. This is especially important in tobacco cessation and related services, as people who are seeking help often already feel vulnerable and potentially uncomfortable. However, community stakeholders explained that their community-based organizations are generally not involved in tobacco work or, if they are, it is funded as a sub-grantee of larger, non-community-specific organizations. Because cessation services are often not provided in an appropriate language (spoken language and the vernacular) and cultural context, community members do not use them. In other instances, community members are not familiar with statewide resources and need a trusted source to explain the benefits and services available to them.

> *"Generally speaking, it is hard to point to organizations that have done work in our community... And you can barely point to a person; we don't have people who are consistent. For example, the state, ClearWay and Blue Cross – who would be a 10 year African or African American person who is doing tobacco control? There aren't any."* **– African American Interviewee**

> *"People want to go to people they trust who they know and are credible, rather than new organizations. Partnering and implementing those programs at a community level is so important."* **– LGBTQ Interviewee**

> *"The person who is doing the work, is working with the community, needs to understand the language and culture, [and] understand that it is difficult when you are working on tobacco - it's sensitive, it's hard, it's an addiction. It would take patience for whoever is involved. They need to be understanding."* **– East African Interviewee**

> *"With our community and the community of smokers, it's so diverse. You have young and old and so many different cultures and groups. To approach that you need a bunch of different strategies – no one size fits all. You need culturally, linguistically appropriate messaging and services, as well as age-appropriate."* **– American Indian Session Participant**

African American and American Indian community members spoke about the need to focus on the family rather than the individual in cessation efforts. Several groups talked about the importance of person-to-person connections.

> *"If you want a doctor, you sit down, tell her your symptoms and she says, 'why don't we try this,' and negotiate a course of action. It's not like that when we go to be doctored; the whole family goes; everyone is responsible for the healing."* **– American Indian Session Participant**

"Talking about the family rather than the individual does work better. For example, a lot of African women will not smoke in public because it is not seen as culturally appropriate." – **African American Session Participant**

"Bring it with you, don't explain it. We have a hard time communicating; 1-800 numbers, it's hard to communicate. Culturally relevant services could be this, prevention program, community-based, in an accessible place. So many places are accessible, easy to come to." – **Asian American Session Participant**

Community-based organizations are in a unique position to address cessation needs.

Community members want to receive cessation services from people whom they trust, who understand their needs and context and who are located within their communities. Many individual community organizations have had success providing services that meet diverse community needs; cessation could be added to their slate of services.

African American and Latino groups mentioned that cessation activities must address the root causes of why people smoke.

LGBTQ groups talked about the importance of incorporating efforts with creating safe and supportive environments (especially to reduce youth use and youth at risk of starting).

"Services that can really speak to the reason why people smoke: is it a stress reliever? Is it because it feels good? Is it because you're doing it to be sociable? Is it a social connector (we all smoke together). A program that could get to the root of it. I don't think people talk like that. I don't think people have the time to have an honest conversation or dialogue." – **African American Interview Participant**

"With that population (LGBTQ) I try not to do scare tactics; they don't work anymore – everyone's desensitized...I try to tie it into other culturally relevant topics – feminism, child labor, racism rather than getting cancer at 60 when they can't see that far down the line." – **LGBTQ Session Participant**

"As far as what it looks like, it's going to already existing people and organizations and being like 'we're doing this thing, would you be interested?' as opposed to creating a brand new organization with new people, no connection to the community, [and] no understanding or history." – **Asian American Session Participant**

Cessation strategies: How community members seek help with quitting

In addition to conversations regarding culturally relevant cessation services, community members discussed common strategies for quitting tobacco, including the methods that their communities are and are not using. The following section describes findings related to how community members quit tobacco and existing barriers to common quitting methods.

Cultural community members most often seek the support of family, friends, and faith communities.

Across community groups, relationships are key; people want help from those who will understand their situation and know their needs. They also want to learn from others in their communities who have quit using tobacco. They use their faith, family, and community support systems to quit smoking. Several community groups (American Indian, West African, Latino, and African American) talked about the role of faith leaders in quitting. Family members, especially children, can also be motivators for quitting. For populations with the highest use rates (especially the American Indian and LGBTQ communities), there may be support from community leaders or those who have quit, but not to the same degree that other communities experience.

"Seeking family and community support – people can be more open about it. Opening up to people close to them, they'll recommend people who have quit before, to learn from. Recommending other people, comfortable where they are, call VSS, Lao services, other places that they know. People won't go to the internet, call a number, especially those without higher education, who are more likely to smoke. Seeking people close to them who used to smoke and quit. If they know of people who were successful." **– Asian American Session Participant**

"…people tend to do social support – friends and somewhat family, depending on if they're accepting and everything. Very little do I hear people going to the quitline, or doctor's offices. I think it's mainly friends, or people going cold turkey and relying on themselves." **– LGBTQ Session Participant**

"The ones that are useful for the community are: look for family. If you belong to a church go to the church that helps. Looking for your faith. I will say that for the older generations." **– Latino Interviewee**

People likely use a variety of methods to quit smoking.

People may try multiple methods to quit smoking, including group cessation classes, e-cigarettes, or attempting to quit on their own. American Indian community leaders said that individuals are most likely to quit "cold turkey." Community members noted, however, that people from cultural communities are not likely to use quitline or online services because they do not perceive it to be culturally relevant, as will be discussed further.

"I've talked with varied groups and heard answers that made me think a lot about peoples' quitting journeys and how they are really dependent on who they are, what's going on in their lives. Having a variety of options available for quitting help is so important, also culturally appropriate for people, not just one type of person." **– LGBTQ Session Participant**

"A lot of people believe that when you are going to quit, it's healthier to do e-cigarettes. There is nicotine in both of them people don't understand. If you move to e-cigarettes, you're still having nicotine in your body, that's the addiction, that's why people are addicted. There's no proof that it is any healthier or safer. A lot of people don't understand that, that's why they do it." **– East African Session Participant**

Those in greater Minnesota may be most likely to use nicotine replacement therapies or prescription medications; they may also talk to a healthcare provider or go to the doctor's office to get help quitting.

Cultural community members are less likely to use these strategies. Affordability and a lack of knowledge about options may influence their use of such options. Some groups also talked about a lack of awareness about QUITPLAN® services.

> *"Primary care clinics – they see an affordability factor. NRT costs a lot of money; they don't know cessation services are covered if you have insurance. I don't even think the doctors know. A lot of understanding costs, making it affordable is a big piece."* **– Asian American Session Participant**

> *"We did focus groups and found a real lack of knowledge about QUITPLAN®, people that didn't even know about it, or didn't know what to expect when using it so they didn't feel comfortable calling or reaching out. There was a perception of it being an option, but not knowing what it would be like, creating a real reluctance to use it."* **– LGBTQ Session Participant**

Some people, especially those who are younger, use the web or phone apps when they are trying to quit; community members suggested that this is a potential area of growth.

> *"I've seen people reaching out on social media, posting a status asking for accountability or asking for people that they can reach out to. They're looking for accountability from their friends, and seeking family and friend support through the internet."* **– LGBTQ Session Participant**

> *"There seems to be more Apps out there; tons. I think youth are particularly drawn to those."* **– LGBTQ Session Participant**

> *"I'm interested in apps – the QuitIt app – connected to the internet, if an app would be helpful for thinking about motivations, or message with someone, or needing to delay for 5 minutes to get through a craving."* **– LGBTQ Session Participant**

Barriers prevent healthcare providers from playing a greater role in cessation.

Community groups acknowledged the importance of healthcare providers' roles with cessation but cited barriers, such as lack of health insurance, not having a regular, trusted provider, and cultural norms towards not using doctors for preventative services. One community member suggested that, to have greater impact on cessation, healthcare providers could learn ways to interact with individual community groups.

Latino and Asian American community members said that their community's respect for doctors could influence behavior, but the complicated processes for getting cessation services may keep them from following through.

> *"I think they will value the authority of a doctor prescribing or recommending it, but it quickly needs to be followed by some sort of connector. Maybe if they leave by the initiative of the person they will lose interest very quick. If the person is responsible for following up – there are a lot of barriers for registering, seeking more information, etc. They [Latino] value the decision of someone in authority like a doctor or pastor but they need more concreate options to follow up like a group with a specific content and material."* **– Latino Interviewee**

"A friend had mental health issues and asthma, so the doctor said she couldn't smoke. It was the only thing she had to stop, the doctor's order, that has the biggest impact. It makes that decision easier. Doctors need to be aware of it, to say it, not to smoke, that people will listen to them." **– Asian American Session Participant**

"We did a survey for youth. 50% of those who use commercial tobacco want to quit but they don't have cessation resources. They are offered at clinics, but our people don't go to the clinic for preventive things." **– American Indian Session Participant**

"Primary care physicians, they're asking that question, 'Do you smoke'. If they have language specific to each community, making it culturally specific, language specific, physicians can say 'do you smoke, would you like this?' You can't force it, but if they want information, the doctor can give it." **– LGBTQ Session Participant**

Community members do not perceive quitlines to be culturally relevant.

While there was a general perception that many cessation services are not culturally relevant, this is particularly true of quitlines. Community members may not be likely to use quitline services to support cessation. They think they were designed by and for the mainstream community and that counselors will not understand cultural context. Recent immigrant populations reported reluctance to use quitlines because operators are unlikely to be able to speak their language, and that there will likely be a lack of cultural understanding. People also reported reluctance to use a quitline because they fear not knowing what to expect when they call, and uncertainty about whether health insurance is required to call.

"The ones that I think won't work is the quitline. I saw the commercial in Spanish. I work with the Spanish and they won't call that line. They say they don't need it. They say, 'I can handle it myself.' Or, 'I've been using the patch and it's fine.'" **– Latino Interviewee**

"I don't think communities of color use Quit Plans… And it's not because we don't speak English. Language is one thing, but it's because we're not sure if the person on the other end of the line is going to be culturally sensitive, or able to understand where we are coming from, what's going on in our community. There may or may not be a language barrier, but we're not calling someone before we light up, especially if we do it socially, rather than as a social smoker." **– Asian American Session Participant**

LGBTQ community members explained that transgender community members face additional barriers to using quitline services that are tied to operators making assumptions about gender identity based on the sound of a caller's voice.

"If quit services are over the phone, the only recognition you have is what their voice sounds like. And if you continue to call them ma'am or miss when they prefer to be called male. It's simple language; you record it, when they give you the name, what pronoun would you like to use, as a part of the script. So someone knows they prefer… if you misuse it, people are not coming." **– LGBTQ Session Participant**

OPPORTUNITY FOR ACTION: Expand and integrate cessation activities into existing services and community networks.

Community members clearly stated that there are few if any culturally appropriate cessation services; but because attempts to create such services have not worked in the past, emphasis must be placed on promoting and raising awareness about what is currently available.

OPPORTUNITY FOR ACTION: Identify opportunities for community-based organizations to provide linkages to cessation services.

Community-based organizations and community leaders should be tapped into to create an infrastructure that can be used to promote and provide those services within communities. Cessation efforts should be paired with other services that organizations are providing, and could be linked to more relevant or compelling areas of interest, such as addressing racism or feminism, when appropriate.

Advisory committee overarching conclusions and recommended actions

Upon conclusion of the community input process the advisory committee reviewed the findings and developed the following conclusions and recommendations.

A health equity lens should be applied at all levels of tobacco prevention and control work and at all levels of decision making. To identify how inequities are being addressed, the following questions must be considered:

- Who is advocating for tobacco control?
- Who is part of the decision-making process for funding and priorities?
- How are funders and advocates working together to reflect the most at risk communities?

The socio-economic, cultural, and environmental conditions in which people live play a critical role in explaining why many people use tobacco. There is a continuum of tobacco use (never starting, initiation, addiction, and cessation) and multiple determinants of tobacco use that must be considered in order to successfully reduce tobacco-related disparities. Tobacco prevention and control should be framed as a social justice issue.

There is a need to further strengthen relationships and integrate the work among MDH, other funders, and community partners. Strengthened relationships between state and local public health departments and community-based organizations promote mutual capacity building and opportunities to learn with each other and from each other. Partnerships are essential and collaboration is key; collaborative efforts must be peer-to-peer and share equal power. Communities need the tools, training, and investment of resources to increase leadership and advocacy skills; building and strengthening the community's capacity to create their own healthy future is high priority.

There is also a need for both an increase in overall funding for tobacco prevention and control, as well as funds for community-based organizations to do the work within their own communities. Funding opportunities should provide flexibility for programs to be designed and implemented with input from communities that recognizes and maximizes their strengths. Funding opportunities should include health equity metrics and assess cultural competency to prioritize funding and ensure efforts are aimed at reducing tobacco-related disparities.

Acknowledgements

This project demonstrates our commitment to engage communities and better understand their unique strengths, needs, and barriers to work more effectively towards eliminating tobacco-related inequities.

This report and its findings were made possible by the many individuals who shared their time, insights, and networks. Many community stakeholders and partners have been extremely helpful and generous by offering their time and feedback through interviews, group sessions, and surveys, as well as by helping to organize and facilitate in-person input sessions.

In addition, we thank the following members of our advisory committee for valuable contributions leading to this report:

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We express gratitude to the LAAMPP Fellows that also helped to plan or attended community-specific in-person input sessions.

About DeYoung Consulting Services

Founded in 1996, DeYoung Consulting Services, LLC, helps build on organizations' core strengths with specialized services for evaluation, training, outreach, and organizational development. Serving educational, non-profit, and public institutions, they use collaborative processes that help their clients achieve their desired outcomes. And by working with organizations to enhance their processes and programs, they help our clients reach those outcomes.

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The Improve Group conducts rigorous studies to help organizations make the most of information, navigate complexity, and ensure their investments of time and money lead to meaningful, sustained impact. The Improve Group is based in St. Paul, Minnesota, and provides research, evaluation, and strategic planning services to organizations locally, nationwide, and internationally.

Appendices

Appendix A: Minnesota State Leadership and Policy Academy Summit

In October 2015, fifty-two leaders and advocates in public health, behavioral health, and tobacco control came together for the Minnesota State Leadership and Policy Academy Summit to design a state action plan for reducing tobacco use addiction among individuals with mental illness and substance use disorders, and to create an environment of collaboration and integration among the fields of public health (including tobacco prevention and control), mental health, and substance use services.

The action plan includes strategies needed to help reduce tobacco use among people with mental illness and substance use disorders. The discussions, as well as the needs identified in the action plan, are compiled below.

Education and Awareness

Increase recognition of people with mental illness and substance use disorders as a priority population disparately impacted by tobacco use.

- Culturally appropriate outreach and educational resources and materials are needed for patients and clients.
- Increased awareness and education about the data (specific to people with mental illness and substance use disorders) is needed for providers, patients and clients, the recovery community, and the general population.

Training and Outreach

Few providers receive tobacco treatment training or education about tobacco use within the population(s) they serve; training should be provided and integrated into ongoing education opportunities.

- Peer specialists are needed to provide support and education to patients and clients; peer-to-peer, train-the-trainer, or other outreach models are essential.
- There is a need to identify best practices for peer support programs; existing support programs and outreach models must be leveraged.
- Providers need training on providing cessation services and referrals, as well as reimbursement policies for providing cessation services; this should include what cessation medications and services are available in Minnesota and covered under the Affordable Care Act.
- Professional associations and other potential partners should be engaged for outreach support; champions should be identified in all agencies that provide services for people with mental illness and substance use disorders.
- Positive reinforcement of quit attempts and seeking cessation services should be emphasized.

Screening and Access to Cessation Services

Tobacco use is a relapsing condition and should be treated as such; cessation is a process and requires screening, counseling, and access to appropriate and affordable medications and services.

- Nicotine addiction should be treated the same as other substance use disorders; this includes how the addiction is treated and being funded (should be on par with substance use disorders).
- All patients and clients should be screened for tobacco use (including e-cigarettes) and provided needed cessation opportunities. Tobacco screening measures must be incorporated into documentation and clinical protocols.
- Policies should be in place to include reimbursement for mental health and substance use licensed professionals for nicotine replacement therapies; address financial barriers to accessing cessation medication and services; assure proper reimbursement; and employee benefits for cessation.
- Reimbursement policies for cessation coverage may need to be adapted to reflect the medical needs of patients and clients.
- Cessation services should be embedded in other services provided within mental health and substance use treatment facilities.
- Patients and clients should receive services in an environment that is tobacco free.

Appendix B: Power and Interest Grid for stakeholder identification

Power in this case refers to the ability to influence others, and *interest* refers to whether they have a stake in MDH's tobacco prevention and control work. We then used the grid to determine how we would engage stakeholder groups.
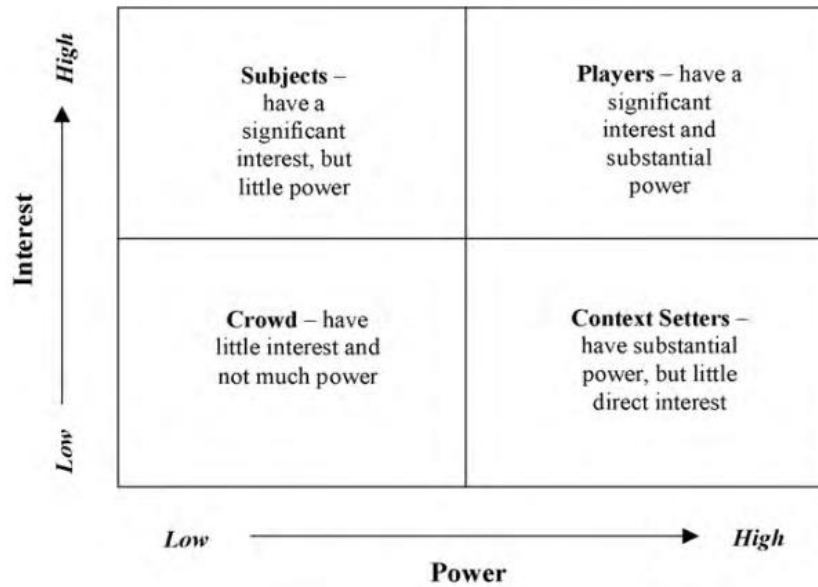
We focused on the *Subjects* and *Players* (the top two quadrants). *Subjects*, have a vested interest in the work of the project, but may think they have no role to play. *Players*, are often the "usual suspects", and are easily accessed. (It was assumed that these individuals would naturally be included in the process.)

To create a plan for engaging stakeholders, we identified *Players* who could link us to *Subjects*, ensuring a comprehensive approach.

Appendix C: Protocol questions

Regional grantee meeting discussion protocol

EFFORTS TO ADDRESS TOBACCO USE IN THE COMMUNITY

1. **What efforts have you made to address tobacco use in your community?**
   a. Who were these efforts aimed at?
2. **What strategies have been most effective at reducing and/or preventing commercial tobacco use and exposure?**
   a. Why have these efforts worked? What contributed to their success?
3. **What types of partnerships or collaborations have worked best or would be most beneficial for addressing tobacco issues in your community?**
4. **What types of resources and trainings have worked best or would be most beneficial for addressing tobacco issues in your community?**
5. **What improvements would you make to technical assistance, training, and resources?**
   a. What is missing?
6. **What strategies have been challenging or less effective?**
   a. Who were these efforts aimed at?
   b. Why were they challenging?

STRENGTHS AND CHALLENGES

7. **What are local public health's strengths in addressing tobacco related issues in the community?**
   a. How does public health's capacity compare to what a community organization can do?
8. **What community resources can public health tap into to address tobacco prevention and cessation?**
9. **Where are the remaining gaps or challenges in addressing tobacco use or prevention in your community?**
   a. What do think would be effective approaches for addressing these gaps/challenges/threats in your community?
   b. What do you need to be more successful in addressing the gaps/challenges/threats?

STAKEHOLDER CONCERNS AND AWARENESS

10. **What populations within your community seem to need the most help?**
    a. What populations or communities, if any, seem to get left out of the tobacco work? Or, do not receive enough attention?
11. **What are the biggest concerns among community stakeholders about tobacco use or exposure in your community?**
    a. What are – or would be – effective strategies to address these concerns?

POLICY EFFORTS

12. **What impact does each of the following have on tobacco use in your community?**
    ☐ Flavored products
    ☐ Current price/tax
    ☐ Current legal age to purchase
    ☐ Multiple unit housing that are not smoke-free

☐   Children's exposure to tobacco use and secondhand smoke
☐   Other tobacco-free grounds?
      a.   Would a policy change in these areas affect use for your community?

IN CLOSING

13. **If our efforts are successful, in 5 years, what will tobacco control look like in the communities you work with?**
14. **Finally, who else in the community do you suggest we contact who could provide input on this topic?**

In-person adult stakeholder input session, interview, and survey protocol

TOBACCO IN YOUR COMMUNITY

1. **Thinking about how commercial tobacco use impacts your community, what are the greatest tobacco-related threats your community faces?** (Consider: youth at risk of starting, people who are trying to quit, or those who may be exposed to secondhand smoke)
2. **Of the following strategies, which _two_ or _three_ would have the greatest impact on reducing commercial tobacco use in your community?**

☐   Limiting the sale of flavored tobacco products (including menthol)
☐   Limiting the number of tobacco retailers near each other, or near youth-oriented places such as schools or parks
☐   Increasing the legal age to buy tobacco products (from age 18 to 21)
☐   Restricting advertising or tobacco product placement in stores where tobacco is sold
☐   Stronger penalties for selling tobacco to minors
☐   Limiting use and access to new or other tobacco products (such as e-cigarettes and shisha/hookah)
☐   Increasing tobacco taxes
☐   Prohibiting coupon redemption or other discounts (such as _buy one get one free_ deals)
☐   Requiring minimum prices and minimum pack sizes for tobacco products
☐   Increasing the availability of smoke-free multi-unit housing
☐   Increasing the number of tobacco-free parks or community events
☐   Increasing the number of tobacco-free worksite grounds or college campuses
☐   Increasing access to culturally relevant cessation services
☐   Other:

CESSATION

3. **There are several ways people seek help with quitting. When people want to quit, what do they do or where do they go for help?**
☐   Call a quitline (phone counseling)
☐   Search the Internet/seek web-based counseling
☐   Talk to a healthcare provider/go to the doctor's office
☐   Use nicotine replacement therapies (NRT) or prescription medications
☐   Seek family/faith/community support
☐   Attend group cessation classes
☐   Use e-cigarettes or other substitute products

☐   Other:
a.   What culturally relevant cessation services or resources are needed in your community?

COMMUNITY BARRIERS AND STRENGTHS

4. **What are your community's biggest barriers to reducing commercial tobacco use?**
5. **What social, cultural, or environmental factors should be considered to successfully reduce commercial tobacco use in your community?**
    a.   How can we incorporate community assets into those efforts?
6. **What types of partnerships or collaborations have worked best or would be most beneficial for addressing commercial tobacco use in your community?**

LOOKING AHEAD

7. **Finally, who else is familiar with the impact of tobacco use on your community and should be contacted to participate in this input process?**

In-person youth stakeholder input session, interview, and survey protocol

TOBACCO IN YOUR COMMUNITY

(Warm-up question) **Why do you think youth start using tobacco?**
1. **Thinking about the different types of tobacco products (cigarettes, chew, cigarillos/little cigars, shisha/hookah, e-cigarettes, etc.) do youth view any to be:**

    ▪   Safer/healthier?
    ▪   Easier to buy?
    ▪   Cooler to use?

2. **Which of the following do you think is the most important tobacco-related issue facing youth:**
   Exposure to secondhand smoke
    □   Menthol and/or other flavored tobacco products
    □   Aggressive tobacco advertising
    □   New or emerging tobacco products such as: e-cigarettes or shisha/hookah
    □   Other:
3. **Of the following strategies, which _two_ or _three_ would have the greatest impact on reducing tobacco use among youth?**

    ▪   Improving the tobacco retail environment, such as:
        ▪   Limiting the sale of flavored tobacco products (including menthol)
        ▪   Limiting the number of tobacco retailers near each other, or near youth-oriented places such as schools or parks
        ▪   Increasing the legal age to buy tobacco products (from age 18 to 21)
        ▪   Restricting advertising or tobacco product displays where tobacco is sold
        ▪   Stronger penalties for selling tobacco to minors
        ▪   Limiting use and access to new or emerging tobacco products (such as e-cigarettes and shisha/hookah)
    ▪   Increasing the price of tobacco, such as:
        ▪   Increasing tobacco taxes (making tobacco more expensive overall)

- Prohibiting coupon redemption or other discounts (such as buy one get one free deals)
- Requiring minimum product prices and pack sizes (can't buy just one or two little cigars at low prices)
  - Limiting exposure to secondhand smoke, such as:
    - Increasing the availability of smoke-free multi-unit housing
    - Increasing tobacco-free parks or events
  - Helping people quit, such as:
    - Increasing access to culturally relevant cessation services
  - Other, such as what?
    a. How do you think youth can be most helpful in this work?

MESSAGING AND MEDIA

4. **Tobacco companies spend a lot of money to promote and advertise their products. Anti-tobacco campaigns and community education are important to increase understanding of the harmful effects of tobacco. What are the best ways to raise awareness about the harms of tobacco for the youth?**
   a. How should these messages be delivered?
   b. What types of settings would be best?
5. **How effective is it to use social media like Facebook or Twitter for reaching youth with these types of messages? What other social media sites might be effective?**

Appendix D: Community participation, by community group

COMMUNITY	NUMBER OF GROUP SESSION PARTICIPANTS	NUMBER OF INTERVIEWEES
Regional[7]		
Detroit Lakes, Minnesota	12	-
Duluth, Minnesota	9	-
Marshall, Minnesota	11	-
Minneapolis, Minnesota	17	
Otsego, Minnesota	9	-
North West Area Youth	79	
Rochester, Minnesota	13	-
South Central Area Youth	63	
Twin Cities (Urban) Youth	21	-
West Central Area Youth	13	
Community-specific		
African American	9	3
American Indian (Adult)	10	1
American Indian (Youth)	11	-
Asian American	14	-
East African	2	3
Hispanic or Latino	-	4
LGBTQ	9	-
West African	12	-
Total:	314	12

Note: Some participants may have contributed more than once.

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[7] Regional group sessions include both MDH-organized grantee regional meetings and "community-specific" groups that were convened based on region (geographic area).