Addressing Tobacco in Colorado's Socio-Economically Disadvantaged Communities

A Community Blueprint for Action

A report prepared by the Colorado Community Coalition for Health Equity

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Executive Summary

According to the World Health Organization (WHO) in its 2004 report, *Tobacco and Poverty: A Vicious Cycle,* "The contribution of tobacco to premature death and disease is well documented. However, little attention has been paid to the link between tobacco and poverty. Tobacco tends to be consumed by those who are poorer. In turn, it contributes to poverty through loss of income, loss of productivity, disease and death. Together, tobacco and poverty form a vicious circle from which it is often difficult to escape. "

In Colorado in 2008, the Colorado Tobacco Attitudes and Behavior Survey (TABS) showed smoking rates were nearly triple for those living beneath the poverty line when compared with those at 200% or more of poverty (29.2%). In addition, Colorado's Quitline shows successful quit attempts in 2008 were three times higher in non-socio-economically disadvantaged (SED) populations and significantly lower in populations with tobacco-related health disparities.

Tobacco is seen as less of a problem than it is a solution in SED communities. Stress, social norms, accessibility of tobacco, and a lack of affordable quitting and culturally competent support resources enable and even encourage high rates of tobacco use. Smoking is a stress reliever, a comfort and a distraction from the challenges of daily life where immediate survival needs take precedence over addressing tobacco use or other health concerns. Additionally, low income people are surrounded by other smokers, including their families. Poorer neighborhoods, predominant targets for tobacco industry advertising campaigns and free giveaways, also lack the resources and education to resist tobacco use under the assault of such campaigns. Although quit aids, such as Quitlines and nicotine replacement therapy (NRT) are increasingly accepted, the stories about bad experiences with these resources travel fast. The cost for quit aids is also seen as prohibitive, and the misinformation about available quit aids and resources is widespread.

Building community capacity through education, resource development and norm change utilizing trusted community-based organizations, leaders, and incentive-based programs and outreach are shown to have an impact over the challenging effects of tobacco in the SED communities.

Resources are needed to provide alternatives to replace the immediate gratification provided by smoking, and to educate and empower community role models, educators and existing programs to provide support, resources and success stories that can assist in the daily challenges to staying quit.

It is critical to think outside-the-box for best practices when working with the SED populations. It's also important to partner with leaders, both formal and informal, to pass and enforce local policies which make tobacco use less convenient and less a community norm.

Introduction

The World Health Organization (WHO) in its 2004 publication, *Tobacco and Poverty: A Vicious Cycle,* states that "The contribution of tobacco to premature death and disease is well documented. However, little attention has been paid to the link between tobacco and poverty. Tobacco tends to be consumed by those who are poorer. In turn, it contributes to poverty through loss of income, loss of productivity, disease and death. Together, tobacco and poverty form a vicious circle from which it is often difficult to escape."

According to the National Network on Tobacco Prevention and Poverty (NNTPP), tobacco poses a greater burden on minority, low income and low literacy populations, and the greatest single predictor of whether or not a person uses tobacco is their socio-economic status. NNTPP's 2004 report entitled, "Smoking Habits and Prevention Strategies in Low Socio-economic Status Populations", states that "Americans living in poverty and other low SES populations suffer disproportionately from tobacco related morbidity and mortality. This may be due to the fact that low SES communities are less likely to have members with access to and/or who participate in cessation programs or receive cessation advice. In addition, little research and funding are available to support resources for smoking cessation and prevention strategies that effectively target low SES populations and many tobacco education materials and programs are not culturally or linguistically appropriate for low SES populations."

In Colorado in 2005, the Colorado Tobacco Attitudes and Behavior Survey (TABS) showed smoking rates doubled for those living beneath the poverty line when compared with those at 200% or more of poverty. In addition, Colorado's Quitline shows successful quit attempts in 2008 were three times higher in non-SED populations (5% vs. 14%), and significantly lower in populations with tobacco-related health disparities. The publication of *Cancer and Poverty in Colorado: 1995-2006* found that "Coloradans with lower incomes were more likely to smoke tobacco, to be obese, to be less physically active, and to not participate in screening tests for breast, cervical, or colorectal cancer." Further, the report recommends that "policymakers and public health agencies should focus on efforts to reduce health disparities caused by poverty."

In order to understand Colorado's SED populations, their needs related to tobacco use, and to create strategies for addressing the disparately high tobacco rates among the populations in urban and rural Colorado, the Colorado Community Coalition for Health Equity's Addressing Tobacco in Colorado's Socially-Economically Disadvantaged Communities project was funded in 2009-10 by the State Tobacco Education and Prevention Program (STEPP) and the American Legacy Foundation.

Project Overview

To embrace the goal of reducing high tobacco use rates among SED Coloradans, 11 Colorado nonprofit and local health agency organizations came together with the intention of creating a strong, diverse coalition having the capacity to better serve SED tobacco users across Colorado. To increase their understanding of the SED tobacco users, a needs assessment and inventories of community assets were developed to gain insight and knowledge about the motivations, attitudes, beliefs, existing resources and service access points of the SED populations. This base of knowledge enabled the Coalition and community stakeholders to develop a plan for addressing tobacco-related health disparities that exists in SED communities, and to provide a blueprint for building the capacity of the communities involved.

Process evaluation measures were designed to ensure stakeholder satisfaction throughout the project, as well as, to assess organizational knowledge of the SED populations and confidence to meet education, cessation and service needs. Data for the project was collected using focus groups comprised of participants from SED populations; interviews with local and national experts; meetings with local Community Advisory Committees made up of SED service providers who developed community asset inventories; and a literature review to provide lessons learned and promising practices. The review also assisted in the development of cultural considerations for the diverse segments of the SED population. All data collection methods were assessed for cultural competency.

The following assumptions guided the project.

Guiding Assumptions

1. The term SED refers to people living under 200% of poverty level.
2. The data speaks in broad generalizations and is acknowledged and recognized for its inadequacy in describing the lives and experiences of the individual lives they describe.
3. Honoring and considering culture and community norms are a critical component of any successful populations-based intervention.
4. Being low income does not mean people are unhappy, have low self-esteem or are dysfunctional in any way. Many low income people and families are close knit, hard working and high functioning.
5. Many tobacco users see no need and have no desire to quit. As long as they are aware of the consequences and their use does not endanger the lives of others, this is their right, without judgment. The project's goal is to do whatever is possible to assist those who want to quit to be successful.

The following describes how the study was conducted, the findings, and recommendations.

Focus Groups

The purpose of the focus groups was to gain insight and knowledge about the motivations, attitudes, and beliefs about personal health opinions, existing health care and cessation resources, and access points for cessation services in SED communities across Colorado. Focus groups were conducted in Denver, Colorado Springs, Ft. Morgan, Trinidad, Durango, Ordway and Rocky Ford. Nineteen homogenous groups were gathered representing the following groups: American Indian, Black, Latino/Hispanic, Lesbian, Gay, Bisexual and Transgender (LGBT), and Rural. All participants were living at less than 200% of poverty level.

Expert Interviews

Twenty national, and nine Colorado experts in SED tobacco or health programs were interviewed to inform this qualitative research with promising practices, lessons learned, and innovative programs.

Community Advisory Committees

Local experts from each of the SED priority populations developed Community Asset Inventories. The inventories identified community strengths, resources, trusted leaders, communications vehicles and informal gathering places that currently exist and could be potential partners or access points for reaching these communities.

Literature Review

The literature review was conducted to explore promising practices and cultural considerations of the SED populations in general, as well as, specific to each group. Cultural considerations were developed for the American Indian, Black, Latino/Hispanic, LGBT and Rural SED populations by CCCHE members.

Outcomes

In Their Own Words: Findings from the Focus Groups

- Tobacco is less a problem than a solution.

Stress and boredom keep people smoking---
"There's nothing to do…nowhere to go…nobody to help."
Smoking is the norm in low income communities.
Low income people are surrounded by other smokers.
Quitting takes resources---"it's too expensive to quit."
The tobacco industry targets poor neighborhoods.

For the SED populations, stress, social norms, accessibility and lack of resources were given as reasons for smoking. Smoking is a stress reliever. It's a comfort. It's a distraction. It's also seen as a family and friends activity that is acceptable. There are so many more immediate things to stress about than worrying about cigarettes. It is low on the priority list.

Here's how some participants stated it:

- "It is worth the price to calm down just a little bit, just to have a little stress reliever. I will pay the $6.00 just so I can know that I can deal."
- "The stress of living in an area that is economically deprived, losing your job, not knowing where you are going to get work, no medical insurance, terrified to get sick, terrified to go to the hospital. It's a vicious cycle. So, you smoke a cigarette to make yourself feel better."
- "Smoking is a comfort to people, so when you are bored or you don't have anything to do, you pull out a cigarette. What would I do if I wasn't going outside to smoke? The house is clean and everything. I have nothing to do, and I am tired of watching TV, so I decide to have a smoke."

The tobacco industry also targets poor neighborhoods. Advertising, coupons, free cigarettes, selling single cigarettes are all marketed to the lower income. Participants know this.

- "Free giveaways entice you. Buy-one-get-one for Camel. That makes it harder to quit because you think you have something for free."
- "You can definitely tell, when you go into the ghetto, signs are just plastered all over the windows of all the convenience stores. You can't even see inside and you look around and more people are smoking."
- "I mean as nice as the coupons are for somebody that does not have a lot of money, you know, get them out of my face because…this is probably the only time I will ever say this, but you know, it's not helping."

Low self-esteem, fatalism and depression are also common among the SED. "We see all this poverty around us and we're like, forget it. We might as well just smoke and drink and not eat healthy right along with everybody else."

What about Quitlines?

"So I called them and told them, "I want to quit smoking."
She said, "Well, let's set up a day then."
"What? I quit today."
"Well, I'll have a counselor call you on Monday."
"This was like Tuesday or Wednesday."
"No," I said. "Can't you do that?"
She says, "I'll do a little bit, but the counselor will call you back
and do the rest of the intake."
I said, "I don't know if I'll last that long. It's been two days now."
She says, "Well, ma'am, when you talk to the counselor she'll tell
you things that you need to know that will help you stop smoking."
So, I said, "Okay."
"I lasted like two more days. She never called me. They sent me a book".

Perceptions of Quitlines

- Nosey
- Bureaucratic
- Time Consuming
- Impersonal
- Inconsistent

What about NRT and Medications?

- Dangerous
- Addictive
- Expensive
- Ineffective

"They don't know anything, my counselor never even smoked."

"It's scary, are 800 numbers really free all the time? I don't want to get a bill, my immigration status is not fixed yet and I don't want to get in trouble. Even if it's free, it sounds too good to be true."

What did work?

Persistent, reliable and kind counselors

Education about

- Money saved
- Days added to life
- Understanding addiction and the brain

Quitting is considered by some to be intimate. They would like the same counselor throughout the process rather than being "just another number to them." As one participant stated, "They're very impersonal. And I know there are no Indians on the Quitline, so I don't think it works."

- Suggestions for assisting those trying to quit.
  - Supportive relationships and/or environments are important.
    - Culturally appropriate support groups like AA
      - Have support groups that are local, offer sponsor-type, one-on-one relationships while teaching coping skills.
      - There was widespread knowledge and acceptance of AA by the focus groups, and a nearly unanimous desire for something similar for tobacco….Smokers or Nicotine Anonymous. These groups might be particularly beneficial if they focused on specific ethnic minority groups.
    - Utilize organizations and individuals already trusted by the community as liaisons to the Quitline to assist with the process if needed.
      - Make Quitline more immediate, less bureaucratic and more consistent.
      - Provide education on NRT and medication options to dispel myths.
      - Make quitting resources free and unlimited.
    - Counseling
      - Provide assistance "to understand better who you are today and why you smoke."
      - Provide individual support for those who need it.

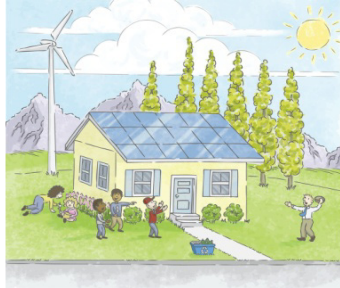
- Community, family, friends, churches, neighbors
    - Encourage family and loved ones, especially children, to exert positive pressure on smokers to quit. "In families, parents aren't discouraging kids but sometimes kids are discouraging parents and they listen."
    - Churches and schools are the primary gathering places in SED neighborhoods.
    - Provide opportunities for smoke-free activities.
- Healthy activities, hobbies, exercise and cooking classes "so we don't gain weight."
    - Encourage and/or enable lifestyle changes with more exercise and activities that are free or low cost and do not involve drinking.

Remember

One size and shape doesn't fit all! Cultural competence matters.

- Increase culturally appropriate education and outreach programs
    - The meth ads work. Use something like this for tobacco.
    - Make health effects visual.
    - Start tobacco education early in schools.
    - Have a program on the understanding of health risks associated with tobacco.
    - Create "bring a friend" classes.
    - Childcare and transportation must be considered.
- Make smoking illegal and inconvenient
    - Be more stringent with punishing people who market and sell to minors.
    - Increase the legal age to buy cigarettes to 25.
    - Increase the number of places where smoking is prohibited.
    - Make it inconvenient. Allow it only under uncomfortable conditions (like outside in the cold).
    - "I just wish they were illegal. For some reason I quit the illegal stuff a lot easier….but this is legal so I do not know. It makes it harder."
- Rewards/incentives for quitting
    - "Pay people to quit smoking."
    - "Perhaps similar to what some jobs do for their employees, pay non-smokers an extra $20 a month."
    - "Give a discount on a gym membership for quitting, perhaps in January for the New Year."
- Raise awareness of industry targeting to poor communities
    - Highlight tobacco industry targeting. "Letting people know this stuff does not happen in rich, white communities. That would have a big impact on our community. Huge. Bring them together to be more aware of what is going on in our community versus what is going on in other communities."
    - "Just get rid of the tobacco industry."
- Prohibit "free coupons" and cigarette "samples"

- Healthier communities matter
    - Organize neighbors for walks and exercise
    - Make healthier foods affordable
    - Increase educational opportunities
    - Plant more trees and flowers



- Community Resources used by participants
    - Churches
    - Schools
    - Job Service Centers
    - Food banks
    - Community-based clinics, emergency rooms, child immunization sites

Opinions differ about health care services

- Many distrust the healthcare system because it is profit oriented.
- Relationship is key: providers are trusted if they have known a client a long time and have a personal connection.
- There are concerns about the quality of health facilities in rural and ethnic minority communities. Doctors in rural areas are often accused of being incompetent and/or inferior.
- Many distrust doctors, saying they:
    - "don't take their time"
    - "cost too much for what you get"
    - " just give the same advice over and over"
    - "don't keep or are late for appointments"
    - "they don't care about us, they are only there for the money"

- Primary sources of health information and community resources used by participants
    - Clinics

- TV
  - Programs that feature doctors are trusted, particularly because they offer visual evidence.
  - The news and especially commercials are not trusted because of profit motive.
- Trusted individuals---- ministers, beauticians, promotoras/es, neighborhood business owners
- Word of mouth----bowling alleys and bingo groups
- Internet
- Local and community newspapers…..especially those that are free
- Billboards and bus stop benches
- Health flyers
  - In stores
  - Laundromats
  - Churches
  - Personal emails
  - Schools
  - Social service organizations
  - Direct to doorsteps

Advice from the Field: National Experts

> "We have to watch our own biases. We make excuses that their lives are so hard, how could we ask them to quit? They deserve the same opportunities to quit that others have."

For those working with the SED populations, it's important to understand who they are in order to provide resources and programs that will meet their needs. The SED can be categorized into three groups: 1) long term poor with serious barriers and few resources; 2) long term poor with resources; and 3) on-the-edge. Let's take a look at what that means.

- Long term poor with serious barriers and few resources
  - Chronically homeless
  - Drug addicted/alcoholic
  - Mentally ill

- Long term poor with resources
  - Welfare
  - Disabled
  - Subsidized housing

- On-the-edge
  - Working poor
  - Unemployed

There is a subset of the SED population that has begun to realize that their lives could improve somewhat if they quit smoking. That is good news. However, there are many SED smokers who feel a sense of control over their smoke breaks and decide to smoke in a world where they feel very little

control over their lives. In the SED populations, "it is easier to get a cigarette than a meal, and smoking kills hunger. Stores in their neighborhoods sell single cigarettes for a quarter" shared one interviewee.

Day-to-day survival is a focus of the SED populations. One interviewee shared that "most low SED people are the working poor, many are doing multiple jobs. This group can rarely plan for anything in life as the focus is on day-to-day survival. " Another stated that "for most low income people decisions and even relationships are based on survival. If family members get too much education they may leave and that is a threat. They need each other to survive."

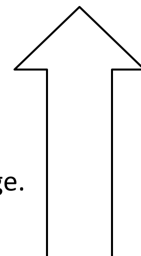
"It is important to work with agencies that know the population. Many think they know about the lives of these people, but they have no idea how different their lives are than middle class lives," stated one respondent. Remember the importance of culture. The SED, and especially minority SED, don't trust people they don't know.

Regarding Quitlines, "many do not have landlines, they use message phones or are paying for phones by the minute. Quitline is not accessible to this group," stated one respondent. The SED populations will often require a greater number of quit attempts, therefore, they keep feeling like a failure. They need hope and to know they will be supported even if they relapse. They are asking for 1:1 help and want to talk with people they know, and who have been successful, when working with programs.

Additionally, "incentives are a must, especially meals. Provide transportation and childcare for programs if you want them to consider participating, but remember, follow-up is very challenging as this population is often transient."

In some cultures cigarettes are a multi-generational issue and tobacco must be honored as a part of the family and community culture. It is more than the individual.

What works

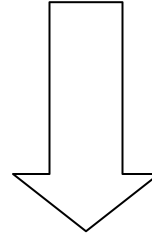


- Building community capacity
  - ………..hire staff and decision makers from within the community.
  - …………develop local champions.
  - …………partner with grassroots leaders to create transformative change.
- Using existing community-based organizations
  - …………be mindful of their time. They're already working with limited resources.
  - …………find ways to support their existing programs and infrastructure.
  - …………create a network of providers to integrate tobacco into their organizations.
  - …………learn from each other.
- Outreach, outreach, outreach
  - ………….it's important.
  - ………….go into the community. It "makes them feel important and builds relationship."
  - ………….use homes, schools, churches, and community gathering places.

❖ Using motivators

…………..emphasize family and children. Money to cigarettes is money from family.
…………..emphasize the control smoking has. It takes away personal choice.
…………..provide education. They do not know the dangers we assume they know. Assume they are not ready to quit.
…………..identify their needs. What do they think they need? Help them meet their more pressing needs and build tobacco control into their processes.
…………..provide media literacy training. Message: we're targeted by big tobacco.

What does not work



❖ Best practices alone

………...think outside the box – be creative.

❖ Ongoing classes

………...provide one-time education about resources.
………...facilitate connections.
………...offer support.

❖ Quitlines

………...calling a stranger is a "foreign concept".
………...NRT is too expensive and the fears around the products exist.
………...make quitting as affordable and easy as smoking.

Promising Practices

"Work with those making changes in their lives."

Employers and Job Training

- Integrate tobacco education into job training.
- Educate and incentivize employers to hire those who are quitting.
- Provide equal break times for nonsmokers to reduce smoker's perceived loss of free time if they quit.
- Educate employers about benefits to productivity and lower insurance rates of nonsmokers.

Consumer Credit Counseling

- Use CCC and Homeless Programs
- Include education
    - Cost of smoking
    - 2A's and R (ask, assess, refer)
    - Fax referral to Quitline
    - Address smoking in budgeting and life skills classes

Use Trusted People, Organizations and Programs

- WIC Programs, Food Banks, Churches
  - Identify organizational champions for tobacco education and support programs.
  - Modify Freedom from Smoking Train-the-Trainer programs for inclusion into existing programs.
- Community Health Clinics
  - Combine NRT with computer-assisted telephone relapse prevention counseling.
- Youth Leadership Programs
  - Use youth anti-smoking campaigns.
  - Train youth to carry messages to elders.
- Civic Engagement Programs
  - Form ex-smoker community "service corps" to meet and socialize with past smokers for support in remaining smoke free.
  - Tend public gardens.
  - Clean up neighborhood lots.
- Grassroots Campaigns
  - Join and support efforts to improve neighborhoods and build community leaders.
- AmeriCorps Volunteers
  - Train to work in rural communities.
- Quit and Win Contests
  - Use quitting contests. They are found to be particularly effective in SED rural communities.
- Policy Readiness
  - Use resources such as the "Social Will Index". The Social Will Index was used by the California rural SED program to study variations in California's smoke-free workplace law. The Index indicates which communities or regions are ready to comply with the law, and which ones need assistance to activate the will to implement the law.
- Smoking Substitutes
  - Explore opportunities to subsidize substitutes that could lead to healthier lifestyles and routines.
  - Provide vouchers for activities such as gym membership, art classes, and cooking classes.

Policies

- ❖ Smoke Free Housing
  - Multi-unit housing exposes non-smokers to toxins.
- ❖ Clean Indoor Air Laws
  - Often ignored in low income areas.
- ❖ Tobacco Tax
  - Funds must support programs for SED. Medication and Quitline are not enough.
- ❖ Point of Sale Advertising
  - Enact laws that require equal exposure to graphic health messages at point of sale.
- ❖ Smoke Free Casinos

- Sponsorships
    - Encourage community organizations to refuse event sponsorships from tobacco companies.

Advice from the Field: Community Advisory Committees

The CCCHE convened leaders from eight diverse Colorado communities to develop an Asset Inventory of their respective communities. The completed Inventories identified existing community resources that provide services to the SED communities. The CCCHE and other community partners can use this tool to identify resources to add value to those already listed in the Inventories in order to improve health outcomes in SED populations. Copies of these inventories are available through the CCCHE Program Director.

Literature Review

The Literature Review was conducted to explore promising practices and cultural considerations of the SED populations in general, as well as, specific to each racial/ethnic group. Cultural Considerations were developed by CCCHE members and are attached in the Appendix.

Research Conclusions

- Quitting
    - SED populations believe that quitting is mind over matter. Willpower is the only way to be successful.
    - Unsuccessful quit attempts leave the SED feeling ashamed and weak. Education should include the fact that it takes the average smoker eight attempts to succeed.
- Challenges and barriers to quitting
    - Low income people are surrounded by other smokers.
    - Families smoke. Grandparents and parents are smokers and accept smoking in children in some SED populations.
    - Stress and boredom keep people smoking: nothing to do, nowhere to go, nobody to help.
    - Being poor. It takes a specialized skill set to survive with few resources.
    - Most do not have a future orientation as the well being of families, work and basic needs take priority.
    - Quit aids are increasingly accepted, but myths about their safety, bad experiences, lack of education and the cost keep utilization low.
- Supports for quitting
    - Resources are needed to counter the immediate gratification provided by smoking.
    - Role models and success stories from trusted sources can help in handling stress, boredom, anger and depression.
    - Incentives work. Meals and gift cards provide opportunities for positive social interaction.
    - Parents are listening to their children. Work with kids around supportive messaging.
    - Provide education with no pressure to quit. Include choices of quitting options, effects of tobacco on family and the individual, years of life and money saved.

Recommendations

The CCCHE recommends the following strategies to address smoking and cessation in Colorado's SED populations.

Make the environment tobacco free – ensure enforcement of smoke free policies

- Where we work - enforce Clean Indoor Air laws
- Where we live – work toward smoke free multi-unit housing policies
- Where we hang out: parks, bars, casinos, events – strengthen Clean Indoor Air laws.

"Educate" trusted spokespeople to carry the "live smoke free" message

- Integrate the tobacco-free messages, programs and services used by this group.
- Support local influencers and trusted messengers with resources and information.

"Build" support services that are appropriate to a specific community

- Use peer to peer groups/counseling.
- Adapt Quitlines where appropriate.
- Increase access to smoke free activities such as walking, gym memberships, and bowling.

Make nicotine replacement (NRT) and other cessation aid products affordable and easily accessible.

- Make information about access to these products available.
- Address myths of nicotine replacement products.
- Give SED people the same access and availability of NRT as the insured.

Overpower the industry messages with equally strong marketing

- Have strong presence of health messages in tobacco retail outlets.
- Use culturally appropriate media to include TV/ media/ posters/ flyers.
- Have strong presence of health messages in tobacco retail outlets.

For more information or a live presentation of this report contact:

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Appendices

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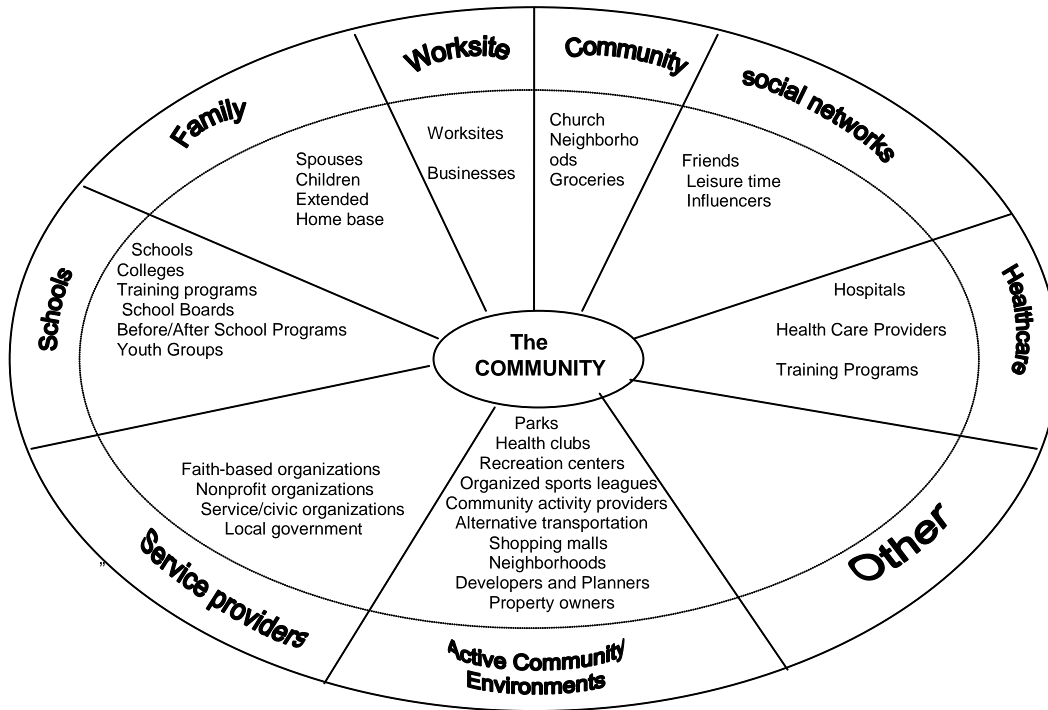
Appendix A

Asset Inventory Diagram



American Indian Cultural Considerations

- In Colorado, most American Indians are either broadly dispersed across the Denver area or on rural reservations.
  - Lack of transportation resources make it challenging to gather or provide services
  - The two reservations in Southern Colorado have very different stories.
    - The Ute Mountain Ute Tribe has very few resources and is primarily low income.
    - The Southern Ute tribe is wealthy although has many low income members.

- American Indians come from hundreds of different tribes and identity is tribal first.

- Family, Unity, Culture, Generosity, and Spirituality are primary values in American Indian Culture.
  - Unity is highly valued and provides the community its strength.
    - Unity is particularly strong on the two reservations in Southwestern Colorado.
  - Women and elders are greatly respected.

American Indian Cultural Considerations

- There is a wide spread feeling of fatalism and hopelessness among American Indian people.
  - Some feel disenfranchised and have become accepting of lower quality of care
  - Many have adopted the idea that they do not deserve high quality care.
  - Often when they see their families in ill health they feel there is nothing they can do about it and that their fate is predetermined.
- Culture and Education are the primary things that offer this community hope.
  - They do not know the health information that we assume they know. They may have heard it but do not understand it.
- Most are very private people and don't want to share their troubles, especially with people from outside of their community.

American Indian Cultural Considerations

- Historical trauma has led to high levels of mistrust.
  - "We have been lied to a lot". " Just be supportive, be there and do not lie".
  - There is a belief that the care at white hospitals is better but is not available to them as most can not pay for it. Limited free health services are available on reservations as a result of treaties Tribes made with the US Government. They will go there to get free medications but services are very limited that care for serious illness is often not available.
  - There is great mistrust of government and health care on the reservations, "The government is trying to kill us off", "the doctors are just there to get paid or do internships so we aren't getting the best".
  - Many, especially elders will not seek care even in emergencies due to past bad experiences. They will use native medicine or herbal remedies but many do not have access to traditional healers or modern medicine.
  - Many have been treated badly and shamed because of their lifestyle, hygiene or appearance.

American Indian Cultural Considerations

- There is some resistance to talking about chronic disease due to the cultural belief that to discuss it invites it into your life but once they have some education they become hungry for more.
- Ceremonial use of tobacco is a positive component of Native American culture that can lead to more positive health outcomes.
- Many have received low quality health care or have been mistreated by providers. They often avoid medical care even in emergencies.
- This group often takes non-traditional approaches to care for their health. Healthcare is often limited by access to care due to lack of insurance, or mistrust of western medicine and healthcare.
  - Many American Indians do not have access to traditional healers or modern medicine.

American Indian Cultural Considerations

- Communications:
  - When working with tribes or on reservations it is important to begin all communications through the tribal elders.
  - Many in the Denver area feel particularly connected to the Denver Indian Center
    - Fliers at the DIC was the most widely suggested as a way to inform the community
  - Teresa Halsey – Community E-Newsletter
  - American Indian Websites
  - The March Powwow is the major community event.
    - "I believe when I go to the Powwow I feel that spirit and it empowers me to stay native because we lose our nationality being so entwined with different other minorities".

Black/African American Cultural Considerations

- The term Black community is a term used to be inclusive of African immigrants and bi-racial peole who consider themselves black.
- The Black culture has built its foundation on spiritual, communal strength. The majority of community cohesion is based in the churches.
- Participants were clear that they did not feel connected to a larger Black community , “there is too much division”, but their connections to family and church were strong.
- Appearance and aesthetics are very important in this community. Low SES is not as visible in African Americans, especially women who tend to value fashion and hygiene and tend to dress well in public regardless of socio-economic status.
- There is strong recognition of women, and especially mothers as the leaders in family and community. There is also a sense of community kinship that strives to protect families and views children as the shared responsibility of the Black community.
- Twice as many Black women than men live in poverty, 62% of Black families are led by single parents, primarily women.
- Health is important to this population. Information and education are sought after, and messages about healthy foods seem to be having an effect.

Black and African American Cultural Considerations

- Presentation of health information tends to raise their level of concern, but if they are not emotionally prepared to change their behavior, they will question the information.

- This community feels strong and like they can overcome, as they have so many times.
  - They avoid talking in ways that appear weak; financial difficulties, depression, use of social services.
  - They feel stronger than many health issues and that they will escape the consequences of smoking, being overweight and alcohol.
  - Addressing obesity in the black community is particularly challenging as “skinny is a white thing”.
  - This group responds to “strengths-based” language which assumes that people know what is good for them and are making decision that are right for them and their families.
  - They usually respond well when provided options and choices that put them in control of their own processes rather than one prescribed solution to a challenge.

- Trust of “messengers” is critical and is based on relationship;
  - Trusted: pastors, elders, family members and doctors, if they have a relationship with them.
  - Not trusted: researchers, government, media and corporations
    - They feel that government and corporations threaten working class people of color and by taking their smoking, their freedom is being threatened.
    - People from outside the community or who do not understand their lives and attempt to bring services are not trusted. For example, non-smokers talking about cessation, “skinny white people” teaching exercise and nutrition.

Latino/Hispanic Cultural Considerations

- The primary values in the Latino/Hispanic culture are work, faith and family.
  - Work ethic is high and health is assumed good if you are not sick and health is termed in the form of its effect on work.
  - Churches are important gathering places in this culture
- The Latino/Hispanic family runs as a strong unit. Women often are the leaders in the household and family decisions. Women show respect to their husbands by taking decisions to them before they are final. Men usually control the finances.
- Education interventions can cause a rift in families if women are trained without considering how their families can be included. Men can feel threatened by “not knowing” something that his wife or family knows.
- Less acculturated, urban Latino/Hispanics often live in “small towns” within large cities, “within a 10 block radius” and have a more rural culture. The more one is acculturated the more comfortable they become to venture out in the city and mix with different cultures.
- Cohesiveness and loyalty characterize relationships among close and extended family members, regardless of the number of years in the U.S.

Latino/Hispanic Cultural Considerations

- Latino/Hispanic culture values behaviors that promote smooth and pleasant social relationships. Assertive behaviors can be perceived as rude.
- People are open to those they recognize and who look like they belong to the same culture.
  - Promotoras tend to have success because they are hired directly from a community and seen as trustworthy.
  - Follow through is often minimal unless a relationship is formed.
- Organizations earn trust over time by having a continuous presence and following through with what they promise.
- People from outside the community, from the government or different ethnicities are treated with politeness, and with authority but are not trusted.
- This culture values politeness and avoids conflict. Assertive or succinct communication can be seen as threatening or rude.
- Priests and ministers are trusted leaders other leaders are often not those in positions of power but are often those best known in neighborhoods as information sources, role models, and problem-solvers.

Latino/Hispanic Cultural Considerations

- Latino/Hispanic culture values relationship which takes time, friendly interaction, listening and a sincere concern about each others lives.

- Acculturation is a primary determiner of education and work ethic.
  - New immigrants come to this country often with little education but a strong desire to work.
  - More acculturated , long term residents are more open to try new things and a few will “work the system” going from one program to another.

- Historical trauma has caused many immigrants (including legal) to have great fear of the “system”, they “lay low”, won’t accept help and avoid government programs.
  - When they do access services of any sort there is a level of nervousness and skepticism about how they will be treated and whether they will be questioned about their immigration status.

- Finances are unpredictable in many low income Latino families due to high rates of contract or seasonal work.
  - They can make large amounts for a short time and then nothing for months.
  - Often can not qualify for assistance because they apparently, make too much money.

- Latinos with health insurance typically do not believe that they need health education.

Latino/Hispanic Cultural Considerations

- Latino/Hispanic families are very busy as they spend most of their time working or trying to find work. There is little time for recreation or educational activities.
- Once they have some education and can see the benefits of the information to their families, they want more.
- They tend to be self-sufficient and seldom ask for help, but are quick to respond if asked to be involved or help.
- The tobacco industry has identified assimilation (Americanization) as a force that can promote smoking among the Hispanic population.
  - Less acculturated Latino smokers more strongly want to quit, have fewer resources for help and more often hold false beliefs about quitting.
  - More acculturated Latino smokers have more accurate knowledge about tobacco use but are more resistant to quitting.
- Most effective communication channels:
  - Men: radio and employment settings
  - Women: churches, schools, informal social networks

LGBT
Cultural Considerations

- The term LGBT culture or community is a misnomer as really there is not one culture or community but there is a feeling of shared identification.
  - This community encompasses many small homogenous groups based on gender, class, race and ethnicity and interest.
- Access to health care is very different between the women's, men's and transgender segments of this population. Most gay men and transgendered people have close relationships with the health care system whereas lesbians will often avoid going to doctors due to financial constraints and prior negative experiences with the health care providers.
- The LGBT population is the only priority population where the women smoke more than the men (46% vs. 30%).
- Data shows that LGBT people are concentrated in urban areas. It is important to note that it is also easier to identify as LGBT in urban areas while people living in rural and suburban areas more often are not "out" in their communities and can feel very isolated. In this case, the internet can play an important role as their social connection.

LGBT
Cultural Considerations

- It is a myth that the LGBT population in wealthy. Often the most visible member of the community are wealthy gay men which can lead to this perception. Low income LGBT experience more discrimination and isolation than higher income especially in people of color and as they age which may account for the very high rates of anxiety, depression, drug and alcohol use in this community.

- The higher the social exclusion the lower the income.

- Historical trauma has caused many older LGBT people to hide their sexual orientation from family, friends and their neighbors. Younger LGBT people are much less hidden and open with their lives.

- There is a widespread feeling that programs and services may not welcome LGBT people. It is very helpful to have visual clues in offices or have inclusive paperwork that lets them know that they are welcome and can share details of their lives with health care and other service providers. There are very few services that offer culturally competent services to them.

LGBT
Cultural Considerations

- Transgender people experience high rates of social exclusion, very low income and very high smoking rates.
- LGBT people seek out others like themselves more than most populations. Social support is especially important to this group as they more often do not have access to support from family, schools or churches. They can be overly dependant on friends and their friends usually smoke.
- The internet is a valuable life line to many LGBT people who are hidden because of unsafe family, living or work situations.
- Communications:
  - Bars are a primary gathering place for this community.
  - PrideFest celebrations are held in Denver, Ft. Collins, Boulder and Colorado Springs and are attended by significant segments of the LGBT communities in those areas.
  - LGBT friendly churches, primarily Metropolitan Community Church serve many low income members of this community.

Rural Communities Cultural Considerations

- Each rural community is unique, very close knit, and people usually know each other.
- In Colorado, most small, rural communities have large Latino populations and Black populations are very small.
- Families are strong and often grandparent either live with, or near their children's families.
- Many families although low income, are functional and hard working, just struggling to make ends meet .
- Low income residents are usually completely integrated into most small towns.
- Schools and church activities and athletic events are the major gathering place.
- Lack of employment is the primary stressor.
- Fatalism and depression are common and smoking is the least expensive thing to make them feel better. There is pervasive pessimism about the future.
- Smoking is the norm and typically social occasion revolve around smoking and often drinking.

Rural Communities
Cultural Considerations

- Personal relationships are valued highly and new ideas have more success if brought into communities by local opinion leaders. Opinion leaders are often from local youth serving groups and local business owners.
- Opportunities for free or low cost entertainment and activities are rare especially in the winter. Local events, festivals, and fairs are widely attended by many in rural communities.
- Time and transportation demands are greater in rural areas as most residents live away from town centers.
- Reciprocity is an important value.
- Communication works differently in small rural counties than in urban areas and they often differ from each other. In some, there are local radio shows that are the source for information while in others it is community newspapers. Always, it is **word of mouth**.
- The primary businesses and gathering places in rural areas are bars.