- They may be unable to afford the high cost of some group interventions.
- They may perceive such efforts to be inconvenient (e.g., requiring transportation and child care) and time consuming.
- They may prefer to deal with personal problems alone or in the family rather than to seek professional or other help outside of the home.
- They may lack access to linguistically appropriate services.
- They may distrust researchers and health care providers who are not members of their racial/ethnic groups or who are unaware of their culture and behavioral expectations and traditions.
- If they have physically demanding jobs or heavy caregiving responsibilities, they may be too exhausted to attend program meetings.

The difficulty in obtaining enough individuals to participate in smoking cessation groups or even to continue their participation after a few initial sessions has been a problem for many ethnic smoking cessation programs, including those targeting Hispanics in San Francisco, California (Pérez-Stable et al. 1993) and Queens, New York (Nevid and Javier 1992), African Americans in Atlanta, Georgia (Ahluwalia and McNagny 1993), and Chinese restaurant workers in Boston, Massachusetts (Betty Lee Hawks, personal communication, 1993). As a result, many programs have stopped using cessation groups as a possible intervention strategy and as a way to deliver information personally.

As an alternative to group approaches, intervenors in San Francisco began offering personal consultation over the telephone and face-to-face (Pérez-Stable et al. 1993). Trained individuals provide information and support to smokers who want more information than is provided in a self-help manual. This approach (labeled *consultas*, or personal consultations), although demanding in terms of time and personnel, is considered culturally appropriate among Hispanics, who traditionally value personal attention. This alternative also allows telephone advisors to tailor the information to each person's needs. Another alternative program, which provides individual counseling to Southeast Asian smokers in their homes rather than in clinics, has been well received in Long Beach, California (Mary Anne Foo, personal communication, 1994).

Community Approaches

Most community smoking cessation programs targeting members of racial/ethnic groups have been conducted in fairly large urban communities and have used self-help materials together with mass media and outreach workers. In a recent overview of community-wide programs targeting cardiovascular disease, Winkleby (1994) noted the need to conduct focused studies with populations that have not been reached successfully in the past with large-scale projects, as is the case with members of the four racial/ethnic minority groups considered in this report.

Because so many racial/ethnic groups place a high value on the family and on the authority of older relatives (Sabogal et al. 1987), some community programs have employed family-centered interventions, working under the assumption that a smoker's children and other relatives can effectively intervene and that parents can be a child's best source of information regarding smoking-prevention programs. In Boston, the South Cove Community Health Center involved more than 350 Chinese elementary school children in a poster contest to depict the hazards of tobacco. Many of these posters depicted the father smoking at home and motivated children to discuss cigarette smoking in their homes (Esther Lee, personal communication, 1993). In a Vietnamese Saturday language school program in Sacramento, California, youths have been mobilized to carry antismoking messages to their families and to encourage them to avoid using tobacco (Debra Oto-Kent, personal communication, 1993). In another project, Asian American and Pacific Islander children were asked to compete in a "letter to my parents" writing contest, asking them not to smoke (Irene Linayao-Putman, personal communication, 1993). Anecdotal information about this and similar programs indicates that the children enjoy these activities and that their parents are seldom discomforted by the letters, particularly when they perceive the programs to be sanctioned by the school system. Nevertheless, the usefulness of such an approach may be limited in families that maintain strict patriarchal or matriarchal structures in which children's interventions may be perceived as a lack of respect toward adults or as a challenge to the parents' authority.

As mentioned previously, large-scale community projects generally have used multiple strategies and channels to disseminate smoking cessation information and to motivate smokers to quit. A sample of programs targeting members of the four racial/ethnic groups is presented below. This listing represents the

variety of community approaches developed to help racial/ethnic smokers quit but should not necessarily be perceived as a list of model programs.

Stanford Five-City Multifactor Risk Reduction Project

Researchers at Stanford University developed the Stanford Five-City Multifactor Risk Reduction Project to examine cardiovascular disease and related risk factors over a nine-year period in five small communities in northern California. The project was based on behavior-change models and social-learning theory (Farquhar et al. 1985, 1990) and used television, mass-distributed print media, direct mailings, contests, correspondence courses, and school-based programs for youths. In the communities with very high concentrations of Hispanics, Spanish-language radio and newspaper columns were chosen as the primary methods of disseminating information. The decline of smoking rates was 13 percent greater in the treatment cities than in the control cities (Farquhar et al. 1990). Although researchers observed no differences in the proportion of experimental or control respondents who reported ever receiving advice from physicians on quitting smoking, whites (51.1 percent) were much more likely to report having received this advice than Hispanics (32.6 percent) (Frank et al. 1991).

Researchers found that the project was fairly successful in promoting the use of self-help smoking cessation materials among whites. A greater proportion of smokers in the experimental communities (22.1 percent) than in the control communities (15.0 percent) reported using smoking cessation materials in the 12 months before the interview (Jackson et al. 1991). In the experimental communities, Hispanics and whites did not differ in their reported use of materials to reduce cardiovascular risk. When asked about their use of tobacco control materials, 31.0 percent of Hispanic women and no Hispanic men reported using smoking cessation print materials during the previous 12 months, compared with 21.3 percent of white women and 13.7 percent of white men.

The project was less effective in promoting smoking cessation programs; no Hispanic smokers reported using such programs, compared with 6.3 percent of white smokers. More recent analyses of and comment on risk-reduction data from this and other community-based interventions suggest that such interventions can achieve more positive results by being coupled with policy initiatives, developing more focused studies, and broadening evaluation concepts (Winkleby et al. 1992; Fortmann et al. 1993; Winkleby 1994).

Programa Latino Para Dejar de Fumar (Hispanic Program to Quit Smoking)

The Programa Latino Para Dejar de Fumar was a community-based, culturally appropriate intervention designed specifically for Hispanic smokers in San Francisco (Pérez-Stable et al. 1993; Marín and Pérez-Stable 1995). Funded by the NCI for 1985–1995, the program was operated jointly by the University of California, San Francisco, and the University of San Francisco. To motivate Hispanic smokers to quit and to inform them of strategies to stop smoking, the program used mass media (primarily radio and television public service announcements), outreach efforts, and distribution of the *Guía*. Program planners developed the various versions of the *Guía*, implemented the *consultas* approach to deal with individual needs for counseling, and used a periodic raffle to reward individuals who quit smoking within a given period of time (Pérez-Stable et al. 1993). Intervention messages were based on research that identified the attitudes, norms, expectancies, and values of Hispanic smokers (Marín et al. 1990a,b). The strategies incorporate significant cultural values such as *familialism* (the normative and behavioral influence of relatives) (Sabogal et al. 1987) and *simpatía* (a social mandate for positive social relationships) (Triandis et al. 1984). For example, a key message of the program was that smokers should quit to protect the health of their children and to avoid setting a bad example for children. To incorporate *simpatía* into the program, planners developed intervention materials that emphasized the positive aspects of quitting and avoid confrontational approaches. This latter approach was similar to that used in materials developed for American Indians (American Indian Cancer Control Project 1991).

The Programa Latino Para Dejar de Fumar has been evaluated through a number of cross-sectional and longitudinal surveys as well as through smaller scale studies that have examined the effectiveness of specific strategies (Marín et al. 1990c, 1994; Pérez-Stable et al. 1993; Marín and Pérez-Stable 1995). The program has significantly increased Hispanics' knowledge about the dangers of smoking, awareness of the program, and participation in the program. Most important, the program has decreased the prevalence of smoking among Hispanics in San Francisco (Marín and Pérez-Stable 1995). These changes have been observed primarily among the less acculturated Hispanic smokers who make up the targeted group. For example, during the first year of the program, 24.9 percent of the less acculturated Hispanics in San Francisco reported awareness of the program; two years later, that

proportion had increased to 48.5 percent (Marín et al. 1990b; Marín and Pérez-Stable 1995). During the first year in which the *Guía* was available, 23 percent of the less acculturated Hispanic women and 12 percent of the less acculturated Hispanic men in San Francisco reported having a copy. One year later, the proportion of the less acculturated Hispanics who reported having a copy of the *Guía* had increased to 37.7 percent of the women and 34.1 percent of the men.

Sí Puedo (Yes, I Can)

Sí Puedo was an eight-week smoking cessation program designed specifically for Hispanic smokers in a largely Hispanic area of Queens, New York. The program used the *Guía* and other print materials, weekly bilingual group meetings, regular telephone calls to offer support to participants, and videotaped vignettes in which Hispanic actors conveyed smoking cessation messages. Persons were recruited through mass media advertising, direct mailings to Hispanic physicians and clergy, and fliers posted throughout the community. Most participants were from South America (57 percent); the rest were from the Caribbean (25.4 percent) or Central America (9 percent). Some people participated in all aspects of the program, whereas others used only the self-help materials. Preliminary figures show that 55.6 percent of the participants who took part in all components of the Sí Puedo smoking cessation program stopped smoking by the end of the program (Nevid and Javier 1992). In comparison, 21.7 percent of those who used only the self-help materials abstained from smoking.

Pathways to Freedom Community Demonstration Project

The American Cancer Society (ACS) used the *Pathways to Freedom* manual and videotape as part of a demonstration project to lower the prevalence of cigarette smoking among African Americans (Robinson et al. 1992; Robinson and Sutton, in press). During the first phase (1992–1993), the ACS provided funds to eight of its local units in Long Beach and central Los Angeles, California; Philadelphia, Pennsylvania; Delaware; the District of Columbia; Georgia; Kansas; and Texas. The ACS units developed programs to recruit African American smokers to quit smoking using the *Pathways to Freedom* materials and to expand the ACS's outreach into African American communities. Many of them planned their projects to coincide with the Great American Smokeout (GAS).

In the second phase of the project (1993–1994), the ACS provided funding to seven more local units in Contra Costa and San Diego Counties, California; Maryland; Nebraska; Chattanooga and Memphis, Tennessee; and Utah. Cessation activities expanded to include efforts to mobilize African American communities and to identify more individuals and groups willing to become tobacco control advocates.

The process evaluation of the first phase showed that the program was easier to implement in communities with a previous history of community-based outreach efforts (Robert G. Robinson et al., unpublished data). Dissemination of the self-help manual was most difficult in multiethnic communities and areas of a city. Most ACS agencies used a variety of distribution channels, including churches, health care organizations, and recreation centers. The program helped the ACS to approach African Americans and to gain support from African American volunteers. Even though the project emphasized self-help approaches, several ACS units incorporated *Pathways to Freedom* materials into smoking cessation groups conducted in African American communities.

The outcome evaluation of the first phase consisted of telephone interviews with 763 smokers who returned a screening postcard that was attached to each *Pathways to Freedom* manual. Respondents reported a favorable impression of the manual and a 10 percent quit rate at 30 days. In addition, smokers who viewed the *Pathways to Freedom* videotape were significantly more likely than others to accept and use the self-help materials as well as to move from precontemplation to contemplation in the process of changes involved in smoking cessation.

Quit Today!

A two-part study funded by the NCI will evaluate the effectiveness of the *Pathways to Freedom* manual and videotape when incorporated into a community-based campaign targeting adult African American smokers. In the first phase of the project, the *Pathways to Freedom* videotape will be distributed communitywide, and paid radio announcements will be aired, encouraging smokers to call the CIS for help. In the second phase of the project, callers to the CIS will be randomly selected to receive either the *Pathways to Freedom* manual and smoking cessation counseling related to the manual or an NCI manual and standard CIS smoking cessation counseling. Results of this study should produce important information about the effectiveness of targeted self-help smoking cessation materials for African Americans combined with established services such as the CIS.

Chicago Lung Association's Multifaceted Smoking Cessation Intervention

In 1985, Warnecke and colleagues (1991) launched a multifaceted smoking cessation intervention on behalf of the Chicago Lung Association. Like a number of programs, this intervention used materials originally produced for whites to target members of other racial/ethnic minority groups. The program used televised messages on techniques for quitting smoking and avoiding relapse as well as the ALA self-help manual and smoking cessation groups. More than 325,000 smokers in the targeted population viewed televised messages featuring role models who encouraged them to obtain a self-help manual, *Freedom from Smoking in 20 Days*, by mail or at one of three locations—a local hardware store, an HMO, or the Chicago Lung Association. A total of 9,182 smokers (23 percent of whom were African American) registered to participate in the study and were followed for 24 months. The results showed that African American and white smokers responded differently to various smoking cessation strategies. For example, African Americans were more likely than whites to report seeing the televised messages on a daily basis and were more likely to recall the messages. However, African Americans were less likely than whites to attend smoking cessation groups.

As an adjunct to the Chicago Lung Association's program, Jason and colleagues (1988) studied the effects of a television program in the West Garfield Park neighborhood of Chicago, where 86 percent of the residents were African American. Before the television program aired, individuals who reported smoking were randomly assigned to a control group (91 percent were African American) or to an experimental group (96 percent were African American). Members of the control group viewed the program or read the self-help manual at their leisure, whereas members of the experimental group received motivational calls prompting them to view the television program and inviting them to attend smoking cessation meetings at a community health center three times during the 20-day program. Eight percent of the smokers in the experimental group reported quitting at the end of the program, compared with 1 percent of those in the control group. After four months, 20 percent of the smokers in the experimental group had quit, compared with 9 percent of those in the control group.

Chicago Community-Based Interventions for Low-Income African Americans

In conjunction with the smoking cessation television program sponsored by the Chicago Lung Association, Lacey and colleagues (1991) designed community-based interventions for low-income African Americans living in four subsidized housing projects in Chicago. Residents were trained as lay health advisors to deliver smoking cessation messages to their neighbors. They made weekly home visits during the 20 days in which the television program was aired, and they used reminder cards to support the positive behaviors outlined in the program. A subsample of women in the housing projects watched the televised program and participated in six smoking cessation classes, which used a curriculum similar to the one presented in the television program. Health educators gave the women supplemental materials appropriate for them and tips on sources of social support for smoking cessation. Classes were held in the housing projects. Of the 235 residents who preregistered for the smoking cessation intervention, 141 attended at least one class or accepted at least one home visit. Of the 56 women who attended at least one class session, 11 percent quit smoking. About one-half of the 174 residents who registered for the home visitation accepted such a visit, but none quit smoking. Focus groups conducted in conjunction with the intervention indicated that residents of the housing projects perceived that they were not vulnerable to the negative health consequences of smoking, that smoking helped them to cope with stress, and that they had few environmental supports for quitting smoking.

Freedom from Smoking® for You and Your Family on TV/Por Su Salud y Su Familia

Like the Chicago Lung Association's intervention, the Freedom from Smoking® for You and Your Family Project in California featured role models in televised pieces and distributed self-help materials. In 1991, project planners produced special editions of the ALA *Freedom from Smoking® for You and Your Family* self-help manual and the *Guía* and placed them in a newspaper insert that was distributed throughout seven English-language television markets—Eureka, Fresno, Los Angeles, Sacramento, Santa Barbara, San Diego, and the San Francisco Bay area—and four Spanish-language television markets—Fresno, Los Angeles, Sacramento, and the San Francisco Bay area. In addition, locally produced television pieces in both English and Spanish were shown for seven days as part of the daily news. These news pieces included interviews with Hispanic and white experts on tobacco-use control and with four local residents who had volunteered to use the self-help materials to quit smoking. The program reached nearly 1.2 million

smokers (C. Anderson Johnson et al., unpublished data). The newspaper insert was most frequently read by white (22 percent), Asian American and Pacific Islander (18 percent), and African American (16 percent) smokers; smaller proportions of English-speaking Hispanics (14 percent) and Spanish-speaking Hispanics (10 percent) read the insert. The television pieces were viewed most frequently by Spanish-speaking Hispanics (25 percent), followed by African Americans (14 percent), Asian Americans and Pacific Islanders (9 percent), whites (9 percent), and English-speaking Hispanics (9 percent). A year after the intervention, 3.1 percent of the people who had read the English-language newspaper insert and had viewed the television piece were former smokers; this was true among all racial/ethnic minority groups except Spanish-speaking Hispanics. In comparison, 1.5 percent of the people who did not participate in the program were former smokers. By itself, neither the English-language television piece nor the newspaper insert was effective in promoting smoking cessation. Viewers of the Spanish-language television program, which used culturally appropriate materials, were more successful; 9 percent of viewers were former smokers at 12 months, compared with 2 percent of smokers who did not view the program.

A Su Salud (To Your Health)

A Su Salud was a mass media health promotion program conducted from 1985 through 1990 to reduce smoking among Mexican Americans residing along the U.S.-Mexico border in Eagle Pass and Del Rio, Texas (Ramirez and McAlister 1988; Amezcua et al. 1990). This mass media campaign used role models, an extensive media campaign, community volunteers, and behavioral modeling techniques grounded in the principles of Bandura's (1977) Social Learning Theory. It was modeled after a similar program implemented in North Karelia, Finland (McAlister et al. 1982; Puska et al. 1987). A Su Salud recruited individuals who wanted to quit smoking, organized focus groups to determine their needs and levels of awareness about tobacco use, and then featured community role models in a series of informational programs that were televised on local Spanish-language stations. The media messages were reinforced through a network of community volunteers who personally contacted the targeted population individually or in small groups. The volunteers delivered calendars with community events and stories about the role models. The program also produced *fotonovelas*—pictorial stories, presented in a comic-book format, which depicted smoking cessation behaviors. The program resulted in a modest but notable increase in smoking cessation rates among community members. Out of the 17 percent of smokers who reported that they had quit smoking, 8 percent were verified (McAlister et al. 1992).

University of North Carolina/North Carolina Mutual *Quit for Life Guide*

The Quit for Life program used lay leaders to promote smoking cessation messages. The *Quit for Life Guide* was based on the ALA's Freedom from Smoking® for You and Your Family Project and targeted policyholders of the predominantly African American North Carolina Mutual Life Insurance Company (Schoenbach et al. 1988). The program was novel in that it was delivered by the company's life insurance sales agents, who discussed the health consequences of smoking with their customers and provided social support for quitting and avoiding relapse (Orleans et al. 1989). The Quit for Life program was moderately effective in promoting smoking cessation among the targeted low- to middle-income smokers. Over a two-year period, 2,042 smokers enrolled in the program. About 14.9 percent of the participants who received self-help materials, telephone counseling, and agent support quit smoking at 12 months, compared with 14.1 percent of the participants who received just self-help materials and agent support, and 12.3 percent of the control subjects, who received agent support only. Verifying these self-reported quit rates was impossible, however, because few respondents agreed to provide saliva samples for a cotinine test, which would have provided biochemical verification (Schoenbach et al. 1988).

In an eight-week follow-up study, the Quit for Life program targeted the insurance company's corporate employees in a large urban center. Preliminary results regarding policyholders in one sales district and lasting eight weeks showed that 8 of the 126 African American smokers enrolled in the program (6 percent) were nonsmokers six months after enrollment (Sandra W. Headen et al., unpublished data).

Legends

Beginning in 1993, the NMA and CDC began cosponsoring the Legends campaign. Legends is the only national-level, mass media motivational campaign directed at African Americans who want to quit smoking. The campaign consists primarily of public service television and radio announcements that use famous African American leaders and historic figures, such as Martin Luther King, Jr., and Malcolm X, to motivate

smokers to quit. Individuals interested in quitting can request the *Pathways to Freedom* cessation guide by calling a toll-free telephone number; the Legends campaign generated more than 7,500 calls for the *Pathways to Freedom* guide within the first 18 months. The NMA has supported the campaign at the local level by promoting media and community outreach activities, including billboard advertisements, in 14 NMA-sponsored "Healthy People 2000" cities across the country.

Great American Smokeout

GAS is an annual ACS-sponsored event that encourages smokers to quit. The results of a 1991 Gallup poll indicated that smokers of various racial/ethnic minority groups may respond favorably to the GAS (CDC 1992). Fewer African Americans and Hispanics than whites reported being aware of the Smokeout. However, 25 percent of African Americans and Hispanics who were aware of the GAS reported participating in the project, and 14 percent of those who participated reported that they were not smoking cigarettes one to three days after the GAS (CDC 1992). The same poll estimated that during the 1991 GAS, approximately one-third of smokers in the United States participated, either by not smoking or by reducing the number of cigarettes they smoked (CDC 1992). Lieberman Research Inc. (1993) found that 26 percent of smokers from racial/ethnic communities (i.e., African Americans, Asian Americans, Hispanics, and others) participated in the 1993 GAS, compared with only 19 percent of white smokers. In interviews conducted 1 to 10 days after the GAS, however, similar proportions of racial/ethnic group members (18 percent) and whites (17 percent) reported that they had quit or that they were smoking less than before the GAS.

Suc Khoe La Vang! (Health is Gold!)

From 1990 to 1992, Suc Khoe La Vang! (Health is Gold!), the Vietnamese Community Health Promotion Project, conducted media-led smoking reduction campaigns targeting Vietnamese men in San Francisco and Alameda Counties and in Santa Clara County, California (McPhee et al. 1993, 1995; Jenkins et al. 1997). Both interventions used materials that were produced in Vietnamese. The programs included antitobacco counteradvertising campaigns that used billboard, print, and television advertisements; published articles in Vietnamese-language newspapers; a videotape that aired on Vietnamese-language television stations; health education materials such as brochures, a quit kit, posters, bumper stickers, and a calendar; a continuing medical education course on smoking cessation counseling methods for Vietnamese physicians; and the distribution of printed "no smoking" signs and ordinances. Unlike the Santa Clara intervention, the San Francisco campaign was preceded by a 15-month pilot antitobacco media program and included a component for students and their families.

The evaluation of the programs showed that the Santa Clara intervention did not influence cigarette smoking prevalence or recent quitting status (quitting during the prior two years) (McPhee et al. 1995). However, a program effect was observed in the San Francisco trial, such that the odds of being a smoker were significantly lower and the odds of quitting recently were significantly higher in San Francisco than in a comparison community (Jenkins et al. 1997). The authors explained the difference in two ways, the longer duration of exposure to the antitobacco campaign in San Francisco (39 months) than in Santa Clara (24 months) and the added school- and family-based component of the San Francisco campaign.

Involvement of Health Care Providers

A number of successful smoking cessation approaches use health care providers, primarily physicians and dentists, to inform patients about the urgency of quitting smoking and to suggest quitting strategies (Health and Public Policy Committee 1986; Flay et al. 1992; Reid et al. 1992; NCI 1994; Fiore et al. 1996). Although this approach may be effective with members of the four racial/ethnic minority groups studied in this report—particularly those groups that exhibit high *power distance* (i.e., the respect for and deference to authority figures such as physicians, teachers, and older people) (Hofstede 1980)—a number of structural characteristics limit the usefulness of this approach. The most important limitation is that a large proportion of members of these racial/ethnic minority groups lack access to primary care providers. This problem has been widely documented among adult members of racial/ethnic groups (Aday et al. 1993) and adolescents (Lieu et al. 1993), such as among African Americans (Hopkins 1993) and Hispanics (Treviño et al. 1991; GAO 1992; Pierce et al. 1994b).

Data from the 1990 California Tobacco Survey showed that 46.9 percent of Hispanic smokers had not visited a physician in the 12 months before the survey, compared with 42.0 percent of Asian Americans and Pacific Islanders, 26.7 percent of African Americans, and 33.4 percent of whites (Burns and Pierce 1992). According to the 1992 NHIS data on

cigarette smokers, 37.6 percent of Hispanics, 26.1 percent of African Americans, and 29.2 percent of whites had not visited a physician during the year preceding the survey (Tomar et al. 1996). Data from the 1989 NHIS on the number of annual visits per person to the dentist showed that African American men (1.0 visits) and women (1.4 visits) made fewer visits than Hispanic men (1.5 visits) and women (1.7 visits) and white men (2.1 visits) and women (2.4 visits) (Bloom et al. 1992). Among smokers, national data collected in 1992 showed that 42.6 percent of African Americans, 39.3 percent of Hispanics, and 54.4 percent of whites had visited a dentist during the preceding year (Tomar et al. 1996). In addition, because many health care providers lack linguistic skills and training in cultural sensitivity, they tend to be ineffective advocates of smoking cessation among members of ethnic groups. Equally problematic is the fact that few physicians have the necessary training, feel qualified and supported, or express interest in recommending quitting to smokers (Kottke et al. 1994).

Available data indicate that a large proportion of health care providers, primarily physicians, do not take advantage of office visits to encourage smokers to quit. In general, members of racial/ethnic groups are less likely than whites to receive advice on quitting smoking from their physicians, and they are even less likely to receive such advice from their dentists (e.g., Kogan et al. 1994; Winkleby et al. 1995; Hymowitz et al. 1996). According to data from the 1992–1993 CPS, about 42.4 percent of Hispanics and 45.4 percent of African Americans who had visited a physician during the previous year reported that within that year they had received a physician's advice on quitting smoking, compared with 50.4 percent of whites (Table 5) (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993). In general, women reported receiving a physician's advice in greater proportions than men. When asked if they had ever received a physician's advice on quitting smoking, only 39.8 percent of Hispanics said they had, compared with 47.2 percent of African Americans, 45.7 percent of Asian Americans and Pacific Islanders, 54.5 percent of American Indians and Alaska Natives, and 58.1 percent of whites. Results of the 1991 NHIS show that whereas 38.2 percent of whites reported receiving advice to quit from a physician or other health care professional at any visit during the preceding 12 months (CDC 1993a), a percentage significantly higher than for Hispanics (30.6 percent), such advice was received by 34.4 percent of African Americans, 41.4 percent of American Indians and Alaska Natives, and 34.4 percent of Asian Americans and Pacific Islanders. According to the 1992 NHIS data on cigarette smokers who had visited a physician during the previous year, 55.5 percent of whites, 50.2 percent of African Americans, and 35.1 percent of Hispanics reported that a physician had advised them to quit smoking during the preceding year; among smokers who had visited a dentist during the previous year, 23.4 percent of whites, 26.3 percent of African Americans, and 27.2 percent of Hispanics reported that a dentist had advised them to quit during the preceding year (Tomar et al. 1996). Because questions were worded differently about advice from health care providers on quitting smoking, estimates based on data from the 1991 NHIS and the 1992 NHIS are not directly comparable and cannot be interpreted as indicating a secular trend. Findings from other surveys show that among African Americans, pregnant women are the most likely to receive smoking cessation advice and services in a health care setting (O'Campo et al. 1992; Tiedje et al. 1992).

Results from the 1992 California Tobacco Survey showed that among smokers who visited a physician in the previous year, 60.9 percent of Hispanics did not receive advice on quitting smoking, compared with 56.0 percent of African Americans and 47.8 percent of whites (Pierce et al. 1994b). These figures are comparable to those found in the Stanford Five-City Multifactor Risk Reduction Project, in which 63.4 percent of Hispanic smokers reported never being advised to quit smoking by their physician, compared with 45.9 percent of whites (Frank et al. 1991). These differences seem to be particularly notable among less educated Hispanics (Winkleby et al. 1995).

Despite these limitations, the use of health care providers to promote smoking cessation can have promising results (Royce et al. 1995). The CDC has funded the design of protocols that will prescribe strategies health care providers can use when counseling patients in smoking cessation, using the *Guía* for Hispanics and the *Pathways to Freedom* program for African Americans. In addition, the NCI has produced a number of publications reviewing this approach (NCI 1994) as well as training materials to teach health care personnel how to promote smoking cessation (Glynn and Manley 1992), and a recent publication has evaluated the effectiveness of various smoking cessation approaches available to primary care clinicians (Fiore et al. 1996).

For You and Your Family

The For You and Your Family project provides tobacco-use prevention services to racial/ethnic communities in health care settings. The project, sponsored by California's Department of Health Services, was

Table 5. Percentage of adult smokers who have received advice to quit smoking from either a medical doctor or a dentist, by race/ethnicity and gender, Current Population Survey, United States, 1992–1993

Characteristic	African Americans		American Indians/ Alaska Natives		Asian Americans/ Pacific Islanders		Hispanics		Whites	
	%	±CI*	%	±CI	%	±CI	%	±CI	%	±CI
	Received advice from a medical doctor in past year†									
Total	45.4	1.7	48.3	6.2	49.6	5.3	42.4	2.6	50.4	0.7
Men	42.5	2.6	45.2	9.0	50.1	6.8	39.6	3.6	48.8	1.0
Women	47.3	2.2	51.0	8.5	48.8	8.6	45.5	3.8	51.7	0.9
	Received advice from a medical doctor ever									
Total	47.2	1.4	54.5	5.3	45.7	4.1	39.8	2.0	58.1	0.6
Men	40.5	2.1	50.4	7.5	43.7	4.8	33.2	2.5	53.1	0.8
Women	53.1	2.0	58.6	7.4	50.4	7.5	50.0	3.3	63.1	0.8
	Received advice from a dentist in past year‡									
Total	20.6	1.8	21.1	6.3	30.5	5.0	22.6	2.6	19.6	0.6
Men	22.0	2.8	28.5	10.1	36.3	6.4	23.3	3.6	21.4	0.9
Women	19.6	2.3	14.2	7.5	19.3	7.3	21.7	3.7	18.0	0.8
	Received advice from a dentist ever									
Total	14.7	1.0	18.2	4.1	24.9	3.5	16.7	1.6	18.6	0.4
Men	15.4	1.5	21.2	6.1	26.7	4.3	15.7	2.0	19.4	0.6
Women	14.1	1.4	15.2	5.4	20.8	6.1	18.2	2.6	17.8	0.6

*95% confidence interval.
†Among persons who visited a medical doctor during the past year.
‡Among persons who visited a dentist during the past year.
Source: U.S. Bureau of the Census, National Cancer Institute Tobacco Use Supplement, public use data tapes, 1992–1993.

developed recently by a team of California researchers. This multicultural perinatal project seeks to reduce cigarette smoking among pregnant women and to limit their exposure to ETS. The project includes a trainer's guide, a health care provider's guide, and targeted client education materials for African Americans, American Indians, Hispanics, and Asian Americans (i.e., Cambodians, Chinese, Koreans, and Laotians). Materials for clients differ in their content and format, depending on the racial/ethnic group being targeted; the materials range from a brochure for African Americans entitled *Hey, Girlfriend, Let's Talk About Smoking and You* to a four-color magazine entitled *La Mujer: La Familia y el Cigarrillo*, which motivates Hispanic women to quit and provides suggestions and techniques for quitting and maintaining abstinence (Otero-Sabogal and Sabogal 1991).

The importance of developing smoking cessation programs for pregnant women of various races/ethnicities has been documented recently among American Indians (Bulterys et al. 1990). By using statistical models with information on the health status of American Indians in the Aberdeen IHS area, Bulterys and colleagues found that by quitting smoking, American Indian pregnant women would prevent 2.6 percent of all infant deaths, 3.7 percent of postneonatal deaths, and 1.2 percent of neonatal deaths.

American Indian Cancer Control Project

The American Indian Cancer Control Project in California used self-help techniques, individual counseling, and cultural interventions to help American Indian smokers quit. Access to American Indians over the age of 18 years was facilitated through 18 northern California clinics owned and operated by American Indians. Fourteen rural clinics located on or near reservations and four urban clinics participated in the project. The project has been testing a clinic-based, physician-initiated message enhanced by using American Indian community health representatives who also provide outreach support. Recent data indicate that the clinic-based procedures were an acceptable and accessible means of reaching the American Indian population in northern California (Hodge et al. 1995, 1996). Evidence from this project suggests the need for culturally appropriate smoking cessation programs (Hodge et al. 1995).

Involvement of Employers

Employer-provided smoking cessation programs could help to lower the prevalence of smoking, yet very few individuals report having such programs available to them. Data from the 1992–1993 CPS showed that 23.6 percent (95 percent confidence interval [CI] = ± 0.9 percent) of African Americans reported having such services at work, compared with 22.4 percent (CI ± 0.3 percent) of whites, 21.8 percent (CI ± 1.8 percent) of Asian Americans and Pacific Islanders, 18.8 percent (CI ± 3.6 percent) of American Indians and Alaska Natives, and 15.8 percent (CI ± 0.9 percent) of Hispanics (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993). Among smokers, 25.0 percent (CI ± 1.8 percent) of African Americans, 19.7 percent (CI ± 0.6 percent) of whites, 18.4 percent (CI ± 4.1 percent) of Asian Americans and Pacific Islanders, 17.7 percent (CI ± 5.8 percent) of American Indians and Alaska Natives, and 14.3 percent (CI ± 1.9 percent) of Hispanics reported having access to employer-provided smoking cessation services (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993).

Involvement of Nontraditional Providers

Community members who traditionally have not been perceived as health promoters also have become involved in tobacco control efforts. For example, African American religious leaders have been involved in tobacco control efforts as well as in other health promotion activities, such as the National High Blood Pressure Education Program (1992). These ministers and pastors carry great influence among African Americans and are responsible for dictating social and moral values. In addition, the church often has been central in mobilizing African American communities around issues of social justice. Examples of tobacco control efforts involving community members, including religious leaders, are presented in this section. Unfortunately, little evidence is available about the success or effectiveness of this type of intervenor.

Heart, Body, and Soul is a church-based intervention in east Baltimore, Maryland, a predominantly (88 percent) African American community (Stillman et al. 1993; Voorhees et al. 1996). Focus groups conducted before the intervention revealed that African American smokers were knowledgeable of the health risks of smoking but knew few strategies beyond quitting cold turkey. The smokers perceived little support for quitting from their friends and family, with the exception of their children, who tended to be strong motivators to quit smoking. The smokers participating in the focus groups did not approve of nicotine replacement and viewed it as substituting one addiction for another. The intervention phase of the study emphasized the importance of self-efficacy to promote behavior change and social actions that promote large, systemic, social changes as a strategy for affecting individual behavior. The project was carried out through a partnership with the local ministerial alliance. Of 130 churches in the area, 22 participated in the intervention.

After introductory activities, which included a health fair, churches were randomly assigned to receive either an intensive smoking cessation intervention or the minimal level of activity, which involved distribution of the ALA educational brochure *Don't Let Your Dreams Go Up in Smoke* (ALA 1990a). Churches participating in the intervention received the same brochure but also were involved in the following activities: (1) training of smoking cessation specialists, who conducted weekly support groups with a spiritual overtone; (2) a kickoff service that included an inspirational sermon, distribution of *One Day at a Time* (a Scripture-based book of inspirational messages for smokers), and an inspirational audiocassette on quitting smoking; and (3) reinforcement of successful quitting through recognition during church services and the provision of certificates to volunteers participating in the program. The program is now being extended to churches in 13 cities throughout the country. As a result of this program, a number of African American clergy have formed a coalition, Black Clergy

for Substance Abuse Prevention, to implement tobacco control programs and other substance abuse prevention efforts. The coalition is affiliated with the National Association of African Americans for Positive Imagery (NAAAPI). A recent study showed that church-based programs can be effective in moving individuals along the continuum of change toward quitting smoking (Schorling et al. 1997).

Innovative programs are also under way in California. In San Diego, the Union of Pan Asian Communities of San Diego County delivers antismoking messages through fortune cookies (Irene Linayao-Putman, personal communication, 1993). The St. Mary Medical Center and the United Cambodian Community, Inc., in Long Beach, California, developed audiocassettes that feature traditional Laotian and Cambodian music as well as antismoking messages. These audiocassettes are distributed through racial/ethnic shops, health fairs, and other community events. Barbers and beauty parlor operators also have been trained to provide antismoking messages to their clients in small community programs in California and other states.

Although not all of these smoking cessation interventions are culturally appropriate, preliminary figures on the overall effectiveness of these massive interventions show that progress is being made in a number of areas. In California, for example, the overall prevalence of smoking has declined, more smoking cessation services are available, people are more aware of the dangers of cigarette smoking, and increases in adolescent smoking appear to have stopped (Breslow and Johnson 1993; Pierce et al. 1994b; Elder et al. 1996). These results are true for members of racial/ethnic minority groups as well as for whites.

Environmental Tobacco Smoke and Clean Indoor Air Policies

A large number of individuals from racial/ethnic groups work in the service industry (e.g., restaurants) and in blue-collar jobs (e.g., factories and repair shops)—areas of employment where cigarette smoking usually is allowed. Thus, they are probably heavily exposed to ETS.

Although the data are incomplete, a few studies indicate the extent to which nonsmokers, particularly those who are members of racial/ethnic groups, are exposed to ETS. Data from the 1993 California Tobacco Survey showed that 32.0 percent of nonsmoking Hispanics were exposed to ETS at indoor workplaces, compared with 19.1 percent of African Americans and 19.0 percent of whites (Pierce et al. 1994b).

Exposure to ETS at home is also a concern among members of racial/ethnic groups. Data from the 1992–1993 CPS (Table 6) showed that a majority of Asian Americans and Pacific Islanders (60.6 percent) and Hispanics (56.6 percent) did not allow cigarette smoking in their homes (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993). In comparison, smaller proportions of whites (41.3 percent), African Americans (38.9 percent), and American Indians and Alaska Natives (35.6 percent) reported that they prohibited smoking at home. Minor gender differences were observed in the reporting of such restrictions. Other surveys indicate that exposure to tobacco smoke at home is a valid concern.

An analysis of data from the Hispanic Health and Nutrition Examination Survey indicates that 31 to 62 percent of Mexican American nonsmoking women had household exposure to ETS (Pletsch 1994). In addition, 22 to 59 percent of Puerto Rican women and 40 to 53 percent of Cuban American women had such exposure.

In recent years, businesses and governments have adopted policies, laws, and ordinances that limit cigarette smoking in public places and in workplaces (Rigotti and Pashos 1991). The effects of these policies can be expected to benefit all U.S. residents, including members of racial/ethnic minority groups. In addition, systemwide antismoking policies are being promulgated. For example, no-smoking policies have been implemented in a number of federal workplaces, including IHS hospitals and clinics and Department of Defense installations. States have also been restricting smoking at a fairly rapid pace by banning smoking on public transportation vehicles as well as in health care offices and facilities, airports, other public buildings, and elevators (O'Connor 1992). A number of states also restrict smoking in indoor cultural and recreational facilities, including libraries, museums,

Table 6. Percentage of adults who reported that no one is allowed to smoke anywhere inside the home,* by race/ethnicity, smoking status, and gender, Current Population Survey, United States, 1992–1993

Characteristic	African Americans		American Indians/ Alaska Natives		Asian Americans/ Pacific Islanders		Hispanics		Whites	
	%	±CI†	%	±CI	%	±CI	%	±CI	%	±CI
Overall										
Total	38.9	0.7	35.6	3.2	60.6	1.6	56.6	0.9	41.3	0.3
Men	37.7	1.1	34.1	4.7	57.9	2.3	54.3	1.3	41.2	0.4
Women	39.6	0.9	36.8	4.3	63.2	2.2	58.5	1.2	41.4	0.4
Nonsmokers										
Total	49.9	0.9	53.4	4.2	67.3	1.6	64.5	1.0	51.7	0.3
Men	50.2	1.4	54.1	6.6	66.7	2.5	63.6	1.5	51.6	0.5
Women	49.8	1.1	52.9	5.5	67.8	2.2	65.2	1.2	51.8	0.4
Smokers										
Total	7.4	0.8	7.9	2.9	25.2	3.5	21.6	1.7	10.1	0.3
Men	9.2	1.2	8.7	4.2	28.5	4.4	26.7	2.4	12.4	0.5
Women	5.9	0.9	7.1	3.9	17.5	5.7	13.9	2.3	7.8	0.4

*Includes persons who reported having a rule that no one is allowed to smoke anywhere inside the home.
†95% confidence interval.
Source: U.S. Bureau of the Census, National Cancer Institute Tobacco Use Supplement, public use data tapes, 1992–1993.

theaters, galleries, shopping malls, sports arenas, and auditoriums. An ever-increasing number of states have restricted smoking in schools and on school grounds for students, school personnel, and other persons with access to the school; 27 states restrict smoking in child day-care centers. As of December 31, 1997, 41 states have some kind of restriction on smoking in government worksites, 21 have restrictions on smoking in private worksites, and 31 restrict smoking in restaurants (CDC, Office on Smoking and Health, State Tobacco Activities Tracking and Evaluation System, unpublished data).

An increasing number of employers are also restricting cigarette smoking. In the 1992–1993 CPS, a substantial proportion of respondents reported that their employers had policies prohibiting cigarette smoking in work areas and in indoor public areas, such as lobbies, rest rooms, and lunch rooms. Gerlach and colleagues (1997) used data from the 1992–1993 NCI Tobacco Use Supplement to the CPS to document the prevalence and restrictiveness of workplace smoking policies reported by African Americans, Asian Americans and Pacific Islanders, Hispanics, and whites who were employed in indoor workplaces. Their data showed that 43.3 percent of African Americans, 51.4 percent of Asian Americans and Pacific Islanders, 45.1 percent of Hispanics, and 46.2 percent of whites worked for employers who provided smoke-free policies. In all four groups, women were more likely than men to be protected by smoke-free policies. Overall, about one-third of employees worked in places that either had no policy on smoking or allowed smoking in private work areas. These minimal policies were reported by 33.9 percent of African Americans, 29.7 percent of Asian Americans and Pacific Islanders, 37.3 percent of Hispanics, and 35.6 percent of whites. This report did not present data on American Indians and Alaska Natives.

Members of the racial/ethnic minority groups considered in this report tend to favor restrictions on tobacco smoking (see Royce et al. 1993 for data on African Americans). In the 1992–1993 CPS, Asian Americans and Pacific Islanders and Hispanics were generally more likely to support the total restriction of cigarette smoking in restaurants, hospitals, indoor workplaces, and indoor shopping malls (Table 7) (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993). Smokers were more

likely to agree with partial restrictions of cigarette smoking (limiting smoking to some areas within each enclosed space) than to support the total restriction of cigarette smoking in each of the public places included in the CPS. Results of an ABC News/*The Washington Post* poll conducted in February 1993 showed that larger proportions of African Americans (54.3 percent) and Hispanics (52.9 percent) favored banning smoking in public places, compared with whites (48.3 percent) (Roper Center for Public Opinion Research 1993). The same poll showed that fairly similar proportions of Hispanics (87.9 percent), African Americans (84.3 percent), and whites (84.1 percent) felt that ETS was a health risk. However, Hispanics (50.8 percent) and African Americans (44.2 percent) reported worrying more about ETS than whites (34.4 percent).

Data from the 1992 California Tobacco Survey showed that members of racial/ethnic groups had limited support for the complete ban of cigarette smoking in restaurants and in workplaces (Pierce et al. 1994a). For example, smoking bans in restaurants drew support from 53.5 percent of Hispanics, 41.9 percent of African Americans, 35.0 percent of Asian Americans and Pacific Islanders, and 34.7 percent of whites. The data on smoking bans in the workplace were similar. Hispanics (54.5 percent) were more likely to support banning cigarette smoking in the workplace than were Asian Americans and Pacific Islanders (43.5 percent), African Americans (40.2 percent), and whites (34.4 percent).

More recently, findings from a 1993 survey indicate that residents of eight California cities (Fresno, Hercules, Indio, Los Angeles, Paradise, Sacramento, San Bernardino, and San Diego) significantly supported strong ETS controls (Sherwood et al. 1994). In this 1993 survey, 78 percent of whites supported a complete ban on smoking in restaurants, compared with 91.4 percent of Asian Americans, 89.5 percent of Hispanics, 82.6 percent of American Indians, and 82.5 percent of African Americans. In addition, 84.5 percent of whites strongly supported a complete ban on smoking in the workplace, compared with 93.5 percent of Asian Americans, 92.0 percent of Hispanics, 87.9 percent of African Americans, and 85.6 percent of American Indians.

The degree to which existing no-smoking policies are enforced in racial/ethnic communities is unknown. In a recent survey of 39 American Indian tribes, Glasgow and colleagues (1995) found significant intertribal variations in the types of policies and places covered by clean indoor air policies. For example, 64 percent of the tribes reported having a no-smoking policy that designated tribal schools, council meeting areas, and private offices as nonsmoking areas, but none banned smoking in bingo halls. Those tribes that received a specially developed policy workbook and direct consultation on ways to implement tobacco control policies were found to have adopted stringent policies within two years of having received the intervention materials (Lichtenstein et al. 1995). A recent observational study of American Indian facilities in California, Idaho, New Mexico, New York, Oregon, and Washington found that smoking policies and practices varied considerably across settings (Hall et al. 1995). Tribal schools and Indian health care facilities had the most restrictive policies. Tribal council meeting areas and private offices were less likely to be designated nonsmoking areas. No-smoking signs were observed most frequently in clinics (46 percent) and tribal offices (37 percent); no-smoking posters also were prominent in clinics (49 percent). Evidence of smoking (e.g., persons smoking, cigarette stubs, and ashtrays) was observed most frequently in tribal offices and cultural centers or community buildings (Hall et al. 1995).

A number of programs have tried to promote clean indoor air policies and practices among members of the racial/ethnic minority groups included in this report, but little information is available on their effectiveness. For example, Asian Americans for Community Involvement of Santa Clara County, based in San Jose, California, has targeted 400 Asian American restaurants and businesses to encourage them to have smoke-free areas. However, the researchers had difficulties assuring Asian American merchants that providing smoke-free areas would be good for business (Jung 1993).

Among American Indians, efforts have been made to help various tribes develop comprehensive smoke-free programs. For example, Glasgow and colleagues (1995) worked with 39 tribes in Washington, Oregon, and Idaho to review, modify, and develop tobacco-use policies that would protect tribal members from ETS. Tobacco policy committees were established to advise tribes during the policymaking process. A tobacco policy workbook also was developed to guide the tribes. Although tribal leaders expressed support for more stringent tobacco-use policies, changes in tobacco policies were not produced through the tobacco policy committees as the project had originally planned.

Table 7. Percentage of adults who think that smoking should be allowed in some areas or not allowed at all in selected public locations,* by race/ethnicity and smoking status, Current Population Survey, United States, 1992–1993

Characteristic	African Americans		American Indians/ Alaska Natives		Asian Americans/ Pacific Islanders		Hispanics		Whites	
	%	±CI†	%	±CI	%	±CI	%	±CI	%	±CI
	Restaurants (allowed in some areas)									
Total	50.8	0.7	52.4	3.3	42.1	1.6	38.1	0.9	52.9	0.3
Nonsmokers	44.3	0.9	39.1	4.1	37.6	1.7	33.5	0.9	44.4	0.3
Smokers	69.5	1.3	73.4	4.7	66.4	3.9	58.8	2.1	78.6	0.5
	Hospitals (allowed in some areas)									
Total	22.8	0.6	26.6	2.9	12.8	1.1	12.9	0.6	25.8	0.2
Nonsmokers	18.5	0.7	15.6	3.1	11.2	1.1	10.5	0.6	19.0	0.3
Smokers	35.0	1.4	44.3	5.3	21.7	3.4	23.4	1.8	46.3	0.6
	Indoor work areas (allowed in some areas)									
Total	39.3	0.7	43.9	3.3	24.7	1.4	25.8	0.8	40.7	0.3
Nonsmokers	32.6	0.8	30.1	3.9	21.0	1.4	21.6	0.8	32.4	0.3
Smokers	58.5	1.4	65.8	5.0	44.3	4.1	44.1	2.1	65.5	0.5
	Restaurants (not allowed)									
Total	45.3	0.7	42.5	3.3	54.5	1.6	58.8	0.9	43.1	0.3
Nonsmokers	53.0	0.9	58.7	4.2	59.8	1.7	64.2	1.0	52.9	0.3
Smokers	23.5	1.2	16.9	4.0	25.9	3.6	34.9	2.0	13.6	0.4
	Hospitals (not allowed)									
Total	75.3	0.6	71.3	3.0	85.1	1.1	85.7	0.6	72.5	0.3
Nonsmokers	80.0	0.7	83.5	3.2	86.9	1.2	88.3	0.6	79.9	0.3
Smokers	62.0	1.4	51.8	5.3	75.8	3.5	74.2	1.8	50.6	0.6
	Indoor work areas (not allowed)									
Total	57.0	0.7	52.2	3.3	71.8	1.4	70.9	0.8	55.7	0.3
Nonsmokers	64.6	0.8	68.3	4.0	75.8	1.5	75.7	0.9	65.1	0.3
Smokers	35.6	1.4	26.5	4.7	50.5	4.1	50.3	2.1	27.6	0.5

*In response to the question about each place, "Do you think that smoking should be allowed in all areas, in some areas, or not allowed at all?"
†95% confidence interval.
Source: U.S. Bureau of the Census, National Cancer Institute Tobacco Use Supplement, public use data tapes, 1992–1993.

Table 7. Continued

Characteristic	African Americans		American Indians/ Alaska Natives		Asian Americans/ Pacific Islanders		Hispanics		Whites	
	%	±CI	%	±CI	%	±CI	%	±CI	%	±CI
	Bars and cocktail lounges (allowed in some areas)									
Total	44.2	0.7	36.6	3.2	45.7	1.6	38.8	0.9	44.0	0.3
Nonsmokers	44.2	0.9	38.5	4.1	46.4	1.8	39.0	1.0	44.9	0.3
Smokers	44.3	1.4	33.3	5.0	42.2	4.0	37.8	2.0	41.3	0.6
	Indoor sporting events (allowed in some areas)									
Total	30.3	0.7	25.8	2.9	23.0	1.4	22.4	0.7	28.7	0.3
Nonsmokers	27.1	0.8	17.9	3.3	21.1	1.4	20.2	0.8	23.9	0.3
Smokers	39.2	1.4	38.2	5.2	32.8	3.8	31.9	1.9	43.3	0.6
	Indoor shopping malls (allowed in some areas)									
Total	39.9	0.7	40.8	3.3	32.3	1.5	28.2	0.8	41.6	0.3
Nonsmokers	35.7	0.8	31.7	4.0	29.1	1.6	25.2	0.9	35.2	0.3
Smokers	51.7	1.4	54.8	5.3	49.5	4.1	41.3	2.1	61.2	0.6
	Bars and cocktail lounges (not allowed)									
Total	25.6	0.6	22.2	2.8	29.8	1.5	31.3	0.8	22.6	0.2
Nonsmokers	31.8	0.8	33.2	4.0	33.5	1.7	35.6	1.0	28.8	0.3
Smokers	8.1	0.8	5.2	2.4	9.6	2.4	12.1	1.4	4.0	0.2
	Indoor sporting events (not allowed)									
Total	64.5	0.7	68.2	3.1	72.3	1.4	72.9	0.8	65.9	0.3
Nonsmokers	68.9	0.8	79.3	3.4	74.8	1.5	75.8	0.9	72.3	0.3
Smokers	52.5	1.4	50.5	5.3	59.5	4.0	60.0	2.0	46.5	0.6
	Indoor shopping malls (not allowed)									
Total	54.4	0.7	52.3	3.3	62.7	1.6	67.2	0.8	52.6	0.3
Nonsmokers	59.7	0.8	65.2	4.0	66.5	1.7	70.8	0.9	60.6	0.3
Smokers	39.7	1.4	32.3	5.0	42.7	4.0	51.3	2.1	28.6	0.5

Economic Efforts to Reduce Tobacco Use

Numerous efforts have been made to reduce the use of cigarettes through excise and sales taxes. Because these taxes increase the price of cigarettes, higher tax rates generally curb the demand for cigarettes, and ultimately, tobacco consumption (Grossman 1989; Peterson et al. 1992; Keeler et al. 1993; Townsend et al. 1994). Peterson and colleagues (1992) evaluated the effects of state cigarette tax increases on cigarette sales in the 50 states from 1985 through 1988. The researchers found that state cigarette tax increases were associated with an average decline in cigarette consumption of three cigarette packs per capita (a decline of about 2.4 percent). Likewise, larger tax increases were associated with larger declines in consumption. In a recent study in Britain, Townsend and colleagues (1994) found that individuals of low-socioeconomic status were more responsive to changes in the price of cigarettes than those who were more affluent.

As of June 30, 1996, all states, the District of Columbia, and 451 localities currently impose taxes on cigarettes in addition to the federal tax (Tobacco Institute 1997). As of December 31, 1997, state taxes ranged from a low of 2.5 cents in Virginia to a high of $1 in Alaska; the average state tax was 37.76 cents per pack (CDC, Office on Smoking and Health, State Tobacco Activities Tracking and Evaluation System, unpublished data).

Members of some racial/ethnic minority groups have supported increases in taxes for tobacco products. In a 1990 survey of California smokers, 29.1 percent of African American smokers and 34.5 percent of Hispanic smokers reported that they would support a cigarette tax increase (Burns and Pierce 1992). A much smaller proportion of whites who smoke (20.0 percent) supported such an increase. Recently, larger proportions of California adults have supported an increase in cigarette taxes. The 1992 California Tobacco Survey among both smokers and nonsmokers found that cigarette tax increases were supported by 60.2 percent of Asian Americans and Pacific Islanders, 50.4 percent of Hispanics, 49.5 percent of African Americans, and 49.8 percent of whites (Pierce et al. 1994a). Furthermore, a 1993 nationwide survey conducted for the ACS found that Hispanics (71 percent) and African Americans (63 percent) supported an increase of $2 per pack to pay for a national health insurance program (Marttila & Kiley, Inc. 1993). These proportions were fairly similar to those found among whites (66 percent).

Although tobacco taxes are effective in discouraging smoking, some people consider increases in excise taxes to be regressive because the poorer members of society pay a higher proportion of their income in taxes. Wasserman (1992), for example, states:

> With respect to excise tax increases, however, we must be mindful of the distributional consequences of higher taxes. More precisely, because low-income smokers do not appear to be any more responsive to higher cigarette prices than high-income smokers, higher excise taxes will result in disproportionate economic harm, and, in some cases, could lead poorer smokers to forgo food, shelter, and needed health care to fulfill the persistent and pernicious demands of their smoking habits. As a result, higher cigarette taxes should be accompanied by measures to compensate the poor for the larger burden that they will necessarily have to bear. For example, federal and state income tax structures could be modified to facilitate such compensation (p. 20).

A 1990 federal government report supported this argument by presenting data from the 1984–1985 Consumer Expenditure Survey Interview showing that families in the lowest income quintile spent 4 percent of their posttax income on tobacco products, compared with families in the highest quintile, who spent 0.5 percent of their posttax income on tobacco products (U.S. Congressional Budget Office 1990). On the other hand, some argue that the hardship of increased taxes on the poor is outweighed by the fact that smoking-related health costs and suffering decline among persons who smoke fewer cigarettes or stop smoking because of the higher taxes on tobacco. A group of economists meeting in 1995 concluded that additional research on costs is needed before an optimal cigarette excise tax from an economic perspective can be determined (Warner et al. 1995). These economists agreed that the strongest argument currently for increasing cigarette taxes is the protection of children.

The actual effects of excise tax initiatives on members of racial/ethnic minority groups are difficult to ascertain. Nevertheless, reductions in the consumption of tobacco products resulting from increases in excise taxes should ultimately benefit members of U.S. racial/ethnic groups by lowering their prevalence of

cigarette smoking and by limiting or lowering their exposure to ETS. California's experience after increasing the tax on cigarettes shows that a number of community-based projects, school-based interventions, and research activities, which directly benefit members of the racial/ethnic groups and could not have been funded from other sources of tax revenue, can be funded through the revenue generated by the increased taxes (Breslow and Johnson 1993). In addition, given the need to help community-based programs and organizations rely less on tobacco industry support (Satcher and Robinson 1994), earmarked tax revenues may prove to be a viable alternative.

Efforts to Control Tobacco Advertising and Promotion

Tobacco products are heavily advertised in racial/ethnic publications and in racial/ethnic communities. Efforts to restrict the effects of advertising and promotion of tobacco products in racial/ethnic communities have been limited by various factors, including the communities' reliance on the tobacco industry (see Chapter 4), difficulties in mobilizing communities that are faced with problems perceived to be in need of more immediate attention (e.g., affordable housing, unemployment, unequal education, and racial/ethnic minority discrimination), the lack of trained community leaders interested in health issues, and possibly the lack of infrastructure for tobacco prevention and control initiatives in racial/ethnic communities (Robinson et al. 1995). As a result, persons residing in racial/ethnic communities are continually exposed to the advertising and promotion of tobacco products. A recent study in Los Angeles County, for example, examined the risk of exposure to outdoor advertising of cigarettes among residents of various communities (Ewert and Alleyne 1992). The results suggest that persons residing in the city of Los Angeles were more likely to be exposed to cigarette and alcohol billboard advertisements than residents of nearby suburbs. Cigarettes were advertised on 59 of the 299 billboards (19.7 percent) surveyed on 46.2 miles of streets. The number of cigarette advertisements was 4.6 times greater in the city of Los Angeles than in its suburbs.

Members of some racial/ethnic minority groups tend to be more likely than whites to support a ban on tobacco product advertisements (Table 8). Data from the 1992–1993 CPS showed that 37.5 percent of whites supported a ban on advertising tobacco products, compared with 44.7 percent of Hispanics, 39.5 percent of Asian Americans and Pacific Islanders, and 38.3 percent of African Americans (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993). In each racial/ethnic group, women and nonsmokers were more supportive of a total ban on tobacco advertising than were men and smokers. The 1992 California Tobacco Survey found that adult Californians supported the banning of such advertising in newspapers and magazines as well as on billboards (Table 9) (Pierce et al. 1994a). The same survey also showed support for banning tobacco companies from sponsoring cultural events. Hispanics tend to show the greatest level of support for these measures, whereas whites support them the least. Data from the 1992–1993 CPS also showed that fairly large percentages of racial/ethnic group members would support a ban on the free distribution of tobacco samples (Table 10) (U.S. Bureau of the Census, NCI Tobacco Use Supplement, public use data tapes, 1992–1993). Hispanics (59.4 percent) and Asian Americans and Pacific Islanders (57.5 percent) were the most likely respondents to state that they supported such a ban. In all groups, women and nonsmokers were more likely than men and smokers to favor the ban.

The 1994 RWJF Youth Access Survey (Table 4) found varying support for restricting or banning different types of tobacco advertising. Hispanics and African Americans were more likely than whites to support such proposals (Nancy Kaufman et al., unpublished data). Hispanics were more supportive of bans on billboard, newspaper, and magazine advertising than were African Americans and whites. Requiring plain packaging of tobacco products (brand name and warning label in black letters on white background) was supported substantially more by Hispanics than by African Americans or whites.

In recent years, the tobacco industry has shifted expenditures for advertising to promotional marketing, with 89 percent of 1995 expenditures devoted to nonadvertising promotions (Federal Trade Commission 1997). The RWJF Youth Access Survey found that broad-based support exists for eliminating coupon

Table 8. Percentage of adults who think that the advertising of tobacco products should be always allowed or not allowed at all,* by race/ethnicity, smoking status, and gender, Current Population Survey, United States, 1992–1993

	African Americans		American Indians/ Alaska Natives		Asian Americans/ Pacific Islanders		Hispanics		Whites	
Characteristic	%	±CI†	%	±CI	%	±CI	%	±CI	%	±CI
Total										
Always	17.3	0.6	21.5	2.7	12.6	1.1	13.7	0.6	21.4	0.2
Not at all	38.3	0.7	36.6	3.2	39.5	1.6	44.7	0.9	37.5	0.3
Men										
Always	19.8	0.9	24.0	4.2	15.6	1.7	16.8	1.0	25.5	0.4
Not at all	35.2	1.1	30.5	4.5	35.9	2.2	39.2	1.3	32.9	0.4
Women										
Always	15.7	0.7	19.4	3.5	9.7	1.3	11.2	0.8	17.9	0.3
Not at all	40.3	0.9	41.6	4.4	43.0	2.2	49.2	1.2	41.5	0.4
Nonsmokers										
Always	13.6	0.6	13.0	2.9	10.5	1.1	11.4	0.6	16.7	0.2
Not at all	42.2	0.8	44.3	4.2	41.8	1.7	47.8	1.0	42.0	0.3
Men										
Always	16.5	1.0	15.6	4.8	13.4	1.8	14.0	1.1	20.7	0.4
Not at all	38.3	1.4	38.1	6.4	38.3	2.5	42.3	1.5	37.0	0.5
Women										
Always	11.8	0.7	11.2	3.5	8.2	1.3	9.6	0.8	13.4	0.3
Not at all	44.5	1.1	48.7	5.6	44.7	2.4	51.6	1.3	46.3	0.4
Smokers										
Always	28.2	1.3	34.7	5.1	23.7	3.5	24.0	1.8	35.6	0.5
Not at all	27.2	1.3	24.3	4.6	27.5	3.6	31.1	1.9	23.9	0.5
Men										
Always	27.5	1.9	34.8	7.1	23.2	4.1	25.4	2.3	38.8	0.8
Not at all	28.1	1.9	20.1	6.0	28.1	4.4	29.9	2.5	21.5	0.7
Women										
Always	28.7	1.8	34.5	7.2	25.0	6.5	21.9	2.8	32.4	0.7
Not at all	26.5	1.7	28.5	6.8	26.1	6.6	32.9	3.1	26.2	0.7

*In response to the question, "Do you think advertising of tobacco products should be always allowed, allowed under some conditions, or not allowed at all?"
†95% confidence interval.
Source: U.S. Bureau of the Census, National Cancer Institute Tobacco Use Supplement, public use data tapes, 1992–1993.

promotions, such as promotional gear or free cigarettes by mail (Nancy Kaufman et al., unpublished data). Hispanics continue to be more supportive of promotional bans than non-Hispanics, with 89.8 percent of Hispanics supporting elimination of coupons for obtaining free cigarettes by mail, compared with 79.5 percent of African Americans and 80.4 percent of whites. In addition, 82.4 percent of Hispanics favor elimination of cigarette pack coupons that can be exchanged for promotional items such as clothing, compared with 76.5 percent of African Americans and 67.8 percent of whites. The public is more ambivalent about not allowing tobacco company sponsorship of sporting or entertainment events in which their cigarette brand names are featured during television broadcasts. Hispanics were more supportive of such a ban than were African Americans and whites (Table 4).

Racial/ethnic minority communities have begun to respond to the tobacco industry's targeted advertising and marketing efforts by mobilizing against the industry. The strong community response in Philadelphia against the planned introduction of Uptown

Table 9. Percentage of Californians* who support curtailment of tobacco advertising and promotion efforts, by race/ethnicity, 1992

Curtailment	African Americans	Asian Americans/ Pacific Islanders	Hispanics	Whites
Ban advertising in newspapers and magazines	60.2	51.2	74.7	47.7
Ban advertising on billboards	64.9	57.6	78.1	54.9
Ban sponsorship of sporting or cultural events	63.7	59.4	70.1	50.7

*Data on American Indians and Alaska Natives are not reported because of small sample size.
Source: Pierce et al. 1994a.

cigarettes, a brand targeting African Americans, resulted in the cancellation of the test marketing of the cigarette by its producers and a renewed interest in tobacco control efforts among African Americans in Philadelphia (see Chapter 4). The Coalition Against Uptown Cigarettes, which led the campaign, succeeded by building on previous efforts by Philadelphia organizations and individuals to control tobacco use among the city's African Americans. These organizations include some African American clergy as well as voluntary associations, particularly the ALA and the ACS, the Fox Chase Cancer Center, the local Committee to Prevent Cancer among Blacks, and the Philadelphia chapter of the National Black Leadership Initiative on Cancer (NBLIC). Indeed, the NBLIC in Philadelphia served as a common meeting ground for leaders from various agencies and provided opportunities for the development of mutual trust needed during the campaign. The NBLIC had been formed several years before under the leadership of Louis W. Sullivan, M.D., then and now president of Morehouse School of Medicine. Subsequently, Dr. Sullivan provided strong support to the coalition's efforts in his role as Secretary of Health and Human Services. The fact that the Uptown coalition was led by African Americans in this historic benchmark in the tobacco control movement was central to its ultimate success. Moreover, the participation of Philadelphia's African American clergy and the participation of an African American minister as a key coalition spokesperson were critical in obtaining community support for the Coalition Against Uptown Cigarettes. This support added to the campaign's credibility and guaranteed its success as a grassroots communications vehicle.

The experience of the Coalition Against Uptown Cigarettes is significant not only for the result it achieved but also because it provides a case study in community mobilization. The coalition focused its efforts primarily on African Americans—both smokers and nonsmokers—with the goal of derailing the introduction of Uptown cigarettes by convincing smokers to refuse to sample the new brand. To accomplish this, the coalition crafted messages that targeted R.J. Reynolds rather than smokers. In addition, the coalition aimed at forming a partnership among African American smokers and nonsmokers around the issue of limiting minors' access to this new tobacco product. Also central to the success of the Coalition Against Uptown Cigarettes was its strategic use of mass media (Robinson and Sutton, in press). Coalition leaders expanded the debate beyond health; identified the tobacco industry's major positions related to economics, civil rights, and self-determination; and developed specific counterarguments. For example, when tobacco industry supporters argued that tobacco control advocates were taking away smokers' right of free choice, coalition spokespersons countered by stating that the community had not asked for Uptown cigarettes, that excessive billboard advertising of cigarettes in African American communities did indeed take away choices, that smokers had the right to choose to reject Uptown cigarettes, and that communities had the right to choose what products entered their neighborhoods.

Another example of community mobilization in tobacco control occurred early in 1995, when a new mentholated cigarette brand named "X" being marketed in Boston was withdrawn by its manufacturer and distributor after protests by the African American community, led by the NAAAPI and Boston-based Churches Organized to Stop Tobacco (COST) (Jackson 1995). X cigarettes were packaged in the Afrocentric colors red, black, and green and featured a prominent

Table 10. Percentage of adults who think that giving away free tobacco samples should be always allowed or not allowed at all,* by race/ethnicity, smoking status, and gender, Current Population Survey, United States, 1992–1993

	African Americans		American Indians/ Alaska Natives		Asian Americans/ Pacific Islanders		Hispanics		Whites	
Characteristic	%	±CI†	%	±CI	%	±CI	%	±CI	%	±CI
Total										
Always	11.4	0.5	12.8	2.2	6.9	0.8	7.7	0.5	12.2	0.2
Not at all	49.9	0.7	49.9	3.3	57.5	1.6	59.4	0.9	54.3	0.3
Men										
Always	13.4	0.8	14.6	3.5	9.1	1.3	9.9	0.8	15.3	0.3
Not at all	46.8	1.2	46.4	4.9	52.2	2.3	53.8	1.3	48.9	0.4
Women										
Always	10.0	0.6	11.2	2.8	4.8	1.0	5.8	0.6	9.4	0.2
Not at all	52.0	0.9	52.9	4.5	62.7	2.2	63.9	1.2	59.1	0.4
Nonsmokers										
Always	7.7	0.5	6.8	2.1	5.3	0.8	5.9	0.5	8.4	0.2
Not at all	55.9	0.9	61.2	4.1	61.0	1.7	63.5	1.0	62.2	0.3
Men										
Always	9.4	0.8	8.1	3.6	7.1	1.3	7.8	0.8	11.2	0.3
Not at all	52.6	1.4	57.8	6.5	55.9	2.6	58.6	1.5	56.3	0.5
Women										
Always	6.8	0.5	5.8	2.6	3.9	0.9	4.6	0.5	6.0	0.2
Not at all	57.9	1.1	63.7	5.3	65.1	2.3	66.9	1.2	67.3	0.4
Smokers										
Always	21.8	1.2	22.1	4.4	15.7	3.0	15.5	1.5	23.6	0.5
Not at all	33.3	1.4	32.1	5.0	38.9	4.1	41.1	2.1	30.6	0.5
Men										
Always	22.5	1.8	22.8	6.3	16.5	3.6	16.4	2.0	26.9	0.7
Not at all	33.9	2.0	31.3	7.0	39.2	4.8	39.1	2.6	28.4	0.7
Women										
Always	21.1	1.6	21.3	6.2	13.8	5.2	14.1	2.3	20.5	0.6
Not at all	32.7	1.9	32.9	7.1	38.4	7.3	44.1	3.3	32.9	0.7

*In response to the question, "Do you think that giving away free samples by tobacco companies should be always allowed, allowed under some conditions, or not allowed at all?"
†95% confidence interval.
Source: U.S. Bureau of the Census, National Cancer Institute Tobacco Use Supplement, public use data tapes, 1992–1993.

"X," a symbol associated with African American leader Malcolm X. Although X cigarettes were manufactured and distributed by two relatively small companies with modest marketing efforts, African American community leaders feared that even a small success could fuel the creation of similar products by major tobacco companies with larger resources for advertising and promotion. Unlike the case of Uptown cigarettes, however, both the manufacturer and the distributor of X cigarettes denied that their product was targeted to an African American market.

NAAAPI demanded in writing that X cigarettes be withdrawn. Extensive media coverage was given to NAAAPI leaders invited to speak, as part of Boston Black History Month events, to large audiences about the need for communities to mobilize against tobacco. As a result of NAAAPI's organizing efforts, the creator and distributor of X cigarettes (Stowecroft Brook Distributors, Charlestown, Massachusetts) and the manufacturer (Star Tobacco Corporation, Petersburg, Virginia) received protests from around the country, including calls from organizations in the African

American Tobacco Control Network of California. This successful strategy demonstrated again the effectiveness of united action against tobacco within the African American community and the ability of NAAAPI and its African American tobacco control network to extend the achievements of the Uptown experience.

In other racial/ethnic communities, some groups have rejected billboards advertising tobacco products. In Detroit, for example, Wayne County Commissioner Alberta Tinsley-Williams founded the Coalition Against Billboard Advertising of Alcohol and Tobacco, which enlisted the support of churches, schools, and civic groups to seek the removal of such billboards. Other communities have gone even further. For example, inspired by the anonymous Chicagoan "Mandrake," who painted over tobacco and alcohol billboards in ethnic neighborhoods, Reverend Calvin Butts led parishioners on walking tours in New York City to document and whitewash billboards advertising tobacco and alcohol (Associated Press 1990). Such acts were emulated by Dallas County, Texas, Commissioner John Wiley Price and Chicago-based Reverend Michael L. Phleger (Collins 1990). These grassroots efforts culminated in a meeting of African American community leaders in Greensboro, North Carolina, in 1991. This meeting led to the founding of a national group to combat tobacco and alcohol advertising in ethnic communities, NAAAPI (*Food & Drink Daily* 1991). Chaired by the Reverend Jesse W. Brown, the NAAAPI aims to increase public awareness of the devastating effects of cigarette and alcohol advertising among African Americans. The NAAAPI has gained affiliates in various communities throughout the United States. In 1994, the association supported efforts to drape covers over cigarette billboards in African American communities and led memorial services for persons who had died because of tobacco use.

Another example of community mobilization against the advertising and promotion of tobacco products is taking place in California. To coordinate racial and ethnic-specific, state-funded activities supported by the increase in the cigarette sales tax, the California Department of Health Services's Tobacco Control Section developed and funded four racial/ethnic minority networks, the first of which was the Hispanic/Latino Tobacco Education Network. This network was hosted by the University of San Francisco through 1996 and has attracted more than 500 members. The other networks include the Asian Pacific Islander Tobacco Education Network (initially hosted by the Asian American Health Forum), which comprises approximately 200 organizations; the African American Tobacco Education Network (initially sponsored by the Bay Area Urban League), which has approximately 300 members; and the American Indian Tobacco Education Network. These networks have been charged with coordinating and mobilizing tobacco control efforts among various communities and helping community agencies to better design and implement their programs. The various networks have different goals, responsibilities, and levels of funding, but one common thread is their commitment to ensuring that racial/ethnic communities take an active role in defining their own tobacco control needs. In general, the networks organize a variety of strategy and training sessions, media and advocacy campaigns, and technical assistance programs. They also help develop and evaluate resources on tobacco control and prevention and promote networking among their members. Although evaluations of these networks have not yet been completed, the networks' role as catalysts is already evident. Thus far, the networks have garnered the support of community agencies funded to carry out tobacco control efforts in California. For example, 70 percent of the funded community agencies in California reported attending meetings of these racial/ethnic minority networks during the summer of 1993 (Elder et al. 1993a).

One emergent network is the International Multicultural Partnership, which grew out of the ASSIST program and provides technical assistance to racial/ethnic communities interested in tobacco prevention and control. It is a consortium that includes members from over 31 states and several countries. Its mission is to develop and implement culturally appropriate health education programs and services that will effectively reach those population groups at highest risk of tobacco-related illness and death.

In addition to efforts to control tobacco advertising in specific racial/ethnic communities, the FDA regulations approved by President Clinton in August 1996 broadly support such activities in racial/ethnic and other communities in the form of the provisions that ban billboards advertising tobacco products within 1,000 feet of schools and playgrounds, limit in-store advertising (except in adult-only facilities) and billboards to black-and-white text, limit advertising to black-and-white text in publications with significant readership under age 18, prohibit brand logos on various promotional items, and prohibit sponsorship of sporting or entertainment events using brand or product identification. The FDA regulations are intended to reduce teenage access and attraction to tobacco products among all racial and racial/ethnic minority groups (*Federal Register* 1996).

Tobacco Product Regulations

An important approach to controlling and preventing tobacco use is the drafting and enacting of product regulations. These large social interventions range from the use of cigarette warning labels to the licensing of tobacco product sales, and they can regulate the product's packaging, its distribution, and even its components. Because most of these regulations affect all people residing in the United States, rather than just members of racial/ethnic communities, they are not described in detail here. The 1994 Youth Access Survey commissioned by RWJF found significant public support among all those surveyed for requiring tobacco companies to list the additives to their products on package labels (African Americans, 88.9 percent; Hispanics, 90.4 percent; and whites, 93.6 percent). Most respondents also supported government regulation of cigarettes, although support was somewhat stronger among Hispanics (81.1 percent) than among African Americans (72.6 percent) and whites (69.5 percent) (Table 11).

Among the few tobacco product regulations to specifically target a racial/ethnic group are Spanish-language warning labels, which appear in cigarette advertisements and promotions in Spanish-language

Table 11. Public beliefs about and support for policies related to nicotine and tobacco product regulation, Robert Wood Johnson Foundation Youth Access Survey, 1994

	African American* (N = 486)		Hispanic (N = 402)		White* (N = 1,341)	
Characteristic	%	±CI†	%	±CI	%	±CI
Think nicotine in cigarettes is addictive	90.9	2.90	86.8	4.16	92.6	1.65
Believe that cigarette companies deliberately adjust nicotine levels to keep smokers addicted to cigarettes	57.5	5.41	56.8	5.62	54.9	3.06
Favor requiring tobacco companies to gradually reduce the amount of nicotine in cigarettes	77.7	4.68	84.8	4.02	79.1	2.43
Favor requiring insurance companies to cover the cost of programs to quit smoking	66.7	5.35	77.0	4.64	63.4	2.96
Favor requiring tobacco companies to list additives on package labels the way food and drug companies are required to list ingredients	88.9	3.64	90.4	3.41	93.6	1.63
Agree that because the government regulates all other products containing nicotine, such as nicotine patches and nicotine gum, the government should also regulate cigarettes	72.6	5.00	81.1	4.19	69.5	2.82

*Non-Hispanic.
†95% confidence interval.
Source: Nancy Kaufman et al., unpublished data. Ethnic differences in public attitudes about policy alternatives for limiting youth access to tobacco products: results of a national household survey, 1994.

publications or on billboards located in Hispanic communities. The use of warning labels is one of the earliest and best known mechanisms that the federal government has employed to inform the public about the health hazards of smoking. Warning labels have been required on cigarette packages and in cigarette advertising since 1966, and four rotating health warnings have been required on cigarette packages and advertisements since October 12, 1984, through Public Law 98–474. Warning labels are not required on cigarettes made for export, cigarettes manufactured abroad by U.S. tobacco companies, or other tobacco products, such as cigars, pipe tobacco, and roll-your-own cigarette tobacco. Warning labels on smokeless tobacco containers have been required since passage in 1986 of Public Law 99–252, which took effect in 1987.

Little is known about the level of awareness or effectiveness of cigarette warning labels among members of racial/ethnic groups or members of the U.S. population at large. A 1991 study of Hispanics in San Francisco has shown that Hispanics are more aware of the presence of warning labels on cigarettes (69.3 percent) than on other products, such as diet soda (27.2 percent), wine (27.6 percent), beer (31.5 percent), and aspirin (36.7 percent) (Marín 1994). The same study also found that the level of awareness of cigarette warning labels was higher among highly acculturated Hispanics (76.5 percent) than among less acculturated Hispanics (65.5 percent). This finding may be attributable to the fact that highly acculturated Hispanics have greater fluency in English—the language used for most product warning labels and cigarette packages.

Support for warning labels does not seem to differ significantly across racial/ethnic minority groups. In a 1992 Louis Harris and Associates poll of 488 smokers, 65 percent of Hispanics, 58 percent of African Americans, and 56 percent of whites favored legislation that required stronger warning labels on cigarette packages than those currently required by law (Louis Harris and Associates, unpublished data).

Conclusions

1. More research is needed on the effect of culturally appropriate programs to reduce tobacco use among racial/ethnic minority groups. Interventions should be language appropriate; addressing psychosocial characteristics such as depression, stress, and acculturation may increase the acceptance of programs by members of racial/ethnic groups.

2. To be culturally appropriate, tobacco control programs must reflect the targeted racial/ethnic group's cultural values, consider the group's psychosocial correlates of tobacco use, and use strategies that are acceptable and credible to members of the group. Culturally competent program staff must be aware and accepting of cultural differences, be able to assess their own cultural values, be conscious of intercultural dynamics when persons of different cultures interact, be aware of a racial/ethnic group's relevant cultural characteristics, and have the skills to adapt to cultural diversity.

3. Numerous strategies are needed to control tobacco use among racial/ethnic youths: restricting minors' access to tobacco products, establishing culturally appropriate school-based programs, and designing mass media efforts geared to young people's interests, attitudes, expectations, and norms. Recent provisions of the Synar Amendment, designed to prevent minors' access to tobacco products, and the FDA regulations aimed at reducing the access to and appeal of tobacco products to young people are intended to reduce tobacco use among all youth, including members of racial/ethnic minority groups.

4. Members of racial/ethnic groups are less likely than the general population to participate in smoking cessation groups and to receive cessation advice from health care providers. Barriers to ethnic group participation include limited cultural competence of health care providers and a lack of transportation, money, and access to health care.

5. Available data indicate that racial/ethnic groups support smoking restrictions, such as increasing cigarette excise taxes, banning cigarette advertisements, restricting access to cigarette vending machines, raising the legal age of purchase, prohibiting sponsorship of events by tobacco companies, and establishing clean indoor air regulations. Additional research is needed to evaluate how best to build on this base of public opinion support to strengthen existing tobacco prevention and control programs within racial/ethnic communities.

6. Prevention and cessation efforts in racial/ethnic communities are limited by underdeveloped tobacco control infrastructures and low levels of resources for research, program development, and program dissemination. Greater resources are needed in racial/ethnic minority communities to build tobacco control infrastructures and to develop initiatives.

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