Incorporating Principles of Social Justice to Tobacco Control

Introduction

A 2000 Surgeon General's report, *Reducing Tobacco Use*, stated that eliminating health disparities related to tobacco use posed a major public health challenge.[1] The National Association of County and City Health Officials (NACCHO) believes that directing traditional tobacco control programming toward vulnerable communities is not enough to meet this challenge.[2] Local health departments (LHDs) should also integrate principles and practices associated with health equity and social justice into their tobacco control programs[3] through actions such as the following:

- Addressing racism, classism, sexism, and other forms of discrimination[4] that can lead to stress, which in turn can lead to smoking.
- Examining related issues, such as low wages and lack of affordable housing and unemployment, which contribute to stress and increased vulnerability to targeting marketing strategies.[5]
- Integrating interventions into the community's institutions to enhance sustainability of tobacco control efforts.[6]
- Encouraging community input about interventions.

Translating concepts of health equity and social justice into practice can be difficult for LHDs, which often lack human and financial resources to carry out this work effectively.[7,8] Traditionally, public health tends to focus on disease intervention rather than changing social conditions. Health practitioners may have limited knowledge about the subject of health inequity and the principles of social justice, as well as an inability to frame these issues around tobacco control. In addition, standard workforce recruitment and training practices limit the ability to hire people with the necessary training in addressing health inequities.

This issue brief provides information to help LHDs integrate health equity and social justice principles effectively into their tobacco control programs. After offering an overview of tobacco control programs in LHDs, this brief outlines a strategy based on principles of social justice and provides an example of an LHD turning the social justice concept into action.

Background

Much of disease prevention and health promotion focuses on encouraging behavior changes that will improve an individual's quality of life. These behavior changes routinely involve the adoption of healthy eating habits, engaging in daily exercise, tobacco cessation, and other lifestyle changes. Although one can argue that the health and well-being of an individual largely depends on the lifestyle choices he or she makes, solely relying on this tactic to advance the population's health is too narrow a view. Ignoring social context, i.e. social determinants of health, avoids the influence of socioeconomic indicators, marketing tactics that target vulnerable communities and discriminatory policies and practices that often affect individual choices.

A viewpoint that "blames the victim," or faults the individual for exhibiting a poor health outcome because of his or her risky behaviors, fails to consider the socioeconomic influences generating that behavior. For example, one could consider why a person began to smoke. Could social factors have contributed to developing this habit? What is the social context in which smoking occurs? Are there patterns of conditions under which people live and work that provide clues? Asking these types of questions helps to identify the root causes of smoking. Consider this:

- In the past 40 years, smoking has changed from something done by many people from a broad range of backgrounds to something primarily done by low-income, less educated, and disenfranchised individuals; these individuals suffer a disproportionate burden of tobacco-related disease.[9]
- Americans below the poverty line are 40 percent more likely to smoke.[4]
- Thirty-eight percent of Americans with 9–11 years of education smoke versus 13 percent of those with an undergraduate degree.[4]
- Poverty may make people less likely to participate in changes of social norms.[4] In other words, simply because society increasingly views smoking as unacceptable may have no effect on a low-income individual.

Because data demonstrate that tobacco use is highly prevalent among low-income groups, and high smoking rates are associated with poverty, it makes sense to ask why poor people are more likely to smoke. Part of the answer lies in exploitation due to predatory marketing practices of the tobacco industry[6]:

Incorporating Principles of Social Justice to Tobacco Control

- Tobacco companies have addicted those who have the least information about the health risks of smoking, the fewest social supports, and the least access to cessation services.[9]
- Marketing expenditures by the tobacco industry have risen from $6 billion in 1998 to $11.2 billion in 2001.[9]
- The tobacco industry has a history of targeting specific populations. It has increased marketing in youth magazines and campaigns directed at lesbian, gay, bisexual, and transgender communities.[9] The tobacco industry also targets women and communities of color and people of low socioeconomic status.
- The tobacco industry has optimized "freedom of choice" or "smokers' rights" issues and downplayed nicotine addiction and predatory marketing.[9]

Local, state, and federal policies also have an impact on tobacco use, because smokers who wish to quit have a much harder time doing so without resources. The following examples illustrate how policies can affect tobacco use:

- Over the past five years, states have received $39.4 billion in Master Settlement Agreement (MSA) funding but have devoted only five percent to tobacco prevention, with much of it addressing budget crises.[9]
- Smokefree policies cover more white-collar workers than blue-collar workers.[4]
- About half of all federal officials have accepted donations from the tobacco industry, providing a disincentive for them to advocate for strong tobacco control policy.[6]

Overview of Tobacco Control Programs in LHDs

2005 National Profile of Local Health Departments

Before discussing methods to address tobacco control from a social justice perspective, one must first acknowledge the current practices of tobacco programs in LHDs across the nation. In 2005, NACCHO conducted a national profile of all 2,800 LHDs in the country, the *2005 National Profile of Local Health Departments*, which collected information on a wide range of public health topics, including tobacco control. The profile found the following:

- Sixty-nine percent of respondents reported providing tobacco use prevention services. LHDs serving larger populations were more likely to provide tobacco use prevention services; for example, 87 percent of LHDs serving populations of 500,000 or greater provided them.
- Twenty-eight percent of LHDs have the ability or capacity to oversee the regulation of smokefree ordinances completely.
- Fifteen percent have oversight over tobacco retailer regulation, inspection, or licensing.[10]

Needs Assessment of Tobacco Control Program Managers at LHDs

In spring 2005, NACCHO's Tobacco Prevention and Control Project conducted an informal needs assessment of LHDs' tobacco control programs. Out of the 500 LHDs that received the query, 77 responded, representing 30 states. Below are the results of the needs assessment:

- Fifty percent of respondents reported that tobacco prevention and control is most often housed within community health, followed by health education/health promotion (31%) and chronic disease (24%).
- A program's ability to provide services and commit to an approach based on principles of social justice to tobacco control is related to staff capacity and funding.
  - The majority of respondents reported staffing 0–2 full-time employees or part-time employees.
  - Nearly a third reported that their tobacco control funding came solely from state government, while another third stated that funding came from a combination of state and federal or local sources.
- Approximately 40 percent of respondents experienced a decrease in funding within the last two years, with 16 percent having experienced a 26–50 percent decrease. They compensated by cutting staff and programs/activities such as materials development, trainings, and advertising campaigns.
- Thirty-six percent reported no change in funding levels, and 12 percent reported an increase of 1–25 percent.

Respondents most often indicated that the following kinds of activities were needed:

- Development of smokefree policies;
- Local counter-marketing campaigns;
- Promoting the state quitline;
- Cessation programs for youth and adults;
- Educating the public about smokefree policies; and
- Surveillance.

Tobacco Control Programming and Health Equity

The Tobacco Prevention and Control Project's needs assessment found that 83 percent of respondents addressed disparities in their tobacco control programs. The activites utilized included targeted programs, such as smoking cessation or education, outreach activities, such as conferences, and collaborative efforts. Those that did not most commonly cited barriers of limited funding and resources, the lack of interest or commitment in the workforce, and the lack of knowledge in cultural competency. The *2005 National Profile of Local Health Departments* also looked at how LHDs are addressing health inequity within their programs and practices. Nearly two-thirds of respondents reported that efforts to eliminate health inequity are integrated into many of their programs, and 69 percent stated that their staffs have at least some tools and resources necessary to address health inequities.

The *2005 National Profile of Local Health Departments* also revealed several correlations between tobacco control programming and addressing inequity:

- LHDs that directly conduct primary tobacco prevention services are significantly more likely to participate in activities that address health inequities and their causes.
- LHDs that directly provide primary tobacco prevention services are significantly more likely to be characterized as having attitudes and beliefs that are consistent with an overall effort to address health inequities.

A Strategy Grounding in Principles of Social Justice

What features of public health practice and organizational structure would enhance the capacity of LHDs to address the root cause of tobacco use from a social justice perspective? How can social justice principles be incorporated into the overall design of an approach to practice in all parts of the LHD, rather than remain isolated as a special initiative? The following is a checklist of 12 features of an effective general strategy adapted from *Tackling Health Inequities Through Public Health Practice: A Handbook for Action*[7]:

1. Supporting Equity as a Value and Social Right: Make support for health equity an explicit goal of public health practice.
2. Leadership: Offer colleagues latitude to work on health equity and seek grants related to eliminating health inequity.
3. Interagency/Multi-Disciplinary Coordination: Consider that the location of public health practice is not limited to organizations designated as health departments.
4. Workforce Development and Education: Engage staff members in dialogue about principles of social justice and its historical link to public health and recruit racially and ethnically diverse staff with multi-disciplinary training.
5. Working and Collaborating with Communities: Involve community residents and be accountable by building trust and solidarity, as well as using community knowledge, to strengthen advocacy for social change and strengthen local assets and capacities.
6. Communications Strategy and Public Education: Communicate basic messages through the mass media about systemic and institutionalized injustice in a compelling manner to increase the awareness of the root causes of ill health and poor quality of life.
7. Health Promotion: Use dialogue, rather than a professional education model, to complement communications and education.
8. Building Alliances and Coalitions: Establish alliances with social movement organizations committed to social justice e.g. civil rights, human rights and environmental justice.
9. Public Policy Development and Analysis: Consider policy related to employment, taxes, trade, labor market and transportation to assist in the identification of local policies that affect the social determinants of health.
10. Advocacy: Offer technical assistance, provide meeting support and conferences for and by community members, organize the community, and engage in the political process to consider decisions relevant to population health.
11. Monitoring and Surveillance: Monitor the nature and level of health inequity in a community to ensure that the appropriate areas are being addressed by the community and health workers.
12. Addressing Health Inequity through the Ten Essential Services of Public Health: Provide the framework for public health activities in communities across the nation.

Example from the Field: The Community Action Model

The San Francisco Department of Public Health has successfully integrated principles of social justice into its tobacco control work. The San Francisco Tobacco Free Project (SFTFP) of the Community Health Promotion and Prevention section of the San Francisco Department of Public Health has viewed tobacco control as a social injustice issue and moved away from projects that focus solely on changing individual lifestyle and behavior to projects that mobilize community members and agencies to decrease environmental factors that promote health inequity, such as tobacco advertising and promotion and tobacco access for minors.

As part of the comprehensive tobacco control plan for San Francisco, the SFTFP has funded community-based agencies to implement the Community Action Model (CAM), a five-step model focused on environmental change through policy development or change in organizational practices rather than individual behavior change.[9] The CAM involves participatory action research approaches and is asset-based. Its intent is to create change by building community capacity; collaborating with communities; and providing a framework for community members to acquire skills and resources to investigate the health of the place where they live and then plan, implement, and evaluate actions that change the environment to promote and improve health. For more detailed information about CAM, please visit the following Web site: www.sfdph.org/CHPP/CAM/cam.htm.

Conclusion

LHDs can accomplish a great deal to address tobacco prevention and control through principles of social justice. Findings from the *2005 National Profile of Local Health Departments* and the needs assessment of tobacco control program managers suggest that increased staff training, support from LHD management, and support from state partners would enhance the ability of LHDs to apply a social justice strategy to protect and promote health within vulnerable communities.

National Association of County & City Health Officials

ISSUE*brief*

NACCHO
National Association of County & City Health Officials

Incorporating Principles of Social Justice to Tobacco Control

References

[8]Health equity: The absence of systematic disparities in health or in major social determinants of health between groups with different levels of underlying social advantage or disadvantage – that is wealth, power, or prestige. Inequities in health put groups of people who are already socially disadvantaged (for example, by virtue or being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health.

Notes

1. Fagan, P., King, G., Lawrence, D., Petrucci, S., Robinson, R., Banks, D., Marable, S., and Grana, R. (Feb. 2004). Eliminating tobacco-related health disparities: Directions for future research. *Am J Public Health*, 94, 211–217. (http://tinyurl.com/ygwsxj)

2. Association of State and Territorial Health Officials, National Association of County and City Health Officials, and National Association of Local Boards of Health (April 2007). *Joint policy action steps toward tobacco use prevention and control.* Washington, DC: NACCHO.

3. National Association of County and City Health Officials (2005). *Resolution to promote health equity.* Res. 05-02. Washington, DC: NACCHO. Available at http://archive.naccho.org/documents/resolutions/05-02.pdf.

4. Tobacco and Social Justice. American Legacy Foundation. (http://repositories.cdlib.org/context/tc/article/1214/type/pdf/viewcontent/)

5. Haviland, L. (Feb. 2004). A silence that kills. *Am J Public Health*, 94, 176–178. (http://tinyurl.com/ylomgc)

6. ASSIST. Shaping the Future of Tobacco Prevention and Control.

7. Hofrichter, R. (2006). Transforming elements of public health practice: Preliminary considerations. In Hofrichter, R. (Ed.), *Tackling health inequities through public health practice: A handbook for action* (pp. 59–76). Washington, DC: W.K. Kellogg Foundation.

8. Braveman P. and Gruskin S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, 57: 254-258.

9. Avila, A., Hrushow, A., Lavery, S., Moore, M., Reed, D., & Smith, M. (2005). The community action model: San Francisco Health Department takes a social justice approach. *NACCHO Exchange*, 4, 12–14.

10. National Association of County and City Health Officials (2006) *2005 National Profile of Local Health Departments.* Washington, DC: NACCHO. Available at www.naccho.org/topics/infrastructure/documents/NACCHO_report_final_000.pdf.