TOBACCO USE IN RURAL AREAS

by Stacey Stevens, Brian Colwell, and Linnae Hutchison

SCOPE OF PROBLEM

- Tobacco use is one of the 10 “leading health indicators” selected through a process led by an interagency workgroup within the U.S. Department of Health and Human Services.[16]
- Rural adolescents (except in the Midwest) are more likely than their urban counterparts to smoke.[4]
- Adult men and women in the most rural counties, with some variation across regions, are more likely to smoke than those in urban counties.[4]
- Tobacco has been ranked as the leading “actual cause of death” in the United States, i.e., contributing to the diagnosed condition associated with a death.[17]

GOALS AND OBJECTIVES

One Healthy People 2010 goal is to reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.[1] Tobacco use shared a sixth-place ranking among the Healthy People 2010 focus areas in terms of rural health priority rating, selected by an average of 26 percent of four groups of rural health leaders across the states.[2]

This summary addresses the following Healthy People 2010 objectives:

- 27-1. Adult tobacco use.
- 27-2. Adolescent tobacco use.
- 27-3. Initiation of tobacco use.
- 27-4. Age of first tobacco use.
- 27-6. Smoking cessation during pregnancy.
- 27-7. Smoking cessation by adolescents.
- 27-9. Exposure to tobacco smoke at home among children.
- 27-10. Exposure to second hand smoke (SHS).
- 27-14. Enforcement of illegal tobacco sales to minors.
- 27-16. Tobacco advertising and promotion targeting adolescents/young adults.

PREVALENCE

Cigarette use is more prevalent in rural areas than in large and small metropolitan areas.[3]

Cigarette use is more prevalent in rural areas than in large and small metropolitan areas.[3] Adults living in the most rural areas have the highest prevalence rates for smoking.[4] This trend reflects two factors, delayed access to medical and media resources and lower educational attainment.[4] Smokeless tobacco use is also more prevalent among adults in rural settings,[5] particularly among young males aged 18 to 24 years.[6]

Of all groups, tobacco use by adolescents has experienced the sharpest increase—nearly 78 percent between 1988 and 1996.[7] There is wide disparity in tobacco use between adolescents living in rural versus urban settings. This is the case in terms of the prevalence of past month smoking in adolescents aged 12 to 17;[4] eighth graders likely to smoke cigarettes and use smokeless tobacco;[8] and age at first use of smokeless tobacco.[9]

Smokeless tobacco use is also more prevalent among adults in rural settings.[5]

There is evidence suggesting that smoking rates among rural pregnant women remain higher than

Tobacco use remains the leading cause of preventable death, resulting in 430,000 deaths annually.

smoking rates among urban pregnant women.[10] Tobacco-related illnesses as a result of exposure to SHS are present in both rural and urban settings; however, some evidence suggests a great acceptance of SHS and associated SHS illnesses in rural settings.[11] Thus, we might expect to find a higher prevalence of SHS-related illnesses in rural settings, though sufficient research has yet to be completed. Studies conducted in rural areas indicate the most common reasons for tobacco use in rural areas are a lack of knowledge, issues related to susceptibility, and modeling of the social environment.

IMPACT

The impact of tobacco use on mortality and morbidity is well known. Tobacco use remains the leading cause of preventable death, resulting in 430,000 deaths annually. The resulting cost is an estimated 50-73 billion dollars in medical bills.[7]

Tobacco use is also a significant contributor to many health problems including coronary heart disease, lung disease, cancer, damage to the female reproductive system, and injury to the unborn fetus.[12] More than five million youth under 18 years old living today will die prematurely as a result of their involvement with tobacco.[13] Additionally, SHS contributes to an estimated 3,000 lung cancer deaths and 62,000 coronary heart disease deaths in nonsmokers annually, as well as contributing to increased severity and frequency of asthma, sudden infant death syndrome (SIDS), bronchitis, chronic middle ear infection, and pneumonia.[14]

BARRIERS

There are several barriers in rural settings to tobacco intervention efforts. These include a lack of resources, lack of transportation, lower median income to pay for treatment, lower prevalence of insurance coverage, limited media resources designed to change unhealthy habits, and minimal access to medical services for cessation assistance and treatment.[8] In addition, rural dwellers face limited access to care providers.

PROPOSED SOLUTIONS

To identify potentially effective interventions or solutions to tobacco use, particularly among the high-risk populations identified previously such as adolescents and pregnant women, it is necessary to isolate factors contributing to tobacco use.

Nicotine dependence, lack of educational resources, proximity to tobacco growers, and failure to adequately enforce laws regarding tobacco sales to minors may contribute to an increased prevalence in rural areas. While the number of community tobacco prevention policies has increased in the past decade, rural communities do not necessarily comply with these policies.

There is a clear difference in tobacco use prevalence among those living in rural versus urban areas, whether the individual is an adolescent, adult, or a pregnant woman.

Seven basic components to community tobacco control have been identified. These include surveillance, problem assessment, legislation, health department and community-based programs, public information campaigns, technical information collection and dissemination, and coalition building.[15] While interventions have been conducted in rural communities, applicability and feasibility of implementation in other rural communities is not known.

SUMMARY AND CONCLUSIONS

There is a clear difference in tobacco use prevalence among those living in rural versus urban areas, whether the individual is an adolescent, adult, or

pregnant woman. Higher tobacco use in rural areas will eventually lead to increased mortality rates and to higher numbers of people with health problems that rural areas are ill equipped to handle. Past research has shown that education, enforcement of existing laws, product labeling, and anti-tobacco advertising campaigns may reduce tobacco use. More research is needed to understand the factors that contribute to higher prevalence of both smoke and smokeless tobacco use in rural areas and to understand how to effectively intervene with rural populations.

MODELS FOR PRACTICE

The following models for practice are examples of programs utilized to address this rural health issue.

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MODELS FOR PRACTICE
FOCUS AREA: TOBACCO USE

Program Name: Stickers-Suckers-Smokers Pregnancy Tobacco Cessation Program
Location: Mesa County, Colorado
Problem Addressed: Tobacco Use among Pregnant Women
Healthy People 2010 Objective: 27
Web Address: http://www.rmhp.org

SNAPSHOT

Smoking is associated with low birth weight infants and preterm deliveries. Stickers-Suckers-Smokers Pregnancy Tobacco Cessation Program is a collaborative effort to reduce the incidence of smoking-related preterm births and low birth weight infants in rural Mesa County, Colorado. The program addresses tobacco use among pregnant women through a program of screening, assessment, and cessation education. The founding agency for the tobacco cessation program, Rocky Mountain Health Plans (RMHP), has expanded its outreach to pregnant women to include a prenatal dental care program as well.

The program addresses tobacco use among pregnant women through a program of screening, assessment, and cessation education.

THE MODEL

Blueprint: The program represents a collaborative effort between Rocky Mountain Health Plans, Rocky Mountain Health Foundation (RMHF—a 501[c][3]), Hilltop Community Resources B4 Babies and Beyond program, Mesa County Tobacco Education Coalition (MCTEC), and March of Dimes. The core staff consists of a Rocky Mountain Health Plans care coordinator and obstetrics (OB) screener/tobacco cessation counselor, and B4 Babies and Beyond provides intake staff, a director, and a paid counselor/statistician. B4 Babies is a unique program that provides a one-stop site for prenatal services to low-income women in Mesa County. MCTEC provides incentives and funding; the March of Dimes provides a grant for the B4 Babies counselor; and RMHF provides grant-writing services.

The program provides assessment, education, and incentives for patients. Caregivers get educational information, a chart sticker program that identifies smokers for follow-up and tracking, and “train-the-trainer” educational programs. Pregnant women who smoke are identified, through entry into the B4 Babies and Beyond program, by health care providers and by RMHP OB screeners.

Pregnant women who smoke and agree to participate in the program receive one-on-one assessment of stage and counseling at the point of entry (physician office, B4 Babies, or RMHP). They are sent quit kits, and their primary care providers are notified of the patient's participation. The primary care providers play a vital role as screeners, educators, counselors, and supporters by closely tracking the patient's progress at each prenatal visit.

One strength of the program is providing care providers with the tools to screen and counsel patients. Counselors and providers use the 5A's Method (Ask, Advise, Assess, Assist, and Arrange) to help patients to quit or reduce smoking. Prochaska stages of change modified for pregnancy is also used.

Making a Difference: Birth certificate data from 2001 in Mesa County revealed a 28 percent smoking rate for pregnant women as compared to the Colorado state average of 12 percent. The B4 Babies and Beyond program showed a smoking rate of 35 to 45 percent of their clients. Prior to 2001, there was evidence of a greater prevalence of pregnant women smoking in Mesa County.

To date, 570 prospective clients have been seen, and 213 smokers have been identified. Of those, 100 clients agreed to enroll in the program. Of the 100 clients, 16 percent agreed to either quit or reduce their cigarette use to under five per day. The low birth weight rate in Mesa County declined from 7.1 percent in previous years to 6.3 percent in 2001. B4 Babies and Beyond program participant data are collected in a registry to track quit rates and reductions in smoking.

Beginnings: Rocky Mountain Health Plans spearheaded the development of the smoking cessation program for pregnant women in Mesa County. The county had one of the highest rates of smoking among pregnant women in the state. Rocky Mountain Health Plans case managers asked providers to identify at-risk patients and offer education and cessation options to patients; however, providers were unable to comply due to a lack of resources in the area. In response, Rocky Mountain Health Plans created the Stickers-Suckers-Smokers program to serve as a method to address the issue of smoking during pregnancy. The program began in June 2001.

The program is funded through a variety of sources. The Rocky Mountain Health Foundation obtained a grant from the March of Dimes to fund the program initially. Community businesses and organizations have also contributed to maintaining the program's success.

Challenges and Solutions: Although the program has completed Year One, plans are underway to expand the program's services and service area. The program hopes to expand the smoking cessation program to two additional counties.

The program has also expanded to include a dental care component specifically for pregnant women. Evidence indicates that there is a link between periodontal disease and preterm labor. Pregnant women can receive no-cost to reduced-cost dental care through the Marillac Dental Clinic.

The program is publicized through word of mouth, brochures, community programs, and presentations by the Rocky Mountain Health Plans case manager. She has presented to the Colorado Care Council, a statewide organization composed of obstetricians, perinatologists, neonatologists, and related practitioners. Rocky Mountain Health Plans has also mailed providers information about smoking education/cessation and Marillac Dental Clinic services.

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MODELS FOR PRACTICE
FOCUS AREA: TOBACCO USE

Program Name: Tobacco Intervention and Prevention Strategy
Location: Prosperity, South Carolina
Problem Addressed: Tobacco Use
Healthy People 2010 Objective: 27
Web Address: Under Construction

SNAPSHOT

Tobacco Intervention and Prevention Strategy (TIPS) is a tobacco education, prevention, cessation, policy development, and community empowerment program implemented in rural Newberry County, South Carolina. TIPS targets adults, teenagers, adolescents, and pregnant mothers.

THE MODEL

Community empowerment is achieved through the development of a TIPS task force, which is comprised of local community leaders.

Blueprint: The Tobacco Intervention and Prevention Strategy program is multifaceted and delivered in a variety of settings including worksites, schools, the health department (during prenatal and Women, Infant, and Children [WIC] program visits), and the physician's office. TIPS is a coalition between the Lovelace Family Medicine Practice and the South Carolina Department of Health and Environmental Control (SC DHEC). Community empowerment is achieved through the development of a TIPS task force, which is comprised of local community leaders. The program is designed around the Stages of Change Theory and Clinical Practice Guidelines. The components of TIPS include smoking cessation, education, and prevention; policy development and change; and community empowerment.

The program office is located in the Lovelace Family Medicine Practice. Staffing includes one full-time program manager, and Dr. Lovelace acts as the principle investigator. Volunteer and donated staff are also utilized. The program manager, office space, computer equipment, and telephone lines are provided as an in-kind donation by the Lovelace Family Medicine Practice. As a 501(c)(3) organization, the program is eligible to receive funding from a variety of sources, including its original funder—the Lovelace Family Medicine Practice, as well as the South Carolina Department of Health and Environmental Control, the American Cancer Society, the March of Dimes, the Tobacco Free Midlands Coalition, and various pharmaceutical companies and community members.

The program is designed as a comprehensive approach to combating tobacco use. Smoking cessation interventions include the Stages of Change assessment, health education, stress management, and behavior modifications. Worksite and prenatal cessation is a primary focus of the cessation component. Free bassinets (paid for by a grant from the March of Dimes) are provided to pregnant women who complete the program. Smoking prevention is delivered through strategies targeting youth and adolescents, including programs such as the National Lung Association's NOT (Not on Tobacco) program and Tar Wars (a program endorsed by the American Academy of Family Practice). The program also uses the American Cancer Society's Fresh Start Program and Counseling Women Who Smoke Program. Policy development includes promotion of smoke-free environments. Community empowerment is achieved through establishment of a TIPS task force.

Making a Difference: Both process and outcome measures are utilized to determine the program's effectiveness. During workshops, presentations, and training events, participants are given evaluation forms that include qualitative and quantitative questions. Data on participant demographics, opinions, program delivery, and logistics are collected at each activity.

Beginnings: Dr. Oscar Lovelace, MD, an established Newberry County family physician, saw the devastating effects of tobacco abuse among his patients in rural Newberry County. In 1998, Dr. Lovelace, with assistance from the School of Public Health Community Oriented Primary Care (COPC) residents, began a grassroots effort to not only raise community awareness of the problem but devise a smoking prevention, education, cessation, and policy development strategy for the county. The initial costs of underwriting the program were borne by the Lovelace Family Medicine Practice. As the program grew, it became necessary to involve additional partners. The TIPS program is currently a collaboration between the Lovelace Family Medicine Practice and the South Carolina Department of Health and Environmental control. The program also applied for and received status as a 501(c)(3) organization chartered by the Living Water Foundation, Inc. A TIPS task force, comprised of local community leaders, was also initiated, which serves as an advisory body to the program. The program was fully implemented in April 2001 and has received funding through 2003.

The program was developed to respond to the county's alarming tobacco use statistics when compared to state data. The smoking rate for Newberry County High School was equal to the state average of 36 percent. Ten percent of the high school students use smokeless tobacco compared to the state average of 7.7 percent. Lung cancer in the county exceeded the state average. Adult tobacco use was only slightly less than the state average. Most disturbing was the rate of tobacco use among pregnant women. In South Carolina, 15.1 percent of pregnant women are smokers compared to

Newberry County where nearly 16.3 percent are smokers. Newberry County also has a low birth weight rate of 9.9 percent, with a ranking of 36 out of 46 counties.

Challenges and Solutions: Transportation is a hurdle that is overcome by delivering the program to the people in worksite, school, and community settings. Enlisting the help of other physicians requires the program manager to build relationships with providers. The South Carolina Department of Health and Environmental Control's Tobacco Control Program has expressed interest in replicating TIPS throughout South Carolina.

The program manager acts as the community liaison and is responsible for community awareness. In addition to local newspaper advertising, billboards, and public service announcements to the community, TIPS is promoted at the state and national levels through abstracts, policy papers, and a policy advocacy video. Dr. Lovelace also promotes the program through presentations at the state level.

The program received the National Tar Wars Star Award through the American Academy of Family Practice in 2001.

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MODELS FOR PRACTICE
FOCUS AREA: TOBACCO USE

Program Name: Too Smart to Smoke Tobacco Prevention Campaign
Location: Newport, Vermont
Problem Addressed: Tobacco Use
Healthy People 2010 Objective: 27
Web Address: http://www.nchsi.org

SNAPSHOT

The vision of the Health and Traffic Safety Coalition for Orleans and Northern Essex (HTS ONE) in Vermont is to promote the health and well being of the community. Fundamental to this pursuit is the mission of HTS ONE to support and foster freedom from tobacco and other substances of abuse as well as providing healthy behavior choices to community youth and adults. Too Smart to Smoke is a tobacco prevention campaign implemented in two rural counties in economically disadvantaged areas of Vermont—Orleans and Essex Counties.

THE MODEL

Blueprint: The tobacco prevention program is spearheaded by North Country Hospital's (NCH) community health planner and is implemented by a part-time coordinator hired by the hospital. The Tobacco Prevention coordinator is responsible for organizing and implementing the tobacco prevention activities and events according to grant guidelines. The grant-funded coordinator's role is to enlist participation of community groups, primarily youth, to engage in tobacco prevention activities and events. The coordinator is supervised by the NCH community health planner who initiates the grant process, completes all reports, and generally oversees the direction of the grant.

NCH provides a significant amount of funding and in-kind support in the form of space, supplies, supervision, and program administration. Funding is also through the Vermont Department of Health, first from Centers for Disease Control (CDC) money that came to the state and since 2001, tobacco settlement money.

The goals of the program are to:

- reduce the percentage of youth in the HTS ONE area who smoked cigarettes in the past month to 16 percent by 2010;

- reduce the percentage of adults in the ONE area who smoke to 12 percent by 2010; and
- reduce the percentage of young children in the ONE area who are regularly exposed to tobacco smoke in the home to 10 percent by 2010.

These goals are congruent with Healthy Vermonters 2010. To accomplish these goals, a variety of cessation and prevention strategies are used, aimed at changing perceptions regarding tobacco use.

The following list of events and programs are used in tandem to meet the objectives:

- recruitment of local youth and adults to write and record tobacco prevention messages that are aired on local radio stations;
- a youth summit, youth and family day sponsorship;
- poster contests in all elementary schools;
- anti-drug theatre productions at local schools;
- a “Clear the Air” program aimed at reducing exposure to second-hand smoke in the area;
- a Focus on Life photo workshop where teens learn the basics of picture-taking while focusing on healthy lifestyles. The photos are then exhibited for public viewing throughout the area; and
- support of healthy youth behaviors, such as community winter carnivals, school/community dinner dances, scholarships for local summer camps, wilderness camps and teen leadership workshops, and school projects that focus on healthy hearts, aerobic exercise, and not using tobacco.

Each of these activities is a collaborative effort between the Tobacco Prevention Program and various community members. The program attributes its success to a strong sense of cooperation and collaboration held in this rural area.

Making a Difference: Orleans and Essex Counties are rural, economically disadvantaged areas of Vermont. Smoking contributes to chronic obstructive pulmonary disease (COPD) at higher incidence in these counties compared to state rates. State COPD-related deaths were 44 per 100,000 adults in 1998 compared to Essex and Orleans Counties with a rate of 57 per 100,000 adults. Smoking during pregnancy rates are also higher in the North Country Hospital area (ranging from an all time high of 40 percent to a current 33 percent) compared to the state average in 2001 of 21 percent. However, as of 2001, the rate of smoking cessation among pregnant women before the fourth month is 28 percent in the NCH service area compared to the state average of 22 percent.

In 1999, the state's estimated smoking rate among eighth and twelfth graders was 22 percent and 42 percent, respectively. At the same time, twelfth graders in two of the three school districts in Orleans and Essex Counties reported higher smoking rates of 48 percent and 54 percent, respectively. One of the school districts reported a prevalence of smoking (28 percent) among eighth graders.

Data from 2001 revealed significant progress toward smoking cessation in not only Vermont as a whole but also in Essex and Orleans Counties. In 2001, the state rate of smoking among twelfth graders was 30 percent (a 12 point drop from 1999). All three of the school districts in Orleans and Essex Counties were below or equal to the state average. Among eighth graders, the Vermont smoking rate dropped from 22 percent in 1999 to 13 percent in 2001. In Orleans and Essex Counties, one school district showed a significant decrease in smoking among eighth graders from 28 percent in 1999 to 18 percent in 2001. However, an increase was seen in another school district (from 20 percent to 25 percent). The adult smoking rates for Orleans (23.6 percent) is slightly higher than the state rate (22.7 percent); however, the Orleans rate has decreased since 1999. In Essex County, the adult smoking rate has remained consistently lower than the state average at 20.9 percent.

Data from 2001 revealed significant progress toward smoking cessation in not only Vermont as a whole but also in Essex and Orleans Counties.

These data indicate that rates of smoking for twelfth graders in these two counties have significantly declined from 1999 to 2001; rates among eighth graders reveal mixed results. Adult rates have declined as well.

In designing the various programs and events, program organizers also consider the Developmental Assets as one mechanism to improve program effectiveness. The Developmental Assets were developed by the Search Institute and are now used by the state of Vermont.

Beginnings: The Health and Traffic Safety Coalition for Orleans and Northern Essex was initiated by the North Country Hospital in 1991. The coalition was originally formed to allow various members of the community to join together with the mission of improving traffic safety, with a particular focus on preventing and reducing the incidence of driving while under the influence of alcohol and increasing seat belt use. Over the years, the coalition's mission has expanded to include broader community health issues including combating tobacco and substance use. Today, the coalition's membership exceeds 40, with representation from a broad cross-section of the community ranging from businesses, health agencies, youth groups, schools, and legislators.

North Country Hospital has been instrumental in the development of the smoking prevention program. NCH, a leader and the facilitator of the HTS ONE coalition, acts as the fiscal agent of the tobacco prevention funds.

NCH provided tobacco prevention/cessation assistance through its Wellness Center for almost 20 years. However, in 1996, with the receipt of increased grant funding, the tobacco prevention program became more structured and firmly established. In 1998, tobacco prevention strategies for the community were officially implemented. The rural counties of Orleans and Essex were targeted due to a higher prevalence of tobacco use compared to state rates. The program serves three school districts comprised of 21 elementary schools (public and private), a junior high school, and four high schools (public and private).

Challenges and Solutions: The primary challenges to the HTS ONE coalition are continued funding. As the program has expanded, funding has expanded from both the national level as well as the local level, including grants from NCH and HTS ONE. The program utilizes a variety of communication channels to disseminate information on the program including newspapers, newsletters to students, press releases, radio, and informational booths at numerous community events.

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Literature reviews for each of the focus areas addressed in Volume 1 are presented in Volume 2 (Appendix) of Rural Healthy People 2010: A Companion Document to Healthy People 2010.