

Indiana Tobacco Use Disparities and Diversity (ITDD) Strategic Plan

A statewide collaboration to identify tobacco-related disparities and to develop a statewide strategic plan to eliminate those disparities.

Funded by the Centers for Disease Control and Prevention
Administered by Smokefree Indiana through a contract
with the Indiana State Department of Health

Indiana Tobacco Use Disparities and Diversity Workgroup
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TABLE OF CONTENTS

	Page
I. Executive Summary	3
II. Introduction and Background	5
III. Overview of the Strategic Planning Process	6
IV. Data Analysis	9
V. Environmental Scan	10
Population Assessment	10
Consumer Health Profile	11
SWOT Analysis	11
VI. Key Findings	12
VII. Goals and Strategies	13
VIII. Next Steps	15
IX. Appendices	
A. Working Definitions on Diversity and Disparity	18
B. ITDD Meeting Agendas	19
C. Logic Model	25
D. Quantitative Data Findings and Sources	26
E. Qualitative Data Findings and Sources	30
F. Responses to Key Informant Interviews	45
G. Listing of Identified Critical Issues	49
H. ITDD Workgroup Members	50

I. Executive Summary

In 2002, the Centers for Disease Control and Prevention (CDC) commissioned a special effort through state health departments' tobacco control programs in regard to the fourth goal "identifying and eliminating tobacco-related disparities," which has been most difficult to address. Funding was provided to the Indiana State Department of Health to build capacity for the identification and elimination of tobacco-related disparities by engaging a diverse and inclusive workgroup in a strategic planning process. Under the auspices of Smokefree Indiana, the Indiana Tobacco Use Disparities and Diversity (ITDD) Workgroup, consisting of state and local community representatives, was developed.

The resulting strategic plan will provide a framework for future programs, interventions, surveillance, and evaluation associated with tobacco-related disparities. The plan describes what the workgroup believes needs to take place in Indiana in order to address the fourth goal area. It incorporates the most current information as well as diversity of thought from the groups affected by disparities.

The ITDD Workgroup identified five critical issues which significantly affect the ability to identify and eliminate tobacco-related disparities in Indiana. They are:

- **Gaps in Data:** State-specific data are insufficient to adequately identify populations disproportionately impacted by tobacco use.
- **Funding Challenges:** Since no single funding source is available to support the implementation of the strategic plan, it will require resources from a number of organizations, combined with the identification and acquisition of outside funding, to implement the strategic plan.
- **Capacity Issues:** New tobacco-control partners exist statewide, many with organizations with no previous tobacco control experience. Other partnerships will need to be developed to reach population groups with identified disparities. Efforts must be made to continually increase the capacity of these organizations to implement effective tobacco control programs. Capacity issues include financial and staff resources; training and education; access to materials, programs and best practices.
- **Tobacco Industry:** The tobacco industry spends large amounts of money to fund specific populations' events, buy influence and to conduct target marketing to specific populations. Alternative funding sources are needed to support these populations and their projects to counteract the influence of the industry. Historically, industry contributions have been used to buy influence among, and to oppress, these populations. Counter marketing is needed and must be specific to the disparately affected population.
- **Programming for Populations with Identified Disparities:** Programs, marketing efforts and tobacco control interventions must be tailored to meet the specific needs and culture of each population disproportionately impacted by tobacco use in Indiana.

In order to adequately identify and eliminate tobacco-related disparities in Indiana, the ITDD Workgroup recommends five specific goals to be accomplished by the year 2008:

- Identify and strengthen funding for tobacco prevention and control in Indiana

- Eliminate information gaps in data that prevent the identification of tobacco-related disparities in Indiana
- Promote a comprehensive approach to tobacco prevention and control that is population and community specific
- Reduce the influence of the tobacco industry on population groups disproportionately impacted by tobacco use in Indiana
- Reduce disparities of tobacco use among specific populations identified in this plan

The most effective tobacco control program is comprehensive and multifaceted. It uses a state-coordinated, decentralized approach that puts many resources into identified communities and organizations outside of state government. The direction specified in the plan will guide the efforts of individuals, organizations and decision makers in Indiana to collaboratively eliminate tobacco-related disparities in Indiana.

The state of Indiana can successfully address disparities in tobacco use, despite the powerful tobacco industry that has targeted such groups. With the adoption of these key findings and the goals and strategies identified by the ITDD workgroup, a statewide, collaborative effort can provide the framework for increasing the number of years of productive life among our specific populations with disparities and reducing the social and economic costs of tobacco use.

II. Introduction and Background

The Centers for Disease Control and Prevention, Office on Smoking and Health (CDC/OSH) provides funding to all 50 States, the District of Columbia and 7 U.S. territories through the National Tobacco Control Program (NTCP). The NTCP funds are used to address the following four goal areas:

Four Goals of the National Tobacco Control Program

- | | |
|-----|---|
| (1) | Eliminate exposure to environmental tobacco smoke (ETS) |
| (2) | Promote quitting among adults and youth |
| (3) | Prevent initiation among youth |
| (4) | Identify and eliminate tobacco-related disparities |

Overall, NTCP partners understood the interventions required to accomplish the first three goals; however, many have struggled with the intent of Goal Four. NTCP partners have had different interpretations of the term “disparities.” Tobacco use and its related health effects have tremendous impact on population groups that have higher prevalence rates than the average population. Identifying these populations, finding ways to assess their tobacco use prevalence rates, describing their disparities related to tobacco use, developing and prioritizing strategies to reach them, and then implementing those strategies have created immense challenges for statewide tobacco control programs. As a result, the strategies used to address this goal have been varied and sometimes ineffective. See Appendix A, page 18, for the working definitions on diversity and disparity.

Recognizing the challenges among NTCP partners, CDC/OSH made available supplemental funding to provide financial and programmatic assistance to strengthen the abilities of states and territories to address Goal 4. The funding also enabled them to develop tools and strategies to:

- (1) Convene a diverse and inclusive workgroup for the purpose of engaging in a strategic planning process;
- (2) Identify and define the disparities among specific populations in their states and/or territories;
- (3) Conduct a strategic planning process with community and state partners that will address these disparities; and
- (4) Translate the goals and strategies identified in the strategic plan into specific objectives for NTCP’S annual action plan.

Indiana was one of 13 states and U.S. territories to be funded by the Centers for Disease Control and Prevention (CDC) to identify disparities related to tobacco use, and to develop a statewide strategic plan to eliminate those disparities. Other partners included Arkansas, Idaho, Iowa, Maine, Michigan, Minnesota, Nebraska, North Carolina, Oregon, Utah, Virgin Islands and Washington.

III. Overview of the Strategic Planning Process

The supplemental funding from CDC/OSHA to Indiana was used for a strategic planning process resulting in a comprehensive plan to address disparities related to tobacco use and its effect among different population groups in Indiana.

CDC required the establishment of a diverse and inclusive workgroup to participate in the strategic planning process. In order to ensure statewide participation reflecting the diversity of the state, Smokefree Indiana (SFI) sought nominations, solicited from tobacco-control partners statewide, prior recipients of SFI's diversity mini-grants, and organizations representing diverse populations in Indiana. Nominations were reviewed and invitations were made to individuals representing diverse communities [youth, women of childbearing age, communities of color, indigenous people, rural/urban, GLBT (Gay, Lesbian, Bisexual, Transgender), and geographic regions of the state]. All nominees received an invitation to join the workgroup, and each accepted the invitation. Commitments were made by each ITDD Workgroup member to actively participate in monthly meetings and the strategic planning process.

SFI hired outside consultants to facilitate the strategic planning process, collect and interpret data, and to evaluate the strategic planning process. The ITDD Workgroup created the strategic plan based upon existing data in Indiana which identifies populations with tobacco-related health disparities, and made recommendations for eliminating those disparities.

Lessons learned and case studies from the 13 NTCP states' strategic planning experiences will be analyzed by the CDC and modifications and recommendations will be made available to other states going through a similar process.

The Strategic Planning Process

Following CDC's recommendations, the following steps were used in the ITDD Workgroup strategic planning process:

- STEP 1. Organize the structure and form the strategic planning workgroup.
- STEP 2. Collect and analyze data/information on specific population groups.
- STEP 3. Conduct an environmental scan to assess identified populations and analyze the strengths, weaknesses, opportunities and threats (SWOT) of implementing this plan.
- STEP 4. Identify critical issues and establish goals and strategies for each critical issue.
- STEP 5. Determine feasibility of identified goals and strategies.
- STEP 6. Conduct a marketing analysis and create final document.
- STEP 7. Market the plan to key organizations statewide.
- STEP 8. Implement, monitor and evaluate the plan.

See Appendix B, page 17 for ITDD meeting agendas.

STEP 1: Organize the structure and form the strategic planning workgroup.

Once established, the ITDD Workgroup members engaged in activities to get to know each other, develop the workgroup name and mission statement, set up officers, and develop procedures for the strategic planning process. The Workgroup convened monthly throughout the year. Discussions on the identification and elimination of tobacco-related disparities were included in a participatory strategic planning process

The workgroup has representatives from the following community organizations:

- American Cancer Society – Great Lakes Division, Inc
- American Indian Center of Indiana, Inc.
- Asian Help Services
- National Cancer Institute’s Cancer Information Service
- HealthVisions Midwest, Inc.
- Indiana Latino Institute, Inc.
- Indiana State Department of Health, Office of Minority Health
- Indiana State University
- Indiana Tobacco Prevention and Cessation Agency
- New Perspectives Minority Health Coalition, Inc
- Smokefree Allen County
- Wishard Health Services

Populations represented by the workgroup included, but were not limited to:

- African Americans
- American Indians
- Asian Americans
- Gay, Lesbian, Bisexual, Transgender communities
- Latinos/Hispanics
- Low Socioeconomic Status (SES) populations
- Rural communities

STEP 2: Collect and analyze data/information on specific population groups.

Available state-specific data were collected to identify and describe tobacco-related disparities. In the process of collecting data, it became abundantly clear to ITDD Workgroup members that additional research is needed. Currently, insufficient state-specific data exists to adequately identify populations disparately affected by tobacco use or have indicators identifying them as a possible risk. Gaps in data were identified and qualitative and national data were collected to make constructive correlations in identifying populations with tobacco-related disparities in Indiana.

See Section IV, page 10 for the chart listing the populations identified by ITDD as having disparities.

STEP 3: Conduct an environmental scan to assess identified populations and analyze the strengths, weaknesses, opportunities and threats (SWOT) of implementing this plan.

The purpose of conducting an environmental scan is to gather additional information to supplement the quantitative data collected. The environmental scan was conducted on population groups identified during data analysis. The components of the environmental scan include a population assessment and a SWOT analysis. The information from the environmental scan was used to further define critical issues that need to be addressed.

See Section V, page 10 for a summary of the environmental scan.

STEP 4: Identify critical issues and establish goals and strategies for each critical issue.

The data gathering and analysis process identified key findings, or critical issues Indiana must address in order to successfully eliminate tobacco-related disparities. The ITDD Workgroup developed a long-term goal to address each critical issue. For each goal statement, the Workgroup identified strategies for accomplishing the goal. In order to ensure the greatest success, the Workgroup recommends each organization adopting the strategic plan determine appropriate activities and tasks to address each strategy based upon organizational capacity and constituents served.

The Workgroup identified five key findings, or critical issues, which significantly affect the ability to identify and eliminate tobacco-related disparities in Indiana. See Section VI, page 12 for a complete listing of the key findings.

STEP 5: Determine feasibility of identified goals and strategies.

The Workgroup determined each of the goals and strategies were realistic and feasible if the plan is adopted by multiple organizations as an overall state plan. However, the factors that will ultimately affect the accomplishment of each goal lie in the identification of organizations to take responsibility of one or more of the five goals, their allocation of resources, and the organization's capacity to address the strategies. Once partnerships are identified, each of the partners will need to establish their objectives, action plan and timelines to contribute to the success of the strategic plan. It is recommended the goals be achieved within 5 years.

STEP 6: Conduct a marketing analysis and create final document.

The workgroup identified key stakeholders and analyzed political conditions in creating a marketing plan to disseminate this strategic plan. The plan identifies potential and current partners to educate about the plan and solicit support.

STEP 7: Market plan to key organizations statewide.

Since no one organization has the capacity and/or resources to address every goal and strategy outlined in this plan, several organizations must be recruited to work collaboratively to ensure the overall success of this strategic plan.

ITDD members are committed to marketing the strategic plan to current and future partners statewide. A statewide forum to release the strategic plan to identify and eliminate tobacco-related disparities will be held in Spring 2003. Key organizations and individuals will be invited to the forum and encouraged to adopt the plan. In addition to the forum, one-on-one meetings will be held with several organizations to promote the plan and obtain their commitment to adopt one or more of the goals.

STEP 8: Implement, monitor and evaluate the plan.

Smokefree Indiana and the ITDD Workgroup have made a commitment to the following next steps in order to continue the work of this initiative. See page 16 for the evaluation plan.

- 1) Create and disseminate a newsletter to key stakeholders explaining the workgroup's effort.
- 2) Implement a marketing plan with the goal to identify partnerships.
- 3) Secure key partnerships for each of the five goals in the strategic plan.
- 4) Monitor the collaborative process and the implementation of the strategic plan.

The ITDD Logic Model For The Strategic Planning Process

The ITDD logic model provides a visual diagram of the strategic planning process and the expected outcomes (short, intermediate and long-term) to be achieved if the plan is successfully implemented. The logic model provides indicators of success, indicators that are incremental and ultimately achieve the desired goal to eliminate tobacco-related health disparities. See Appendix C, page 25 for an illustration of the logic model.

IV. Data Analysis

The following chart lists the populations with disparities identified by the Workgroup using available qualitative data. They are divided into three categories:

- “communities” - populations having a shared history, context or culture;
- “strata” - populations having a commonality but do not necessarily share culture; and
- “high risk” - populations identified with limited or no quantitative data; however, qualitative data suggest risk for disparity.

Identified Populations in Indiana Disproportionately Impacted by Tobacco Use*

Communities	Strata	High Risk – <i>no state prevalence data available</i>
African American Males	Income under \$25,000	Asians
Rural Youths (this group may also be considered in the strata category)	Low Education – High school or less	American Indians
Hispanics	Age 18-24	GLBT
	Unemployed	
Note: Communities are considered population groups that share history, context or culture.	Note: Stratum are population groups that have commonality but do not necessarily share a common context or culture.	Note: Limited or no state prevalence data exists for these populations but national figures and trends show risk for disparity. Several populations are increasing significantly in Indiana, and on a national level are historically at risk for acculturation and use of tobacco.

* Data or literature supports that a particular population or sub-population has a tobacco-related disparity.

See Appendix D, page 26 for detailed quantitative data and Appendix E, page 30 for documentation on qualitative data findings.

V. Environmental Scan

The components of the environmental scan include a population assessment and a SWOT analysis. The population assessment was conducted on population groups identified during data analysis. This information is to be used to further define critical issues that need to be addressed. The SWOT analysis is based on the workgroup representative organizations’ abilities to carry out the plan and an assessment of the larger environment in which implementation of the plan will take place.

Population Assessment

The workgroup conducted a population assessment to review and determine what is known about the attributes, resources, and capacity/infrastructure of populations identified during data analysis as having a tobacco-related disparity, or at risk of tobacco-related disparity.

Two sources were used: key informant interviews and consumer health profiles. To conduct key informant interviews, Workgroup members identified key leaders of disparately-affected populations. The key leaders were contacted and asked questions about tobacco-related norms

and attitudes specific to the population they represented. Key informants were asked questions regarding:

- Communication channels
- Tobacco-related norms and attitudes
- Assets/challenges in tobacco prevention and control issues
- Existing community/population-based interventions
- Policy/regulatory interventions
- Capacity and infrastructure
- Leadership representation

See Appendix F, page 45 for responses to key informant interviews.

As workgroup members conducted the population assessment, it became clear how complex and important it is to design population-specific programming to be successful in reaching identified populations with effective tobacco prevention and control messages.

Consumer Health Profiles

Consumer Health Profiles were prepared for each population groups identified during data analysis and presented by a workgroup member from the National Cancer Institute's Cancer Information Service. The workgroup unanimously determined the Consumer Health Profile was an excellent resource that would help in geographically locating specific populations and aid in the effective development of population-specific messages. Consumer Health Profiles can be tailored to identified populations in Indiana based on Census categories of age, race, income, and education, and provide the following information:

- Populations in need of outreach;
- Geographic illustrations of where members of the population group live in the state;
- Lifestyle characteristics, such as media habits; hobbies; and knowledge, attitudes and beliefs about cancer and specifically about tobacco use.

Both the key informant interviews and the Consumer Health Profiles confirmed the need to create population- and strata-specific messages in order to provide effective education and outreach. Organizations are strongly encouraged to utilize the Consumer Health Profiles in order to develop successful program, intervention and marketing campaigns to address specific populations.

SWOT Analysis

As a component of the environmental scan, a SWOT analysis was conducted by Workgroup members on their organization's capacity to carry out the strategic plan. The analysis determined strengths, weaknesses, opportunities, and threats related to the larger environment in which the planning takes place. The SWOT analysis identified the following facilitators (expedite progress) and barriers (impede progress) that may lead to the success of the plan or hinder it.

Facilitators to ITDD Strategic Plan

- Majority of organizations are local and community oriented and have access to specific population groups.
- There are existing minority coalitions to build linkages to help implement the strategic plan.

Barriers to ITDD Strategic Plan

- Data is limited and there are many gaps in available data. State-specific data are insufficient to adequately identify populations disparately affected by tobacco use or have indicators identifying them as a possible risk.
- Future funding for tobacco prevention and control efforts may be in jeopardy due to competition for the MSA funds and unrealistic expectations by decision makers. Some decision makers are expecting to see dramatic outcomes in tobacco-related disease and death that are unrealistic and may choose to reallocate the MSA funds.
- Due to a budget deficit, there is extensive competition for the MSA funds to remain dedicated to tobacco prevention and control. Increased collaboration is needed among all tobacco control partners (Indiana Tobacco Prevention and Cessation Agency, ISDH, SFI and ITPC-funded projects) to build the state's tobacco prevention and control effort.
- Training opportunities for all the newly-funded, local partners in tobacco control are limited, and most do not have adequate resources for evaluation efforts.

Other issues identified

- Appropriation of the MSA funding occurs biannually.
- Resources to implement the strategies, and therefore the plan, are limited.
- There is a need for a central repository to collect, interpret and disseminate data on tobacco-related disparities. Newly-funded, local partners do not have adequate resources to collect local data.
- The majority of ITDD Workgroup member organizations have minimal or weak political connections. Two Workgroup member organizations have substantial political connections.
- Messages and programs must be tailored to meet the different needs and culture of each target populations.

VI. Key Findings

The following five key findings, or critical issues, were identified by the ITDD Workgroup, which may significantly affect the ability to identify and eliminate tobacco-related disparities in Indiana. The Workgroup identified five (5) critical issues which significantly affect the ability to identify and eliminate tobacco-related disparities in Indiana. They are:

- **Gaps in Data:** State-specific data is insufficient to adequately identify populations disparately affected by tobacco use.
- **Funding Challenges:** Since no single funding source is available to support the implementation of the strategic plan, it will require resources from a number of

organizations, combined with the identification and acquisition of outside funding, to implement the strategic plan.

- **Capacity Issues:** New tobacco control partners exist statewide, many with organizations with no previous tobacco control experience. Other partnerships will need to be developed to reach population groups with identified disparities. Efforts must be made to continually increase the capacity of these organizations to implement effective tobacco control programs. Capacity issues include financial and staff resources; training and education; access to materials, programs and best practices.
- **Tobacco Industry:** The tobacco industry spends large amounts of money to fund specific populations' events, buy influence and to conduct target marketing to specific populations. Alternative funding sources are needed to support these populations and their projects to counteract the influence of the industry. Historically, industry contributions have been used to buy influence among, and to oppress, these populations. Counter marketing is needed and must be specific to the disparately affected population.
- **Programming for Populations with Identified Disparities:** Programs, marketing efforts and tobacco control interventions must be tailored to meet the specific needs and culture of each disparately-affected population in Indiana.

See Appendix G, page 49, for more description on the above stated critical issues.

VII. Goals and Strategies

From the key findings, the ITDD Workgroup developed a long-term goal to address each critical issue. For each goal statement, the ITDD identified strategies to accomplish the goal. The Workgroup recommends each organization adopting the strategic plan determine appropriate objectives, activities and tasks to address each strategy based upon organizational capacity and constituents served.

Critical Issue	Goal Statement	Strategies
Funding	By 2008, identify and strengthen funding for tobacco prevention and control in Indiana	1. Identify possible funding opportunities.
		2. Develop an education plan and solicit support from Key Stakeholders (see list of identified Key Stakeholders) to adopt Tobacco prevention and control as a program interest area.
		3. Maintain MSA funding, within CDC's <i>Best Practices</i> recommended levels of funding, for Indiana tobacco-control programs.

Gaps in Data on Disparately-Affected Populations	By 2008, eliminate information gaps in data that prevent the identification of tobacco related-disparities in Indiana	1. Increase the number of researchers from populations with disparities.
		2. Encourage agencies to expand tobacco research among populations with disparities.
Capacity	By 2008, a population and community specific, comprehensive approach to tobacco prevention and control is implemented	1. Develop a statewide clearinghouse, containing relevant and credible statewide research on tobacco-related disparities, with the ability to disseminate information.
		2. Promote the use of available resources in the development of a comprehensive community-specific approach for tobacco prevention and control.
		3. Identify models of comprehensive approaches to eliminate tobacco use disparities and provide education based on selected models.
Tobacco Industry	By 2008, reduce the influence of the tobacco industry on specific populations in Indiana	1. Educate and empower organizations and communities in obtaining non-tobacco industry monies to support their programming.
		2. Develop marketing strategies to counteract tobacco industry influence on specific populations.
		3. Support advocacy efforts addressing legislative policies restricting tobacco use and tobacco industry influence.

Programming for populations with identified disparities	Reduce disparities related to tobacco use among specific populations identified in this strategic plan	1. Cultivate relationships and collaborate with organizations to implement comprehensive tobacco control programs that reach population groups with disparities.
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VII. Next Steps

Monitoring and the Continued Workgroup Role

Indiana will be continuing the ITDD Workgroup and the facilitator through June 2003. The Workgroup is very interested in continuing to meet to monitor the adoption of strategies and efforts to achieve the goals outlined in the strategic plan. The Workgroup and SFI have made a commitment to the following next steps in order to continue the work of this initiative.

1. Create and disseminate a newsletter to key stakeholders explaining the workgroups effort.
2. Implement marketing plan with the goal to identify partnerships.
3. Secure key partnerships for each of the five goals in the strategic plan.
4. Oversee the implementation of the strategic plan by partnering organizations.
5. Monitor and evaluate the collaborative process and the implementation of the strategic plan.

Smokefree Indiana Action Planning

Goals and strategies developed by the ITDD Workgroup through the strategic planning process will be incorporated into each SFI annual action plan for NTCP's cooperative agreement.

Marketing Plan

The ITDD Workgroup will conduct a public forum to inform key stakeholders of the strategic plan. Potential partners will be identified and meetings will be conducted to secure collaborative commitments to the plan

Evaluation Plan

The chart provided on page 16 represents the short-term, intermediate, and long-term outcomes anticipated as a result of implementing this strategic plan. The evaluation will use the several methods to determine when the outcomes have been reached. The methods include:

1. Report findings of ITDD Workgroup's public forum to Smokefree Indiana staff. Staff and the workgroup will use the information to improve the program as it progresses.
2. The ITDD Workgroup, tobacco control partners and Smokefree Indiana will use the information to raise additional program funds.
3. Staff and participant interviews.

4. To implement the evaluation, Smokefree Indiana’s Director of Diversity will work with the Managing Director. The Director of Diversity will report quarterly progress to the ITDD Workgroup members through a quarterly e-mail progress report.

Evaluating Implementation of the ITDD Strategic Plan: Planning Goals and Outcomes			
Strategic Planning Goals	Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
1. Identify and strengthen funding for tobacco prevention and control in Indiana	<ul style="list-style-type: none"> • Possible funding sources identified • Increased support from key stakeholders 	<ul style="list-style-type: none"> • Sustained funding for populations with disparities 	<ul style="list-style-type: none"> • Disparities among populations are eliminated • • Reduced tobacco-related morbidity and mortality
2. Eliminate information gaps in data that prevent the identification of tobacco-related disparities in Indiana	<ul style="list-style-type: none"> • Agencies expand tobacco research among populations with disparities • Increased participation in research among Indianans from disparately affected populations 	<ul style="list-style-type: none"> • Complete and accurate tobacco use data on all populations in Indiana • Valid and reliable statewide indicators for tobacco-related disparities 	
3. Promote a comprehensive approach to tobacco prevention and control that is population and community specific	<ul style="list-style-type: none"> • Statewide clearinghouse of data on tobacco-related disparities • Comprehensive community-specific programs developed • Best practices and model approaches to tobacco prevention and control are used 	Sustained comprehensive community-specific programming with disparately affected populations	
4. Reduce the influence of the tobacco industry on disparately-affected populations in Indiana	<ul style="list-style-type: none"> • Counter-marketing efforts underway to reduce tobacco industry influence on disparately-affected populations • Reduced dependency of communities/community-based organizations on tobacco industry monies for programming • Increased support for policies to restrict tobacco use and tobacco industry influence 		

<p>5. Reduce disparities of tobacco use among specific populations identified in data analysis</p>	<ul style="list-style-type: none"> • Established partnerships for implementation • Organizations representing disparately-affected populations adopt policies to restrict tobacco use • Organizations advocate for policies to safeguard disparately-affected populations 		<ul style="list-style-type: none"> • Decreased medical costs and years of potential lives lost in Indiana due to tobacco-related diseases
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Appendix A – Definitions for Diversity and Disparity

Working Definitions

The following working definitions were developed by the Centers for Disease Control and Prevention's (CDC) National Workgroup on Identifying and Eliminating Disparities and Increasing Diversity.

Increasing Diversity and Inclusivity (Promoting Representation and Involvement): Increasing diversity and inclusivity requires including representatives from populations at all levels of decision-making about tobacco-related health issues. Diverse populations include, but should not be limited to racial and ethnic populations; low socioeconomic status populations, out-of-school youth, and lesbian, gay, bisexual and transgender communities.

Identifying and Eliminating Disparities (Closing the Gap): Identifying disparities involves using data and/or other sources to identify groups with significantly higher rates of tobacco use and/or exposure to secondhand smoke. Eliminating disparities involves ensuring diverse communities' access to planning and decision-making, capacity and infrastructure building, funding opportunities, services, and comprehensive initiatives to address the disproportionate use of tobacco and/or exposure to secondhand smoke

Appendix B

**Smokefree Indiana's
Identifying and Eliminating Disparities Workgroup
Tuesday, January 29, 2002, 10 a.m. to 3 p.m.
American Cancer Society 6030 W. 62nd Street, Indianapolis, IN**

- I. Welcome and Introductions - Cecilia B. Williams, Director of Diversity
- II. Ice Breaker - Cecilia
- III. Overview of CDC Project - Kelly Alley, Managing Director
 - Review of current disparities activities & funding
 - Purpose of the Workgroup
- IV. Identifying and Eliminating Disparities/
- V. Increasing Diversity & Inclusivity - Definitions - Cecilia
Lunch (On Your Own)
- VI. Roles & Responsibilities of Workgroup - Cecilia
 - Overall Role and Function of the Workgroup
 - Guidelines
 - Nancy Schlapman, Research Consultant
 - Olga Villa Parra, Evaluation Consultant
 - Structure of Workgroup (positions, name of workgroup)
 - Conflict of Interest
- I. Overview of the Strategic Planning Process - Kelly
- VIII. Milestones - Cecilia

**Smokefree Indiana's
Identifying and Eliminating Disparities Workgroup
Friday, February 22, 2002, 10 a.m. to 3 p.m.
Hope Lodge, Indianapolis, IN**

- I. Welcome and Introductions - Cecilia B. Williams
- II. Environmental Scan
- III. Data Sources - Nancy
 - What's been found
 - Other sources of data
- III. Lunch (Carry-In)
- IV. Conflict of Interest
 - Issues that warrant COI
- V. Who do we want to keep informed
 - Who to provide regular updates of activities
 - ITPC
- VI. Name of Workgroup (revisited)
 - Reopen nominations for group name
 - Vote on name
- VII. Workgroup Members
 - Approval of perspective members
 - Workgroup Coordinator Position Update

**Smokefree Indiana's
Identifying and Eliminating Disparities Workgroup
Friday, March 22, 2002 - 10 a.m. to 3 p.m.
American Cancer Society, Indianapolis, IN**

- I. Welcome/Disparity Activities Update - Chair, Yasenka Peterson
Review of Minutes/Notes – Chair, Yasenka Peterson
- II. Review Guidelines for meeting – Cecilia Williams, SFI
- III. New Workgroup Members: Ami Davidson, Sung Boon Baik
Introductions
Get to Know Ya Activity
- IV. Coordinator Update – Cecilia Williams, SFI
- VI. Conflict of Interest Update – Cecilia Williams, SFI
CDC form for COI
- VII. Data Analysis Update
- VIII. Lunch
- IX. Mission Statement
- X. S.W.O.T. Analysis overview (handouts)
- XI. Progress of Workgroup: Opinions? Suggestions?
- XII. Announcements
Dr. Robinson's visit
Visitors at workgroup meetings
-ITPC Minority Coordinator, ILI, other

**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday, April 26th, 2002 - 10:00 a.m. to 3:00 p.m.
American Cancer Society, Indianapolis, IN**

- I. Welcome/Disparity Activities Update – Chair, Yasenka Peterson 10 min.
- II. Review of Minutes/Notes – Chair, Yasenka Peterson 2 min.
- III. Introduction of Facilitator Cheryl Hunt – 10 min.
Facilitator role and background – Cecilia Williams, SFI
- IV. Video: “Why” 3 min.
- V. Data Analysis presentation – Nancy Schlapman, Research Consultant 1 hour 30 min.
Identify critical issues related to data analysis
- VI. Lunch 1 hour
- VII. SWOT Analysis of Workgroup members' organizations 1 hour 45 min.
Report from each work group member on his or her organization
Identify critical issues related to SWOT Analysis
- VIII. Population Assessment – process overview – Cecilia Williams, SFI 10 min.
- IX. Announcements - Dr. Robinson's visit 5 min.

**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday, May 24th, 2002- 10:00 a.m. to 3:00 p.m.
American Cancer Society- Indianapolis, IN**

I.	Welcome/Disparity Activities Update – Chair, Yasenka Peterson	10 min.
II.	Review of Minutes/Notes – Chair, Yasenka Peterson	2 min.
III.	Introduction - Lori Peterson	10 min.
IV.	Review Environmental Scan process – Cheryl Hunt	2 min
V.	New Data - presentation – Nancy Schlapman	30 min.
VI.	Cancer Information Services – Data profiles – Rivienne Shedd-Steele	60 min.
VII.	Lunch 12:00 noon	1 hour
VIII.	Critical Issues Identified for Data segment	45 min.
IX.	Small Group Discussion and brainstorm list	15 min
X.	Report back to Large group and merge lists into one	15 min
XI.	Combine similar issues and then use Nominal Voting technique to select top 10 issues	15 min
XII.	Environmental Scan Review and Critical Issues Identified	45 min.
XIII.	Population Assessment Identify key leaders and discuss best approaches for data collection. Assign Homework on Population Assessment questionnaire	25 min.
XIV.	Announcements “Why” Video Nebraska Model to be present at future mtg. Next Meeting, June 28, 2002	

**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday, June 28, 2002 - 10:00 a.m. to 3:00 p.m.
American Cancer Society, Indianapolis, IN**

I.	Welcome/Disparity Activities Update – Chair, Yasenka Peterson	10 min.
II.	Review of Minutes/Notes – Chair, Yasenka Peterson	2 min.
III.	Introduction - Leena Koottungal, Smokefree Indiana media intern	2 min.
IV.	Cancer Information Services – Subcommittee Recommendations	10 min.
V.	Distribute information on Best Practices – Yasenka Peterson	5 min.
VI.	Review Critical Issues developed at last meeting that were based on Data Research and prioritize them - Cheryl Hunt	20 min.
VII.	SWOT Critical Issues– review statewide analysis of workgroups’ Strengths, Weaknesses, Threats and Opportunities and create a list of critical issues based on SWOT analysis - Cheryl Hunt	40 min.
VIII.	Population Assessment - Cheryl Hunt Present revised Questionnaire and different survey processes for workgroup members to conduct a population assessment on certain populations Identify existing assessments for disparate populations	30 min.
IX.	Lunch	1 hour
X.	Key Stakeholder exercise - Cheryl Hunt	1 hour & 45 min.
XI.	Newsletter Development – Goals/Objectives of the newsletter, who should receive the update? - Cecilia Williams Next Meeting, Friday, July 26	15 min.

**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday, July 26, 2002 - 10:00 a.m. to 3:00 p.m.
American Cancer Society, Indianapolis, IN**

I.	Welcome/Disparity Activities Update – Chair, Yassenka Peterson	10 min.
II.	Review of Minutes/Notes – Chair, Yassenka Peterson	2 min.
III.	New Data - presentation – Cheryl Hunt	30 min.
IV.	Critical Issues- Disparate Groups Identification - Data	30 min
V.	List Critical Issues - Data Research and prioritize them	45 min
	▪ Small Group Discussion and brainstorm list	15 min
	▪ Report back to Large group and merge lists into one	15 min
	▪ Combine similar issues and then use Nominal Voting technique	
	to select top 10 issues	15 min
VI.	Lunch 12:00 noon	1 hour
VII.	Population Assessment reports from workgroup members	45 min.
VIII.	List Critical Issues from Pop. Assessment	45 min.
	▪ Small Group Discussion and brainstorm list	15 min
	▪ Report back to Large group and merge lists into one	15 min
	▪ Combine similar issues and then use Nominal Voting technique	
	to select top 10 issues	15 min
IX.	SWOT Analysis – Critical Issues prioritized Top 10	15 min.
X.	Homework and Next Steps - Finalize Population Assessments.	10 min.
XI.	Announcements	5 min.

**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday, August 23rd, 2002 - 10:00 a.m. to 3:00 p.m.
American Cancer Society, Indianapolis, IN**

I.	Welcome/Disparity Activities Update – Chair, Yassenka Peterson	10 min.
II.	Review of Minutes/Notes – Chair, Yassenka Peterson	2 min.
III.	Review of overall Strategic Planning Process and Progress	10 min.
IV.	Review Data Issues Created at July Meeting	30 min.
	• List populations identified with disparities by:	
	- SES and Prevalence “known” populations	
	- Possible grouping based on risk factors – SES and acculturation	
	• Select Ten Data Issues	
V.	SWOT – Present Selected Ten Issues	10 min.
VI.	Population Assessment –	45 min.
	• Summary of reports	
	• Review Recommendations of Issues from Population Assessment	
	• Select ten issues	
VII.	Lunch	1 hour
VIII.	Select 6 Critical Issues from 30 Critical Issues	90 min.
	• Assess critical issues by the criteria of:	
	1) Attention (issue being attended to by others), 2) Impact, 3) Feasibility,	
	4) Integration (linkage and tie-in with other issues) and 5) Time frame	
IX.	Sub-committee to create goal statements and strategies	10 min.
X.	Next Steps including Best Practices report Key Stakeholders, Political	15 min.
XI.	Considerations, and Marketing	
XII.	Announcements	10 min.

**Smokefree Indiana's
Identifying and Eliminating Disparities Workgroup
Friday, September 27, 2002 - 10 a.m. to 3 p.m.
American Cancer Society, Indianapolis, IN**

IV.	Welcome/Disparity Activities Update - Chair, Yasenka Peterson	10 minutes
V.	Review of Minutes/Notes – Chair, Yasenka Peterson	2 minutes
VI.	CDC review of Best Practices in Tobacco Control – Cecilia	10 minutes
VII.	ITDD Goals & Strategies Subcommittee Report – Cheryl	30 minutes
VIII.	Feasibility Exercise for Goals and Strategies – Cheryl	1 hour
IX.	Lunch	1 hour
X.	Audience Assessment & Political Considerations – Cheryl	1 hour
IV.	Newsletter Draft – Cheryl	30 minutes
V.	Where We Are, and Where We Are Going – Cheryl	15 minutes
VI.	November Celebration	15 minutes
VII.	Adjournment	

Next Meeting – October 25, 2002

**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday, October 25th, 2002 - 10:00 a.m. to 3:00 p.m.
American Cancer Society, Indianapolis, IN**

I.	Welcome/Disparity Activities Update – Chair, Yasenka Peterson	10 min.
II.	Review of Minutes/Notes – Chair, Yasenka Peterson	2 min.
III.	Marketing Analysis Exercise – Cheryl	1 hour
IV.	Political Considerations – Cheryl	45 min.
V.	Lunch	1 hour
VI.	Strategic Plan Draft – Review and approval – Cecilia and Cheryl	1 hour
VII.	Newsletter Draft – Review	30 min
VIII.	November Celebration Plans	15 min
	Announcements	

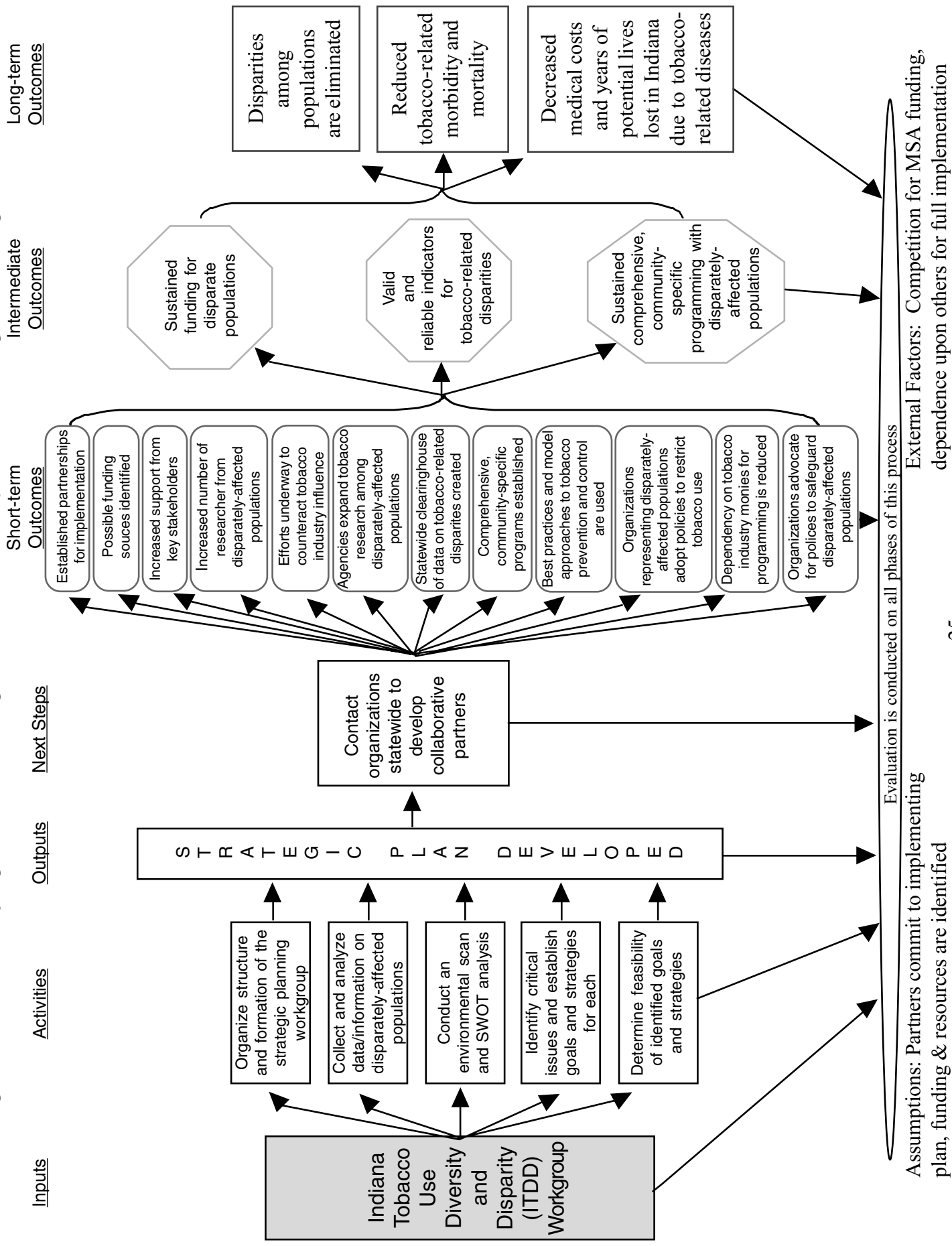
**Smokefree Indiana's
Identifying and Elimination Disparities Workgroup
Friday November 15, 2002 - 10:00 a.m. to 3:00 p.m.
American Cancer Society, Indianapolis, IN**

- | | | |
|-------|--|---------|
| I. | Welcome/Disparity Activities Update – Chair, Yassenka Peterson | 10 min. |
| II. | Review of Minutes/Notes – Chair, Yassenka Peterson | 2 min. |
| III. | Update on meeting with ITPC – Yassenka, Kelly, Cecilia & Olga | 10 min. |
| IV. | Strategic Plan Draft Update – Cecilia | 5 min. |
| V. | Newsletter Update - Cecilia | 5 min. |
| VI. | ITDD Workgroup Forum Update - Cecilia | 15 min. |
| VII. | Q & A preparation for forum - Cecilia | 45 min. |
| VIII. | CELEBRATE!!!! Lunch and Recognition Ceremony | |

**December 4th, 2002
Conference Call
2:00 p.m. to 4:00 p.m.**

- I. Review purpose of the forum
- II. Review list of key stakeholders to invite
- III. Review PowerPoint presentation
- IV. Review Q & A sheet (FAQ sheet)
- V. Discuss roles of each workgroup member in attendance (who key spokespeople will be)

Logic Model: Identifying and Eliminating Tobacco Use Disparities Strategic Planning Process



Assumptions: Partners commit to implementing plan, funding & resources are identified

Evaluation is conducted on all phases of this process

External Factors: Competition for MSA funding, dependence upon others for full implementation

Appendix D Quantitative Research Data

Populations Potentially At Risk of Tobacco-Related Disparities in Indiana

Factors Indicating disparately affected or at-risk population	American Indian/Alaskan Native	Black/African American	Asian/Pacific Islander	Hispanic	White	Other	GBLT	Male	Women	Women of reproductive years age 15 to 44	Rural
Total Population - 6,080,485 ¹								2,982,474	3,098,011	1,309,417	
Population Count - one race ¹	15,815	510,034	59,126	214,536	5,320,022						
Population Count - race alone or in combination w/ one or more races ¹	39,263	538,015	72,839	N/A	5,387,174						
Percentage of Population 2000 ¹	0.30%	8.40%	1%	3.5%	87.5			51%	21%	35%	
Growth from 1990 to 1999 ¹	15.50%	14.70%	54%	17.0%							
Households - Same Sex Unmarried Partner 2000 ¹							10,219				
Tobacco Use - Indiana Statistics											
Tobacco Use - Indiana -Do you smoke cigarettes now? 2000 ²	N/A	24.6%	N/A	22.5%	27%	31%	N/A	28.40%	25.50%	21.10%	N/A
Current Smokers - 10th grade ⁷											40% (35% non-rural)
Tobacco Use National Statistics											
Smoking Prevalence 2000 ²		22.8%		21.9%	23.0%	24.4%	41.5% male				

Smoking among women of reproductive age by race - 1998 ⁶	34.5%	21.9%	11.2%	13.8%	29.5%				12.90%
Smoking prevalence youth - 1990-1994									
males - high school seniors	41.1%	11.6%	20.6%	28.5%	33.4%				
females - high school seniors	39.4%	8.6%	13.8%	19.2%	33.1%				29.70%
Smoking Prevalence during pregnancy 1998 ⁵									
18 to 24 years of age									17.10%
25 to 49 years of age									10%
Male - no H.S. diploma, current smoker, 1999 ⁴		44%			36.3%				
Female - no H.S. diploma, current smoker, 1999 ⁴		30.20%			30%				
Income									
Poverty Level-1999		26%			8%				
Factors of at-risk populations									
American Indian/Alaskan Native		Black/African American	Asian/Pacific Islander	Hispanic	White	GB LT	Women	Women of reproductive years age 15 to 44	Rural
Employment									
Unemployment - 1999		9%			4%				
Insurance									
Uninsured ⁸		19.70%		33.60%	11.30%				
Cancer Facts									
Smoking attributable deaths from lung, trachea, and bronchus 1998									
Men per 100,000		81.6	27.9	23.1	54.9				
Women per 100,000	18.4	27.2	11.4	7.7	27.9				

Average annual age-adjusted mortality rates lung cancer per 100,000 1995-1999					
Indiana		82.8	19.7	19.5	65.8
National	36.2	67.8	29	23.4	57.7

- 1 - Census 2000, U.S. Census Bureau
- 2 - Behavioral Risk Factor Surveillance System, Indiana Statewide Survey Data, 2000, Center For Disease Control and Prevention
- 3 - Women and Smoking, A report of the Surgeon General, 2001
- 4 - National Health Interview Survey, Centers for Disease Control and Prevention 1999
- 5 - Surgeon General's Report 2001: Women & Smoking Fact Sheet
- 6 - National Health Interview Survey, CDC 1997-1998
- 7 - Rural Indiana Profile, Alcohol, Tobacco & Other Drugs, The Indiana Prevention Resource Center at Indiana University
- 8 - Percentage Uninsured Among the Non-elderly Population, by Race and Ethnic Origin, 2000, Covering the Uninsured, The Robert Wood Johnson Foundation

	AGE				Education				Income			
	18-24	25-34	35-44	45-54	Less than H.S.	H.S. or G.E.D.	Some Post H.S.	College Graduate	Less than \$15,000	\$15,000 - 24,999	25,000 - 34,999	35,000 - 49,999
Total Population - 6,080,485 ¹		831,125	960,703	816,865								
Percentage of Population 2000 ¹		13.7%	15.8%	13.4%								
Tobacco Use - Indiana Statistics												
Tobacco Use - Indiana - Do you smoke cigarettes now? 2000 ²	37.4%	29.9%	31.9%	29.9%	46.5%	30.2%	28.0%	12.9%	35.7%	36.8%	27.2%	27.1%
Tobacco Use - National ²	31%	26.6%	31.9%	29.9%	31.7%	27.7%	23.5%	12.3%	29.7%	28.6%	26.1%	24.3%

* Census data given for different age range than 18-24

Appendix E – Qualitative Data Findings

American Indian and Alaska Native

Population in Indiana ¹

American Indian and Alaska Native

- One race, YR 2000 = 15,815 or .3%
- Race alone or in combination with one or more other races = 39,263
- There was a 15.5% increase in population from 1990 to 1999

Age Distribution, YR 1999²

- 9% of the population is age 15 to 19 years old
- 17.5% of the population is age 20 to 29
- 24.5% of population is age 30 to 44

In Indiana there is no federally recognized tribe located in the state.

National Statistics

Population and Growth Trends

- There are over 560 federally recognized tribes and over 100 state recognized tribes, of which each has its own unique culture.³
- Since 1990, the U.S. population of American Indians and Alaska Natives has increased by 10.4%.⁴
- AIAN population has a younger median age compared to other racial groups. This would especially impact and result in lower cancer incidence and death rates since cancer is primarily a disease that affects older people.³
- In reporting, there is a 40-50% misclassification of American Indians as either white or Hispanic^{3,5}

Income

AIAN population continues to be among the poorest populations in the US.³

Insurance

Access to health care is a problem for American Indians and Alaska Natives, who are second only to Hispanics in lacking health insurance^{3,6}

Medical Access

Access to health care is a problem for AIAN who are second only to Hispanics in lacking Health insurance.⁶

Cancer Facts

- SEER Cancer Incidence and U.S. Death Rates, 1995-1999 by cancer site and race of American Indian/Alaska Native ⁷
 - Incidence = 34.5 per 100,000
 - Mortality = 36.2 per 100,000
- Smoking-attributable deaths from cancers of the lung, trachea, and bronchus were slightly higher among AIAN (33.5% per 100,000 men and 18.4% per 100,000 women) than those of Asian American and Pacific Islander, and Hispanics, but lower than rates among African Americans and white population.⁴

- Although American Indians would seem to be a high-risk group on the basis of socioeconomic status, when compared with other racial groups, the incidence of cancer among American Indians is low. It is not known if that comparatively low rate is due to racial misclassification resulting from 1) undercounting American Indians on health records; 2) reflective of cancer rates among Southwestern Indians which are not generalizable to American Indians from other regions of the U.S. or 3) an accurate assessment of cancer rates.⁸
- Cancer rates, which were previously reported to be lower in AIAN population, have been shown to be increasing in the past 20 years³
- AIAN populations have the poorest survival rate from “all cancers combined” than any other racial group.³
- Nationally, lung cancer is the second most commonly diagnosed cancer in male American Indian/Alaskan Native at 18.2%.⁹
- Lung cancer diagnosis is also the second most commonly diagnosed cancer (behind breast cancer) among female American Indian/Alaskan Natives but at a lower rate than males (12.1%)⁹

The average annual age-adjusted mortality rates for lung cancer deaths per 100,000 persons, by race, 1995–1999¹⁰

	Indiana	National
Overall	65.8	57.7
White	65.1	57.5
Black	82.8	67.8
Hispanic	19.5	23.4
Asian/Pacific Islander	19.7	29.0
Am. Indian/Alaska Native	-	36.2

Hyphens represent suppression of rates when there were 75,000 or fewer persons in the denominator or 20 or fewer deaths in the numerator.¹⁰

- Nationally from 1990-1995, death rates from respiratory cancers increased among American Indians/Alaskan Natives – the only group for which smoking rates increased during this period.¹¹

Tobacco Use – Indiana Statistics

- In the BRFSS Prevalence Data report for Indiana, racial categories, such as Asians, and American Indians and Alaska Natives were collapsed into a single racial category of “Other” due to small sampling size. To the question “Do you smoke cigarettes now?”, the percentage of the “Other” category responding yes was 31.4%.¹²
- Collapsing racial categories into a single racial category of “other” is of no benefit to public health policy makers, researchers, tribal planners, and so on. It has the same effectiveness as having no data or being excluded from a study or study findings.³

Tobacco Use – National Statistics

- In the 1998 National Health Interview Survey (NHIS) prevalence of current smoking (self reported) was the highest among the population of American Indians/Alaska Natives (40.0%),¹³
- In the year 2000, prevalence of cigarette smoking was reported as 41.7% for men and 38.1% for women.⁵
- Since 1978, the prevalence of cigarette smoking has remained strikingly high among American Indians and Alaskan Native women of reproductive age and has not declined as it has among other minority populations.¹³

Culture and Tobacco

Although many tribes consider tobacco a sacred gift and use it during religious ceremonies and as traditional medicine, the tobacco-related health problems they suffer are caused by chronic cigarette smoking and spit tobacco use.⁴

Source

1. U.S. Census Bureau, Census 2000. Profile of General Demographic Characteristics: 2000, Indiana
2. STATS Indiana, Indiana Business Research Center at Indiana University's Kelley School of Business.
www.stats.indiana.edu Population Estimates by Age, Sex, Race and Hispanic Origin
3. Intercultural Cancer Council, www.iccnetwork.org/cancerfacts
4. American Indians and Alaska Natives and Tobacco; Tobacco Information and Prevention Source (TIPS): National Center for Chronic Disease Prevention and Health Promotion,
http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-nat.htm
5. Centers for Disease Control and Prevention. Cigarette Smoking among Adults U.S. 1998
www.cdc.gov/mmwr/preview/mmwrhtml/mm4943a2.htm
6. US Department of Health and Human Services. Indian Health Service. Regional Differences in Indian Health 1998-1999 Rockville, MD: Department of Health and Human Services. Indian health service; 2000 www.ihs.gov/publicinfo/publications/trends98/region98.asp
7. SEER Cancer Statistics Review 1973-1999, SEER Cancer Incidence and U.S. Death Rates, 1995-1999 by cancer site and race, http://seer.cancer.gov/faststats/html/inc_lungb.html
8. Native American Monograph #1, Documentation of the Cancer Research of American Indiana and Alaskan Native, National Cancer Institute, NIH, Publication #93-3603
9. Data Evaluation & Publication Committee of the North American Association of Central Cancer Registries
10. Centers for Disease Control and Prevention. Cancer Burden Data.
www.cdc.gov/cancer/cancerburden/in.htm
11. Tobacco Use Among U.S. Racial/Ethnic Minority Groups 1998, Department of Health and Human Services: Center For Disease Control and Prevention
12. BRFSS Prevalence Data, Race Grouping, Centers for Disease Prevention and Control
13. Tobacco Use Among U.S. Racial/Ethnic Minority Groups, A report of the Surgeon General 1998
www.cdc.gov/tobacco Office of Smoking and Health

Asian and Pacific Islanders

Population in Indiana

Asian Americans Pacific Islanders

- 59,126 - One Race, 2000 YR or 1.0%
- 72,839 - Race alone or in combination with one or more other races ¹
- The two largest populations are Asian Indian and Chinese
- There was a 54% increase in population from 1990 to 1999

Age Distribution, YR 1999

- 8% of the population is age 15 to 19 years old
- 18% of the population age 20 to 29
- 27% of population is age 30 to 44

National Statistics

Population

- The six largest subgroups of Asian Americans are from China, the Philippines, Japan, India, Korea, and Vietnam.

Medical Access

Hispanic, American Indian, Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, culture, and negative provider attitudes, which negatively affect their health status.

Cancer Facts²

- The average annual age-adjusted mortality rates for lung cancer deaths is 19.7 per 100,000 persons, 1995–1999
- The death rate for lung cancer was 27.9 per 100,000 for Asian American and Pacific Islander men and 11.4 per 100,000 for women, 1998.

Tobacco Use – Indiana Statistics

- No data available

Tobacco Use – National Statistics³

- The 1997 National Health Interview Survey data show that overall adult smoking prevalence was lower among Asian Americans and Pacific Islanders (16.9%) than among Hispanics (20.4%), whites (25.3%), African Americans (26.7%), and American Indians and Alaska Natives (34.1%).
- In 1997, 21.6% of Asian American and Pacific Islander men smoked, compared with 27.4% of white men. However, Asian American and Pacific Islander women (12.4%) were significantly less likely to smoke than white women (23.3%).
- Among high school seniors, aggregated 1990–1994 Monitoring the Future Survey data show that for racial/ethnic groups, smoking prevalence was: males, 20.6%; females, 13.8%.

- In 1998, Among Asian American and Pacific Islander high school seniors 4.4% of male students and 4.5% of female students reported smoking one-half pack or more per day.
- Research shows an association between cigarette smoking and acculturation among Asian American and Pacific Islander adults from Southeast Asia. Those who had a higher English-language proficiency and those living in the United States longer were less likely to be smokers.
- Among Chinese men, the average number of cigarettes smoked per day increased with the percentage of their lifetime spent in the United States.

Tobacco Industry Targeting

- Studies have found a higher density of tobacco billboards in racial/ethnic minority communities. For example, a 1993 study in San Diego, California, found the highest proportion of tobacco billboards were posted in Asian American communities and the lowest proportion were in white communities.

Source

- 1) American Factfinder, U.S. Census Bureau, 1990 Summary Tape File 1 (STF 1) - 100-Percent data http://factfinder.census.gov/servlet/DatasetMainPageServlet?_ds_name=DEC_1990_STF3_&_program=DEC&_lang=en
- 2) Cancer Burden Data., Centers for Disease Control and Prevention., <http://www.cdc.gov/cancer/CancerBurden/in.htm>
- 3) Asian Americans and Pacific Islanders and Tobacco, Tobacco Information and Prevention Source, Center of Disease Control and Prevention, http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-asi.htm

Black/African Americans Populations

Indiana Statistics ¹

- Black /African American population in Indiana – one race = 510,034.
- Race alone or in combination with one or more races = 538,015.
- The Black/African American population in Indiana increased 14.7% from 1990 to 1999 and is 8.4% of the total population, the largest minority population in Indiana.

Age Distribution, YR 1999²

- 9% of the population is age 15 to 19 years old
- 15% of the population is age 20 to 29
- 23% of the population is age 30 to 44

National Statistics

Population Growth Trend

There was a 21.5% increase in the Black /African Population from the 1990 Census to the 2000 Census report.³

Education

In 1999, 44% of Black males did not have a high school diploma or GED only. 32.7% had a high school diploma. 30.2 % of female Blacks did not have a high school diploma or GED. 22.% had a high school diploma or GED only.⁴

Income

The poverty rate is higher for African Americans than for Whites (26 versus 8 percent) Nearly 31% have incomes below the poverty level.⁵

Employment

In 1999, the unemployment rate for Black/African Americans was more than twice that for Whites (9 percent and 4 percent, respectively).⁵

Insurance

Nationally, 19.7% of the non-elderly Black/African Americans were uninsured compared to 11.3% white and 33.6% Hispanic.⁶

Medical Access

Although search at this time provided no specific information related to general medical access, there were many specific articles on poor access and inadequate care for heart disease and diabetes for African American populations.⁷

Cancer Facts

- African-American men bear one of the greatest health burdens of the four ethnic groups, with death rates from lung cancer that are 50% higher than those of white men.⁸
- From 1988 – 1992 Lung and Bronchus incidence rates were higher than any other race at 117 per 100,000 population. Black women were second highest among races at 44.2 per 100,000. Mortality

rates from Lung and Bronchus among Black men was also the highest among races at 105.6 per 100,000. Women were fourth highest among races at 31.5 per 100,000.⁹

- From 1990 – 1995, death rates from respiratory cancers declined substantially among African-American men.
- Cigarette smoking among African-Americans has increased in the 1990's after several years of substantial decline
- African Americans with cancer have shorter survival rates than Whites at all stages of diagnosis. This difference is believed to be due to poverty, reduced access to medical care and later diagnosis.^{5,10}
- Lung cancer is the leading cause of cancer death in African Americans among both men (30%) and women (21%).¹⁰

Tobacco Use – Indiana Statistics

- 24.6% of African Americans answered yes to “Do you smoke cigarettes now?” in the BRFSS 2000 survey.¹¹

Tobacco Use – National Statistics

- Both incidence and death rates from lung cancer are higher among African American men than among whites.¹⁰
- 2000 BRFSS data shows that 24.6% African Americans surveyed smoke cigarettes now.¹¹
- According to the Youth Risk Behavior Surveillance Survey (YRBSS), the prevalence of current cigarette smoking in 1999 among African-American high school students has increased approximately 34% among males and 23% among females since 1993.^{10,11}

Tobacco Industry Targeting

- Approximately three of every four African American smokers prefer menthol cigarettes.¹²
- Among adults, the most popular brands are Newport, Kool and Salem. Similar brand preference was found among African American teens with 61.3% preferred Newport, 10.9% preferred Kool, and 9.7% preferred Salem.¹²
- A one-year study found that three major African American publications – Ebony, Jet. And Essence – received proportionately higher profits from cigarette advertisements than did other magazines.¹²
- The tobacco industry attempts maintain a positive image and public support among African Americans by supporting cultural events and making contributions to minority higher education institutions, elected officials, civic and community organizations, and scholarship programs.¹²

Sources

1. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance – U.S. 1999.
2. STATS Indiana, Indiana Business Research Center at Indiana University's Kelley School of Business. www.stats.indiana.edu Population Estimates by Age, Sex, Race and Hispanic Origin
3. Census 2000, Population by Race and Hispanic or Latino Origin for the U.S., U.S. Census Bureau
4. Age-adjusted prevalence of current cigarette smoking by persons 25 years of age and over, according to sex, race, and education. Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey.
5. Intercultural Cancer Council, African Americans & Cancer, www.iccnetwork.org/cancerfacts
6. Covering The Uninsured, a project of the Robert Wood Johnson Foundation 2002, www.coveringtheuninsured.org

7. Gender and Race Bias in Medical Treatment, the Journal of Gender Specific Medicine, Columbia College of Physicians and Surgeons, Columbia University, New York, NY
8. Surgeon General's Report Warns of Health Reversals as Minority Teen Smoking Increases, Tobacco Information and Prevention Source (TIPS), National Center for Chronic Disease Prevention and Health Promotion.
9. Seer Program, Incidence and Mortality Rates, 1988-1992, U.S., National Cancer Institute
10. Cancer Facts & Figures for African Americans 2000-2001, American Cancer Society
11. BRFSS Prevalence Data, Race Grouping, Centers for Disease Control and Prevention. www.cdc.gov.
12. African Americans and Tobacco, Tobacco Information and Prevention Sources (TIPS), Centers for Disease Control and Prevention.

Gay, Lesbian, Bisexual, Transsexual Population

Indiana Statistics¹

The U.S. Census Bureau collected same sex partner data in the 2000 Census poll. The following is the number of households reporting for Indiana:

Unmarried-partner households –

Male householder and male partner	5,054
Female householder and female partner	5,165

National Statistics

- Like the general U.S. population, GLBT people are diverse in terms of cultural background, ethnic or racial identity, age, education, income and place of residence.²
- Because of stigma and prejudice, and because LGBT people represent a minority of the U.S. population, clinical and public health studies and program evaluation have been scarce in all sectors of health delivery and research. For example, population-based national health surveys virtually never include ways to assess sexual orientation, and those that have sought federal support have been denied funding. In addition, methodological challenges including problems in recruitment of subjects and definitions of homosexuality or transgender identity have thwarted research on LGBT public health issues. Public health researchers and planners must turn to small studies that often use convenience samples. Such data are often biased and uninformative for public health purposes.²

Medical Care

- Because of negative attitudes prevalent in the U.S. public as well as among physicians and other medical staff, LGBT individuals are subject to discrimination and bias in medical encounters. Moreover, they are likely to receive substandard care, or remain silent about important health issues they fear may lead to stigmatization. Bias from health care professionals and perception of such bias have been identified as personal and cultural barriers to care, leading to reduction in help-seeking and quality of care.²
- Forty percent of physicians in one study were sometimes or often uncomfortable providing care to lesbian or gay patients.
- In response to lack of and poor quality of health care, local community LGBT organizations have developed and clinics and volunteer initiatives providing community based primary health care services directly to LGBT communities are found throughout the U.S.

- A variety of LGBT organizations, deal in a comprehensive manner with HIV/AIDS, mental health, cancer, violence and other issues.²

Insurance

Barriers to care for LGBT people include systemic bias in health insurance and public entitlements, which routinely fail to cover gay and lesbian partners or to provide reimbursement for procedures of particular relevance.²

Cancer

While definitive studies are lacking, preliminary data lend credence to the suggestion that gay men and lesbians are at increased risk for certain cancers... the authors found no difference in the incidence of cancer for other sites such as respiratory.²

Tobacco Use

- There is no apparent data or statistics available for the state of Indiana on GBLT tobacco use.
- Nationally, small group studies have shown that “adolescent and young adult gay men and lesbians appear to be especially at risk for substance abuse.”²
- Evidence suggests that the rates of tobacco use among sexual minority men and women may exceed those of the general population, ultimately leading to increased rates of tobacco-related disease.... Studies of tobacco use in these populations tended to use nonrandom samples, often drawn from bar patrons, and to report rates of tobacco use sharply higher than those of their heterosexual counterpart.² More representative studies show that the prevalence rate is strikingly higher among gay men than in the general male population. Using a household-based sample 41.5% (1999) of gay adults were smokers, a rate far in excess of the national rate of tobacco use by men generally.²
- Representative studies of lesbian tobacco use have yet to be completed.²

Source

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2. Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns; 2000 The Gay and Lesbian Medical Association, www.glma.org
Sources for this white paper from the GLMA included 1) Center for Gay, Bisexual and Transgender Health, Columbia University, 2) Lesbian Health Research Institute, Center for gay, Bisexual and Transgender Health, Columbia University 3) Gay and Lesbian Medical Association, San Francisco, CA 4) Harry Benjamin International Gender Dysphoria Association and 5) Gender Education and Advocacy, Washington, D.C. See whitepaper at www.glma.org/pub/jglma/vol4/3/j43text.pdf for extensive list of documentation.

Hispanic or Latino Population

Indiana Statistics

Hispanic of Latino of any race =214,536¹ - Represents 3.5% of the state population

- **Mexican** 153,042
- **Puerto Rican** 19,678
- **Cuban** 2,754
- **Other Hispanic or Latino** 39,062

The Hispanic population in Indiana increased 17% from 1990 to 2000 compared to a 13.2% increase nationally. Compared to 9.7% increase for total state population.¹

National Statistics

Population Growth Trend

Over the next 5 decades the Hispanic population is expected to increase dramatically from 9.0% of the population in 1990 to an estimated 21.1% in 2050. “These estimates underscore the need to develop appropriate interventions to avert disturbing tobacco addiction patterns in this large segment of the population.”²

Education

- Educational levels, which are associated with economic levels and health status, are also lower among Hispanics than other populations.

Income

- In 1998, the median income for Hispanic households was \$28,330, considerably lower than the \$42,439 median income for non-Hispanics.^{3,4,5}
- Poverty rates among Hispanics were over three times higher (25.6% vs. 8.2%) compared with non-Hispanic Whites^{3,4,5}

Employment

- Hispanics are more likely to be unemployed than non-Hispanics Whites. Unemployment rate for Hispanics in 1999 was 6.7% compared with 3.6% for non-Hispanic Whites^{1,3}

Insurance

- While Latinos represent about 12% of the population, they make up 25% of the Nation’s uninsured.^{3,6}
- Uninsured are less likely to have a regular source of medical care, less likely to have had a recent physician visit, more likely to delay seeking medical care, more likely to report they have not received needed care, and less likely to use preventive services.^{3,6}

Medical Access

Three times less likely to have a consistent source of medical care and rely more heavily on emergency room treatment.

- Latinos are 1.5 times more likely to use the hospital ER as a primary source of care.
- Health risks include reduced access to care and poorer medical outcomes.

Cancer Facts

- Leading cancer sites for Hispanic men and women are the same as those for Whites: prostate, breast, lung and colon/rectum.⁷
 - The five most common types of cancer deaths among Hispanic men and women includes lung/bronchus.⁷
 - Overall, lung cancer is the leading cause of cancer deaths among Hispanics.^{3,7}
- Uninsured Hispanics are two to three times more likely to have cancer diagnosed at a later stage, making it less treatable.^{3,7}

Tobacco Use – Indiana Statistics

- Percentage of Current Smokers in Indiana who are Hispanic dropped from 28% in 1998 to 18% in 2000. This correlates with national trends where prevalence rates also declined for Hispanic adults.⁸

Tobacco Use – National Statistics

- In general, smoking rates among Mexican American adults increase as they learn and adopt the values, beliefs, and norms of American culture.²
- Cigarette smoking prevalence increased nationally in the 1990/s among Hispanic adolescents after several years of substantial decline...⁸
- 51.6% of Indiana Hispanics surveyed indicated that they had smoked at least 100 cigarettes in their lifetime.
- 18.2% said they were a current smoker everyday, 4.2% said they were a current smoker some days, 23.1% said they were a former smoker.⁹
- Declines in smoking prevalence were greater among Hispanics who were high school graduates than they were among those with less formal education.⁸
- Compared with whites who smoke, smokers in each of the four racial/ethnic minority groups (including Hispanics) smoke fewer cigarettes each day.⁸

Tobacco Industry Targeting

- Tobacco products are advertised and promoted disproportionately to racial/ethnic minority communities. Examples of target promotions include the introduction of a cigarette product with the brand name “Rio” and an earlier cigarette product named “Dorado”, which was advertised and marketed to the Hispanic American Community^{3,4,9}
- The high level of tobacco product advertising in racial/ethnic publications is problematic because the editors and publishers of these publications may omit stories dealing with the damaging effects of tobacco or limit the level of tobacco-use prevention and health promotion information included in their publication.⁸

Sources

1. Census Bureau American Factfinder, Percent of persons who are Hispanic or Latino (of any race) 2002.
2. Action on Smoking and Health. Surgeon General's report AT-A-Glance: tobacco use among US racial/ethnic minority groups. 1998 <http://no-smoking.org/april98/04-27-98-7.html>
3. Intercultural Cancer Council, iccnetwork.org/cancerfacts
4. Centers for Disease Control and Prevention. Tobacco information and prevention source (tips) - *Hispanics and tobacco*. 2000 [Http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-hsp.htm](http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-hsp.htm)
5. Ramirez AG, Suarez L. Hispanic cultures, Latinos, Central Americans. 2000 in press.
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8. Tobacco Use Among U.S. Racial/Ethnic Minority groups, A report of the Surgeon General 1998
9. Behavioral Risk Factor Surveillance System, Indiana Statewide Survey ,2000

Rural Populations

Indiana Statistics

In the 1990 Census, 35% of the state population lived in rural farm and non-farm areas.^{1,2}

Tobacco Use – National Statistics

- The rate of current cigarette use is 33.5% in non-metropolitan areas compared to 27% and 28% respectively in large and small metropolitan areas.³

Tobacco Use – Indiana Statistics

- The Rural Indiana profile; Alcohol, Tobacco & Other Drugs; “III. Substance Abuse in Rural Indiana” survey was conducted in the 71 rural Indiana counties. The following information was collected on Tobacco use.

Youth

- In rural Indiana, patterns of alcohol, tobacco and other drug use are distinct. Compared to youth elsewhere, rates of use for most substances are consistently higher among youth in rural Indiana.¹
- From 1993 to 1997, the teenage smoking rate in rural Indiana (all ages combines) increased by 20 percent.⁴
- In 1997, 30 % of 6th graders in rural Indiana said they had tried cigarettes, and 10% said they were current smokers.⁴
- Use rises steadily as children get older; by 10th grade, 40 % are current smokers compared to 35% of 10th graders in non-rural Indiana and 30% across the country.⁴
- Rural Indiana youth use smokeless tobacco at twice the rate reported by nonrural youth. In 1997, 22% of rural 8th graders had tried smokeless tobacco and 10% were regular users. Compared to nonrural 8th graders (12%) and (5%) respectively.⁴

Adults

- There is no information on adult smoking in rural Indiana. Rural focus groups said that tobacco is part of small town culture, and permissive attitudes and adult smoking set “bad” examples for youth.¹

Sources

1. Urban and Rural – Universe: Persons, 1990 Data set, American Factfinder, U.S. Census Bureau
2. Percent of Persons Who Live in Urban Areas:1990, American Factfinder, U.S. Census Bureau
3. 1995 National Household Survey on Drug Abuse, Tobacco Related Statistics, SAMHSA, Substance Abuse and Mental Health Services Administration, Office of Applied Studies
4. Rural Indiana Profile, Alcohol, Tobacco & Other Drugs; III. Substance Abuse in Rural Indiana. The Indiana Prevention Resource Center at Indiana University, 1998 Drug Strategies, 2445 M Street, NW Suite 480, Washington, DC 20037.
www.drugs.indiana.edu/publications/rural/rural3.html

Women Population

Indiana Statistics

Population in Indiana

There are 3,060,401 females in the state of Indiana or 50.33%¹

Age Distribution, YR 1999¹

3.57% (217,361) of the total state population is female and age 15 to 19 years old

6.68% (406,150) of the total state population is female and age 20 to 29

11.28% (685,906) of the total state population is female and age 30 to 44

National Statistics

Women of reproductive years

- Smoking during pregnancy remains a major public health problem despite increased knowledge of the adverse health effects of smoking during pregnancy. Although the prevalence of smoking during pregnancy has declined steadily in recent years (from 19.55 in 1989 to 12.9% in 1998), substantial numbers of pregnant women continue to smoke, and only about one-third of women who stop smoking during pregnancy are still abstinent one year after delivery.²
- In 1998, smoking prevalence among women of reproductive age were higher than the overall population of women.²

Pregnant Women

- Smoking prevalence during pregnancy was consistently highest among young adult women aged 18 through 24 (17.1%) than women aged 25 through 49 (10%).²
- Smoking during pregnancy declined among women of all racial/ethnic populations.²
- Infants born to women who smoke during pregnancy have a lower average birth weight.²
- Eliminating maternal smoking may lead to a 10% reduction in all infant deaths and a 12% reduction in deaths from perinatal conditions.²
- If women would stop smoking during pregnancy, the Indiana infant mortality rate could be reduced 9%.

Female Youth

- In 2000, smoking prevalence in high school senior girls declined to 29.7%.²

- Smoking among young women (aged 18 through 24 years) declined from 37.3% (1965) to 25.1% in 1998. However, recent trends show that smoking rates in this population may be rising.

Trends

- In the 1990's, the decline in smoking rates among adult women stalled and, at the same time, rates were rising steeply among teenaged girls, blunting earlier progress. Smoking rates among women with less than high school educations are three time higher than for college graduates. Nearly all women who smoke started as teenagers – and 30 % of high school senior girls are still current smokers.²

Education

- Women who continue to smoke and those who fail at attempts to stop smoking tend to have lower education and employment levels than do women who quit smoking.²

In 1998, 25.5 % of pregnant women with 9-11 years of education smoked compared to 2.2 % among those with 16 or more years of education.²

Income

- Smoking prevalence is higher among women living below the poverty level (29.6%) than among those living at or above poverty level (21.6%).²

Cancer Facts

- Lung cancer is now the leading cause of cancer death among U.S. women; it surpassed breast cancer in 1987.²

Tobacco Use – Indiana Statistics

- In Indiana, 21.1% of women were current smokers and 4.3% were some day current smokers (BRFSS 2000)

Tobacco Use – National Statistics

- 22% of women smoked in 1998 Smoking prevalence has always been lower among women than among men, however the once-wide gender gap in smoking prevalence narrowed until the mid-1980's and has remained constant. Prevalence was highest among American Indian or Alaska Native women.²
- Smoking prevalence today is nearly three times higher among women who have only 9 to 11 years of education (32.9% vs. 11.2%) compared to those with a college education or higher.²

Environmental Smoke

- Infants born to women exposed to environmental tobacco smoke during pregnancy have a small decrement in birth weight and a slightly increased risk of intrauterine growth retardation compared to infants of non-exposed women.²

Tobacco Industry Targeting

- Tobacco industry marketing is a factor influencing susceptibility to and initiation of smoking among girls. Examples of tobacco ads and promotions targeted to women indicate that such marketing is dominated by themes of social desirability and independence.

- Between 1995 and 1998, expenditures for domestic cigarette advertising and promotion increased from 4.9 billion to 6.73 billion. The dependence of the media on revenues from tobacco advertising oriented to women, coupled with tobacco company sponsorship of women's fashions and of artistic, athletic, political and other events, has tended to stifle media coverage of the health consequences of smoking among women and to mute criticism of tobacco industry by women public figures.²
- Advertising is used in part to reduce women's fear of the health risks from smoking by presenting information on nicotine and tar content or by using positive images.²
 - The tobacco industry uses innovative promotional campaigns offering discounts on common household items unrelated to tobacco and give-a-ways.²

Sources

1. Stats Indiana, Census 2000, Population Counts, Indiana Business Research Center, IU Kelley School of Business, http://www.stats.indiana.edu/c2k/asr_frame.html
2. Women and Smoking, A Report of the Surgeon General – 2001: Centers for Disease Control and Prevention.

Appendix F

A questionnaire was used to interview key informants/leaders in acquiring more knowledge about certain populations:

Populations are influenced by:

African – Americans

Highly influenced by media

Some influence by churches, political leaders, community-based organizations, workplace and schools

LGBT Youth age 12 – 24

Influenced by community-based organizations and adversely by churches

Some influence from the workplace

People with Disabilities

Influenced by community based-organizations

Asians

Influenced by community-based organizations and workplace

Latinos/Hispanics

Highly influenced by churches, and social/douses and family

Somewhat influenced by community-based organizations

There were conflicting responses to media, political leaders and workplace as influences

Native Americans

Highly influenced by Community based organizations and the American Indian Center of Indiana

Barriers to Communication

African – Americans

Level of educational attainment

LGBT Youth age 12 – 24

Age appropriate language, negative behavior

People with Disabilities

Communication in Braille, video with interpreters for deaf

Asians

Communication and cultural and stress

Latinos/Hispanics

Language – Spanish speaking

Native Americans

Population uses tobacco for religious purposes, so messages need to be clarified.

Social Norms and Attitudes Related to Tobacco

African – Americans

Smoking has been rationalized – going to die from something
There's a level of acceptance in order to deal with stress.
Not acceptable for pregnant women

LGBT Youth age 12 – 24

Tobacco use is very accepted
Knowledge and attitudes are greatly varied in this population

People with Disabilities

There is a myth that people with disabilities don't smoke, drink, etc.
Some identify themselves as those highly affected by tobacco use (onset of disability due to tobacco use)
Affected by loneliness and depression
2% knowledgeable

Asians

Role in socializing especially stress resolution
Knowledgeable that tobacco is a big problem

Latinos/Hispanics

Males (Latinos) smoke more than women (Latinas) – more acceptable
Not acceptable for moms and pregnant women to smoke
“It's a part of daily life”
Uninformed about the dangers of tobacco use or choose to ignore it
Not ok for teens

Native Americans

Tobacco is a sacred plant to Native American people but it has become abused in use, now.
Most Native Americans know of the sacred aspect, yet tobacco is still addictively abused.

Assets/challenges in tobacco prevention and control

African – Americans

Lack of support from community leaders for tobacco control, competing interests, poor communication channels, and lack of cohesiveness

LGBT Youth age 12 – 24

Lack of time, staff resources, low on priority of needs for youth

People with Disabilities

Colleges have disabilities segment - Support groups & organizations work with them and provide counselors

Lack of visibility – aren't seen as a population that needs to be advised
Poor communication; community and political leaders seen as barriers

Asians

Need more education, individual counseling and workshops
Lack of cohesion which means community leaders have no responsibilities.

Latinos/Hispanics

Radio, local TV, and Hispanic newspapers, plus Chicago Hispanic newspapers

Many organizations that address the issue
Lack of cohesiveness and sense of community
Lack of culturally relevant programs
Language barrier and lack of capacity building

Native American

American Indian Health Program –asset
Lack of support and poor communication from non-native community and political leaders - challenge

Evidence of Industry Targeting

African – Americans

Tobacco advertising and promotion

LGBT Youth age 12 – 24

Unknown
General population advertising

People with Disabilities

Advertising identifies tobacco with pleasure

Asians

Latinos/Hispanics

Billboards, media and contributions to cultural events

Native American

Native Spirit Products
American Indian images in advertising

Existing Programs for this population

African – Americans

Some billboard advertisements, a few commercials

LGBT Youth age 12 – 24

General population messages – none specific

People with Disabilities

Asians

Latinos/Hispanics

American Cancer Society/FreshStart smoking cessation program, American Lung Association, American Heart Association, Smokefree Indiana, Healthy East Chicago

No tobacco programs in Saint Joseph County for the Latino population

Local hospitals,

One presented by our organization in Fort Wayne, and one youth program associated with Minority Health

Coalition

Radio ads and brochures, Smokefree Indiana and ITPC

Native Americans

American Indiana Health Program

Community Capacity

African – Americans

Rated this very low for representation, key leaders in tobacco prevention, involvement in policy/regulatory activities and infrastructure for addressing tobacco prevention and control issues

LGBT Youth age 12 – 24

Rate Key leaders for tobacco prevention as very supportive
Rated existing infrastructure as being well-established

People with Disabilities

Mixed and conflicting responses
Some rated this very low for representation, key leaders in tobacco prevention, involvement in policy/regulatory activities and infrastructure for addressing tobacco prevention and control issues
One said that representative of population in decision-making were involved, another said there definitely needs to be more involvement

Asians

Rated state and local representation in decision making as – don't know
Key leaders as not being very supportive or tobacco prevention
Need more leadership development in infrastructures

Latinos/Hispanics

Rated this very low for representation, key leaders in tobacco prevention, involvement in policy/regulatory activities and infrastructure for addressing tobacco prevention and control issues
Infrastructure well established in Fort Wayne
Infrastructure good in East Chicago with more need for training and leadership development

Native Americans

Key leaders are supportive for tobacco prevention and control issues
Infrastructure exists for addressing tobacco prevention and control issues
Representatives of the population are involved in decision making at the local level.

Appendix G – Critical Issues Descriptions

Funding

- State budget process makes Master Settlement dollars vulnerable for Tobacco prevention and control
- CDC funding for fourth goal in disparities is limited
- We have limited knowledge of other more diverse sources
- Small grass roots organizations are challenged by capacity and qualifications required for funding

Gaps in Data

- Gaps in information for ethnic/cultural or at-risk populations.
- Inconsistent collection of needed data
- Need focused research based on at-risk populations
- Lack of collaboration and sharing of best practices on processes of data collection from other state organizations that identify & eliminate disparities
- Funding to do more data collection on specific population groups
- Need buy-in and support for additional data collection

Capacity

- Need comprehensive approach to tobacco prevention and control that is population and community specific
- Includes:
 - Flexibility
 - Communication that reaches where people are at
 - Media that is population appropriate
 - Programming that is population appropriate
 - A continuum from training grass root organizations, to programming, to deliverables to outcome and evaluation. This in turn lends credibility to requests for more funding.

Tobacco Industry

Presence of tobacco industry and their promotion and amount of dollars used for targeting is difficult to counter-act.

Serving Populations with Identified Disparities

Eliminating disparities of tobacco use among specific populations identified in data analysis.

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