ADDRESSING TOBACCO USE HEALTH INEQUITIES IN THE CITY OF ALBANY

Abstract

In New York State, people with low-socioeconomic status (low-SES) are 43% more likely to smoke than their more affluent or educated counterparts. As a result, people with low-SES suffer disproportionate health effects from diseases caused by smoking as compared to people with higher-SES. This report explores the reasons for this health inequity, the evidence-based solutions, and the impact of those solutions on the affected communities.

Capital District
Tobacco-Free
Communities

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24 Aviation Road, Suite 204
Albany, NY 12205

P: 518-459-2388
F: 518-459-2633
Email: contact@SmokeFreeCapital.org

Web: www.SmokeFreeCapital.org

Capital District Tobacco-Free Communities (CDTFC) is one of twenty-three programs funded by the New York State Department of Health, Bureau of Tobacco Control, to inform and support evidence-based, policy-driven, and cost-effective approaches that decrease youth tobacco use, make it easier for adult smokers to quit, and eliminate exposure to secondhand smoke.

CDTFC initiatives in Albany, Rensselaer and Schenectady counties include increasing the availability of smoke-free multi-unit housing, tobacco-free shared public spaces, and tobacco-free worksites, and reducing the impact of tobacco marketing on communities.

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The Tobacco Free Wichita Neighborhood Conversations initiative inspired the use of the Neighborhood Conversation model as our method for soliciting community input. Thank you to Tara Nolen, MPH, Tobacco Control Coordinator for the Kansas Academy of Family Physicians, for her invaluable assistance in informing and guiding our Capital District efforts.

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- *Tobacco Price Promotion: Local Regulation of Discount Coupons and Certain Value-Added Sales*
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I. Executive Summary

Tobacco use remains the single largest preventable cause of death and disease in the United States. While there have been declines in both youth and adult tobacco use in New York State, tobacco use continues to cause disproportionately high rates of death and disease among people with low socioeconomic status (low-SES), who are 43% more likely to smoke than those with higher income and education. While there are many reasons for this disparity, an influential environmental factor is the concentration of tobacco marketing in low-income neighborhoods.

Exposure to tobacco marketing increases the likelihood that teens will start smoking, adults who smoke will experience more cravings and impulse buying, and people trying to quit will be less successful. Tobacco is marketed in stores through visual displays of tobacco products behind the counter, indoor and outdoor signage, and price discounts. The concentrated presence of tobacco retailers in a neighborhood increases exposure to tobacco marketing, making tobacco more accessible and acceptable.

The density of tobacco retailers in low-income neighborhoods is typically much higher than in higher-income neighborhoods. This holds true in Albany County, where 33% of tobacco retailers are located in four zip codes with high poverty rates and where only 12% of the Albany County population resides. In fact, the density of tobacco retailers (i.e., the number of tobacco retailers per capita) in these zip codes is as much as ten times that of those in higher income neighborhoods.

In September 2016, Capital District Tobacco-Free Communities (CDTFC) staff visited 37 licensed tobacco retailer (LTR) locations in three of the zip codes with the highest poverty rates (12202, 12206 and 12210) to collect information regarding exterior and interior tobacco advertising, price points for various tobacco products, proximity to schools and playgrounds, and tobacco product displays. The visited LTRs dedicated significant display space for the sale of inexpensive cigars, cigarillos, and flavored tobacco products, and sold deeply discounted off-brand cigarettes. Menthol products were also heavily marketed, as is common practice in low-income, predominantly African American communities. Mentholated products lead to increased smoking initiation among youth and young adults, greater addiction, and decreased success in quitting smoking.

There are multiple approaches to reducing the negative impact of tobacco marketing. These evidence-based solutions include: restricting the location of tobacco sales retailers, limiting the number of tobacco retailers in a specific geographic area, limiting the type of retailer that is allowed to sell tobacco products (e.g., pharmacies), disallowing the use of price promotions and discounts, and prohibiting the sale of flavored tobacco products, including menthol. Several municipalities throughout the country and in New York have successfully implemented these policies.

Through facilitated small group meetings called Neighborhood Conversations (NC), CDTFC sought the input of residents living in the neighborhoods most densely populated with tobacco retailers to better understand the impact of tobacco marketing and the possible solutions on the people living in these communities. In November 2016, a total of 50 adults living in the City of Albany zip codes 12202, 12206, 12207 and 12210 participated in four conversations. The discussions revealed that:

- Participants suffer tremendously as a consequence of their own tobacco use and/or that of someone they love.
- Participants and their children suffer considerably from exposure to secondhand smoke in their homes.
- Participants rely heavily on bus transportation and are plagued by smoking in bus stops.

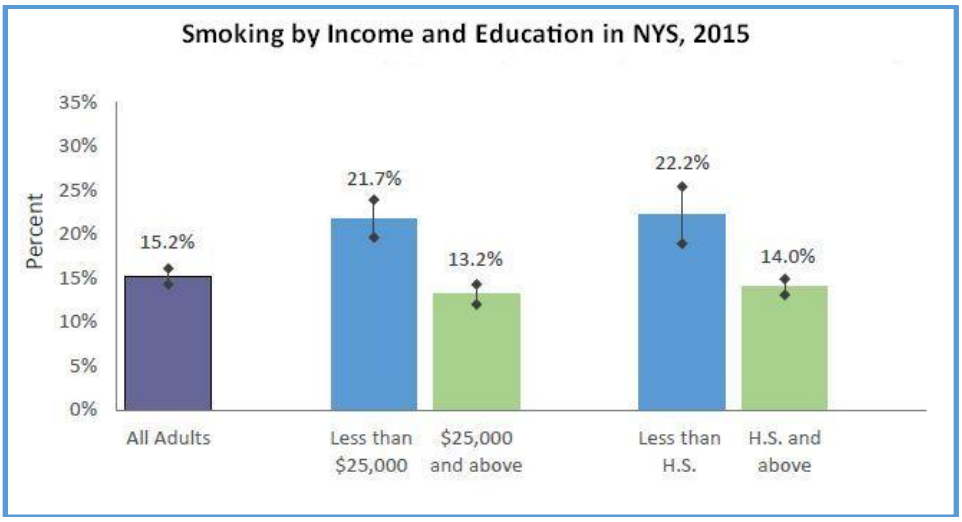
- Participants who are current or former smokers find it very difficult to quit successfully.
- Participants experienced outrage, feelings of victimization, and surprise at the disparities related to tobacco marketing in low-income vs. higher-income neighborhoods.
- Participants did not believe that eliminating price promotions and couponing for tobacco products was as important as stopping the sale of loose, single cigarettes. However, 62% supported disallowing the use of tobacco discounts and coupons.
- Eighty-two percent of participants supported limiting the number of tobacco retailers in a specific geographic area and 82% also supported limiting the number of tobacco retailers within a certain distance of schools.
- Seventy-six percent of participants supported ending the sale of tobacco in pharmacies.

New York State has been a leader in implementing evidence-based tobacco control policies, such as high tobacco taxes and early adoption of the Clean Indoor Air Act. Local government interventions have also been effective in strengthening and complementing state tobacco control laws. The City of Albany made all city parks tobacco-free and Albany County raised the minimum legal age for tobacco sales to 21, and expanded smoke-free restrictions in the county to include electronic cigarettes. The research supporting evidence-based practices in tobacco control, combined with the LTR observation data in the City of Albany and the information collected from the Neighborhood Conversation participants, suggest that reducing the impact of tobacco marketing, especially in low-income neighborhoods, would be an effective complement to existing tobacco control policies. Additionally, the negative impact of tobacco use and tobacco accessibility on city residents could be lessened by actions that improve compliance with existing tobacco-free policies and the implementation of mechanisms to further deter underage sales and the sale of loose cigarettes. Several evidence-based strategies to reduce the impact of tobacco marketing, to deter underage sales and sales of single cigarettes and to reduce exposure to secondhand smoke are outlined this in report.

II. Problem: Health Inequities and Tobacco Use

Tobacco use persists as the single biggest cause of preventable death and disease in the United States, causing more deaths than those attributed to alcohol, other drugs, car crashes, firearms, and sexually transmitted diseases combined.[1] There is no other product being sold today that, when used as directed, kills half of the people who use it.

However, tobacco use is not an equal opportunity killer. While there have been declines in both youth and adult tobacco use in New York State, tobacco use continues to cause disproportionately high rates of death and disease among people living below the poverty level and people with the lowest levels of educational attainment. In New York State, New Yorkers with low socioeconomic status (low-SES) are 43% more likely to smoke than their more affluent or educated counterparts. (See *Figure 1*)



The smoking rate among adults in NYS is 15.2%, according to data from the 2015 BRFSS. Higher rates of smoking persist among adults with:

- Household incomes under $25k per year (21.7%)
- Less than a high school (H.S.) degree (22.2%)

Figure 1

Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2015.

In addition, people with low-SES smoke for longer periods of time[2] and are less successful in their quit attempts than their more affluent counterparts.[3] As a result, people with low-SES suffer disproportionate health effects from diseases caused by smoking as compared to people with higher-SES.

There are also significant racial disparities in tobacco use that correlate with health disparities. The greater use of menthol cigarettes by African American smokers may contribute to the higher rates of tobacco-related diseases among this population as compared to whites. Overall, 85% of African American smokers (ages 12+) smoke menthol cigarettes, compared to 29% of white smokers.[4] The Tobacco Products Scientific Advisory Committee (TPSAC), in its 2011 report to the FDA, estimated that by 2020, 4,700 excess deaths in the African American community will be attributable to menthol in cigarettes, and over 460,000 African Americans will have started smoking because of menthol in cigarettes.[5]

Prevalence of cigar use is higher than that of cigarette use for African Americans, and is higher than other racial/ethnic groups. African American high school students smoke cigars at almost twice the rate of cigarettes (11% for cigars and 6.5% for cigarettes).[6] In the adult population, cigars, cigarillos and little cigars are most popular among African Americans.[7]

Many factors contribute to higher rates of smoking among low-SES as compared to higher-SES populations. People with low-SES have less access to primary care, are more likely to be uninsured, have less social support to quit, and fewer financial resources to assist with cessation.[8] Low-SES populations are also more likely to live in neighborhoods with more tobacco retailers per capita and therefore have higher levels of exposure to tobacco marketing as compared to those living in more affluent neighborhoods.[9] Exposure to tobacco marketing increases the likelihood that teens will start smoking,[10] adults who smoke will experience more cravings and impulse buying,[11] and people trying to quit will be less successful.[12]

There is evidence that tobacco companies have intentionally targeted people living in low-income neighborhoods and communities (See **Resources:** *Point of Sale Tobacco Marketing—Disproportionately Targeting Vulnerable Populations).* For example, an analysis of previously secret tobacco industry documents found that tobacco companies strategically marketed their products to low-SES women by distributing coupons with food stamps, discounting cigarettes, developing new brands specifically to appeal to certain subpopulations within low-SES communities, and promoting luxury images to low-SES African American women.[13]

One of the tobacco control strategies that most pointedly addresses the health inequity between low-SES and high-SES tobacco users is reducing the impact of tobacco marketing on people living in low-SES communities.

III. Intervention Target: Exposure to Tobacco Marketing

Each day in New York State, the tobacco industry spends more than half a million dollars to market its products. More than 95% of those dollars are spent in stores on the visual displays of tobacco products behind the counter, indoor and outdoor signage, and price discounts and promotional payments to retailers.[14] According to a 2012 Surgeon General's report, tobacco marketing in stores is a primary cause of youth smoking.[15]

The density of tobacco retailers (number of stores per capita) in low-income neighborhoods is typically much higher than the density in higher-income neighborhoods.[16] Even when controlling for population size, there are 33% more tobacco retailers in urban areas of the U.S. than in non-urban areas.[17] In addition, stores located in low-income neighborhoods have the most storefront advertising,[18] offer more price promotions,[19] and market menthol products,[20] cigars and cigarillos[21] more heavily than stores in higher income neighborhoods. Studies have directly linked higher neighborhood tobacco retailer density with higher odds of ever smoking.[22]

Tobacco marketing in stores close to schools and youth-centered places are particularly concerning because of the increased likelihood of youth exposure to pro-smoking messages. Studies have shown that stores close to schools were found to have more exterior tobacco advertising than stores farther away.[23]

The cigar and cigarillo products being sold especially appeal to teens because of their typically sweet flavoring, colorful packaging, and inexpensive prices. In addition, marketing of these products includes hip-hop artist endorsements and other tie-ins to hip-hop music culture.

In 2013, the U.S. Food and Drug Administration (FDA) released a report finding that menthol cigarettes lead to increased smoking initiation among youth and young adults, greater addiction, and decreased success in quitting smoking.[24] The cooling and anesthetic effect of menthol makes mentholated tobacco products more appealing to youth.[25] Menthol smokers can inhale more deeply and hold the smoke in the lungs longer, thereby getting more exposure to the dangerous chemicals in cigarette smoke.[26] As a result, menthol smokers show significantly higher levels of nicotine addiction compared with non-menthol smokers in the same age group,[27] increasing the health risk of tobacco use for menthol users and making quitting more difficult.[28] These increased risks led the NAACP to recently recommend that the FDA ban menthol in cigarettes.

IV. Intervention Community: City of Albany

Mapping of licensed tobacco retailer (LTR) locations in the Capital Region indicated a significant cluster of retailers in four zip codes within the city of Albany with particularly high poverty rates–12202, 12206, 12207 and 12210. Of the 339 tobacco retailers located in Albany County, 111 (33%) are located in these four zip codes where only 12% of the Albany County population lives. See Figure 2 below.

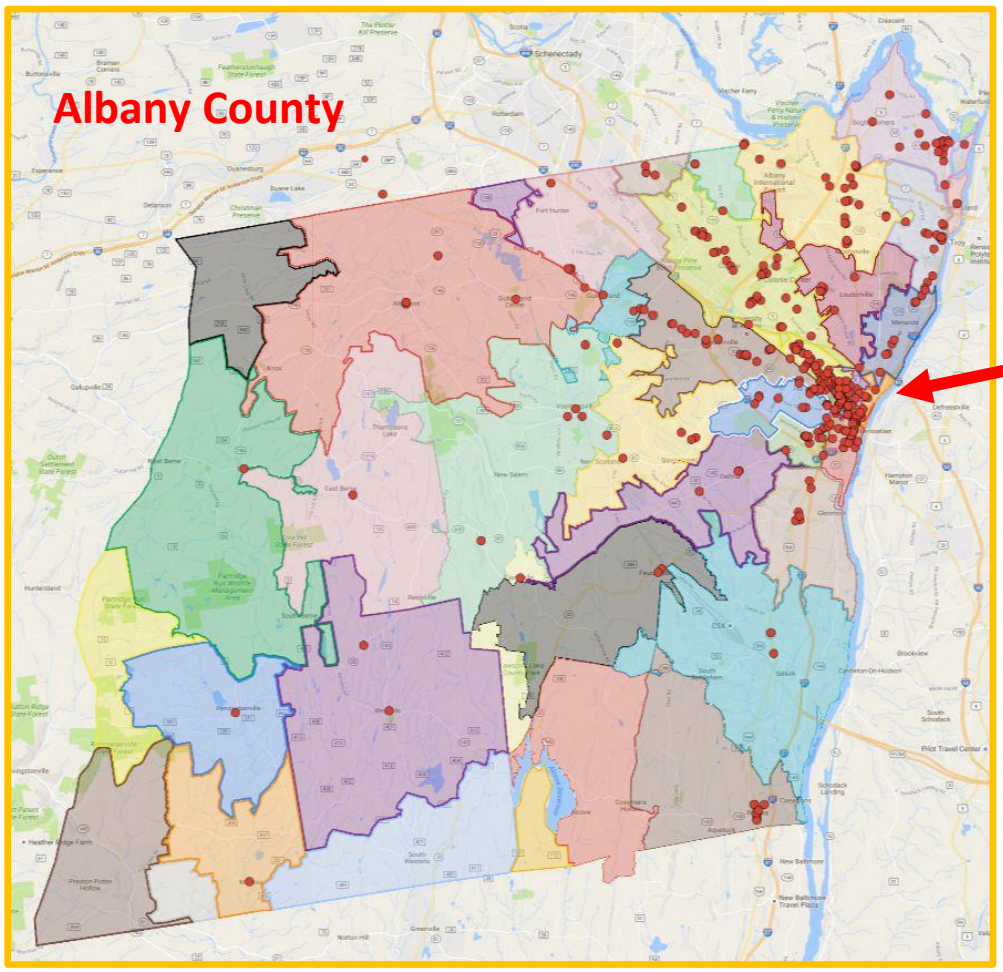


Figure 2

Using U.S. Census Bureau data, Figure 3 compares the number of LTRs per capita in these four zip codes to the number of LTRs per capita in higher-income zip codes in Albany County.

As seen in Figure 3, communities with the highest poverty rates (Downtown, West Hill, South End and Arbor Hill) have more LTRs per capita as compared to low-poverty communities such as Delmar, Loudonville and Guilderland. Arbor Hill has more than four times the number of LTRs per capita than Delmar, nearly three times as many as Guilderland; Downtown Albany nearly ten times more than Delmar, more than eight times those in Loudonville and more than six times those in Guilderland.

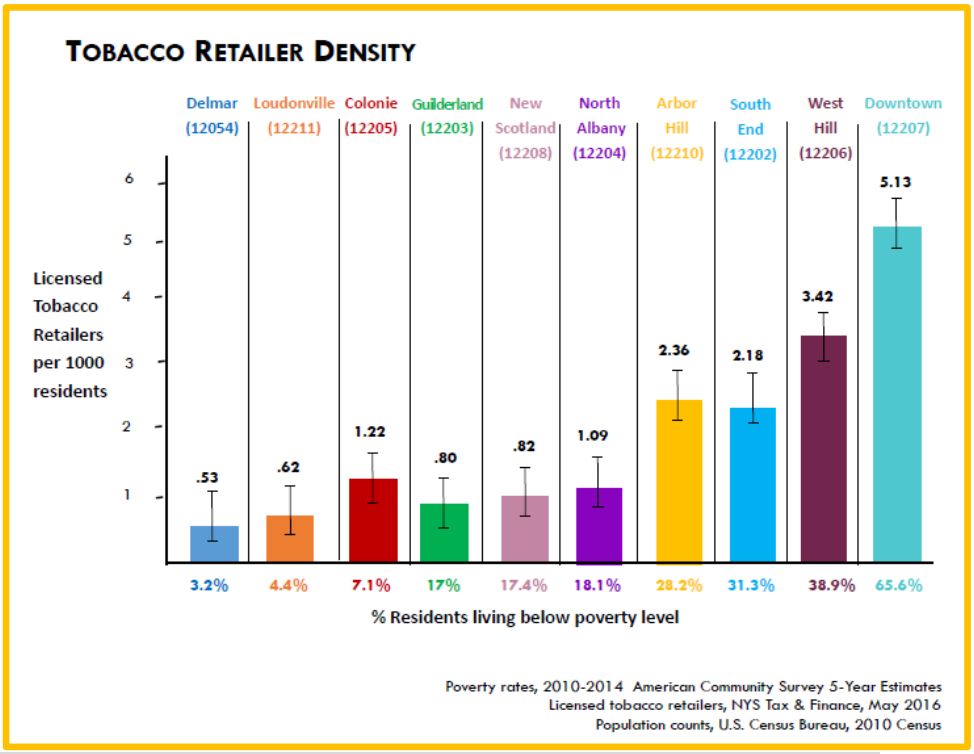


Figure 3

V. Licensed Tobacco Retailer (LTR) Observations

During September 2016, Capital District Tobacco-Free Communities staff visited 37 LTRs (14 in zip code 12202, 12 in 12206, and 11 in 12210) to collect information regarding exterior and interior tobacco advertising, price points for various tobacco products, proximity to schools and playgrounds, and tobacco product displays. When possible, photographs were taken and uploaded to a Google map of LTRs in Albany County. The map can be accessed here: http://bit.ly/2jpT7sQ.

Consistently, the visited LTRs dedicated significant display space for the sale of inexpensive cigars and cigarillos. For example, Swisher Sweets flavored cigarillos were selling two for $.99; Backwoods flavored cigars, three for $1.50; and Show flavored cigarillos, five for $1.00. Currently there is neither regulation on the minimum price of cigars and cigarillos nor on the minimum number sold in a single package.

Also noted in the LTR observations was the plethora of stores labeled “discount” stores selling off-brand, deeply discounted cigarettes, including Fortuna and Maverick. The least expensive cigarette pack was being sold for $7.55, well below the minimum sales price for standard brands which currently ranges from $9.29 to $11.61 per pack in upstate New York.[29]

The prevalence of marketing for mentholated tobacco products is a common phenomenon in low-income, predominantly African American communities, and this was evident in the store observations as well.

In summary, in City of Albany zip codes 12202, 12206, 12207 and 12210:

1) the number of LTRs per capita is as much as ten times the number of LTRs per capita in higher income neighborhoods;
2) tobacco products are available at deeply discounted prices; and
3) menthol cigarettes and flavored cigars and cigarillos are heavily marketed.

VI. Community Input

There are multiple approaches to reducing the negative impact of tobacco marketing on communities. In addition to considering the effectiveness of various strategies, it is important to evaluate the associated risks of legal challenges from the tobacco industry to local municipalities. The Public Health and Tobacco Policy Center is funded by the NYS Department of Health to provide guidance to municipal governments regarding both the effectiveness and risk associated with various tobacco control strategies.

Among the local strategies with high efficacy and low risk are the following: restricting the location of tobacco retailers, limiting the number of tobacco retailers in a specific geographic area, limiting the type of retailer that is allowed to sell tobacco products (e.g., pharmacies), disallowing the use of price promotions and discounts, and prohibiting the sale of flavored tobacco products, including menthol.

In November 2016, Capital District Tobacco-Free Communities (CDTFC) hosted four Neighborhood Conversations with residents living in zip codes 12202, 12206, 12207 and 12210 to better understand the impact of tobacco marketing and the evidence-based solutions on people living in the communities that are most profoundly affected. Participants were recruited with the help of local partners including Albany Housing Authority, Albany Public Library, Asthma Coalition of the Capital Region, AVillage Inc., Cornell Cooperative Extension Albany County, Healthy Capital District Initiative, St. Peter’s Health Partners, Trinity Alliance of the Capital Region and Whitney M. Young, Jr. Health Center.

In an effort to eliminate potential barriers to participation, the meetings were conducted in locations accessible by bus and located within the targeted zip codes. Additionally, each participant was offered a $25 gift card to Price Chopper/Market 32, reimbursement for public transportation, child care, and a light dinner. The recruitment flyer is included as **Appendix A**.

The only requirements for participation were residency in one of the four zip code communities, and being at least 18 years of age. Each meeting began with a brief slide presentation by CDTFC on the impact of tobacco marketing and the evidence-based solutions. During the remaining hour, an independent facilitator prompted participant responses with a series of questions designed to elicit information on the personal impact of tobacco use and tobacco marketing, and opinions about the impact of the evidence-based solutions. The questions are included as **Appendix B**.

The target number of participants for each meeting was fifteen, a goal reached through pre-registration for all four meetings. Actual attendance varied from a low of eight to a high of sixteen, with a total of fifty participants overall. Participants were largely representative of census data demographics for the four zip code communities.[30] Participant demographics are included as **Appendix C**.

For the purposes of the Neighborhood Conversations, the following specific strategies were chosen as the basis for discussion:

- Reducing tobacco retailer density, (e.g., eliminating the sale of tobacco near schools and other youth-centered places, reducing the total number of retailers in a defined geographic area);
- Ending the sale of tobacco products in pharmacies; and
- Eliminating price promotions and couponing for tobacco products.

Neighborhood Conversation Data Collection

Several methods were used to document the information shared by participants of the Neighborhood Conversations.

1. Non-CDTFC volunteers were recruited to take notes at each of the four meetings.

2. Three of the four meetings were audio recorded to verify and expand the note documentation. Participant permission was requested prior to audio recording; one meeting was not recorded due to a single participant who withheld permission.

3. CDTFC staff members were present to listen to participant responses at each meeting.

4. Participant worksheets were distributed, completed by each participant and collected at the end of each meeting. Worksheet is included as **Appendix D**.

After listening to the available audio recordings and collating all of the written notes and worksheet responses, participant comments were organized into thematic categories including Health Impact of Tobacco Use, Youth Smoking, Secondhand Smoke Exposure, Tobacco Marketing, Tobacco Discounts, Quitting, and the various evidence-based solutions to the problem of tobacco marketing.

Impact of Tobacco Use

The following observations of participant experience with tobacco use were overwhelmingly supported by the collected data.

- **Participants suffer tremendously as a consequence of their own tobacco use and/or that of someone they love.**

  Prior to the meeting, nearly 65% (*n*32) of all participants rated the degree to which tobacco use has been a concern for them as "10" on a scale of 1-10; only three participants rated their concern as less than "7".

  Personal stories abounded of family members dying from a variety of chronic diseases due to tobacco use, including Chronic Obstructive Pulmonary Disease (COPD), cancers of the lung and throat, congestive heart failure, and other lung disease. One participant's mother died from lung cancer on the day she was scheduled to attend a Neighborhood Conversation; she asked to reschedule to another date so that she could still participate. A young woman in her 30's reported the passing of her husband from lung cancer. Another participant lost both her mother and sister to tobacco-related diseases, and still another lost her father to throat cancer and has a mother currently suffering with stomach cancer. One participant described the tobacco-related death of her grandfather this way: "He just disappeared."

  Sixty-two percent of participants (*n*31) reported themselves as current or former smokers. Many of them disclosed consequences of their own tobacco use including losing "half a lung," having obstructive lung disease, surviving open heart surgery, suffering from chronic sinus problems, and having difficulty healing from spine surgery due to continued tobacco use. The average age of those identifying themselves as current daily smokers was 55; former smokers' average age was 50; and the oldest among all of the current or former smokers was 65, relatively young given the seriousness of their tobacco-related health problems.

- **Participants and their children experience negative health consequences from exposure to secondhand smoke in their homes.**

  Many participants reported living in multi-unit housing and being exposed to secondhand smoke (SHS) from neighbors' apartments, smokers congregating outdoors near air vents or windows, and community spaces in which smoking is allowed. Several participants reported a child's asthma or their own breathing difficulties as a particular reason for being concerned about SHS exposure. Health consequences of SHS exposure also included sinus infections, bronchitis, allergies, and eye irritation.

  Some of the participants were residents of Albany Housing Authority (AHA) which made all of its units smoke-free in January 2016. While most of the AHA residents agreed that things are better, many reported continuing concern about tenant non-compliance with the smoke-free policy.

  One participant reinforced the health benefits of living in a smoke-free environment when she shared that she had moved from an apartment building that allowed smoking into an apartment building that bans tobacco use, and since the move, her children have not needed emergency hospital treatment for asthma. Another public housing resident expressed her strong support for "no smoking zones" since she is experiencing significant relief from unwanted exposure to SHS in her apartment building.

- **Participants rely heavily on bus transportation and are plagued by smoking in bus stops.**

  Participants were aware that there is a local law in the City of Albany prohibiting tobacco use in bus stops, but reported that tobacco use remains a consistent problem. Several said that they had complained to city officials and requested law enforcement intervention. One participant said she was told by a city official that they were reluctant to have police enforce for fear of inflaming racial tensions.

- **Participants who are current or former smokers find it very difficult to quit successfully.**

  Despite the health concerns and other negative consequences of smoking, participants expressed frustration at their lack of success in quitting, frequently attributing their continued use of tobacco as a way to manage stressors resulting from "life in the hood." The use of tobacco as a stress management tool was widely shared and seen as a primary obstacle for cessation success.

  Without exception, the participants who were current or former smokers had started smoking before age 18, some as young as 12 years old.

Impact of Tobacco Marketing and Evidence-Based Solutions

The most commonly shared participant perspectives/opinions are the following:

- **Participant reaction to the data shared in parts II – V of this report included outrage, feelings of victimization, and surprise at the disparities related to tobacco marketing in low-income vs. higher-income neighborhoods.**

	PARTICIPANT QUOTES
Some participants expressed anger. Many participants were both surprised and alarmed about the differences in tobacco marketing depending on where one lives.	"It pisses me off because I'm a victim of it." "It's almost like it's a conspiracy to kill poor people."
Some comments reflected a sense of hopelessness about reducing smoking among people with low-SES. One participant shared that she had quit smoking for 20 years, but started again after moving back to Albany and being surrounded by people who smoked. Another proclaimed that nothing would ever change because it was "all about the money" and there is a lot of money in the tobacco industry.	"Companies are earning money off of us." "It don't matter what we do, [reducing tobacco marketing] isn't gonna happen."
Still other participants felt motivated to do something about it.	"This is very impactful to see how many stores are in our area. I never knew it was such a problem."

	"It makes me think that we all need to fight for a change." "I'm willing to get a law passed to lessen the number of licensed tobacco retailers in our community, in low-income communities. It would matter."

- **Participants did not believe that eliminating price promotions and couponing for tobacco products was as important as stopping the sale of loose, single cigarettes commonly referred to as "loosies." Nonetheless, 62% (*n*31) supported disallowing the use of tobacco discounts and coupons.**

There was participant consensus that the sale of loosies in neighborhood stores was the primary mechanism by which tobacco users were able to financially afford to continue smoking. Most of the current smokers reported buying loosies at least occasionally for a going rate of $.50/each and many relied on the purchase of loosies exclusively for their tobacco supply.	"People don't think about the coupons because loosies are affordable, not packs."
Participants were well aware that the sale of loosies is illegal, but claimed that most tobacco retailers in their neighborhoods regularly sold loosies to customers who were known to them, including young people under the age of 21.	"My son started at 13 because he could buy anywhere he wanted." "The tobacco buying age is 12 in Albany."
Even though the sale of loosies was viewed as a bigger contributor to tobacco use, participants still reported that price also influenced their legal tobacco purchases. Smokers reported receiving coupons in the mail, often on their birthdays, and such discounts not only influenced what brand they bought, but how much they bought. The availability of deeply discounted off-brand cigarettes was also perceived as a problem.	"Two for one will lure me in even if it's not the kind I smoke." "If they stop selling loosies and off brand cigarettes at places with food like grocery stores and pharmacies, maybe it would help me to quit because I would have to walk farther. Maybe it would make a really big difference."

- **Eighty-two percent (*n*41) of participants supported limiting the number of tobacco retailers in a specific geographic area and 82% (*n*41) also supported limiting the number of tobacco retailers within a certain distance of schools.**

Many participants over age 50 remembered tobacco advertising on TV, billboards and in magazines and hadn't previously considered tobacco displays and signage as marketing. Participants noted that the "music and colors of	"It used to be ads on radio, magazines, and TV. . .but just having cigarettes on the wall is marketing."

tobacco packs target youth." Another was disturbed to realize that "there are four tobacco retailers on my block."	"Older smokers aren't attracted to fruit and candy flavors."
As participants considered the prevalence of tobacco retailers in their neighborhoods, they became increasingly concerned about the impact of tobacco retailer density on people living there, especially young people.	"Kids learn by what they hear and what they see." "Kids hang out at these corner stores and smoke."
Reflecting on their own tobacco use, several participants began to consider the potential positive impact of fewer retailers near where they lived.	"I am a smoker and I can't walk too long. So if the store is five blocks away, I don't smoke." "Availability is a big factor. There's a store right across the street from my house."

- **Seventy-six percent (*n*38) of participants supported ending the sale of tobacco in pharmacies.**

Most participants supported ending the sale of tobacco in pharmacies due to pharmacists' roles as a primary health care providers, but many also felt that it wouldn't do much to impact the smoking rate.	"Lincoln Pharmacy stopped selling tobacco, but people just go elsewhere. You need to stop all stores from selling, in addition to pharmacies."
Nonetheless, at least one participant changed her view about CVS's decision to stop selling tobacco after listening to the presentation and discussion.	"When CVS stopped selling tobacco, I was upset, but now I feel different."

VII. Evidence-Based Strategies

Across the country and in New York State, the implementation of evidence-based tobacco control policies has had a dramatic effect on overall tobacco use rates. New York State's leadership in maintaining the highest state tobacco taxes in the nation, combined with early adoption of the Clean Indoor Air Act, strong enforcement of laws restricting minors' access to tobacco, and years of successful mass media anti-tobacco campaigns, has contributed to a 2015 tobacco use rate of 15.2%, comparable to the national average of 15.1%.[31] If New York State tobacco control funding was more than the current 20% of the Centers for Disease Control recommended level, we expect that the tobacco use rate would be even lower.

Local government interventions have been effective in strengthening and complementing state and national tobacco control laws by expanding the availability of tobacco-free spaces, further restricting youth access to tobacco products, and improving access to cessation resources. To date, the City of Albany has implemented a variety of local tobacco control laws including making all city parks tobacco-free and prohibiting tobacco use in bus shelters. Albany County raised the minimum legal age for tobacco sales to 21, and expanded smoke-free restrictions in the county to include electronic cigarettes.

In addition to full implementation of the above-mentioned proven tobacco control interventions, complementary strategies are likely to accelerate declines in tobacco use. Promising evidence-based state and

local policy options to end the tobacco epidemic include reducing exposure to tobacco retailer marketing. In addition to statewide initiatives, communities can also engage in strategies to address the sale of tobacco; the time, manner and place through which it is promoted; and how and where it is used. Such local interventions have been successfully implemented in communities across the country, including several municipalities in New York State.

Reducing exposure to tobacco product marketing, particularly at the point of sale, could have a dramatic impact on youth smoking initiation and progression to daily smoking and increase successful cessation. The 2012 Surgeon General's report concluded that "the evidence is sufficient to conclude that there is a causal relationship between advertising and promotional efforts of the tobacco companies and the initiation and progression of tobacco use among young people."[32] In addition to advertising and promotions, the 2012 report cited evidence that the tobacco industry has invested heavily in packaging design and brand imagery on packages, which is especially influential during adolescence and young adulthood when smoking behavior and brand preferences are being developed. (See **Resources**: *Cause and Effect: Tobacco Marketing Increases Youth Tobacco Use, Findings of the 2012 Surgeon General's Report*)

The 2012 Surgeon General's report also found that the presence of heavy tobacco advertising in convenience stores, especially in predominately ethnic and low-income neighborhoods, increases the likelihood of exposing youth to pro-smoking messages, which can increase initiation rates among those exposed, particularly if stores are near schools.

The research supporting evidence-based best practices in tobacco control, combined with the Licensed Tobacco Retailer (LTR) observation data collected in the City of Albany, and the information collected from the fifty participants of the Neighborhood Conversations, suggest that reducing the impact of tobacco marketing, especially in low-income neighborhoods, would be an effective complement to existing tobacco control policies. Additionally, the negative impact of tobacco use and tobacco accessibility on city residents could be lessened by actions that improve compliance with existing tobacco-free policies and the implementation of mechanisms to further deter underage sales and the sale of loose cigarettes.

Evidence-Based Strategies to Reduce the Harmful Impact of Tobacco Marketing

1. Limit number of licensed tobacco retailers in the City of Albany with particular attention to decreasing retailer density in geographic areas with the highest poverty rates.

2. Restrict the location of tobacco retailers near schools and other youth-centered places.

3. Increase the minimum package requirements on non-cigarette tobacco products.

4. Disallow the redemption of coupons that reduce the retail price of any tobacco product below the listed or non-discounted price; and disallow the sale of any tobacco product through multi-pack discounts.

5. Prohibit the sale of tobacco products in pharmacies and stores containing a pharmacy.

6. Restrict the sale of flavored tobacco products, including menthol.

Evidence-Based Strategies to Deter Underage Sales and Sales of Single Cigarettes

1. Establish local enforcement for violations of tobacco sales regulations (e.g., through a local license for tobacco retailers) to improve compliance with youth access restrictions and sales of "loosies."

Evidence-Based Strategies to Reduce Exposure to Harmful Effects of Secondhand Smoke

1. Establish meaningful enforcement of existing clean air laws.

2. Create more smoke-free spaces in multi-unit housing and establish effective processes for monitoring and compliance.

VIII. Links to Public Health and Tobacco Policy Center Resources

Additional evidence and rationale for the above tobacco control strategies can be found in the following documents prepared by the Public Health and Tobacco Policy Center.

- *Point of Sale Tobacco Marketing—Disproportionately Targeting Vulnerable Populations*
  http://bit.ly/2knEG9q
- *Tobacco Disparities: Evidence Supports Policy Change*
  http://bit.ly/2cpCpYB
- *Cause and Effect: Tobacco Marketing Increases Youth Tobacco Use, Findings of the 2012 Surgeon General's Report*
  http://bit.ly/2kOnN9d
- *Tobacco Retail Licensing: Local Regulation of the Number, Location and Type of Tobacco Retail Establishments in New York State*
  http://bit.ly/2jrjZdr
- *Tobacco Price Promotion: Local Regulation of Discount Coupons and Certain Value-Added Sales*
  http://bit.ly/2knuXjP
- *Advancing Tobacco Control: The Known the New and the Next – Excerpts and summaries of 2014 Surgeon General's Report*
  http://bit.ly/2jR2l1g
- *Point of Sale Policy: New York Communities Taking Action*
  http://bit.ly/2dEWUxE
- *New York Tenants' Guide to Smoke-free Housing*
  http://bit.ly/2dtp54Z

IX. Endnotes

[1] Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States. Journal of the American Medical Association 2004;291(10):1238–45.

[2] Siahpush M, Singh GH, Jones PR, Timsina LR. Racial/Ethnic and Socioeconomic Variations in Duration of Smoking: Results from 2003, 2006 and 2007 Tobacco Use Supplement of the Current Population Survey. Journal of Public Health 2009; 32(2):210-8 [accessed 2017 Jan 30].

[3] U.S. Department of Health and Human Services. The Health Consequences of Smoking---50 Years of Progress: A Report of the Surgeon General. Atlanta: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2017 Jan 30**].**

[4] Villanti, AC, et al., Changes in the prevalence and correlates of menthol cigarette use in the USA, 2004-2014, Tobacco Control, published online October 11, 2016, doi:10.1136/tobaccocontrol-2016-053329.

[5] U.S. Food & Drug Administration, Tobacco Products Scientific Advisory Committee. Menthol Cigarettes and Public Health: Review of the Scientific Evidence and Recommendations, 2011. http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/TobaccoProductsScientificAdvisoryCommittee/UCM269697.pdf [accessed 2017 Jan 30]

[6] CDC, Youth Risk Behavior Surveillance—United States, 2015, MMWR, 65(6), June 10, 2016. http://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf. [accessed 2017 Jan 30]

[7] Agaku IT, King BA, Husten CG, et al. Tobacco product use among adults--United States, 2012-2013. MMWR Morb Mortal Wkly Rep. June 27, 2014; 63(25); 542-547. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6325a3.htm [accessed 2017 Jan 30]

[8] Woolf, Steven H. et al., Urban Institute and Virginia Commonwealth University. How are income and wealth linked to health and longevity? April 2015. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf [accessed 2017 Jan 30]

[9]Daniel Rodriguez et al., Predictors of tobacco outlet density nationwide: a geographic analysis, 22 Tobacco Control, 349–355 (2013). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3431432/ [accessed 2017 Jan 30]

[10] See supra note 3.

[11] Paynter, Janine & Edwards, Richard. The impact of tobacco promotion at the point of sale: A systematic review, Nicotine & Tobacco Research (2009) 11 (1): 25-35. 01. https://academic.oup.com/ntr/article/11/1/25/1041623/The-impact-of-tobacco-promotion-at-the-point-of [accessed 2017 Jan 30]

[12] Siahpush, Mohammad, et al., The Association of Exposure to Point-of-Sale Tobacco Marketing with Quit Attempt and Quit Success: Results from a Prospective Study of Smokers in the United States, Int J Environ Res Public Health. 2016 Feb; 13(2): 203. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772223/ [accessed 2017 Jan 30]

[13] Brown-Johnson CG, England LJ, Glantz SA, Ling PM. Tobacco industry marketing to low socioeconomic status women in the USA. Tobacco Control, published online 21 January 2014. doi:10.1136/tobaccocontrol-2013-051224

[14] Federal Trade Commission Cigarette Report for 2014 (2016) https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2014-federal-trade-commission-smokeless-tobacco-report/ftc_cigarette_report_2014.pdf [accessed 2017 Jan 30]; Federal Trade Commission Smokeless Tobacco Report for 2014 (2016). https://www.ftc.gov/system/files/documents/reports/federal-trade-commission-cigarette-report-2014-federal-trade-commission-smokeless-tobacco-report/ftc_smokeless_tobacco_report_2014.pdf [accessed 2017 Jan 30]

[15] U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012. https://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/ [accessed 2017 Jan 30]

[16] Rodriguez, D. et al., Predictors of tobacco outlet density nationwide: a geographic analysis. Tobacco Control. 2013 Sep;22(5):349-55.

[17] Ibid.

[18] See, e.g., L. Henricksen et al., Targeted Advertising, Promotion, and Price for Menthol Cigarettes in California High School Neighborhoods, 14(1) Nicotine & Tobacco Research 116 (2012); M.B. Laws et al., Tobacco Availability and Point of Sale Marketing in Demographically Contrasting Districts of Massachusetts, 11 Tobacco Control ii71 (2002); John et al., Point-of-Sale Marketing of Tobacco Products; Taking Advantage of the Socially Disadvantaged? 20(2) 490; Andrew B. Seidenberg et al., Storefront Cigarette Advertising Differs by Community Demographic Profile, 24(6) American Journal of Health Promotion e26, e26-e27 (2010); Scott P. Novak et al., Retail Tobacco Outlet Density and Youth Cigarette Smoking: A Propensity-Modeling Approach 96(4) American Journal of Public Health 670, 673 (2006).

[19] Ibid.

[20] Joseph G. L. Lee, Lisa Henriksen, Shyanika W. Rose, Sarah Moreland-Russell, and Kurt M. Ribisl. A Systematic Review of Neighborhood Disparities in Point-of-Sale Tobacco Marketing. American Journal of Public Health: September 2015, Vol. 105, No. 9, pp. e8-e18. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4529779/ [accessed 2017 Jan 30]

[21] Cantrell, Jennifer et al., Marketing Little Cigars and Cigarillos: Advertising, Price, and Associations With Neighborhood Demographics, Am J Public Health. 2013 October; 103(10): 1902–1909. Published online 2013 October. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780734/ [accessed 2017 Jan 30]

[22] Nina C. Schleicher et al., Tobacco outlet density near home and school: Associations with smoking and norms among US teens. Preventive Medicine, 2016 Oct, 287-293.

[23] L. Henriksen et al., Reaching youth at the point of sale: Cigarette marketing is more prevalent in stores where adolescents shop frequently, Tobacco Control 2004; 13:315-318. http://tobaccocontrol.bmj.com/content/13/3/315.full [accessed 2017 Jan 30]

[24] U.S. Food and Drug Administration, Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol Versus Nonmenthol Cigarettes, http://www.fda.gov/downloads/ScienceResearch/SpeciaLTRpics/PeerReviewofScientificInformationandAssessments/UCM361598.pdf [accessed 2017 Jan 30]

[25] Kreslake, J.M., et al., Tobacco industry control of menthol in cigarettes and targeting of adolescents and young adults. American Journal of Public Health, 2008 Sep; 98(9): p. 1685-92.

[26] Kreslake, J.M. and V.B. Yerger, Tobacco industry knowledge of the role of menthol in chemosensory perception of tobacco smoke. Nicotine & Tobacco Research, 2010 Dec; 12 Suppl2: p. 98-101.

[27] See supra note 24.

[28] Tobacco Product Scientific Advisory Committee (TPSAC), Menthol cigarettes and the public health: Review of the scientific evidence and recommendations, U.S. Department of Health and Human Services Food and Drug Administration, Editor. 2011: Rockville, MD http://www.fda.gov/downloads/advisorycommittees/committeesmeetingmaterials/tobaccoproductsscientificadvisorycommittee/ucm269697.pdf [accessed 2017 Jan 30]

[29] New York State Department of Taxation & Finance. Minimum Wholesale & Retail Cigarette Prices, publication 509. 11/16. https://www.tax.ny.gov/pdf/publications/cigarette/pub509.pdf [accessed 2017 Jan 30]

[30] U.S. Census Bureau, 2010 Census.

[31] Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults---United States, 2005-2015. Morbidity and Mortality Weekly Report 2016;65(44):1205–1211. https://www.cdc.gov/mmwr/volumes/65/wr/mm6544a2.htm [accessed 2017 Jan 30]

[32] See supra note 15.

Appendix A

JOIN US FOR A NEIGHBORHOOD CONVERSATION

...about how tobacco impacts lives and communities.

Tobacco may have taken a toll on you personally, or on someone you love. Tobacco marketing may be tempting your child to start smoking or making it hard for someone you know to quit.

YOU HAVE 4 OPPORTUNITIES TO JOIN US

WEDNESDAY, NOVEMBER 9, 6:00-7:30 PM
Washington Avenue Branch Library, 161 Washington Ave.

THURSDAY, NOVEMBER 10, 6:00-7:30 PM
Howe Branch Library, 105 Schuyler St.

TUESDAY, NOVEMBER 15, 6:00-7:30 PM
Arbor Hill Center, 47 North Lark St.

WEDNESDAY, NOVEMBER 16, 6:00-7:30 PM
Ezra Prentice Homes, 625 South Pearl St.

SHARE YOUR VOICE AND OPINION.

Be a part of the conversation.

Be a part of the solution.

Some communities are harder hit by the impact of tobacco use and tobacco marketing than others. In Albany, this is especially true for people living in the West Hill, Arbor Hill, South End and Downtown neighborhoods. If you live in one of these neighborhoods, we invite you to help us understand the impact of tobacco on you, your family and your community.

TO THANK YOU FOR YOUR PARTICIPATION, WE WILL PROVIDE:

- **$25 GIFT CARD to Price Chopper/Market 32**
- **Complimentary Child Care**
- **Transportation Reimbursement**
- **Dinner on us!**

SEATS ARE LIMITED

CALL THERESA TO RESERVE YOUR SEAT AT THE TABLE TODAY 518-459-2388

SPONSORED BY Capital District Tobacco-Free Communities

Appendix B

Small Group Discussion Questions for Neighborhood Conversations

(Distribute a worksheet on which people can do the first and last exercise)
Take a minute to rank on a scale of 1-10 the degree to which tobacco use has been a concern for you and why. Your concern could be for yourself, or it could be for your children, other family members, friends or your community in general. However it makes sense to you.

1. **Introduce yourself and tell us what number you chose on the scale and why. How has tobacco affected your life and the lives of people you know?**
   - For trouble quitting: Can you talk about what caused you/he/she to have trouble quitting? (If needed: smoking in the home? Stress? Availability?)
   - For sickness: Can you talk about how the sickness affected your family?
     - If needed: financially, not able to spend time with family
   - For secondhand smoke: Has anyone gotten sick because of being around tobacco smoke?
     - If needed: Can you talk about how this affected your family?
   - For youth use: Where are some of the common places you have seen young people using tobacco?
     - If needed: near school, near convenience stores popular kids hangouts

2. **Do you notice tobacco marketing in your neighborhood, meaning displays of tobacco products or tobacco advertisements? Where do you notice them?**
   - In pharmacies, grocery stores, convenience stores, gas stations?
   - On gas pumps, doors, windows, by the counter?
   - If you have ever purchased tobacco products, what type of store advertisements influenced you to make a purchase?
     - Were you already planning to make the purchase? Did you purchase more than you intended because of a sale?

3. **What do you think about the data shared earlier that there is more tobacco marketing in lower-income neighborhoods as compared to higher income neighborhoods?**
   - Do you think it matters?
   - Is it your experience that it's made it hard for you or someone you know to quit?
   - Is it your experience that it's contributed to young people starting to smoke?
   - Do you think something should be done to decrease tobacco marketing in low-income neighborhoods?

4. **There's a view that pharmacies shouldn't sell tobacco products because it's in conflict with their role as health care providers. . .they provide flu shots, diabetes testing and fill prescriptions. What do you think about a law that would end the sale of tobacco in pharmacies and stores that contain pharmacies (such as grocery stores and Walmart)?**
   - Do you think it would make a difference for better or for worse?
   - To what extent do you think it would help smokers quit or keep kids from starting?

5. **There's a view that tobacco companies use tobacco discounts to keep low-income people smoking. What do you think about a law that would prevent stores from accepting coupons or offering other kinds of discounts on tobacco products such as Buy One Get One Free (in Albany County)?**
   - Do you think it would make a difference for better or for worse?
     - If you have or currently use tobacco, do discounts make a difference in whether you purchase tobacco and how much? Do you ever use coupons for tobacco? Where do you get them?
   - To what extent do you think it would help smokers quit or keep kids from starting?

6. **We shared some information suggesting that the more tobacco retailers and tobacco marketing in a particular neighborhood, the harder it is for smokers to quit and the more likely it is that young people will start. What is your opinion about a policy that limits the number of tobacco retailers in a certain geographic area (in Albany County)?**
   - Do you think it would make a difference for better or for worse?
   - To what extent do you think it would help smokers quit or keep kids from starting?

7. **What is your opinion about a policy that would keep tobacco sales at least 1000 away from schools (in Albany County)?**
   - Do you think it would make a difference for better or for worse?
   - To what extent do you think it would help smokers quit or keep kids from starting?

8. **Do you have other ideas on what might help smokers quit or keep kids from starting?**

9. **Complete the following statement provided on your worksheet. We will ask you to share this with the rest of the group: The best thing to do to help smokers quit and keep kids from starting is to**
   _____
   _____

This concludes my questions. Please share any other thoughts you have about tobacco and/or tobacco marketing.

Appendix C

Neighborhood Conversations: Participant Demographic Data

Total	50		
Average Age	52.3		
Race/Ethnicity	*Number*	*Total*	*Percent*
White	4	50	8.00%
Latino/Hispanic	4	50	8.00%
Black	35	50	70.00%
Other	4	50	8.00%
Not indicated	3	50	6.00%
Education	*Number*	*Total*	*Percent*
Less than High School	8	50	16.00%
High School/GED	17	50	34.00%
Some College	20	50	40.00%
Bachelor's	4	50	8.00%
Post Graduate	1	50	2.00%
Sex	*Number*	*Total*	*Percent*
Male	10	50	20.00%
Female	39	50	78.00%
Other	1	50	2.00%
Income	*Number*	*Total*	*Percent*
N/A	3	50	6.00%
<$25,000	31	50	62.00%
$25,000-$49,000	13	50	26.00%
$50,000-$75,000	2	50	4.00%
>$75,000	1	50	2.00%
Smoking Status	*Number*	*Total*	*Percent*
Never a Smoker	19	50	38.00%
Former Smoker	12	50	24.00%
Occasional Smoker	6	50	12.00%
Daily Smoker	13	50	26.00%

Appendix D

Welcome!

To help get us started, please rank on a scale of 1-10 the degree to which tobacco use has been a concern for you. Your concern could be for yourself or it could be for your children, other family members, friends or your community in general.

Not concerned at all — No opinion — Extremely concerned

1 2 3 4 5 6 7 8 9 10

Please indicate (for your use only) why you chose the ranking you did.

Appendix D

Please complete the following statement:

After spending this time listening to what others have to say and talking about the issue, I think the best thing to do to help smokers quit and keep kids from starting is:

_____

_____

_____

_____

_____

Check the policy solutions below that you think would make a positive difference in keeping kids from starting to smoke and/ or helping smokers quit.

- □ Limiting the number of tobacco retailers overall
- □ Not allowing tobacco retailers within a certain distance of schools
- □ Not allowing tobacco discounts and couponing
- □ Ending the sale of tobacco products in pharmacies and stores containing pharmacies

Thank you for participating!

Don't forget to:

- Complete the demographic form
- Pick up your gift card
- Pick up your kids
- Enjoy the rest of your evening