ADDRESSING TOBACCO USE HEALTH INEQUITIES IN THE COUNTY OF SCHENECTADY

In New York State and in Schenectady County, people with low-socioeconomic status (low-SES) smoke at significantly higher rates compared to 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 tobacco use and marketing on affected communities in Schenectady County.

Capital District Tobacco-Free Communities

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Capital District Tobacco-Free Communities (CDTFC) is one of 21 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.

The Neighborhood Conversations referenced in this report were made possible by a grant from St. Peter's Health Partners Mission Services, a regional health ministry of Trinity Health.

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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I. Executive Summary

Tobacco use remains the single largest preventable cause of death and disease in the United States and in New York. While there have been declines in the overall rate of adult tobacco use, tobacco use continues to cause disproportionately high rates of death and disease among people with low socioeconomic status (low-SES), who are notably 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.

Additionally, for the first time in decades, the youth tobacco use rate has risen at an alarming rate since 2014, largely due to the meteoric rise in youth use of e-cigarettes. Attracted by unregulated marketing of slick, discreet, fruit and candy-flavored vaping products, more than 1 in 4 high school students in New York are using e-cigarettes. Research suggests that young people who vape are more likely to begin smoking combustible cigarettes. Because nearly 90% of people who smoke started before the age of 18, preventing young people from ever starting is critical to decreasing the overall tobacco use rate.

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 concentration of tobacco retailers in low-income neighborhoods is typically much more dense than in higher-income neighborhoods. This holds true in Schenectady County where 30.7% of tobacco retailers are located within three zip codes with the highest poverty rates and where only 17.7% of the Schenectady County population resides. In fact, the density of tobacco retailers (i.e., the number of tobacco retailers per capita) in Hamilton Hill, the neighborhood with the highest poverty rate, is more than five times of that in Niskayuna, the highest income neighborhood.

In October 2018, Capital District Tobacco-Free Communities (CDTFC) staff visited 35 state-licensed tobacco retailer (LTR) locations in lower income neighborhoods in the City of Schenectady and 14 LTRs in the higher income neighborhoods of Glenville, Scotia and Niskayuna. Staff used a standardized form to collect information regarding exterior and interior tobacco advertising, prices for various tobacco products, proximity to schools and playgrounds, and tobacco product displays. There were some notable differences between the retailers in the lower and higher income neighborhoods. Compared to those in the higher-income neighborhoods, retailers in the lower-income neighborhoods had, on average:

- Three times as many exterior tobacco ads/per store.
- 40% more interior tobacco ads.
- 60% more tobacco displays that took up more than half the space behind the counter.
- Increased variety and lower prices for tobacco products, including discounted off-brand cigarettes and cigars and cigarillos available in youth-friendly flavors.
- Lower prices for menthol cigarettes.

Menthol cigarettes were 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 retailers, limiting the number of tobacco retailers in a specific geographical area, limiting the type of retailer that is allowed to sell tobacco products, 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 on the people living in these communities and their perspectives on possible policy solutions. In April and May 2019, a total of 40 adults living in the City of Schenectady zip codes 12303, 12304, 12305, 12307, and 12308 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.
- Many participants are concerned about their children being influenced by marketing to use tobacco products.
- Participants who are current smokers find it very difficult to quit successfully; most expressed a strong desire to quit for their health, to save money and for the sake of their children.
- Participants stressed the importance of educating young people and setting a good example in order to prevent future tobacco use among youth.
- Participants voiced the need for new laws to prevent marketing to young people, including enforcing existing laws, decreasing the presence of tobacco marketing, and banning all flavored tobacco and e-cigarettes.

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 . Most recently, in April 2020, NYS enacted several significant tobacco controls that will change the retail environment throughout the state, effectively decreasing the availability, accessibility and affordability of tobacco products.

Local government interventions have also been effective in strengthening and complementing state tobacco control laws. The City of Schenectady made all city parks tobacco-free and Schenectady County raised the minimum legal age for tobacco sales to 21. The Town of Niskayuna restricted tobacco retailers from locating within 1,000 feet of schools and day care centers.

The research supporting evidence-based practices in tobacco control, combined with the LTR observation data in Schenectady County 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 on county residents of tobacco use and tobacco accessibility 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 illegal tobacco sales and to reduce exposure to secondhand smoke are outlined in this report.

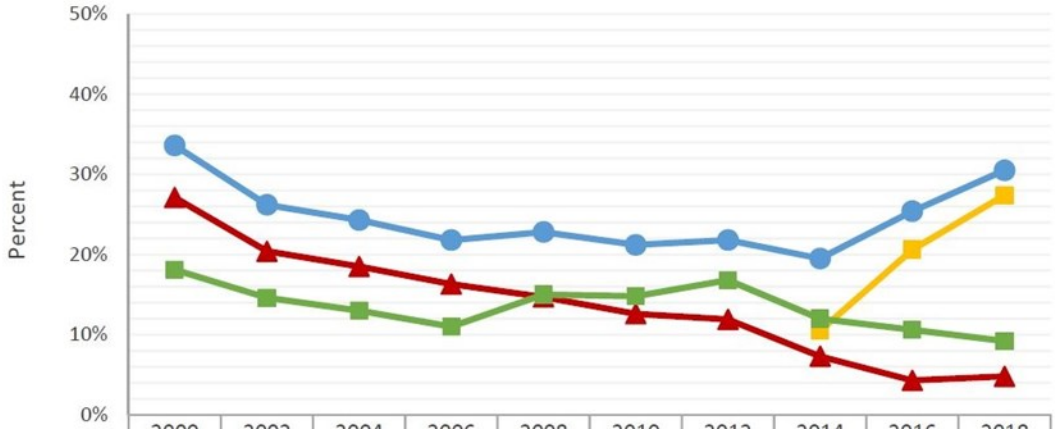
II. Problem: Health Inequities and Tobacco Use

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. Each year, approximately 480,000 Americans die from tobacco-related illnesses and more than 16 million suffer from at least one disease caused by smoking.

Nearly 90% of people who smoke started before the age of 18.[2] Preventing young people from ever starting to use tobacco is, therefore, key to decreasing the tobacco use rate. From 2000 to 2014, the tobacco product use rate among high school students in New York State dropped from 33.6% to 19.5% (Figure 1). Since 2014, however, that rate has skyrocketed to 30.5%, due to the alarming rise of youth e-cigarette use. Attracted by the unregulated marketing of slick, discreet, fruit and candy-flavored vaping products, more than 1 in 4 high school students in New York are using e-cigarettes.

Although more remains to be learned, the research is clear that e-cigarettes are not a risk-free alternative to smoking, especially for youth and young adults. The aerosol from e-cigarettes can contain heavy metals, volatile organic compounds, ultrafine particles and other toxins. In addition, nicotine can have a lasting negative impact on adolescent brain development, altering the brain to become more prone to addiction to other substances. Research has also found that young adults who use e-cigarettes are more than four times as likely to begin smoking tobacco cigarettes as their peers who do not vape.[3]

Trends in Any Tobacco Product Use among High School Students in NYS, 2000-2018

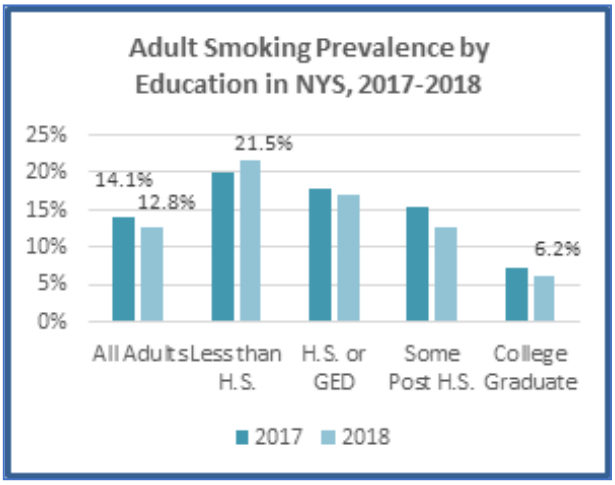


	2000	2002	2004	2006	2008	2010	2012	2014	2016	2018
Any Tobacco Products	33.6%	26.2%	24.3%	21.8%	22.8%	21.2%	21.8%	19.5%	25.4%	30.5%
Cigarettes	27.1%	20.4%	18.5%	16.3%	14.7%	12.6%	11.9%	7.3%	4.3%	4.8%
E-Cigarettes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	10.5%	20.6%	27.4%
Other Tobacco Products	18.1%	14.6%	13.0%	11.0%	15.0%	14.8%	16.8%	12.0%	10.6%	9.2%

Figure 1

Source: NYS Department of Health Bureau of Tobacco Control StatShot Vol.12, No.1/Jan2019
https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume12/n1_electronic_sig_use_increase.pdf

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 the U.S. and in New York State, people with low socioeconomic status (low-SES) smoke at significantly higher rates than their more affluent or educated counterparts.



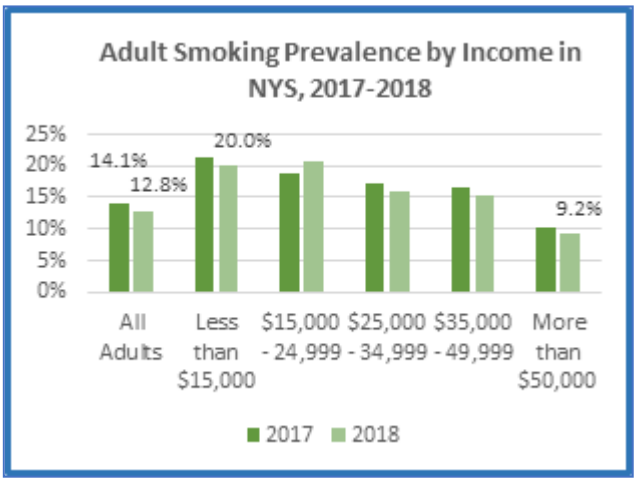


Figure 2
Source: Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence and Trends Data [online].2015.[accessed Jan 20, 2020] URL: https://www.cdc.gov/brfss/brfssprevalence/.]

While the adult smoking rate in New York State has declined from 14.1% in 2017 to 12.8% in 2018 (Figure 2), high rates of smoking persist among adults with lower income and less education. Among adults with less than a high school education and those with an income between $15k-$25K, smoking rates have actually risen. Disconcertingly, those in the lowest income bracket are smoking at more than twice the rate of those making more than $50,000, and those with the least education are smoking at rates nearly 3.5 times that of those with a college degree.

In addition, people with low-SES smoke for longer periods of time[4] and are less successful in their quit attempts than their more affluent counterparts.[5] 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.[6] 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.[7]

Prevalence of cigar use is higher than that of cigarette use for African American youth and is higher than other racial/ethnic groups. African American high school students smoke cigars at nearly triple the rate of cigarettes (9.2% for cigars and 3.2% for cigarettes).[8] In 2019, 12.3 percent of African American high school students were current cigar users, compared to 7.6 percent of whites.[9] In the adult population, cigars, cigarillos and little cigars are most popular among African Americans compared to other racial/ethnic groups.[10] 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.[11] 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.[12] Exposure to tobacco marketing increases the likelihood that teens will start smoking,[13] adults who smoke will experience more cravings and impulse buying,[14] and people trying to quit will be less successful.[15]

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.[16]

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.[17] According to a 2012 Surgeon General's report, tobacco marketing in stores is a primary cause of youth smoking.[18]

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.[19] Even when controlling for population size, there are 33% more tobacco retailers in urban areas of the U.S. than in non-urban areas.[20] In addition, stores located in low-income neighborhoods have the most storefront advertising,[21] offer more price promotions,[22] and market menthol products,[23] cigars and cigarillos[24] more heavily than stores in higher income neighborhoods. Studies have directly linked higher neighborhood tobacco retailer density with higher odds of ever smoking.[25]

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.[26]

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.[27] The cooling and anesthetic effect of menthol makes mentholated tobacco products more appealing to youth.[28] 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.[29] As a result, menthol smokers show significantly higher levels of nicotine addiction compared with non-menthol smokers in the same age group,[30] increasing the health risk of tobacco use for menthol users and making quitting more difficult.[31] These increased risks led the NAACP to adopt a 2016 resolution recommending that the FDA ban menthol in cigarettes.

IV. Intervention Community: County of Schenectady

According to the Healthy Capital District Initiative's (HCDI) Health Equity Report, Hamilton Hill in Schenectady County tops the list of high-need neighborhoods in the six Greater Capital Region counties. [32] Also among the neighborhoods experiencing the most socioeconomic deprivation are the Schenectady neighborhoods of City/Stockade, Goose Hill/Union, and Upper State Street. These neighborhoods experience higher rates of asthma ED visits, COPD hospitalizations, lung cancer mortality and premature deaths than low-need neighborhoods. In fact, residents of a census tract within Hamilton Hill are expected to live 66.2 years, far below the statewide life expectancy of 81 years. In contrast, just two miles north in a census tract bordering on Niskayuna, residents have one of the region's highest expected life spans of 87.4 years.

While tobacco use is certainly not the only reason for this disparity, it is a significant factor. Smoking harms nearly every organ system of the body and leads to disease, disability and, too often, preventable death. While the Schenectady County smoking rate has hovered for years at around 19%,[33] a 2013 door-to-door survey conducted by the Schenectady Coalition for a Healthy Community uncovered a smoking rate of nearly twice that rate (37%) in the lower income neighborhoods in the City of Schenectady.[34]

The tobacco retail environment in Schenectady County aligns with this disparity. Mapping of licensed tobacco retailer (LTR) locations in the Capital Region indicated a significant cluster of retailers in five zip codes within the city of Schenectady with particularly high poverty rates—12303, 12304, 12308, 12305 and 12307. Of the 164 tobacco retailers located in Schenectady County, 94 (57.3%) are located in these five zip codes. The three zip codes with the highest poverty rates (12305, 12307 and 12308) have the highest concentration of tobacco retailers with 30.7% of tobacco retailers and only 17.7% of the Schenectady County population. See Figure 3 below.

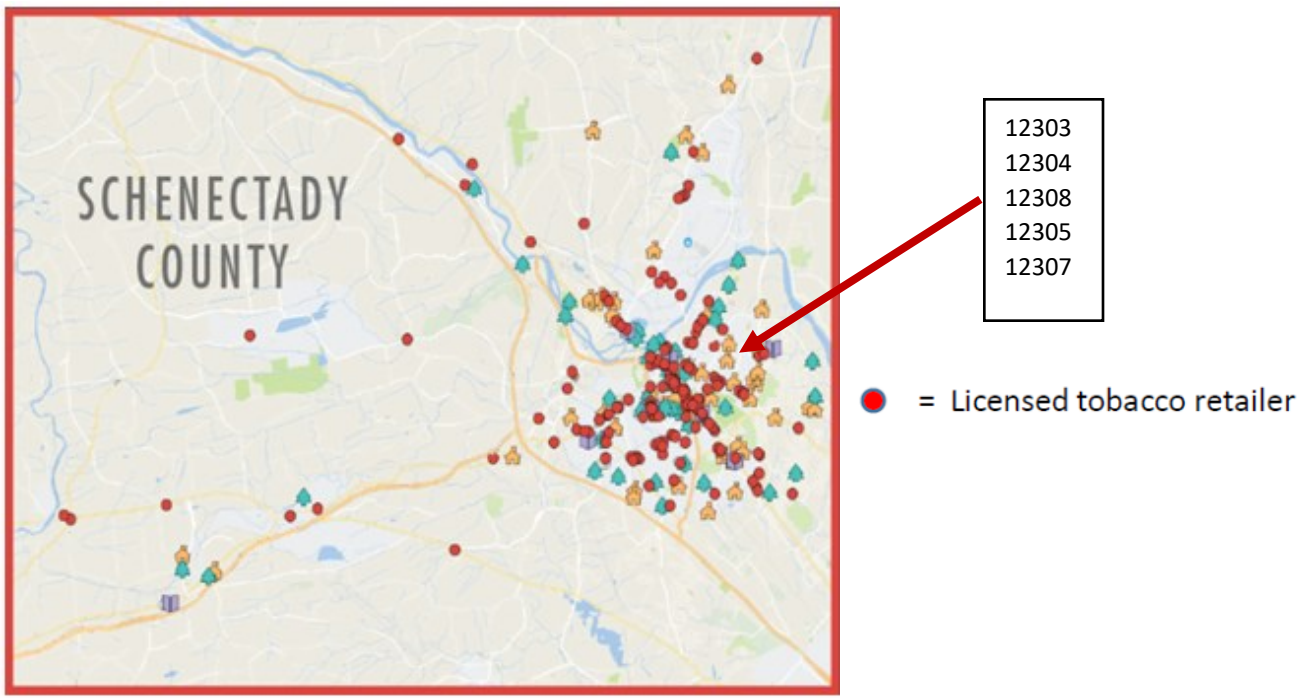


Figure 3

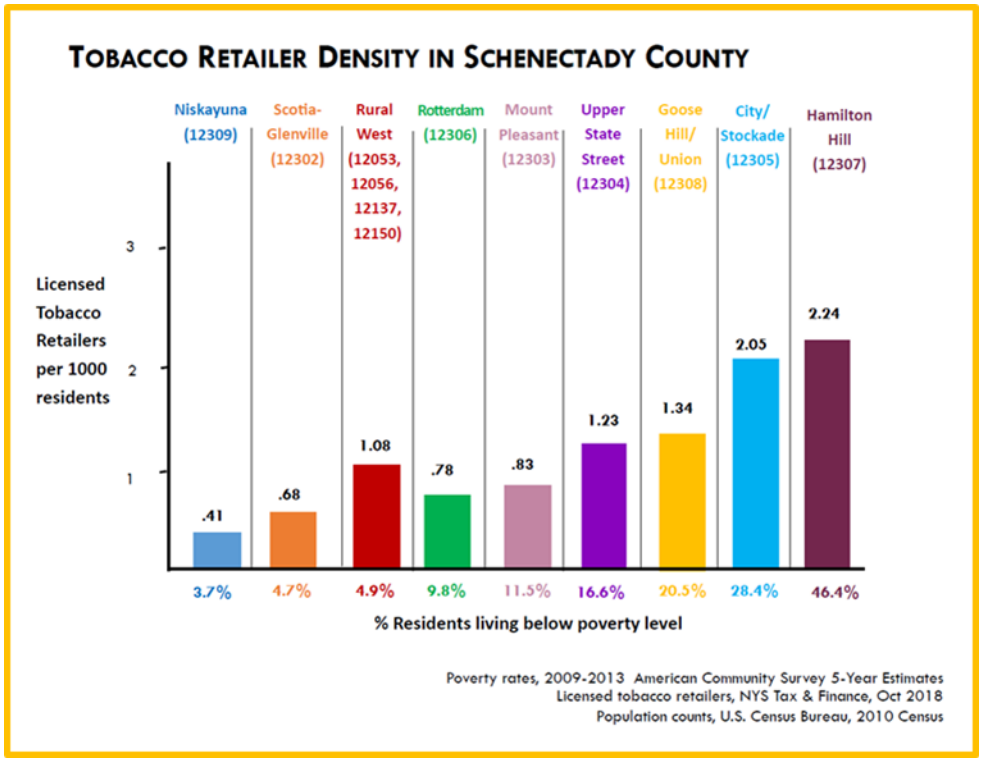


Figure 4

Using U.S. Census Bureau data, Figure 4 compares the number of LTRs per capita in these five zip codes to the number of LTRs per capita in higher- income zip codes in Schenectady County.

As seen in Figure 4, communities with the highest poverty rates (Hamilton Hill, City/Stockade, Goose Hill/Union, Upper State Street) have more LTRs per capita as compared to the low-poverty communities of Niskayuna and Scotia-Glenville. Hamilton Hill has more than three times the number of LTRs per capita than Scotia-Glenville and more than five times the number in Niskayuna.

V. Licensed Tobacco Retailer (LTR) Observations

During October 2018, Capital District Tobacco-Free Communities staff visited 35 LTRs in five zip codes having poverty rates above 11% in the City of Schenectady (zip codes 12203, 12304, 12305, 12307 and 12308) and 14 LTRs in two zip codes with poverty rates below 5% in the Town of Glenville and the Town of Niskayuna (12302 and 12309). An observation tool was used to collect information regarding exterior and interior tobacco advertising, prices 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 Schenectady County. The map, with green markers denoting LTRs that were visited, can be accessed here: https://bit.ly/39sSB4S

The observations led to the following findings:

1. There were three times as many exterior tobacco ads per store in lower-income neighborhoods than in higher-income neighborhoods (average of 6 per store vs. 2 per store).
2. There were 40% more interior tobacco ads in lower-income neighborhoods than in higher-income neighborhoods (average of 14 per store vs. 10 per store).
3. Nearly 60% more LTRs in lower-income neighborhoods had displays that took up more than half the space behind the counter—a prime marketing location— than LTRs in higher-income neighborhoods (57% vs. 36%).
4. Thirty percent more stores in the lower-income neighborhoods contained some form of price discounting or multi-pack discounts than in the higher-income neighborhoods (55% vs. 42%).
5. The average cost of a pack of Newport menthol cigarettes was $10.16 in the lower-income neighborhoods vs. $10.72 in the higher-income neighborhoods.

Consistently, the visited LTRs, particularly in the lower-income neighborhoods 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 neither New York State nor the federal government regulates the minimum price of cigars and cigarillos or the minimum number sold in a single package.

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.

VI. Community Input

In April and May 2019, Capital District Tobacco-Free Communities (CDTFC) hosted four Neighborhood Conversations with residents living in zip codes 12303, 12304, 12305, 12307 and 12308 to better understand the impact of tobacco marketing on people living in the communities that are most profoundly affected and their perspectives on evidence-based policy solutions. Participants were recruited with the help of local partners including Alliance for Better Health, Bridge Christian Church, Schenectady County Public Health Department, Schenectady County Public Library, Schenectady Municipal Housing Authority, Schenectady Neighborhood Associations, Schenectady Works, Schenectady YMCA, Schenectady YWCA, Schenectady Inner City Ministry, and St. Peter's Health Partners.

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 $20 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 five zip code communities and being at least 18 years of age. Each meeting began with a brief slide presentation by CDTFC staff on the results of the tobacco retail store observations, 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 nearly reached through pre-registration for all four meetings. Actual attendance varied from a low of seven to a high of seventeen, with a total of forty participants overall. Participant demographics are included as **Appendix C**.

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, stores allowing entry to persons under 21), disallowing the use of price promotions and discounts , and prohibiting the sale of flavored tobacco products, including menthol.

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, eliminating the sale of tobacco products in pharmacies (The neighborhood conversations took place prior to passage of the state law prohibiting the sale of tobacco products in pharmacies, effective May 18, 2020.);

- Decreasing access to or eliminating the sale of inexpensive, flavored cigars and cigarillos that appeal to young people; and

- Decreasing access to or eliminating the sale of menthol cigarettes.

Participants were also asked what types of stores and places they did and did not want to see more of in their neighborhoods.

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. All four meetings were audio recorded to verify and expand the note documentation. Participant permission was obtained prior to audio recording.

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, Secondhand Smoke Exposure, Quitting, Tobacco Marketing and Youth, Tobacco Discounts and Flavored Tobacco Products.

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, 70% (*n*40) of all participants rated the degree to which tobacco use has been a concern for them as "8", “9” or “10” on a scale of 1-10; only eight participants rated their concern as "6" or less.

  Personal stories abounded of family members dying from a variety of chronic diseases due to tobacco use, Chronic Obstructive Pulmonary Disease (COPD), cancers of the lung and throat, emphysema, and other lung diseases. One participant who currently smoked reported that nine family members had died of lung cancer.

Other participants voiced concern for their children who are smoking, including one mother who said, "I've lost family members to asthma, COPD, cancers that can be traced to smoking. My son smokes—doesn't believe it will get him. Scary to know he's shortening his life."

Eighty percent of participants (*n*40) reported themselves as current or former smokers; 47.5% were current daily smokers; 10% were occasional smokers; and 22.5% were former smokers. Many of them disclosed consequences of their own tobacco use including COPD and difficulty breathing. The average age of those identifying themselves as current smokers was 47; former smokers' average age was 55.

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

  One participant who is a former smoker, lives in a senior development that is supposed to be smoke-free but believes there is more smoking happening now. She said secondhand smoke exposure killed her friend. Others reported developing asthma due to secondhand smoke exposure.

  Smoking has also negatively impacted relationships as one participant said she cannot be around her father because he refuses to quit smoking and she is allergic to the smoke.

  There was a strong perception among participants that secondhand smoke exposure is dangerous and that people should not be smoking around nonsmokers, especially children. One participant asserted that "Secondhand smoke is even more dangerous than smoking."

- **Participants who are current or former smokers have a strong desire to quit, but find it very difficult to fight the addictiveness of tobacco successfully. The number one motivation to quit was concern for their children.**

  Despite knowing 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 stress resulting from living in poverty. One participant who was concerned that her ten grandchildren would start smoking, quit smoking six times but was triggered by stress to start again. Many smokers expressed wanting to quit, "to be there longer for my kids" and "to be a good example for my children."

  Another participant, whose mother and husband both died of lung cancer, and who has tried to quit many times said, "I don't want to live with myself, let alone have someone else live with me."

  A participant who is on multiple medications for borderline COPD said she needs to stop but is very addicted. The extreme addictiveness of tobacco was expressed by another smoker: "It is hard to stop. If I go into a program where I stay for a few months without smoking or if I was in jail, that would be the only way I would quit."

Still another participant in her early twenties who had been smoking daily since age 15 and whose uncle died from lung cancer said, "I can barely walk up the street without my chest hurting. I feel the effects. At this point, I am trying to stop, I want to stop, it's real though, I don't want to die from it. It was brought up around me. I was brought up in poverty. A lot of things need to change. I'm a smoker but I'm not a proud smoker."

Without exception, the participants who were current or former smokers had started smoking at a young age. One participant reported starting at the age of 7.

- **Participants' concern for young people was identified as a primary motivation for them to make personal changes, to educate and to enact changes in their communities.**

  Over and over again, young people were cited as the motivation to stop smoking, to reduce exposure to secondhand smoke, to reduce tobacco marketing and to improve their neighborhoods. Participants took ownership of their own tobacco use and stressed the importance of setting a good example for their children and young people by not smoking, especially around them. They also stressed the importance of educating young people and creating an environment where young people were not exposed to the influence of tobacco marketing and other stressors, such as unsafe, littered neighborhoods. They wanted to "share their experiences" with young people to keep them from starting and wanted "new laws for the sale of cigarettes, especially for kids," such as "banning flavored cigarettes to youth." They wanted to see more after school resources and "activities in the community for our youth that are more positive and [give them] less time to get into trouble."

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 hopelessness at the disparities related to tobacco marketing in low-income vs. higher -income neighborhoods. Participants also expressed a desire to act for change.**

	PARTICIPANT QUOTES
Several participants expressed anger and sadness about the differences in tobacco marketing depending on where one lives. Their anger was mainly targeted at the tobacco industry, but also showed distrust of the government.	"It's really messed up that certain areas have been deliberately targeted for decades. Generations of people are suffering. The tobacco industry is making millions off of killing communities." "I think people are being exploited when they are stressed and they take advantage of that…Yes, those products are purposely put in my neighborhood." "I go between very sad and angry about the whole issue. That's messed up. Beyond terrible that tobacco industry purposely pushed menthol in black communities." "It's sad marketing to low SES – 'Give them something else to die off of.'" "It's a way to kill off people quicker – mostly the Black and Hispanic populations. Let them kill themselves. It's a governmental thing."

Some comments reflected a sense of hopelessness about reducing smoking among people with low-SES.	“I don't think people in the low income neighborhoods have a voice or are respected. I don't think it matters.” "Corner stores don't care – you got the money, you'll get what you want."
Still other participants felt motivated to do something about it.	“People don't want more tobacco retailers and tobacco ads in their neighborhoods. People need to start standing up and fighting for their communities.” "People get together and do things for breast cancer. Why can't it be done for smoking?" "It's about the next generation of children. Need to form groups like this to fight back, to talk about these things so kids don't smoke." "We as a people need to go to politicians' offices to get things to change."

- **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.”**

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. Many of the current smokers reported buying loosies at least occasionally.	"If I can't buy a pack, I'll buy loosies. It's a money thing." "Getting rid of discounts won't matter because kids will be able to get loosies for 75 cents."
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.	"These store owners make it easy for people who live in the hood. 90% of the stores sell loosies and don't ask for ID." "They sell cigs to kids without an ID. They don't care how old you are. The corner stores, they want their money." "You can't get loosies downtown, but you can get them in our community."
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.	"Ads made me go to whatever was the cheapest." "The Newports were cheaper and my parents had me buy them for them."

- **Several participants supported limiting the number of tobacco retailers in their neighborhoods, especially in places that young people frequent. Some questioned whether it would make a difference.**

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 shouldn't see tobacco marketing." "I don't want my babies to start. I think they should take it out of the neighborhoods, cold turkey." "If kids don't see it, they are less likely to start it."
Reflecting on their own tobacco use, several participants began to consider the potential positive impact of fewer retailers near where they lived.	"If I had to walk two blocks away to go smoke a cigarette, that would be it for me. It'd be time to quit." "I think the harder it is to get if you got to walk a mile to get it, you might think about taking that walk."
Some participants expressed the belief that limiting the number of retailers would not impact tobacco use and might increase crime.	"I don't think limiting the amount of retailers will make a difference. People will find a way to get the product." "If people are addicted, they will find it." "If decrease accessibility, it would increase crime rate."

- **Most participants supported ending the sale of flavored tobacco products because of their concern for young people, but were divided on the effectiveness of ending the sale of menthol cigarettes.**

Participants thought ending the sale of flavored tobacco and e-liquids would have an impact on youth use.	"Flavors are geared to young people. Banning flavors will take a dent in young people starting smoking." "It would cut down on kids starting." "We don't need a hundred flavors of stuff." "Definitely should be law to limit flavored e-cigs."

Participants had a wide range of thoughts on the impact of eliminating menthol cigarettes.	"It'd be fine. I'd quit. I'm not going to find another kind to smoke." "I think it would make a difference and people would stop. For me, though, I'd just smoke something else – cigars or other cigarettes." "I'd go to non-menthol."

- **Participants did not hesitate to voice their thoughts on what they want and do not want more of in their communities.**

Participants clearly did not want more bodegas and corner stores selling tobacco products.	"Less bodegas selling bootleg cigarettes." "Corner stores look mostly abandoned. There are more cigarette choices than candy." "Everything that's killing us is in our neighborhood." "Put a cap on the number of stores selling tobacco."
Participants wanted more resources for healthy living in their neighborhoods.	"A real neighborhood with everything you need in one place – a good park in Hamilton Hill." "Things for kids to do – basketball courts, fields, pool, recreation center, positive things." "More stuff for families to do. It deters young people from smoking when they take care of themselves."

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 enacting the second 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 2018 adult smoking rate of 12.8%, lower than the national average of 13.7%.[35] If New York State tobacco control funding was more than the current 20% of the Centers for Disease Control recommended level, the tobacco use rate would likely be even lower.

The recent NYS tobacco control measures enacted in April 2020 and implemented on May 18 and July 1, 2020 will decrease the availability, accessibility and affordability of tobacco products, all factors known to reduce tobacco use. The measures include ending the sale of tobacco products in pharmacies, restricting the sale of flavored vaping products including menthol, stopping home delivery of e-cigarettes, prohibiting the exterior display of tobacco advertising near schools and disallowing the use of tobacco coupons and multi-pack discounts. A summary of the new laws are available on the Public Health and Tobacco Policy Center's website.

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. Schenectady County has led in implementing policies to protect residents from exposure to secondhand smoke and to reduce youth access to tobacco products. In 2008, the Town of Niskayuna became the first municipality in the Capital Region to make all of its parks tobacco-free. Since then, the City of Schenectady and nineteen other municipalities in the Capital Region have made all of their municipal parks tobacco-free. Schenectady Municipal Housing Authority was also the first in the Capital Region to adopt a smoke-free policy for its senior and disabled buildings, several years before Housing and Urban Development passed a smoke-free rule requiring all federally funded public housing authorities to be smoke-free. The Town of Niskayuna was again first in the region to restrict tobacco retailers from locating within 1,000 feet of schools. In 2017, Schenectady County raised the minimum legal age for tobacco sales to 21, ahead of New York State and the federal government passing similar laws in 2019.

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 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 dramatically reduce 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."[36] 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 predominantly 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 observation data collected in the County of Schenectady, and the information collected from the forty 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.

1. Limit number of licensed tobacco retailers in the County of Schenectady 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. Limit the type of retailers authorized to sell tobacco products.

4. 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 any existing tobacco controls, including 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 county-owned properties 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*
  https://tobaccopolicycenter.org/documents/DisparitiesFactSheet.pdf

- *Tobacco Disparities: Evidence Supports Policy Change*
  https://tobaccopolicycenter.org/documents/TobaccoDisparities.pdf

- *Cause and Effect: Tobacco Marketing Increases Youth Tobacco Use, Findings of the 2012 Surgeon General's Report*
  https://tobaccopolicycenter.org/documents/2012SurgeonGeneralReport.pdf

- *Tobacco Retail Licensing: Promoting Health Through Local Sales Regulations*
  https://tobaccopolicycenter.org/documents/TobaccoRetailLicensing.pdf

- *Regulating Sales of Flavored Tobacco Products*
  https://www.tobaccopolicycenter.org/documents/FlavoredTobacco.pdf

- *Advancing Tobacco Control: The Known, the New and the Next – Findings of the 2014 Surgeon General's Report*
  https://tobaccopolicycenter.org/documents/2014SurgeonGeneralReport.pdf

- *Point of Sale Policy: New York Communities Taking Action*
  https://tobaccopolicycenter.org/documents/posProgress.pdf

- *New York Tenants' Guide to Smoke-free Housing*
  https://tobaccopolicycenter.org/documents/TenantGuide.pdf

IX. Endnotes

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X. Appendices

Appendix A

Appendix B

Small Group Discussion Questions for Neighborhood Conversations

(A worksheet on which people can do the first and last exercise was distributed as participants walked in. Make sure that everyone has one they are filling out.)
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.

- **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?**
    - If you smoke: When did you start and why? Did you start on menthol or another flavored product?
        - 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: Do you know any young people under age 18 who currently smoke? Does their tobacco use concern you or others you care about?

- **You just heard about the differences in tobacco marketing in low-income neighborhoods vs. high-income neighborhoods in Schenectady – that there are more stores that sell tobacco, more tobacco ads, more inexpensive, flavored cigars and cigarillos and more menthol products. What do you think about these differences between neighborhoods?**
    - How do these differences make you feel?
    - Do the differences concern you?
    - Do the differences surprise you?
    - Does it seem fair?

- **Do you think it matters that there are more tobacco retailers and more tobacco advertising in low-income neighborhoods?**
    - Does it make it harder for you or someone you know to quit?
    - Does it contribute to young people starting to smoke?
    - Do you think something should be done to decrease the number of tobacco retailers in low-income neighborhoods?

- **Stores that sell tobacco in low-income neighborhoods more often sell tobacco products at a discount. They also sell a lot of cheap flavored cigars and cigarillos which appeal to young people. Do you think it matters that less expensive tobacco products are more available in low-income neighborhoods?**
    - Does it make it harder for you or someone you know to quit?
    - Does it contribute to young people starting to smoke?
    - Do you think something should be done to decrease access to or not allow the sale of cheap, flavored tobacco products?

- **Do you think it matters that menthol products are advertised more and are sold at lower prices in low-income neighborhoods?**
    - Does it make it harder for you or someone you know to quit?
    - Does it contribute to young people starting to smoke?
    - Do you think something should be done to make menthol products less accessible or to not allow the sale of menthol products at all?

- **If you could decide what your neighborhood looked like, what types of stores or places do you want to see more of and what would you like to see less of?**
    - For example, do you want to see more tobacco retailers and liquor stores? Or more grocery stores, gift shops, book stores, restaurants, clothing retailers, community centers or parks?
    - How would this change how you and your family live?

- **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**

  _____

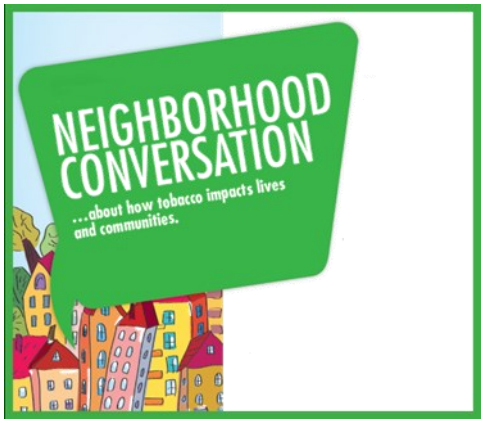
  _____

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

Appendix C

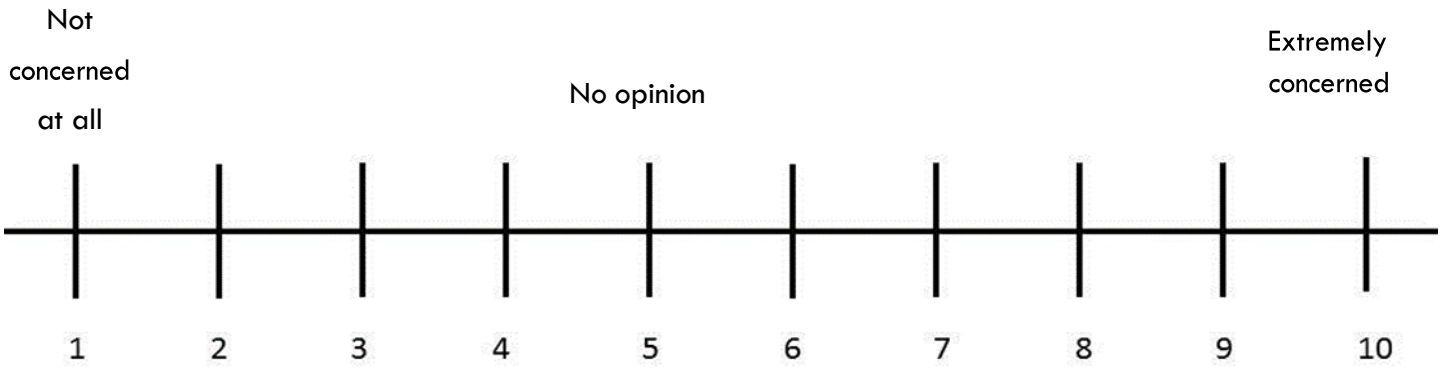
Neighborhood Conversations: Participant Demographic Data

Total	**40**		
Average Age	45.5	n=38 for Age	
Race/Ethnicity	***Number***	***Total***	***Percent***
White	8	40	20.00%
Latino/Hispanic	11	40	27.50%
Black	21	40	52.50%
Pacific Islander	1	40	2.50%
American Indian	2	40	5.00%
Other	3	40	7.50%
Education	***Number***	***Total***	***Percent***
Less than High School	12	40	30.00%
High School/GED	10	40	25.00%
Some College	15	40	37.50%
Bachelor's	1	40	2.50%
Post Graduate	2	40	5.00%
Sex	***Number***	***Total***	***Percent***
Male	14	40	35.00%
Female	26	40	65.00%
Other	0	40	0.00%
Income	***Number***	***Total***	***Percent***
N/A	2	40	5.00%
<$25,000	34	40	85.00%
$25,000-$49,000	3	40	7.50%
$50,000-$75,000	1	40	2.50%
>$75,000	0	40	0.00%
Smoking Status	***Number***	***Total***	***Percent***
Never a Smoker	8	40	20.00%
Former Smoker	9	40	22.50%
Occasional Smoker	4	40	10.00%
Daily Smoker	19	40	47.50%



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.



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

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