



Promising Practices For Commercial Tobacco Prevention & Control in Indian Country

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KEEP IT SACRED

NATIONAL NATIVE NETWORK

Written by
Janis Weber, Ph.D. JCW Research and Evaluation Group



Introduction

Rates of commercial tobacco use¹ among American Indian and Alaska Native (AI/AN) populations are disproportionately higher than all other U.S. populations.ⁱ Current estimates from the National Health Interview Survey (NHIS) suggest that the smoking prevalence rate among AI/AN populations is 31.4% compared to 21% among non-Hispanic whites and 20.6% among non-Hispanic blacks and an aggregated prevalence rate of 19.3%.ⁱⁱ There is wide variance in prevalence rates when controlling for geographic and tribal cultural considerations. Consistently, the Southwest Tribes have had lower prevalence rates than have Northern Plains Tribes ranging from 14% in the southwest to 75% in the Northern Plains.^{iii iv} Alaska Natives smoking prevalence rates remain at 45%.^v Unpublished data from tribes that have fielded the American Indian Adult Survey suggest that smoking prevalence rates are much higher than those published by NHIS, ranging from 28% to over 79%. The variance in data sources can be attributed to several factors. First, the NHIS (as well as state Adult Tobacco Surveys) do not define the terms “American Indian” or “Alaska Native”. Instead, race is self-reported. Respondents may or may not be enrolled members of AI/AN tribes. Respondents in the American Indian Adult Tobacco Survey or the Alaska Native Adult Tobacco Survey are enrolled members of the specific tribe that is fielding the survey. Second, NHIS as well as other national or state surveys employ Computer Assisted Telephone Interviewing methods. Data show that 69% of American Indians who reside on reservations or on federal lands in trust have land-line telephones in their homes. This figure decreases when looking at just reservation populations – for example, on the Navajo Nation reservation, where the largest tribe in the U.S. resides, only 37% have home land-lines.^{vii} Thus, any random sample pulled does so without benefit of a whole population. Third, definition of a “smoker” or other tobacco user may not be correct because questions have not been cognitively tested for cultural appropriateness. For example, if “smoker” is defined as one who has smoked a pipe 20 times in his/her life an American Indian may be incorrectly labeled a “smoker” even though the only time he/she smoked a pipe was for ceremonial/sacred purposes. The American Indian Adult Tobacco Survey poses questions in such a way that ceremonial/sacred use of tobacco is excluded in the questions regarding use of commercial tobacco products.

¹ The term “commercial tobacco” is used to differentiate tobacco products such as cigarettes, cigars, chew/spit tobacco and the like from tobacco used for ceremonial or sacred purposes.



Initiation and regular usage of commercial tobacco among AI/AN youth begins significantly earlier than among the rest of the U.S. population.^{viii} Unpublished findings from American Indian Adult Tobacco Surveys suggest that initiation and regular use among AI/AN youth begins between the ages of 6 to 12 years of age.^{ix x} By the time these children reach high school, prevalence rates among high school students in Bureau of Indian Affairs (BIA) funded schools who regularly smoke cigarettes is 57%.^{xi}

The disproportionate AI/AN prevalence rate is directly related to disproportionate adverse health outcomes among AI/AN populations which include but are not limited to:

- ❖ Cardio-vascular disease, cancer, asthma and other chronic respiratory diseases are among the top seven leading causes of death among AI/AN. All are known to be caused by or exacerbated by smoking and second-hand-smoke exposure.^{xii}
- ❖ American Indians and Alaska Natives have the highest rates of cardio-vascular disease when compared to all populations in the U.S., with rates more than twice that of other populations.
- ❖ Cardio-vascular disease is the leading cause of death among AI/AN populations accounting for approximately 30% of AI/AN deaths for all ages. Among AI/AN individual's aged 45 and older, CVD accounts for more deaths than cancer, unintentional injuries, and diabetes combined.^{xiii}
- ❖ Cancer is second only to CVD as the leading cause of death among American Indians and Alaska Natives. Lung, prostate, and colo-rectal cancers respectively account for the highest incidents of cancers among American Indians and Alaska Natives. Surveillance data suggest that new diagnoses for cancers of the kidney, stomach, liver, cervix, and gallbladder were higher in AI/AN than in white populations.ⁱ
- ❖ Lung and colo-rectal cancer incidence rates among American Indians in the Northern Plains are significantly higher than rates among any other U.S. population or ethnic group.^{xiv}
- ❖ American Indians and Alaska Natives suffer disproportionately from asthma when compared to all populations in the U.S. Nationally, the general population of adults has a 7.5% asthma incidence rate. The incidence rate among AI/AN adults is 11.6%. American Indian and Alaska Native adults are

60% more likely to be diagnosed with asthma than adults in any other U.S. ethnic group.^{iii iv}

- ❖ AI/AN children have a 20% higher incidence of asthma than do children in other U.S. ethnic groups.^{xv xvi}
- ❖ AI/AN infants less than 1 year of age are twice as likely to be hospitalized for asthma, bronchiolitis, and lower respiratory tract illness (LRTI).^{xvii}
- ❖ Five of the ten leading causes of death among AI/AN populations are either caused by or exacerbated by commercial tobacco use and/or exposure to second-hand smoke –
 - ⌘ Heart disease
 - ⌘ Cancer
 - ⌘ Unintentional injuries
 - ⌘ Diabetes
 - ⌘ Chronic liver disease and cirrhosis
 - ⌘ Chronic lower respiratory disease
 - ⌘ Stroke
 - ⌘ Suicide
 - ⌘ Nephritis, Nephrotic syndrome and Nephrosis
 - ⌘ Influenza and pneumonia

The scientific literature suggests that there is now an effective evidence base of interventions that decrease tobacco use. *Ending the Tobacco Problem: A Blueprint for the Nation*, released in 2007 by the Institute of Medicine (IOM), suggests a two-pronged evidence-based strategy for reducing commercial tobacco use:

The first prong envisions strengthening and fully implementing traditional tobacco control measures known to be effective.² The second prong envisions changing the regulatory landscape to permit policy innovations that take into account the unique history and characteristics of tobacco use, such as strong federal regulation of tobacco products and their marketing and distribution.^{xix}

Additionally, the IOM Committee found that states should fund tobacco control efforts at CDC-recommended levels of \$15 to \$20 per capita, depending upon “the

² Note that the word “traditional” means *normal* rather than a cultural reference to American Indian sacred or ceremonial use of tobacco.

state's population, demography, and prevalence of tobacco use.^{xx} Currently, CDC recommendations state that the minimum funding by states should be \$5.98 per capita.^{xxi} The figure of \$5.98 per capita assumes that other funding is in place, for example monies states receive from the Master Settlement Agreement (MSA) through which 46 states receive yearly stipends from the tobacco companies. The MSA settlement agreement summary:

- ❖ Requires [tobacco] industry payments to the states in perpetuity, with the payments totaling about \$206 billion through the year 2025.
- ❖ Provides that distributions to states will be made based on formulas agreed to by [state] Attorneys General.
- ❖ Requires annual payments by the industry to begin April 15, 2000.
- ❖ Provides that if all states participate in the settlement, annual payments will “ramp-up” beginning with a \$4.5 billion payment on April 15, 2000. Ensuing April 15 payments will be at the following rates:
 - ⌘ 2001: \$5 billion
 - ⌘ 2002-2003: \$6.5 billion
 - ⌘ 2004-2007: \$8 billion
 - ⌘ 2008-2017: \$8.139 billion (plus \$861 million to the strategic fund)
 - ⌘ 2018 on: \$9 billion
- ❖ Requires tobacco companies to make “up front” payments of nearly \$13 billion in the following amounts: \$2.4 billion in 1998, \$2.472 billion on January 10, 2000, \$2.546 billion in 2001, \$2.622 billion in 2002, and \$2.701 billion in 2003.
- ❖ Requires the companies, on April 15, 2008 and on April 15 each year through 2017, to pay \$861 million into a strategic contribution fund.

In fact, a study by CDC found that between 1998 and 2010 states collected a total of \$244 billion from the MSA but earmarked only 8.1 billion dollars for commercial tobacco prevention and control efforts.^{xxiii}

Current estimates suggest that American Indians and Alaska Natives number 4 million. The AI/AN populations consist of 566 federally recognized tribes, 34 state recognized tribes, and Urban Indians. CDC currently provides \$1.8 million annually for a Tribal Support Centers for Tobacco Initiative, a commercial tobacco

prevention and control effort among AI/AN populations which amounts to 45 cents per capita. To further complicate the mix, CDC funding is limited to six or seven Tribal Support Centers that serve 60 of the 231 tribes in Alaska and 33 of the 335 tribes in the lower 48 states meaning that these funds only reach 16% of the AI/AN tribes in the U.S. Conventional wisdom also assumes that states provide a portion of their funding to tribes within their boundaries. The truth is that the majority of states do not provide any funding to tribes for commercial tobacco prevention and control even though AI/AN populations have the highest prevalence rates among all state populations. The National Native Network, a CDC-Office on Smoking and Health (CDC-OSH) funded initiative, found that of the 31 states who responded to questions about their funding of AI/AN tribes, only 4 states provide funding to tribes. In fact, among the 31 states who responded to the National Native Network's questions 61% (n=19) do not even have a state employee or representative designated to work with tribes in their state. Clearly, AI/AN tribes are the most under-funded population for tobacco prevention and control efforts and the high prevalence rates reflect the chronic under-funding.

Comprehensive Tobacco Control Programs

In 2000, the Surgeon General outlined a framework for reducing disease, disability, and death related to commercial tobacco use. A comprehensive approach to reducing use and initiation of commercial tobacco integrates educational, clinical, regulatory, economic and social strategies.^{xxiv} As a result of the findings of the 2000 Surgeon General's Report, CDC-Office on Smoking and Health developed a guide for states to implement comprehensive tobacco control programs, *Best Practices for Comprehensive Tobacco Control Programs*. Using empirical evidence from states and guidance from experts, *Best Practices* was updated in 2007 for use by states as a funding guide and blueprint for developing comprehensive tobacco control programs. *Best Practices* suggests that optimal programs include state and community interventions; health communication interventions; cessation interventions; surveillance and evaluation; and administration and management.

The significant reduction in smoking prevalence among mainstream Americans suggests that the states have done a terrific job in employing comprehensive tobacco control programs. However, the disparities in prevalence rates among



AI/AN population suggest that (1) either the commercial tobacco prevention and control efforts of the states did not reach this population and/or (2) the efforts did not resonate with AI/AN populations. Public health workers in tribes, tribal organizations, and the CDC funded Tribal Support Center initiative have integrated evidence based practices and cultural appropriateness in efforts to reduce tobacco prevalence rates and exposure to second hand smoke in tribal populations. This document provides summaries of some of these promising practices, grouped by the MPOWER model components. The checklist below, however, provides a list of some of the culturally appropriate strategies that tribal public health workers have integrated into their Promising Practices. Many are discussed within the context of various Promising Practices presented in this document.



- ✓ Remember that for many tribes tobacco is the most sacred medicine given to us by the Creator
- ✓ Distinguish between sacred/traditional tobacco and commercial tobacco in surveillance and monitoring tools; public health education; and public health messages
- ✓ Rather than using public health messages that speak of “tobacco addiction” use terms such as “nicotine addiction”
- ✓ Avoid any public health messaging that equates tobacco to “bad”
- ✓ Recruit elders as Champions – they are our keepers of wisdom and are highly respected in AI/AN communities
- ✓ Collect and use tribal-specific data to inform and improve commercial tobacco prevention and control efforts
- ✓ Ramp up health education messages that highlight the commercial tobacco-related adverse health effects and include tribal-specific data
- ✓ Cultivate relationships with tribal council members who understand the relationship between commercial tobacco abuse and tribal-specific chronic diseases
- ✓ Build relationships within tribal health systems that allow for integration of commercial tobacco prevention and control efforts and chronic disease programs

- ✓ **Incorporate tribal-specific terms and images and strategies**
 - ◆ **Medicine Wheel**
 - ◆ **Concept of “community”**
 - ◆ **“7th Generation” and other references to tribal longevity**
 - ◆ **Use Talking Circles for qualitative data collection**

- ✓ **Understand that the selling of commercial tobacco products may have a huge economic impact on the tribe – work with tribal enterprises to strategize for other economic venues**

- ✓ **Cultivate an Equal Partner status with the state in which the tribe resides**

- ✓ **Identify tribal leaders who can assist in enforcing commercial tobacco bans; levy fines for non-compliance; raise taxes on commercial tobacco products; and earmark commercial tobacco monies for commercial tobacco prevention and control efforts**
 - ◆ **Tribal Police**
 - ◆ **Tribal Court Judges**
 - ◆ **Directors of Revenue**
 - ◆ **Directors of Medical Systems**
 - ◆ **Tribal Attorneys General**
 - ◆ **Tribal Court Members**
 - ◆ **Tribal Chairmen/Chiefs**

Monitoring tobacco use and prevention policies

Monitoring tobacco use prevalence provides tribal governments with data that can drive policy development, implementation, and enforcement. *Best Practices for Comprehensive Control Programs* advises that

A comprehensive tobacco control program must have a system of surveillance and evaluation that can monitor and document short-term, intermediate, and long-term intervention outcomes in the population to inform program and policy direction, as well as to ensure accountability to those with fiscal oversight

In 2005 several tribal representatives, native researchers, and Tribal Support Centers suggested to CDC Office on Smoking and Health that current state or national surveys were not providing accurate or tribal-specific data that could be used to advise and inform interventions. They argued that variability in tribal customs, traditions, and morés between tribal nations required the need for tribal-specific data to assist tribal health divisions to develop and implement data-driven programs and interventions. In 2002, after discussions with AI/AN expert panels, the Tribal Support Centers Program Managers and tribal members from the Tribal Consultation Board, the Epidemiology Department of the Office on Smoking and Health provided funding to develop culturally appropriate surveys for both American Indians and Alaska Natives to be used by tribes as tribal-specific monitoring and surveillance instruments. For more information on the surveys see a list of resources at the end of this document.

During a two year period, culturally appropriate surveys – the American Indian Adult Tobacco Survey (AI ATS) and the Alaska Native Adult Tobacco Survey (AN ATS) were developed. A team of American Indians cognitively tested the surveys among several AI/AN tribes across the U.S. to ensure cultural appropriateness. Protocols were established using methods that were consistent with native methods of communication that include face-to-face interviews using community members as interviewers. An important aspect of both the AI ATS and the AN ATS is the Supplemental Section. In this section, tribes are encouraged to choose from a list of questions in the survey and/or provide questions of their own which reflect the uniqueness of the tribe. This section gathers data on environmental and personal risk factors as well as data on tribal-specific chronic diseases. A training methodology was developed for interviewer training. Also developed

was an Implementation Guide for both the AI ATS and the AN ATS. The AI ATS and AN ATS are the gold standards for surveillance and monitoring systems for AI/AN tribes. Data are tribal-specific; supplemental questions are tribal specific; protocols are based on native ways of communicating and are respectful of historical trauma regarding “research”. Thus, community members are trained to interview community members. At least one native language speaker is included in the pool of interviewers for elder respondents who may be more comfortable with their native language.

The initial fielding of the American Indian Adult Tobacco Survey occurred in 2005 and 2006. Eleven tribes participated in the implementation with the assistance of the Tribal Support Centers. The data were owned by the tribes that implemented the AI and AN ATS. Data were analyzed and findings provided back to the tribes. As a result of the findings, the Tribal Support Centers and the tribes they represented restructured programs and interventions based on empirical data. Additionally, the Tribal Support Centers shared and began working with other chronic disease divisions within their tribal health systems to address overlaps in issues.

Several tribes, working with their Tribal Support Centers, have since fielded a second AI ATS which now provides surveillance data. These data are used to determine trends, prevalence rates, and to inform and improve programs within tribal health systems both in commercial tobacco prevention and control and chronic disease prevention and control. A huge barrier to comprehensive use of the AI ATS or the AN ATS is funding. There are no funds earmarked from CDC-Office on Smoking and Health for tribes to implement these important surveillance instruments.

As a direct result of tribal-specific surveillance and monitoring data from the AI ATS interventions such as the following were implemented within tribes, some of which are described in greater detail later in this document:

- *Second Wind, First Breath*, a culturally appropriate cessation program targeting AI women of child-bearing age was developed and implemented
- Systems changes were implemented in both IHS managed and some 638 clinics that require direct providers to Ask each patient whether she/he uses commercial tobacco AND if the patient responds in the affirmative then the direct provider Assesses the level of abuse and Assists the patient via referrals, pharmacotherapy, cessation programs, and the like

- Health education and media campaigns were designed to enhance information regarding the association between commercial tobacco use and tribal-specific chronic diseases
- Health education and media campaigns were designed to enhance information regarding tribal-specific chronic diseases caused or exacerbated by exposure to second-hand smoke
- Tool kits and assessment data collection instruments were developed to provide tribal commercial tobacco prevention and control staff with evidence-based strategies to develop, implement and enforce policies, systems, and environmental changes
- Tribal-specific opinion data were used to provide tribal government reasons for implementing tribal resolutions such as commercial tobacco-free tribal housing
- Data suggesting that initiation and regular use of commercial tobacco begins significantly earlier among AI youth when compared to other U.S. populations were the impetus for developing and maintaining SWAT Teams (Students Working Against Tobacco)

The *Smoke-Free Tribal Policy Toolkit* developed by the National Native Network provides sample community readiness assessments including a general community assessment, a tribal leader assessment and a school assessment. These assessments enable tribes to collect data on tobacco policies within the community. Annual or bi-annual use of the Smoke-Free Tribal Policy Toolkit provides surveillance and monitoring data for use by tribal commercial tobacco prevention and control staff.

Protect people from tobacco smoke

The promising practice of passage of tribal resolutions/laws/policies that protect people from tobacco smoke continues to spread throughout Indian Country. Tribal commercial tobacco prevention and control staff continue to work within their communities to develop, implement and enforce such resolutions/laws/policies. Originally, it was found that the easiest policies to get passed were those on clinic and hospital campuses. Once these were passed, tribal tobacco prevention staff worked with administrators of other departments in the passage of commercial tobacco free policies in tribal governance buildings and campuses. Over 30 Alaska Native tribes and over 50 American Indian tribes have passed, implemented, and enforced such policies. Tribes include, but are not limited to:

- ◆ Blackfeet Tribe
- ◆ Bois Forte Tribe
- ◆ Catawba Tribe
- ◆ Cherokee Nation
- ◆ Cheyenne River Sioux Tribe Sault Ste. Marie Tribe of Chippewa Indians
- ◆ Chickasaw Nation Muscogee (Creek) Nation
- ◆ Chilkat Indian Village
- ◆ Ft. Peck Tribe
- ◆ Lumbee Tribe of North Carolina
- ◆ Seminole Tribe of Florida
- ◆ Nez Perce Tribe
- ◆ Oglala Sioux Osage Nation
- ◆ Saginaw Chippewa Tribe
- ◆ Sault Ste. Marie Tribe of Chippewa Indians
- ◆ Skagway Tribe

The Sault Ste. Marie Tribe of Chippewa Indians developed and implemented a smoke-free housing policy. The Tribe identified key tribal stakeholders and recruited them to become members of the Sault Tribe Tobacco Task Force. Members of the Task Force included the Sault Tribe Health Education Supervisor, the Strategic Alliance for Health Project Coordinator, a Sault Tribe community health educator who worked in the nicotine dependence program, an Inter-

tribal Council of Michigan health educator, the Sault Tribe Youth Education and Activities Coordinator, and a local health department tobacco prevention coordinator. This group led the efforts to develop and implement tobacco free policies within the tribe. Early on, the Sault Tribe Housing Authority staff was recruited, and the collaborations and partnerships led to the development and implementation of the smoke-free housing. The Sault Tribe developed an implementation manual *Facilitating Adoption of a Smoke Free Housing Policy for a Tribal Housing Authority*. The manual can be found on www.keepitsacred.org

Designating smoke-free venues for traditional native gatherings such as pow-wows and rodeos is another promising practice that is growing in Indian Country. Again, health education offered through tribal commercial tobacco prevention and control staff was the impetus for the movement creating smoke-free pow-wows. Recruitment of tribal community champions and advocates in addition to close work with tribal council members rounded out the strategies for implementing this promising practice. Smoke-free pow-wows include, but are not limited to:

- ◆ The Nez Perce Tribe in Idaho held its first completely smoke-free Pow-Wow in May, 2011 in Lewiston, Idaho.
- ◆ The Bois Forte are working to designate traditional Pow-wows “smoke-free” by 2012.
- ◆ The Haliwa-Saponi in North Carolina passed tribal resolutions declaring smoke-free pow-wows.
- ◆ The Hawkeye Indian Cultural Center in North Carolina now convenes only smoke-free pow-wows.
- ◆ The Seneca Indians of Salamanca, NY now convene smoke-free pow-wows.

A promising practice that has been slower to come to the forefront but that is gathering steam in tribes throughout the nation is passage and enforcement of commercial tobacco-free policies in tribal gaming facilities. This has not been an easy or quick task given the economic implications of gaming among American Indian tribes. Development and passage of such policies require tribal tobacco prevention and control staff work with community members in providing culturally appropriate health education in the area of the harmful health effects of second hand smoke exposure. Once the health education is provided, staff works with community members in advocacy initiatives such as coalition efforts

and media campaigns. Simultaneously, staff work with identified and willing Tribal Council members who are prepped to serve as champions of the policy initiatives. Promising Practices employed by tribes in efforts to implement smoke-free casinos include:

- Using Talking Circles to gauge community support for smoke-free casinos
- Working with casino workers in areas of
 - ⌘ Health education regarding the adverse health effects of exposure to second-hand smoke
 - ⌘ Providing cessation services for casino workers
 - ⌘ Working with tribal Gaming and Enterprise Directors to allow testing of casino air
- Using data from the AI ATS regarding opinions of tribal members regarding whether smoking should be allowed in their tribal bingo halls and gaming facilities

As of this writing, smoke-free tribal gaming facilities are:

- ◆ Glacier Peaks Casino in Browning, Montana (Blackfoot Tribe)
- ◆ Taos Mountain Casino in Taos Pueblo, New Mexico (Taos Pueblo)
- ◆ Muckleshoot Casino in Auburn, Washington (Muckleshoot Tribe)
- ◆ Lucky Bear Casino in Hoopa, California (Hoopa Valley Indian Tribe)
- ◆ Win River Casino in Redding, California (Redding Rancheria)
- ◆ 4 Bears Casino in New Town, ND (Mandan, Hidatsa, and Arikara Tribes)
- ◆ Oneida Casinos (2) in Wisconsin (Oneida Tribe)
- ◆ Turtle Mountain Chippewa Casino in Belcourt, ND (Turtle Mountain Chippewa)

Southeast Alaska Regional Health Consortium (SEARHC) has been very successful in assisting Alaska Native tribes in the southeast area of Alaska pass tobacco free policies. In 2005 SEARHC began by gathering Alaska Native tobacco use data by working with the Alaska Department of Health to over-sample Alaska Natives in their service area so that reliable data on prevalence rates and the like could be

generated. In the Sitka service area served by SEARHC, Native Alaskans lived alongside non-natives. Thus, SEARHC recruited champions and advocates who helped provide health education on adverse health effects of tobacco abuse and second hand smoke to their service population. By 2008 SEARHC staff, their champions and advocates worked with town councils and tribal councils to pass tobacco free policies in virtually every town within the Sitka service area. In addition, SEARHC worked closely with Alaska Native organizations such as the Alaska Native Brotherhood and Alaska Native Sisterhood organizations and with non-native organizations to advocate successful campaigns to pass tobacco free restaurants and other retail establishments in the towns within the Sitka service area. Advocacy, health education using reliable data, a consistent presence and message from SEARHC staff, a great partnership between SEARHC and the Alaska Department of Health and grooming of champions were the components of their successes.

As a result of the efforts of the Alaska Tribal Support Centers the following BRFSS data provide evidence of the success of their interventions.

- ◆ Significantly more ($p < .05$) Southeast Alaska Native residents do not permit smoking inside their home from 75% in 2005 to 83% in 2008
- ◆ Significantly more ($p, .05$) Southeast Alaska Natives never allow smoking in any vehicle – rates went from 70% in 2005 to 77% in 2008.

Cherokee Nation is an example of a tribe that does not have a reservation. Instead, Cherokee Nation citizens reside in a 14 county area designated as their jurisdictional service area in northeast Oklahoma alongside non-natives. As both Cherokee Nation members and non-members live, work, and play in this 14 county area, Cherokee Nation Healthy Nation Division built coalitions and partnerships with tribal, county, and state stakeholders in efforts to develop and implement commercial tobacco-free policies in common areas. Findings from the Cherokee Nation AI ATS, tribal BRFSS, state BRFSS were used to convince tribal and county officials that both the native and non-native populations preferred smoke-free parks. As a result of their efforts, four city parks are now designated as commercial tobacco-free. Cherokee Nation developed an implementation manual *Tobacco-Free Policy for City Parks: An Implementation Guide* that can be found on www.keepitsacred.org

A huge Indian Country success in protecting people from second hand smoke involves collaboration between tribes in Oklahoma and the Oklahoma

Department of Health in developing and sustaining SWAT (Students Working Against Tobacco) Teams. These are teams of youth who are trained by the state and tribes to work toward passage of 24/7 commercial tobacco-free schools, including all extra-curricular activity venues. SWAT Teams have proven to be a tour-de-force in northeast Oklahoma within the Muscogee (Creek) Nation, Cherokee Nation, and Osage Nation. Over 100 public and tribal schools have gone 24/7 commercial tobacco-free as a direct result of tribal/state collaboration using SWAT Teams.



Offer help to quit tobacco use

An important Promising Practice in Indian Country was recently de-railed as a result of funding issues. Enrolled members of federally recognized tribes typically receive their direct medical care through funding from Indian Health Service (IHS), whether through IHS managed clinics and hospitals or through tribally managed clinics and hospitals. As a direct care provider IHS has not public health component and no funds are earmarked for public health staff. CDC-OSH recognized and discussed the important symbiotic relationship between tribes and IHS with regard to health. As a result, CDC-OSH funded a position within IHS to work with the Tribal Support Centers. This position, which morphed into the IHS Tobacco Task Force, was vital in some of the collaborative successes between Tribal Support Centers and IHS. Unfortunately, funding for this position ceased in 2011.

Perhaps the most successful systems change that occurred in Indian Country was a direct result of a Promising Practice (the AI ATS). Findings from the original fielding of the AI ATS in 2005 found that IHS direct providers were not consistently asking patients whether he or she used commercial tobacco in any form. Further, if a patient were asked and responded in the affirmative, nothing was done to assist that patient in quitting. Working with the Dr. Nathaniel Cobb of IHS, Indian Health Service implemented protocols that require direct service providers to ask each patient whether he or she used commercial tobacco in any form (cigarettes, pipe, cigar, etc.). If the patient responds in the affirmative the direct provider must provide assistance to the patient in the form of pharmacotherapy; referrals to cessation programs/quit lines; and/or materials and guidance. That protocol stands currently. In addition, based on the AI ATS findings, many 638 Clinics adopted this system change. With the advent of Electronic Medical Records in tribal health systems, tribal direct service providers are now typically prohibited from moving forward until the questions about smoking habits and referrals are answered.

The Sault Ste. Marie Tribe of Chippewa Indians implemented a complete systems approach to helping their population quit abusing tobacco. Building upon the 5-As systems model used at Gundersen Lutheran Health System, the Sault Tribe worked within their Health System to create a culturally appropriate model. The Sault Tribe's Health and Human Service Program in conjunction with the Sault Tribe/IHS direct service providers, pharmacists, health educators, clinic

administrators and staff designed and implemented a 5As system in all tribal clinics.

Every patient is:

- ◆ Asked if he/she uses tobacco
- ◆ Advised to quit
- ◆ Assessed for his/her readiness to quit
- ◆ Assisted in quitting and an
- ◆ Arrangement for follow up is implemented



In conjunction with intensive cessation consultation, pharmacists provide pharmacotherapy for tobacco users. Clinics provide the venue and staff for culturally appropriate cessation consultation. Electronic medical records are designed to ensure that direct service providers cannot proceed until responses are provided for patient's tobacco use, and the like.

The Indian Health Service Tobacco Task Force (which has been de-funded) worked with American Legacy and the University of Arizona to develop a systems approach to commercial tobacco control and prevention using the 5As, *Implementing Tobacco Control into the Primary Health Care Setting*. This systems approach is akin to the systems approach implemented by the Sault Ste. Marie tribe discussed above. The curriculum can be found at http://banduraold.sbs.arizona.edu/hcp/ihs/downloads/IHS%20Fieldbook%20Final_2009.pdf. While this could prove to be a Promising Practice in Indian Country, implementation by Indian Health Service has not yet occurred. And with the de-funding of the IHS Tobacco Task Force, it is uncertain whether this intervention will be implemented.

The University of Arizona HealthCare Partnership developed *Basic Intervention Skills Certification for Native Communities*. The program consists of a Train the Trainer model for use among native communities using Best Practices and cultural appropriateness. Trainers are trained in the 5As and are provided strategies for success. This curriculum could be deemed a Promising Practice in Indian Country once funding is secured to test and evaluate the intervention in native communities.

Early on, the Tribal Support Centers recognized the link between commercial tobacco use and exposure to second-hand smoke and chronic diseases from which AI/AN populations suffer disproportionately. Even though funding tends to be in silos, the Tribal Support Centers worked within their tribal health departments to integrate commercial tobacco prevention and control into chronic disease programs. This process was slowed by the need for health education among tribal members about the link between commercial tobacco use and second-hand smoke and chronic diseases. As suggested in the Introduction of this document, findings from the AI ATS and data gathered among Alaska Natives suggested that national and state public health messages had either not reached or did not resonate with AI/AN populations. Data suggested that the association between commercial tobacco use and chronic diseases was not known or even understood among American Indians or Alaska Natives. Thus, a comprehensive health communication initiative was necessary to convince the population as well as managers of tribal public health programs of the association between commercial tobacco use and exposure to second-hand smoke and chronic diseases. As a result of the work of the early Tribal Support Centers, it is now common for tribal commercial tobacco prevention and control efforts to work closely with tribal diabetes programs, maternal and child health programs, WIC programs, asthma programs, cancer programs, and cardio-vascular programs.

Muscogee (Creek) Nation Tribal Support Center developed *Second Wind* which was an adaptation of the American Cancer Society's *Fresh Start*. *Second Wind* is a culturally appropriate cessation program with a curriculum that incorporates concepts that are important to and resonate with American Indian people. Examples of such concepts include but are not limited to: the Medicine Wheel; "community"; a holistic approach to health, wellness, and illness that differ from the western model; and a respect for tobacco as a powerful medicine for sacred or ceremonial purposes. In addition, rather than an individual cessation program, Muscogee (Creek) Nation employed their tribal-specific traditions and allowed the smoker and his/her family to attend these group sessions. It was not uncommon to see several generations of families attending *Second Wind* programs and these culturally appropriate nuances proved wildly successfully. From 2005 through 2007 *Second Wind* was evaluated for efficacy among nine tribes nationwide. Findings suggest that among traditional tribes, quit rates 12 months post program were 51%. The evaluation was replicated among three tribes in Oklahoma, all of whom are traditional tribes, and quit rates 12 months post program were 50%. Among less traditional tribes, quit rates ranged from 15% to 30% twelve months post program.

Warn about the dangers of tobacco

The first cohort of Tribal Support Centers recognized that the typical health communication messages surrounding commercial tobacco use were centered on the premise that tobacco is bad/evil/dangerous. Among tribes who use tobacco ceremonially or in sacred rituals, the notion of tobacco as bad simply did not resonate. Talking Circles conducted by the Tribal Support Centers evaluator found that American Indian tribal members simply “tuned out” when seeing or hearing such messages. Working with the Health Communications Division of CDC-OSH, new health communication campaigns were developed to warn about the dangers of (commercial) tobacco. These health messages, instead, used concepts that were culturally appropriate. A Tribal Support Center that served the Northern Plains developed a highly successful health communication campaign that centered on children and elders – both of whom are revered in AI/AN communities. Without ever stating that tobacco was bad, the messages were clear that second-hand smoke was adversely affecting the health of children and elders. “Take It Outside”, “Whatever You Say” and “Who’s Air Is This” were video graphed commercials that played on radio and television in the Northern Plains. These powerful videos were responsible for a surge in requests by American Indians in the region for Pledge Forms in which they pledged to ban smoking in their homes and cars. There was also an increase in cessation program attendance. Links to such health communications can be found at the CDC funded National Native Network’s website www.keepitsacred.org

A Tribal Support Center that served California tribes developed a health communication campaign that targeted both youth initiation and exposure to second-hand smoke in casinos. The youth campaign used videos developed by native youth for native youth. As a result of the youth campaign’s impact, a training module for tribal tobacco educators was developed that focused on initiation and use of smokeless tobacco.

The video *Nathan’s Story* was developed and disseminated to tribal tobacco programs nationwide. *Nathan’s Story* is the story of Nathan Moose, an enrolled member of the Oglala Sioux Tribe. Nathan never smoked but as a result of second-hand smoke exposure while working for 5 and a half years at an Indian Casino, developed asthma, cancer, pneumonia, and cardio-vascular disease. The video can be found on youtube at http://www.youtube.com/watch?v=K_CxohH3LFI

Conversations between tribes and state led to a very successful collaboration between the Oklahoma Tribes and the Oklahoma Department of Health. Billboards were developed that targeted AI audiences in Oklahoma using the message “Honor the Sacred Tobacco, Quit Commercial Tobacco”. Along with the message were tribal members in full regalia – the billboards featured a Cherokee citizen in the Cherokee Nation Tribal Jurisdictional Service Area; a Muscogee (Creek) citizen in the Muscogee (Creek) Tribal Jurisdictional Area, a Chickasaw citizen in the Chickasaw Nation Tribal Jurisdictional Service Area and so forth. The campaign was very successful and led to significant increases in AI citizens using cessation services and calling the state quit line.

Enforce bans on tobacco advertising, promotion and sponsorship

Big Tobacco moved swiftly into Indian Country, targeting cash poor tribes with funding for events such as Pow-Wows, rodeos, and tribal sponsored events. In addition, Big Tobacco found a willing market in smoke-shops on tribal lands (many of whom are not tribally owned but may be leased to operators by tribes). Free promotions from tobacco companies that give away cigarettes and tobacco advertising products are highly visible in Indian Country, particularly at smoke-shops and mini-markets.

Recently, tribal commercial tobacco prevention and control staff have developed protocols and strategies to thwart such efforts. Using health education, media campaigns, champions, and advocates staff have cultivated “friendly” tribal council members and recruited them to introduce legislature banning tobacco advertising, promotion and sponsorship. Tribal council members, tribal Attorneys General, tribal Revenue Directors, tribal police, tribal Health Directors, and tribal courts were also targeted as being critical partners in passage of such resolutions and policies. Programs of advocacy, health education, and long, hard discussions about the health of the tribe and the responsibility of tribal leaders provided the impetus for passage.

As a result, tribes in California, North Carolina, Oklahoma, Montana and Michigan have banned “give-aways” and promotions by tobacco companies at tribal owned venues. Working with their respective Attorneys General, Revenue Directors, Tribal Police and Tribal Councils, commercial tobacco prevention and control staff helped increase enforcement efforts and increased penalties for non-compliance.

Native SWAT Team members have also worked with their respective tribes to ensure compliance of commercial tobacco product sellers are not selling to minors. Working with tribal police, tribal state attorneys, and tribal revenue directors, Tribal Support Centers train SWAT Team members and then send them into smoke-shops with undercover tribal police. The SWAT Team members attempt to purchase commercial tobacco products – if they are successful, the owners and/or clerks of the business enterprise faces penalties. Among some of the tribes who have worked with Tribal Support Centers, the penalties for retail establishments selling commercial tobacco products to minors are heavier than those of the state in which the tribe resides.

Raise taxes on tobacco

Another promising practice involves raising tribal tobacco taxes in order to fund commercial tobacco prevention and control efforts. This, too, requires training of community members to serve as advocates, but it also involves convincing tribal Attorneys General, Tribal Council members, and tribal Revenue Directors to (a) raise taxes on commercial tobacco products sold on tribal lands and (b) earmark a portion of those taxes to fund commercial tobacco prevention and control efforts. While a slow process due to the political process of compacting with states, tribes have been successful in developing, implementing, and enforcing such policies. The issue of sovereignty plays a large role in this area and efforts by tribal commercial tobacco prevention and control staff are really just beginning in this area. Compacts between tribes and states can further complicate this component of the MPOWER model.

One example of “earmarking a portion of taxes to fund commercial tobacco efforts” can be seen with the Sault Ste. Marie Tribe of Chippewa Indians in Michigan. The Sault Tribe Community Health Education staff succeeded in appealing to their council to receive a tax portion of \$2.50 per carton of cigarettes sold, rather than the 25 cents per carton they were currently receiving, to fund their Health Education efforts toward youth education and to fund cessation medications through their pharmacy to tribal members. This in turn, raised the price of each carton sold to tribal members by \$2.25. It should be noted, that the increase in funds needed was in direct proportion to the success of a comprehensive systems approach to nicotine dependence though out their Tribal service area.

Muscogee (Creek) Nation Tobacco Prevention Program recognized that AI/AN youth initiation and regular usage begins much earlier than other populations in the U.S. As a result, decreasing youth initiation became a central focus of their program. Working with elders, community advocates, and Muscogee (Creek) Nation Health System staff, the Tobacco Prevention Program successfully lobbied tribal council members to pass a tribal resolution earmarking a percentage of tobacco sales for youth prevention services.

Conclusion

American Indian and Alaska Native tribes are disproportionately affected by adverse health effects related to commercial tobacco abuse. While national and state public health campaigns directing messages to mainstream populations is over 40 years old, public health campaigns designed by and for AI/AN populations began only about 10 years ago. Indian Health Service is the direct medical provider for AI/AN tribes but Indian Health Service has no public health component. Therefore, any public health campaigns and initiatives for tribal populations were initiated by tribes themselves.

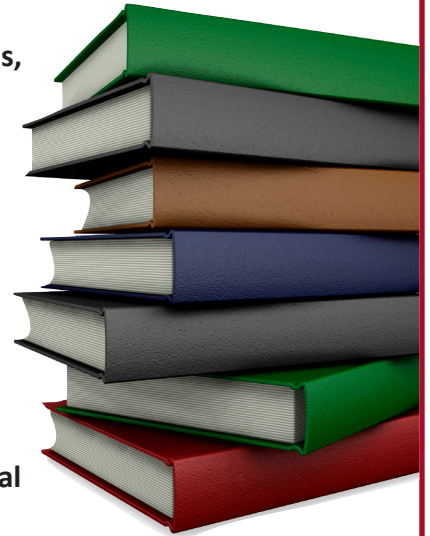
In the short span of ten years, tribal and tribal organization health staff have identified commercial tobacco use as a risk factor for all of the chronic disease from which AI/AN tribes suffer disproportionately. With scant funding and no public health capacity or infrastructure, tribes and tribal organizations looked to *Best Practices for Tobacco Control Programs* as their framework for designing Promising Practices that are both scientifically rigorous and culturally appropriate.

The authors of this document recognize that there are more Promising Practices being used by tribes and tribal organizations than those contained herein. However, this document is intended to begin the process of identifying Promising Practices in Indian Country in an effort to move these into Best Practices. Appendix A provides an exhaustive list of literature reviewed for this document. As is often the case, the majority of promising practices have never been tried among AI/AN populations, but the authors felt it important to include the list.

Finally, on the next page we offer a list of Lessons Learned from the implementation of some of the Promising Practices contained in this document.

Lessons Learned

- Depending upon the tribe, the passage of Tribal Resolutions/Laws may be a better option than implementing departmental policies
 - ❖ With administration changes and new priorities, policies are easier to abolish or disregard than are Tribal Resolutions/Laws
- Understanding and respecting Tribal Sovereignty is paramount
 - ❖ Bringing in external groups to push for tribal law change may be seen as an affront to sovereignty
- Recognize the possible pitfalls of inter-tribal historical enmities
- Be sure that your activities fall within tribal-specific laws
- Respect traditions and recognize the implications for staffing
 - ❖ Some tribes have taboos against women even uttering the word “tobacco”
- Understand the economic importance of commercial tobacco among some tribes
- Foster relationships between commercial tobacco prevention and control staff and Directors of Gaming and Business Enterprises; Tribal Court Judges; Tribal Revenue Directors; Tribal Attorneys General and the like
- Take commercial tobacco public health education and messages to tribal members – don’t wait for them to come to you. Venues to use may include
 - ❖ Pow-wows
 - ❖ Rodeos
 - ❖ Some tribal celebrations
 - ❖ Health fairs



Appendix A

Literature Reviewed

Acton, Kelly; Bullock, Ann. Smoking in American Indian and Alaska Native people with diabetes revisited. *American Journal of Public Health*. Vol.99(1), Jan 2009, pp. 4.

Adams, Karen; Paasse, Gail; Clinch, Darren. Peer-support preferences and readiness-to-change behaviour for chronic disease prevention in an urban indigenous population. *Australian Social Work*. Vol.64(1), Mar 2011, pp. 55-67.

Alderete, Ethel; Erickson, Pamela I; Kaplan, Celia P; Perez-Stable, Eliseo J. Ceremonial tobacco use in the Andes: Implications for smoking prevention among indigenous youth. *Anthropology & Medicine*. Vol.17(1), Apr 2010, pp. 27-39.

Andersen, Susan. Adding addiction to the transtheoretical model for smoking cessation. *Addictive Behaviors*. Vol.32(5), May 2007, pp. 1099-1104.

Andersen, Susan. Do indigenous helpers foster smoking cessation in adult smokers? *Addictive Behaviors*. Vol.31(8), Aug 2006, pp. 1496-1502.

Andersen, Susan. Using indigenous helpers to increase smoking cessation among adult freshstart participants. *Dissertation Abstracts International: Section B: The Sciences and Engineering*. Vol.65(3-B),2004, pp. 1242.

Baker, Amanda; Ivers, Rowena G; Bowman, Jenny; Butler, Tony; Kay-Lambkin, Frances J; Wye, Paula; Walsh, Raoul A; Pulver, Lisa Jackson; Richmond, Robyn; Belcher, Josephine; Wilhelm, Kay; Wodak, Alex. Where there's smoke, there's fire: High prevalence of smoking among some sub-populations and recommendations for intervention. *Drug and Alcohol Review*. Vol.25(1), Jan 2006, pp. 85-96.

Baezconde-Garbanati, Lourdes; Beebe, Laura A; Perez-Stable, Eliseo J. Building capacity to address tobacco-related disparities among American Indian and Hispanic/Latino communities: Conceptual and systemic considerations. *Addiction*. Vol.102(Suppl2), Oct 2007, pp. 112-122.

Barondess, David A; Meyer, Emily M; Boinapally, Prashanthi M; Fairman, Brian; Anthony, James C. Epidemiological evidence on count processes in the formation of tobacco dependence. *Nicotine & Tobacco Research*. Vol.12(7), Jul 2010, pp. 734-741.

Barondess DA, Meyer EM, Boinapally PM, Fairman B, Anthony JC. Epidemiological evidence on count processes in the formation of tobacco dependence. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. *Nicotine Tob Res*. 2010 Jul;12(7):734-41. Epub 2010 May 27.

Boyle, Terry; Shepherd, Carrington C. J; Pearson, Glenn; Monteiro, Heather; McAullay, Daniel; Economo, Kristina; Stewart, Susan. Awareness and impact of the 'Bubblewrap' advertising campaign among Aboriginal smokers in Western Australia. *Tobacco Control: An International Journal*. Vol.19(1), 2010, pp. 83-86.

Burgess, Diana; Fu, Steven S; Joseph, Anne M; Hatsukami, Dorothy K; Solomon, Jody; van Ryn, Michelle. Beliefs and experiences regarding smoking cessation among American Indians. *Nicotine & Tobacco Research*. Vol.9(Suppl 1), Jan 2007, pp. S19-S28.

Cantrell, Betty A. Geishirt; Hodge, Felicia S; Struthers, Roxanne; Decora, Lorelei H. The High Incidence of Cigarette Smoking Among American Indians of the Northern Plains. *Journal of Cancer Education*. Vol.20(1, Suppl), Fal 2005, pp. 97-100.

Chateau-Degat ML, Dewailly E, Louchini R, Counil E, Noel M, Ferland A, Lucas M, Valera B, Ekoe JM, Ladouceur R, Dery S, Egeland G. Cardiovascular burden and related risk factors among Nunavik (Quebec) Inuit: insights from baseline findings in the circumpolar Inuit health in transition cohort study. *The Canadian journal of cardiology*. Can J Cardiol. 2010 Jun-Jul;26(6):190-6.

Chew, Fiona; Palmer, Sushma. Establishing an Internet-based tobacco-control network for Czech health professionals. *Health Promotion Practice*. Vol.6(1), Jan 2005, pp. 109-116.

Choi WS, Faseru B, Beebe LA, Greiner AK, Yeh HW, Shireman TI, Talawyma M, Cully L, Kaur B, Daley CM. Culturally-tailored smoking cessation for American Indians: study protocol for a randomized controlled trial. *Trials*. 2011 May 18;12:126.

Cory S, Ussery-Hall A, Griffin-Blake S, Easton A, Vigeant J, Balluz L, Garvin W, Greenlund K. Prevalence of selected risk behaviors and chronic diseases and conditions—steps communities, United States, 2006–2007. *MMWR. Surveillance summaries : Morbidity and mortality weekly report. Surveillance summaries / CDC. MMWR Surveill Summ*. 2010 Sep 24;59(8):1-37.

Cox LS, Okuyemi K, Choi WS, Ahluwalia JS. A review of tobacco use treatments in U.S. ethnic minority populations. *American journal of health promotion : AJHP. Am J Health Promot*. 2011 May-Jun;25(5 Suppl):S11-30.

Daley, Christine M; Faseru, Babalola; Nazir, Niaman; Solomon, Cheree; Greiner, K. Allen; Ahluwalia, Jasjit S; Choi, Won S. Influence of traditional tobacco use on smoking cessation among American Indians. *Addiction*. Vol.106(5), May 2011, pp. 1003-1009.

Daley CM, Faseru B, Nazir N, Solomon C, Greiner KA, Ahluwalia JS, Choi WS. Influence of traditional tobacco use on smoking cessation among American Indians. *Addiction (Abingdon, England)*. *Addiction*. 2011 May;106(5):1003-9. doi: 10.1111/j.1360-0443.2011.03391.x.

Daley CM, Greiner KA, Nazir N, Daley SM, Solomon CL, Braiuca SL, Smith TE, Choi WS. All Nations Breath of Life: using community-based participatory research to address health disparities in cigarette smoking among American Indians. *Ethnicity & disease*. *Ethn Dis*. 2010 Autumn;20(4):334-8.

Davis KC, Nonnemaker JM, Asfaw HA, Vallone DM. Racial/ethnic differences in perceived smoking prevalence: evidence from a national survey of teens. *International journal of environmental research and public health*. *Int J Environ Res Public Health*. 2010 Dec;7(12):4152-68. Epub 2010 Dec 2.

Doolan, Daniel M; Froelicher, Erika Sivarajan. Efficacy of Smoking Cessation Intervention Among Special Populations: Review of the Literature From 2000 to 2005. *Nursing Research*. Vol.55(4, Suppl), Jul-Aug 2006, pp. S29-S37.

D'Silva J; Schillo BA, Sandman NR, et al. *Evaluation of a tailored approach for tobacco dependence treatment for American Indians*. *American Journal of Health Promotion*. Vol 25(5, Suppl), May-Jun 2011, pp S66-S69.

D'Silva J, Schillo BA, Leonard TL, Boyle RG. Evaluation of a tailored approach for tobacco dependence treatment for American Indians. *American journal of health promotion : AJHP*. Am J Health Promot. 2011 May-Jun;25(5 Suppl):S66-9.

Eichner JE, Wang W, Zhang Y, Lee ET, Welty TK. Tobacco use and cardiovascular disease among American Indians: the strong heart study. *International journal of environmental research and public health*. Int J Environ Res Public Health. 2010 Oct;7(10):3816-30. Epub 2010 Oct 25.

Elton-Marshall T, Leatherdale ST, Burkhalter R. Tobacco, alcohol and illicit drug use among Aboriginal youth living off-reserve: results from the Youth Smoking Survey. *CMAJ : Canadian Medical Association journal*. CMAJ. 2011 May 17;183(8):E480-6. Epub 2011 May 9.

Faseru B, Daley CM, Gajewski B, Pacheco CM, Choi WS. A longitudinal study of tobacco use among American Indian and Alaska Native tribal college students. *BMC public health*. BMC Public Health. 2010 Oct 18;10:617.

Forster, Jean L; Rhodes, Kristine L; Poupart, John; Baker, Lannesse O; Davey, Cynthia. Patterns of tobacco use in a sample of American Indians in Minneapolis-St. Paul. *Nicotine & Tobacco Research*. Vol.9(Suppl 1), Jan 2007, pp. S29-S37.

Fu, Steven S; Burgess, Diana J; van Ryn, Michelle; Rhodes, Kris; Widome, Rachel; Ricards, Jennifer J; Noorbaloochi, Siamak; Clothier, Barbara; Su, Jennifer; Joseph, Anne M. Smoking-cessation strategies for American Indians: Should smoking-cessation treatment include a prescription for a complete home smoking ban? *American Journal of Preventive Medicine*. Vol.39(6, Suppl 1), Dec 2010, pp. S56-S65.

Fu, Steven S; Burgess, Diana; van Ryn, Michelle; Hatsukami, Dorothy K; Solomon, Jody; Joseph, Anne M. Views on smoking cessation methods in ethnic minority communities: A qualitative investigation. *Preventive Medicine: An International Journal Devoted to Practice and Theory*. Vol.44(3), Mar 2007, pp. 235-240.

Fu SS, Burgess DJ, van Ryn M, Rhodes K, Widome R, Ricards JJ, Noorbaloochi S, Clothier B, Su J, Joseph AM. Smoking-cessation strategies for American Indians: should smoking-cessation treatment include a prescription for a complete home smoking ban?. *American journal of preventive medicine*. Am J Prev Med. 2010 Dec;39(6 Suppl 1):S56-65.

Glover, Marewa. Analysing Smoking using Te Whare Tapa Wha. *New Zealand Journal of Psychology*. Vol.34(1), Mar 2005, pp. 13-19.

Glover, Marewa. Descriptions of Depression among a Sample of Maori Smokers. *New Zealand Journal of Psychology*. Vol.34(1), Mar 2005, pp. 4-12.

Gould GS, McEwen A, Munn J. *Jumping the hurdles for smoking cessation in pregnant Aboriginal and Torres Strait Islander women in Australia*. Journal of Smoking Cessation. Vol 6(1), 2011, pp 33-36.

Groth-Marnat, Gary; Leslie, Simon; Renneker, Mark. Tobacco control in a traditional Fijian village: Indigenous methods of smoking cessation and relapse prevention. Social Science & Medicine. Vol.43(4), Aug 1996, pp. 473-477.

Gryczynski, Jan; Feldman, Robert; Carter-Pokras, Olivia; Kanamori, Mariano; Chen, Lu; Roth, Susan Contexts of tobacco use and perspectives on smoking cessation among a sample of urban American Indians. Journal of Health Care for the Poor and Underserved. Vol.21(2), May 2010, p. 544-558.

Gryczynski J, Feldman R, Carter-Pokras O, Kanamori M, Chen L, Roth S. Contexts of tobacco use and perspectives on smoking cessation among a sample of urban American Indians. Journal of health care for the poor and underserved. J Health Care Poor Underserved. 2010;21(2):544-58.

Haring, Rodney C. Describing the process of meaningful change: Seneca stories of becoming smoke free. Dissertation Abstracts International Section A: Humanities and Social Sciences. Vol.68(5-A),2007, pp. 2171.

Harwell, Todd S; Gohdes, Dorothy; Moore, Kelly; McDowall, Janet M; Smilie, Jane G; Helgerson, Steven D. Cardiovascular disease and risk factors in Montana American Indians and non-Indians. American Journal of Preventive Medicine. Vol.20(3), Apr 2001, pp. 196-201.

Heaman, Maureen I; Chalmers, Karen. Prevalence and correlates of smoking during pregnancy: A comparison of aboriginal and non-aboriginal women in Manitoba. Birth: Issues in Perinatal Care. Vol.32(4), Dec 2005, pp. 299-305.

Heavyrunner-Rioux AR, Hollist DR. Community, family, and peer influences on alcohol, marijuana, and illicit drug use among a sample of Native American youth: an analysis of predictive factors. Journal of ethnicity in substance abuse. J Ethn Subst Abuse. 2010;9(4):260-83.

Hebert, Richard. What's new in Nicotine & Tobacco Research? Nicotine & Tobacco Research. Vol.9 (Suppl 1), Jan 2007, pp. S1-S5.

Hodge F, Nandy K. Factors associated with American Indian cigarette smoking in rural settings. International journal of environmental research and public health. Int J Environ Res Public Health. 2011 Apr;8(4):944-54. Epub 2011 Mar 30.

Hodge, Felicia Schanche; Casken, John. Characteristics of American Indian women cigarette smokers: Prevalence and cessation status. Health Care for Women International. Vol.20(5), Sep-Oct 1999, pp. 455-469.

Hodge, Felicia Schanche; Kipnis, Patricia. Demoralization: A useful concept for case management with Native Americans. Manoleas, Peter [Ed]. (1996). The cross-cultural practice of clinical case management in mental health. (pp. 79-98). xv, 255 pp.

Hollis, Jack F; Polen, Michael R; Lichtenstein, Edward; Whitlock, Evelyn P. Tobacco Use Patterns and Attitudes Among Teens Being Seen for Routine Primary Care. *American Journal of Health Promotion*. Vol.17(4), Mar-Apr 2003, pp. 231-239.

Holm JE, Vogeltanz-Holm N, Poltavski D, McDonald L. Assessing health status, behavioral risks, and health disparities in American Indians living on the northern plains of the U.S. *Public health reports (Washington, D.C. : 1974)*. Public Health Rep. 2010 Jan-Feb;125(1):68-78.

Horn, Kimberly; McCracken, Lyn; Dino, Geri; Brayboy, Missy. Applying community-based participatory research principles to the development of a smoking-cessation program for American Indian teens: "Telling our story" *Health Education & Behavior*. Vol.35(1), Feb 2008, pp. 44-69.

Hyland, Andrew; Higbee, Cheryl; Li, Qiang; Bauer, Joseph E; Giovino, Gary A; Alford, Terry; Cummings, K. Michael. Access to Low-Taxed Cigarettes Deters Smoking Cessation Attempts. *American Journal of Public Health*. Vol.95(6), Jun 2005, pp. 994-995.

Ivers, Rowena G. An evidence-based approach to planning tobacco interventions for Aboriginal people. *Drug and Alcohol Review*. Vol.23(1), Mar 2004, pp. 5-9.

Johnson, Carolyn C; Myers, Leann; Webber, Larry S; Boris, Neil W. Profiles of the adolescent smoker: Models of tobacco use among 9th grade high school students Acadiana Coalition of Teens against Tobacco (ACTT). *Preventive Medicine: An International Journal Devoted to Practice and Theory*. Vol.39(3), Sep 2004, pp. 551-558.

Johnson, Karen M; Lando, Harry A; Schmid, Linda S; Solberg, Leif I. The GAINS project: Outcome of smoking cessation strategies in four urban Native American clinics. *Addictive Behaviors*. Vol.22(2), Mar-Apr 1997, pp. 207-218.

Kegler, Michelle C; Malcoe, Lorraine Halinka. Anti-smoking socialization beliefs among rural Native American and White parents of young children. *Health Education Research*. Vol.20(2), Apr 2005, pp. 175-184

Kent KC, Zwolak RM, Egorova NN, Riles TS, Manganaro A, Moskowitz AJ, Gelijns AC, Greco G. Analysis of risk factors for abdominal aortic aneurysm in a cohort of more than 3 million individuals. *Journal of vascular surgery : official publication, the Society for Vascular Surgery [and] International Society for Cardiovascular Surgery, North American Chapter*. *J Vasc Surg*. 2010 Sep;52(3):539-48. Epub 2010 Jul 13.

Kerby, Dave S; Brand, Michael W; John, Robert. Anger types and the use of cigarettes and smokeless tobacco among Native American adolescents. *Preventive Medicine: An International Journal Devoted to Practice and Theory*. Vol.37(5), Nov 2003, pp. 485-491.

King, Teresa K; Borrelli, Belinda; Black, Carolyn; Pinto, Bernardine M; Marcus, Bess H. Minority women and tobacco: Implications for smoking cessation interventions. *Annals of Behavioral Medicine*. Vol.19(3), Sum 1997, pp. 301-313.

Kuhnley R, Cueva M. Learning About Cancer Has Brightened My Light: Cancer Education for Alaska Community Health Aides and Community Health Practitioners (CHA/Ps). *Journal of cancer education : the official journal of the American Association for Cancer Education*. J Cancer Educ. 2011 Sep;26(3):522-9.

Lawrence, Deirdre; Graber, Jessica E; Mills, Sherry L; Meissner, Helen I; Warnecke, Richard. Smoking cessation interventions in U.S. racial/ethnic minority populations: an assessment of the literature. *Preventive Medicine: An International Journal Devoted to Practice and Theory*. Vol.36(2), Feb 2003, pp. 204-216.

Lowe, John B; Saeck, Lynette; Brough, Mark; Carmont, Sue-Anne; Clavarino, Alexandra; Stanton, Warren; Balanda, Kevin; Shannon, Cindy. Smoking behaviour among Indigenous secondary school students in North Queensland. *Drug and Alcohol Review*. Vol.23(1), Mar 2004, pp. 101-106.

Maddison, Ralph; Roberts, Vaughan; Bullen, Chris; McRobbie, Hayden; Jiang, Yannan; Prapavessis, Harry; Glover, Marewa; Taylor, Sue; Brown, Paul. Design and conduct of a pragmatic randomized controlled trial to enhance smoking-cessation outcomes with exercise: The Fit2Quit study.

Maple-Brown LJ, Cunningham J, Nandi N, Hodge A, O'Dea K. Fibrinogen and associated risk factors in a high-risk population: urban Indigenous Australians, the DRUID Study. *Cardiovascular diabetology*. Cardiovasc Diabetol. 2010 Oct 29;9:69.

May, Philip A. The health status of Indian children: Problems and prevention in early life. *American Indian and Alaska Native Mental Health Research*. Vol.1(Mono 1), 1988, pp. 244-283.

Morton, Deborah J; Garrett, Mario; Reid, Jennifer; Wingard, Deborah L. Current smoking and type 2 diabetes among patients in selected Indian Health Service clinics, 1998-2003. *American Journal of Public Health*. Vol.98(3), Mar 2008, pp. 560-565.

Packer, Marie M; Kaur, Judith S; Hodge, Felicia S; Nan, Bin; Trapp, Mary A; Roubidoux, Marilyn A. A Survey of Attendees at Native American Health Care Conferences: Knowledge, Attitudes, and Practices about Cigarette Smoking. *Journal of Cancer Education*. Vol.20(2), Sum 2005, pp. 89-95.

Redwood D, Lanier AP, Renner C, Smith J, Tom-Orme L, Slattery ML. Differences in cigarette and smokeless tobacco use among American Indian and Alaska Native people living in Alaska and the Southwest United States. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*. Nicotine Tob Res. 2010 Jul;12(7):791-6. Epub 2010 Jun 4.

Reed, Mark B; Burns, David M. A population-based examination of racial and ethnic differences in receiving physicians' advice to quit smoking. *Nicotine & Tobacco Research*. Vol.10(9), Sep 2008, pp. 1487-1494.

Reid JL, Morton DJ, Wingard DL, Garrett MD, von Muhlen D, Slymen D, Field M. Sex and age differences in the association of obesity and smoking with hypertension and type 2 diabetes in Southern California American Indians, 2002-2006. *Ethnicity & disease*. Ethn Dis. 2010 Summer;20(3):231-8.

Resnicow, Ken; Futterman, Robert; Weston, Raymond Eric; Royce, Jacqueline; Smoking prevalence in Harlem, New York. et al. American Journal of Health Promotion. Vol.10(5), May-Jun 1996, pp. 343-346.

Rew L, Horner SD, Brown A. Health-risk behaviors in early adolescence. Issues in comprehensive pediatric nursing. Issues Compr Pediatr Nurs. 2011;34(2):79-96.

Robinson, Robert G; Holliday, Rhonda Conerly. Braithwaite, Ronald L [Ed]; Taylor, Sandra E [Ed]; Treadwell, Henrie M [Ed]. (2009). Tobacco use and the black community in the United States: A community-focused public health model for eliminating population disparities. Health issues in the Black community (3rd ed.). (pp. 379-416). xxxvi, 620 pp. San Francisco, CA, US: Jossey-Bass; US.

Robles, Gisela I; Singh-Franco, Devada; Ghin, Hoytin Lee. A review of the efficacy of smoking-cessation pharmacotherapies in nonwhite populations. Clinical Therapeutics: The International Peer-Reviewed Journal of Drug Therapy. Vol.30(5), May 2008, pp. 800-812.

Shavers, Vickie L; Lawrence, Deirdre; Fagan, Pebbles; Gibson, James T. Racial/ethnic variation in cigarette smoking among the civilian US population by occupation and industry, TUS-CPS 1998-1999. Preventive Medicine: An International Journal Devoted to Practice and Theory. Vol.41(2), Aug 2005, pp. 597-606.

Svien LR, Senne SA, Rasmussen C. South Dakota accidental childhood deaths, 2000-2007: what can we do?. South Dakota medicine : the journal of the South Dakota State Medical Association. S D Med. 2010 May;63(5):163-5, 167-9, 171-3.

Teo, Koon K; Ounpuu, Stephanie; Hawken, Steven; Pandey, M. R; Valentin, Vicent; Hunt, David; Diaz, Rafael; Rashed, Wafa; Freeman, Rosario; Jiang, Lixin; Zhang, Xiaofei; Yusuf, Salim. Tobacco use and risk of myocardial infarction in 52 countries in the INTERHEART study: A case-control study. The Lancet. Vol.368(9536), Aug 2006, pp. 647-658.

Thomas JL, Renner CC, Patten CA, Decker PA, Utermohle CJ, Ebbert JO. Prevalence and correlates of tobacco use among middle and high school students in western Alaska. International journal of circumpolar health. Int J Circumpolar Health. 2010 Apr;69(2):168-80. Epub 2010 Apr 12.

Thompson-Evans TP, Glover MP, Walker N. *Cytisine's Potential to be used as a traditional healing method to help indigenous people stop smoking: a qualitative study with Maori*. Nicotine & Tobacco Research. Vol 13(5), May 2011, pp 353-360.

Tran, Sarah-Truclinh T; Rosenberg, Kenneth D; Carlson, Nichole E Racial/ethnic disparities in the receipt of smoking cessation interventions during prenatal care. Maternal and Child Health Journal. Vol.14(6), Nov 2010, pp. 901-909.

Trinidad, Dennis R; Perez-Stable, Eliseo J; Messer, Karen; White, Martha M; Pierce, John P. Menthol cigarettes and smoking cessation among racial/ethnic groups in the United States. Addiction. Vol.105(Suppl 1), Dec 2010, pp. 84-94.

Trinidad DR, Perez-Stable EJ, Messer K, White MM, Pierce JP. Menthol cigarettes and smoking cessation among racial/ethnic groups in the United States. *Addiction* (Abingdon, England). *Addiction*. 2010 Dec;105 Suppl 1:84-94. doi: 10.1111/j.1360-0443.2010.03187.x.

Ubina EC, Van Sell SL, Arnold C, Woods S. *Best Practices Guidelines for nurse practitioners regarding smoking cessation in American Indian and Alaska Native Youth*. *Family & Community Health; The Journal of Health Motion & Maintenance*, Vol 34(3), Jul-Sep 2011, pp 266-274.

Ubina EC, Van Sell SL, Arnold C, Woods S. Best practices guidelines for nurse practitioners regarding smoking cessation in American Indian and Alaskan Native youth. *Family & community health*. . *Fam Community Health*. 2011 Jul-Sep;34(3):266-74.

Unger, Jennifer B; Shakib, Sohaila; Cruz, Tess Boley; Hoffman, Beth R; Pitney, Beth Howard; Rohrbach, Louise Ann. Smoking Behavior Among Urban and Rural Native American Adolescents in California. *American Journal of Preventive Medicine*. Vol.25(3), Oct 2003, pp. 251-254.

Varcoe C, Bottorff JL, Carey J, Sullivan D, Williams W. Wisdom and influence of elders: possibilities for health promotion and decreasing tobacco exposure in First Nations communities. *Canadian journal of public health*. *Can J Public Health*. 2010 Mar-Apr;101(2):154-8

Walsh, Margaret M; Hilton, Joan F; Ernster, Virginia L; Masouredis, Claudia M; Prevalence, patterns, and correlates of spit tobacco use in a college athlete population. et al. *Addictive Behaviors*. Vol.19(4), Jul-Aug 1994, pp. 411-427.

Wardman, Dennis; Quantz, Darryl; Tootoosis, Janet; Khan, Nadia. Tobacco cessation drug therapy among Canada's aboriginal people. *Nicotine & Tobacco Research*. Vol.9(5), May 2007, pp. 607-611.

Willows N, Veugelers P, Raine K, Kuhle S. Associations between household food insecurity and health outcomes in the Aboriginal population (excluding reserves). *Health reports / Statistics Canada, Canadian Centre for Health Information*. *Health Rep*. 2011 Jun;22(2):15-20.

Wilson, K, Rosenberg MW, Abonyi S, Lovelace R. Aging and health: an examination of differences between older Aboriginal and non-Aboriginal people. *Canadian journal on aging*. *Can J Aging*. 2010 Sep;29(3):369-82. Wood, Lisa; France, Kathryn; Hunt, Kerry; Eades, Sandra; Slack-Smith, Linda. Indigenous women and smoking during pregnancy: Knowledge, cultural contexts and barriers to cessation. *Social Science & Medicine*. Vol.66(11), Jun 2008, pp. 2378-2389.

Xueqin Ma, Grace [Ed]; Henderson, George [Ed]. *Ethnicity and substance abuse: Prevention and Intervention*. (2002). *Ethnicity and substance abuse: Prevention and intervention*. xviii, 335 pp.

Resources

1. The National Native Network. www.keepitsacred.org; Contact: Kim Alford, Program Manager, Inter Tribal Council of Michigan, Inc., 2956 Ashmun St., Suite A, Sault Ste Marie, MI 49783 906-632-6896 kalford@itcmi.org
2. JCW Research & Evaluation Group, Inc., Contact: Janis Weber, 1291 N US Highway 1, Suite 7, Ormond Beach, FL 32176 Phone: 386-441-4592 janis@jcwevaluation.com
3. CDC-Office on Smoking and Health, Atlanta, GA. Contact: Stacy Thorne, Phone: 770-488-5366 sthorne@cdc.gov

Current Tribal Support Centers

Northern Plains Tribal Tobacco Technical Assistance Center Program Manager
Northern Plains Health Promotion Programs
Great Plains Tribal Chairmen's Health Board
Vanessa Tibbitts, Program Manager
1770 Rand Road
Rapid City, SD 57702
(605) 721-1922 Ext. 121
vanessa.tibbitts@gptchb.org

Muscogee(Creek)Nation
Division Of Health
Arlene Davis, Program Manager
121 W. Broadway
Okemah, OK 74859
918-623-1189
arlene.davis@creekhealth.org

Cherokee Nation, Healthy Nations
Tobacco Prevention Project
June Maher, Program Manager
886 Markoma Circle
Tahlequah, OK 74464
(918) 453-5617
June-maher@cherokee.org

Inter-Tribal Council of Michigan, Inc.
Deana Knauff, Program Manager
2956 Ashmun St.
Sault Ste. Marie, MI 49783
(906) 632-6896
deanak@itcmi.org

Southeast Alaska Regional Health Consortium (SEARHC)
Andrea Thomas, Program Manager
222 Tongass Drive
Sitka, AK 99835
(907)96-8883
Andrea.thomas@searhc.org

Tanana Chiefs Conference
Shannon Sommer, Program Manager
122 First Avenue, Suite 600
Fairbanks, Alaska 99701
(907) 452-85251
Shannon.Sommer@tananachiefs.org

Nez Perce Tribe
Students for Success Program
Jean Ann Moose, Tobacco Coordinator
116 Veterans Ave
Lapwai, Idaho 83540
(208) 843-7303 x 4612
jeanm@nezperce.org

Black Hills Center for American Indian Health (BHCAIH)
Peter Nez, Program Manager
1302 E Third St
Winslow, AZ 86047
(928) 289-6483
pfnez@bhcaih.org

- ⁱ Centers for Disease Control and Prevention. Vital Signs: Current Cigarette Smoking Among Adults Aged > 18 Years --- United States, 2005-2010. *MMWR* 2011;60(35):1207-1212.
- ⁱⁱ Centers for Disease Control and Prevention. Vital Signs: Current Cigarette Smoking Among Adults Aged > 18 Years --- United States, 2005-2010. *MMWR* 2011;60(35):1207-1212.
- ⁱⁱⁱ Henderson, P, Jacobsen, C, Beals, J. Correlates of Cigarette Smoking Among Selected Southwest and Northern Plains Tribal Groups: the AI-SUPERPPF Study. *American Journal of Public Health*. 2005 May; 95(5): 867-872.
- ^{iv} American Indian Adult Tobacco Surveys. Unpublished Data from 2005 – 2011.
- ^v Alaska Division of Public Health, Department of Health and Social Services. 2002. Alaska Tobacco Facts.
- ^{vi} American Indian Adult Tobacco Survey Implementation Manual. Janis Weber and Stacy Thorne (Eds). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.
- ^{vii} Federal Communications Commission. Federal Subscribership on American Indian Reservations & Off-Reservation Trust Lands. 2003. Washington D.C.
- ^{viii} Henderson, P, Kanekar, S, Wen, Y et al. Patterns of Cigarette Smoking Initiation in Two Culturally Distinct American Indian Tribes. *American Journal of Public Health*. 2009, November; 99(22) 2020-2026.
- ^{ix} Caraballo, R, Yee, S, Gfroerer, J, et al. Tobacco Use Among Racial and Ethnic Subgroups of Adolescents in the United States. *Preventing Chronic Disease*. April 2006; 3(2)3-17.
- ^x American Indian Adult Tobacco Surveys. Unpublished Data from 2005 – 2011.
- ^{xi} Centers for Disease Control and Prevention. Tobacco, Alcohol, & Other Drug Use among High School Students in BIA funded schools, United States, 2001. *MMWR* 2003; 52(44):1070-1075.
- ^{xii} Department of Health & Human Services. Indian Health Service. Trends in Indian Health 2002-2003. Washington DC.
- ^{xiii} CDC 2005. Health Characteristics of the American Indian and Alaska Native Adult Population: United States, 1999-2003. *Advance Data* (356), Table 4. <http://www.cdc.gov/nchs/data/ad/ad356.pdf>
- ^{xiv} Jemal, A et al. Annual Report to the Nation on the Status of Cancer, 1975-2005, Featuring Trends in Lung Cancer, Tobacco Use, and Tobacco Control. *Journal of the National Cancer Institute*. December, 2008; 100(23):1672-1694.
- ^{xv} National Center for Health Statistics. 2008. Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set. *National Vital Statistics Reports* 57(2).
- ^{xvi} Singleton, R, Holman, R, Cobb, N et al. Asthma Hospitalizations Among American Indian and Alaska Native People and the General US Population. *Chest*. 2006; 130:1554-1562.
- ^{xvii} National Center for Health Statistics. 2008. Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set. *National Vital Statistics Reports* 57(2).
- ^{xviii} National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.
- ^{xix} Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation*. Washington, DC: National Academies Press: 2007.
- ^{xx} Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation*. Washington, DC: National Academies Press: 2007.
- ^{xxi} http://www.cdc.gov/tobacco/tobacco_control_programs/ntcp/index.htm
- ^{xxii} <http://oag.ca.gov/tobacco/resources/msasumm>
- ^{xxiii} Centers for Disease Control and Prevention. State Tobacco Revenues Compared with Tobacco Control Appropriations, 1998-2010. *MMWR* 2012; 61(20):370-374.

^{xxiv} U.S. Department of Health and Human Services. *Reducing Tobacco Use: 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; 2000.

^{xxv} Oberly, J and Macedo, J. The R Word in Indian Country: Culturally Appropriate Commercial Tobacco-Use Research Strategies. *Health Promot Pract* October 2004 vol. 5 no. 4 355-361

