

THE ALASKA NATIVE COMMUNITY EVALUATION PROJECT

AN EQUITY LENS REVIEW OF TOBACCO PREVENTION & CONTROL IN ALASKA

State of Alaska

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The Alaska Native Community Evaluation Project: An Equity Lens Review of Tobacco Prevention and Control in Alaska

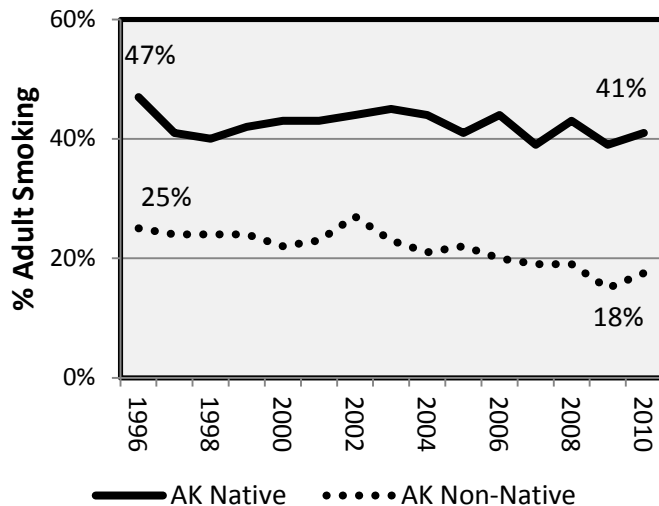
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Executive summary of process and findings

The Alaska Native Community Evaluation Project - Solving the puzzle of how to decrease tobacco-related disparities

This project was sponsored by the Alaska Tobacco Prevention and Control Program. We are grateful for the active participation of Dr. Gary Ferguson, Laura Muller, Caroline Nevak, Andrea Thomas, Tiffany Tutiakoff, Pat Reynaga, Jenny Olenorff, Dana Diehl, Larry Kairaiuak, Andrea Fenaughty, Alex Hicks, Lauren Kelsey. Additional insights were provided by Alaska Native and community-based tobacco control staff at the Alaska Tobacco Control Alliance (ATCA) Tobacco Control Summit held May 2012, Nome, AK.



Source: Alaska BRFSS, 1998-2010

The Puzzle

Great reductions have been seen in tobacco use rates among Alaska's youth and the general population of adults. Unfortunately, similar rates of tobacco use decline have not been seen yet among Alaska Native adults. This project's goal is to create understanding about why these disparities persist and to provide recommendations that result in the *most effective* community-based tobacco control programs for all communities.

Assembling the Pieces

A team of Alaska Native and tobacco control experts has been working for about a year to assess the reach and other dimensions of effectiveness of tobacco control efforts intended to serve Alaska Native people and communities. Examples of questions this group has considered include:

- How have "best practice" tobacco control approaches been tailored to serve Alaska Native people?
- Are efforts reaching Alaska Native people & communities? (all communities covered?)
- Have some community-based programs been more successful than others?
- Have other states successfully supported tribal tobacco control programs?
- Are smoking trends different for Alaska Native people in urban-hub-rural communities?
- What are examples of successful community-level work to change social norms in Alaska Native communities? How can we share "what works"?

To answer these and other questions, the group examined data or information from a variety of sources, identified areas where more information was needed, and contributed perspectives from their experiences about what's working differently in Alaska Native communities or could be improved.

The Picture Emerges

Examples of project findings include:

- ❖ We need more standardized information about local-level activities overall

- ❖ We need to develop and share more detailed stories about successful tobacco control efforts in Alaska Native communities (and there are stories out there!)
- ❖ There are some ways we can improve state surveys to more appropriately capture information from Alaska Native people and community-level efforts
- ❖ People working in tobacco control – perhaps especially in rural areas – need more general support, information about Alaska Native culture, and help with appropriately engaging Alaska Native leaders in their efforts.

Final Recommendations

Some of the issues identified as potentially contributing to the puzzle of continued high tobacco use rates in Alaska Native communities are already being addressed by a variety of partners, including LEAD and ATCA. In June 2012, the advisory team met and identified highest-priority strategies for additional effort:

1. **Provide more support to create relationships among regional partners, share stories of successful approaches, and mentoring of new staff.** (*leadership on this strategy: TPC*)
 Changing some meeting structures, grantee guidance, and allowing for mentoring of staff as a grantee activity may help to address the frequent staff turnover in Alaska Native/rural communities, low or varied skillsets among new or existing staff, and need for more day-to-day support, and more relationship-building to successfully engage Alaska Native people and communities within the Tobacco Control community.
2. **Assure materials, toolkits, training & support are useful, or identify needed adaptation, for use in smaller, rural, and Alaska Native communities.** (*leadership on this strategy: TPC*)
 Existing tools and support strategies should be reviewed, and new ones developed with the expectation that their usefulness and relevance for Alaska Native communities will be considered. Sometimes, tailored tools may need to be provided. For example, model tribal policies for use in small tribes may need to be shorter and simpler than they currently are to be appropriate for the simpler legal structures of those organizations.
3. **Build more infrastructure and momentum for engaging Alaska Native leaders, including from small communities:** (*leadership on this strategy: LEAD & ATCA*)
 Continue to test and evaluate strategies and messaging to engage more new partners and leaders in small villages, including by reaching them through non-traditional (not specifically health-related) statewide or regional Alaska Native leadership groups.

Monitoring Progress Forward

The advisory team agreed to report progress on the above priorities quarterly at standing Tobacco Control Stakeholder meetings (where a variety of partners already convene), and to meet on an annual basis specifically to review new data and determine whether the disparities puzzle is being solved.

For more Information

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Purpose

This report tells the story of the “Alaska Native Community Evaluation Project” (also known as “the puzzle project”), which was supported by the Alaska Tobacco Prevention and Control Program during 2010-2012. This report summarizes the process and findings of that project to provide a record for future reference. This report identifies issues that were addressed programmatically, which may be examined in the future for their effectiveness, and also identifies some issues or opportunities for further work that were not yet addressed, but which could be addressed in the future.

History of concern about tobacco burden among Alaska Native people

The tobacco prevention and control (TPC) program in Alaska has long identified tobacco use among Alaska Native people as an important problem. Reducing tobacco use (cigarettes and smokeless tobacco) among Alaska Native adults and youth specifically were identified as goals for “Healthy Alaskans 2010.”¹ Detailed information about the high prevalence of tobacco use among Alaska Native people was formally documented in a report describing the specific burden of tobacco use in the state in 2004.²

The TPC program was implemented with sufficient funding to reach statewide and community populations in 1997 following a state tax increase, and in 1999 following initial payments from the national Master Settlement Agreement between states’ Attorneys General and the Tobacco Industry.³ Since that time, some specific interventions or approaches have been funded with the intent of specifically reaching Alaska Native people:

- Some media materials were developed with sensitivity to Alaska Native populations (posters and campaigns that included Alaska Native images or people).
- A TPC Disparities-focused strategic plan was developed in 2007, and a workgroup was convened as part of this plan to identify and provide coordination around Alaska Native issues in tobacco control.
- The statewide Tobacco Control coalition organized their leadership structure to assure Alaska Native representation by creating an Alaska Native Tobacco Advisory Group (ANTAG). ANTAG included four Alaska Native representatives appointed by the Alaska Native Health Board. This group’s purpose was to keep Tobacco as a priority in Alaska Native organizations, as well as to bring an Alaska Native perspective to Tobacco Control.

By the mid-2000s, the state had begun to report on statistically significant declines in tobacco use (specifically, cigarette smoking) within the adult general population. Similar declines were not observed among Alaska Native adults. Smoking rates remained twice as high among Alaska Native vs. non-Native adults, and smokeless tobacco use rates were three times higher for Alaska Native vs. non-Native adults. This continued disparity led to a few additional specific projects to enhance efforts to reach Alaska Native communities with tobacco control:

- In 2007, a detailed analysis of tobacco use and related factors among Alaska Native people alone, using three different statewide public health surveillance datasets, provided some additional guidance for program planning.⁴

- In 2007-09, a study of quit rates and satisfaction with services among callers to the Alaska Tobacco Quit Line showed that Alaska Native tobacco users were less likely than non-Natives to call the Quit Line, and that those who did call were less likely than non-Natives to quit successfully.⁵
- In 2008-09, a series of regional interviews was conducted with more than 50 people in Alaska Native and rural communities. The goal of these interviews was to find information that could be used to improve the Quit Line and services. This assessment resulted in development and application of a training curriculum for Quit Line phone counselors (and an associated report) in 2010.
- In 2010, a re-analysis of the regional interview data, additional key informant interviews with several leaders, and critical review of the evidence base for tobacco control interventions were conducted and results summarized in a report “Viewing Tobacco Prevention through a Cultural Lens: Moving Forward with Rural Alaska Native Communities” (June 2010). The primary conclusions of this report were: the TPC program should seek input from the Alaska Native community to inform adaptation of evidence-based tobacco interventions; based on knowledge of Alaska Native culture, need for capacity building and a longer time period before changes in prevalence should be expected are important considerations in design of a program; and more information is needed to effectively incorporate cultural values, practices and traditional approaches with rural Alaska Native communities.

Evolution of the “Community Project”

These previous efforts to understand or address the continued disparity in tobacco use for Alaska Native adults provided some guidance, but not a satisfactory solution, given the importance and magnitude of the problem. Feedback from some stakeholders was that “this program doesn’t work for Alaska Native people.”

In 2009-10, the TPC program considered implementing a focused pilot study in a remote Alaska Native village, or additional interviews, to gather additional information. However, what became apparent in early planning discussions was that more information was not needed as much as better consideration of the information that was already available. In fact, a preliminary scan of program reach suggested that many Alaska Native communities had not been exposed to programs because the current programs did not reach rural settings in a meaningful way.

In 2010, based on findings to date, the “Community Project” was initiated with the purpose of answering these specific questions:

To what extent have best practices been implemented to serve Alaska Native adults?

and

How can we provide *the most effective* community-based tobacco control programs in all communities?

Answers to this question should provide information to inform state-level program design, and also local-level program application (for example, how do “best practices” translate to an Alaska Native village setting? How can “smokefree policy” work occur when there is only one public building in a community?)

What was new about this project, in contrast to past efforts, was:

- a comprehensive, systematic assessment of the TPC program, with dedicated attention to assessing capacity (particularly at the state program or systems within the state program’s control such as surveillance and grant programs), reach of existing efforts within Alaska Native communities, and efficacy of those existing efforts among those who were reached; and
- engagement of a stakeholder advisory group in the systematic review and development of programmatic recommendations.

The project was led by the TPC Evaluation Manager, with intensive support from external evaluation staff, who were contracted with the program.

Engaging stakeholders

Several different groups were engaged at multiple time periods to review findings, plan for further investigation, or translate findings to practice and program design recommendations:

a. Advisory Team

To meet the needs of the project, we wanted to bring together people with multiple perspectives who were experts in tobacco control efforts and/or Alaska Native communities. We identified people who were already working in a leadership role within Alaska’s state tobacco control efforts, and who had experience with supporting Alaska Native communities in tobacco control as potential advisory members. These primarily included current members of the Alaska Tobacco Control Alliance (ATCA), including the ATCA co-chairs and members of ATCA who are part of the specific Alaska Native Tobacco Advisory Group (ANTAG), the Alaska Native Health Board (ANHB), Alaska Native Tribal Health Consortium (ANTHC), and also key staff members from within the State of Alaska Tobacco Prevention and Control (TPC) Program (particularly the Program Manager, staff working to support community-based programs and the staff lead for the disparities strategic plan).

The Advisory team met to review data and develop recommendations between April 2011- June 2012. Meetings among individual members and sharing of documents by email also occurred between meetings:

- April 2011: 3 hour meeting, overview of initial assessment findings and existing data
- October 2011: 2.5 hour meeting, update on BRFSS analysis findings, feedback on report synthesizing interview data to describe Alaska Native culture and tobacco control
- March 2012: 2 x 2 hour meetings, discussed initial recommendations and a dissemination plan

- June 2012: 3 hour meeting finalized recommendations and developed a strategy for accountability to the Advisory group moving forward.
- b. TPC staff and partners
TPC staff and key contractors were engaged through the advisory board, and a broader group of staff were also engaged through program-specific briefings about the project and findings.
- c. ATCA discussion groups
During May 2012, as recommendations for the project were being crafted by the Advisory Team, two hour-long discussion groups were held during an ATCA meeting held in Nome. The groups were attended by 53 people, primarily attended by Alaska Native community stakeholders.

Framework for comprehensive assessment

As guiding principles for the project, we assumed that:

- There is more than one reason we haven't seen changes in smoking/tobacco use among Alaska Native adults – so there is not likely to be a “silver bullet” or single solution for this problem
- “Best Practices” work – but “how” they work may be different in different communities
- Recommendations from this study may be useful to a variety of partners across Alaska, including but not limited to the TPC program.

We described the different types of information being reviewed as “a puzzle” of different assessments, with cross-connecting factors, that when fitted together gradually reveal a clearer picture of what is happening. The assessments – sometimes called “puzzle pieces A through H” – included gathering information to answer the following questions:

- A. *How have Comprehensive TPC Program components been tailored to serve Alaska communities and Alaska Native people?*
- B. *What is the reach and quality of community-based programs in Alaska?*
- C. *What are community-based programs doing to reach Alaska Native/American Indian people?*
- D. *Can we measure success of community-based tobacco control programs? (when success occurs)*
- E. *Are smoking trends different in rural areas, or among different groups of Alaska Native people?*
- F. *What does research say is effective in serving Alaska Native people with tobacco control?*
- G. *What are social norms around tobacco in Alaska villages, and how do social norms change?*
- H. *What does successful community-level work to change social norms look like?*

Detailed approaches and findings from each assessment are described in the next section. The final recommendations were shared with the TPC Program and through meetings with external stakeholder groups throughout the state.

The recommendations were non-binding; however the Advisory Team agreed that evaluation staff supporting the project would continue to brief stakeholders on a quarterly basis at standing quarterly TPC stakeholder meetings (routinely attended by many of the Advisory Team). These briefings would

include information about how recommendations were being put into practice by the TPC, and any evaluation or results from changes in practice.

“Puzzle Piece” approaches and findings

A. Describing current program design: *How have Comprehensive TPC Program components been tailored to serve Alaska communities and Alaska Native people?*

What we studied

We examined different components of the state TPC program (and other major tobacco control efforts in Alaska), and described how they have been tailored to serve Alaska Native and rural communities. In general, we expect that the Best Practice approaches upon which the TPC program is built are effective, and that adaptation assures they will reach specific populations

- LEAD initiative continues to advise program and grantees on specific strategies to engage Alaska Native leaders and strategic partnerships with Alaska Native leadership groups, especially in policy work
- State and local media campaigns/materials feature Alaska Native people and contexts (settings, values, systems, resources)
- Quit Line (QL) staff received cultural competency training by the QL contractor on Alaska Native (AN) culture and better serving AN callers
- Community, school and cessation grantee programs have tailored efforts for local populations (including Alaska Native populations)
- ATCA has a 4-member Alaska Native Technical Advisory Group as part of the executive committee; positions are filled by appointment of Alaska Native leaders.
- Grantees have sought additional funds to extend efforts in Alaska Native communities (such as Tribal Support Center Grants, Community Transformation Grants)

What we learned

Some TPC program components (in the state program) have been tailored or use strategies to specifically reach Alaska Native people, but it is not always clear what the effectiveness of these approaches have been.

Many grantees are tribal organizations, which may suggest capacity to effectively serve Alaska Native people:

- Nearly half of community grants are held by ANHB member organizations (10 of 21 grantees) and approximately two-thirds of the funded organizations work primarily in rural areas that may have high proportions of Alaska Native community members (15 of 21 grantees)
- Nine organizations are funded for cessation, of which 7 are ANHB member organizations.
- The cessation technical assistance contract is co-led by ANTHC.

Previous studies of the Quit Line suggested the QL was less effective at serving Alaska Native callers. Provider-based outreach is another way to potentially serve Alaska Native people, but this may also have relatively less reach in Alaska Native community/rural areas.

- In Alaska, for 2007-08 approximately 60% of smokers saw a healthcare provider. In that same time period, Alaska Native smokers were significantly less likely to see a provider than non-Natives (51% vs. 64%). This suggests provider-delivered cessation may have less reach among Alaska Native people.

What we recommended

- More data/evaluation support for LEAD efforts, creating capacity for influencing program design
- Evaluation of Quit Line service improvement for Alaska Native people (or RFP/identify new funding for supplemental approaches to deliver Quit Line or other modification to QL services?)
- Other thoughts on upcoming (FY14) community-based grantee RFP content
 - Require participation in training modules, TA
 - Incentivizing ATCA membership/action
 - Include travel to regional meetings
- Test/evaluate media promotion of Quit Line in rural/AN communities
- Collaborate and continue to create strategic partnerships with tribal health systems and leaders to take advantage of opportunities as new grants become available/are awarded in chronic disease prevention
 - Creating more liaisons with AN leaders was a recommendation of the National Association of Chronic Disease Directors (NACDD) following a site assessment and interview in Alaska during February 2012
- Package & promote resources across partners, make it easier to access – resources about understanding Alaska Native culture and communities in this context, but this applies to other issues too

B. Describing current program reach: *What is the reach and quality of community-based programs in Alaska?*

What we studied

We reviewed and summarized program coverage and activities from FY10-FY11 TPC grantee workplans and reports to determine whether Alaska Native communities were less likely to be covered (by grantee programs, policies). To a limited extent, we linked Alaska Department of Commerce, Community, and Economic Development (DCCED) database of community demographic characteristics with grantee reports of plans/activities.

What we learned

Most Alaska communities are covered by some TPC grantee programming (estimate 60% of communities) – but fewer Alaska Native than non-Native people overall are covered (estimated only about 75% of Alaska Native people in Alaska vs. 85% of all Alaska residents).

We had difficulty summarizing grantee coverage, strategies, activities and the effectiveness or quality of implementation based on available reporting systems. There are multiple systems in place to track

grantee activities, policies resulting (potentially) from grantee activities, but these are not linked in a way that supports easy, consistent access to information and evaluation of efforts.

What we recommended

Build a community-level database or grantee activity reporting system to more easily support summarization of which communities have been “covered” by community, cessation and school grantees, and the current status of tobacco-related policies (clean indoor air, taxes, other policies). Use to describe which communities are reached/covered by programs and policies, and evaluate progress.

Specific procedures recommended to improve measures of reach:

- Include required “community inventory” in next funding solicitation, to systematically collect relevant information at the community level (e.g., number of tobacco retailers, number of public venues with and without smokefree policies)
- Revise grantee workplans to better measure geographic reach (ex. including a denominator), priority population groups served, consider a menu based workplan tied to outcomes of interest
- Revise reporting tools to be clearly tied to workplans, including more measureable milestones around outcomes of interest
- Implement effective data collection and management systems (consider web-based reporting)
- Create clear expectations for engaging Alaska Native members and organizations in coalitions (with support for how to reach, engage)

Work to engage “uncovered” communities (North Slope?) where smoking is high and there are a high proportion of Alaska Native people.

- Broaden “who can receive” grants beyond health corporations (cities, other organizations)
- Provide smaller, capacity-building grants (including to develop infrastructure like technology)

Specific recommendations to improve measures of quality of general program capacity:

Add summary of grantee expectations (what is prescribed, what is promoted, what is provided to support and train new/ongoing staff at state or local level, esp with regard to Alaska Native community interventions support)

- Do all grantees know about ATCA, and their role in ATCA?
- Recognize the barrier of travel for rural grantees (in training, ATCA participation)

Develop a training protocol for state/local staff, potentially using different multi-layered approaches (cooperative learning, online trainings with confirmatory tests such as CITI modules

www.citiprogram.org). Potential training topics could include:

- ATCA 101 – what is ATCA and why is it relevant to you?
- Alaska Native culture 101 – see “puzzle piece F”
- “90-day recap” for new grantee staff

Develop a tool for describing regional / local coalition strength

- Unique members
- Info disseminated from trainings
- Linkage to ATCA
- Alaska Native representation

Expand evaluation of local activities to also focus on evaluation support for LEAD, ATCA, Mission 100, and other activities (beyond grant programs).

Have resources consistently available to grow and support basic community-based staff capacity, due to high turnover or low capacity in rural settings. Use regional meetings to create a “support team” and foster peer-to-peer “mentoring” of new staff or grantees – build a “baseline capacity assessment” that includes identifying needs for basic skills like computer literacy, as well as basic tobacco control skills or other public health competencies. Maybe assign a state person to support each regional team. Include LEAD, ATCA steering committee members and other regional players.

C. Describing current program activities’ effectiveness: *What are community-based programs doing to reach Alaska Native/American Indian people?*

What we studied

In part B we examined reach and quality of base program capacity in communities; this item describes whether the activities that reached communities were equally effective for Alaska Native people – or what are “best practices” in Alaska Native communities specifically. We examined other states’ “activity menu” for Tribal community programs (Washington and Oregon) to identify models which were well-received and perceived to be effective.

What we learned

Without good information about what community-level grantees were doing overall (see discussion in Part B), it was impossible to determine what specifically they were doing to tailor efforts to reach Alaska Native people.

Many grantees are doing a variety of activities. Although some may appear to be not evidence-based (such as buying sweatshirts), if they are linked to strategic goals they could still be very effective at changing social norms around tobacco use.

Washington and Oregon have used a “best practices” menu-based list of activities that communities can choose from, and allow Tribal communities to adapt “how” they do these activities, while keeping a focus on the evidence-based strategic direction (for example, price increases or smokefree policies). In a Tribal community context, for example, buying sweatshirts – while not effective in a general community setting – might be an effective component of a campaign to raise awareness and support for a Tribal smokefree policy.

What we recommended

See Part B recommendations.

Anticipating key strategies that may be feasible to implement in Tribal settings, make things easy to use in a Tribal setting. For example, provide specific model tribal policies (such as for workplace, youth access, etc.) that can also be used to score the quality of existing tribal policies, so that “best practice” community strategies can be applicable in a Tribal community setting.

Include data elements in the TPC grantee reporting systems specific to Alaska Native communities and activities specific to Alaska Native cultures. Specifically evaluate the effectiveness of Tribal-focused efforts in communities, after development of more consistent reporting systems.

D. Describing capacity to evaluate progress: *Can we measure success of community-based tobacco control programs? (when success occurs)*

What we studied

We reviewed available data collection systems to determine whether there were any measures to effectively capture social norms/behaviors for a variety of communities, and whether all survey measures are appropriate for Alaska Native community members specifically.

What we learned

TPC evaluation staff advocated with CDC to revise BRFSS “core questions” on smokeless tobacco to include specific iq’mik measures beginning in 2012. Also, iq’mik responses were added to the state YRBS in 2013.

There were not good “upstream” indicators to describe community norms around tobacco in Alaska. Evaluation staff with the TPC worked to develop better measures of the social norms around tobacco that would be applicable in rural Alaska Native settings. These included questions about observations of tobacco use and support for rules banning tobacco use in schools, clinics and hospitals (three community venues common in many small village and hub communities), and perceived smoking prevalence in communities. These questions were added to the 2011 Behavioral Risk Factor Surveillance System (BRFSS) for Alaska and data were available for preliminary analysis in mid-2012.

Potential measures for community-based surveillance of environmental measures exist (policy inventories, price measures, other quantifiable measures associated with community, cessation and school grantee efforts), but none are systematically collected.

What we recommended

Potentially, develop new BRFSS measures to assess level of individual affiliation with rural Alaska Native communities/culture (to identify Alaska Native people in urban settings who are closely connected to Alaska Native culture, and identify differences from those not closely connected to culture).

Build more community-level environmental measures (perhaps for inventory/tracking by future local grantees) to track progress at the community level:

- Price tracking

- Availability of tobacco
- Other quantifiable measures?

E. Identifying Alaska Native subgroup differences: *Are smoking trends different in rural areas, or among different groups of Alaska Native people?*

What we studied

We analyzed existing surveillance data (adult data) to more specifically learn about different tobacco use patterns and associated attitudes among Alaska Native people.

What we learned

Three formal papers were published based on exploratory studies. Findings are summarized below.

Discovering unique tobacco use patterns among Alaska Native people.¹

BACKGROUND: Alaska Native people are disproportionately impacted by tobacco-related diseases in comparison to non-Native Alaskans.

DESIGN:

We used Alaska's Behavioral Risk Factor Surveillance System (BRFSS) to describe tobacco use among more than 4,100 Alaska Native adults, stratified by geographic region and demographic groups.

RESULTS:

Overall tobacco use was high: approximately 2 out of every 5 Alaska Native adults reported smoking cigarettes (41.2%) and 1 in 10 reported using smokeless tobacco (SLT, 12.3%). A small percentage overall (4.8%) reported using iq'mik, an SLT variant unique to Alaska Native people. When examined by geographic region, cigarette smoking was highest in remote geographic regions; SLT use was highest in the southwest region of the state. Use of iq'mik was primarily confined to a specific area of the state; further analysis showed that 1 in 3 women currently used iq'mik in this region.

CONCLUSION:

Our results suggest that different types of tobacco use are highly endemic among diverse Alaska Native communities. Our results also illustrate that detailed analysis within racial/ethnic groups can be useful for public health program planning to reduce health disparities.

Tobacco use prevalence – disentangling associations between Alaska Native race, low socio-economic status and rural disparities.²

BACKGROUND:

¹ Dilley JA, Peterson E, Hiratsuka VY, Rohde K. Discovering unique tobacco use patterns among Alaska Native people. Int J Circumpolar Health. 2013. Full text article available at <http://www.ncbi.nlm.nih.gov/pubmed/23971010>

² Dilley JA, Peterson E, Bobo M, Pickle KE, Rohde K. Tobacco use prevalence – disentangling associations between Alaska Native race, low socio-economic status, and rural disparities. Int J Circumpolar Health. 2013. Full text article available at <http://www.ncbi.nlm.nih.gov/pubmed/23967410>

Tobacco use rates are exceptionally high among indigenous people in North America. Alaska Native, low socio-economic status (SES) and rural communities are high-priority populations for Alaska's Tobacco Control program.

DESIGN:

For the purpose of better informing tobacco control interventions, we conducted a descriptive study to describe high-priority groups using prevalence-based and proportion-based approaches.

METHODS:

With data from 22,311 adults interviewed for Alaska's 2006-2010 Behavioral Risk Factor Surveillance System (BRFSS), we used stratified analysis and logistic regression models to describe the current use of cigarettes and smokeless tobacco (SLT) (including iq'mik, a unique AlaskaNative SLT product) among the 3 populations of interest.

RESULTS:

"Population segments" were created with combinations of responses for Alaska Native race, SES and community type. We identified the highest prevalence and highest proportion of tobacco users for each type of tobacco by "segment". For cigarette smoking, while the largest proportion (nearly one-third) of the state's smokers are non-Native, high SES and live in urban settings, this group also has lower smoking prevalence than most other groups. Alaska Native, low SES, rural residents had both high smoking prevalence (48%) and represented a large proportion of the state's smokers (nearly 10%). Patterns were similar for SLT, with non-Native high-SES urban residents making up the largest proportion of users despite lower prevalence, and Alaska Native, low SES, rural residents having high prevalence and making up a large proportion of users. For iq'mik use, Alaska Native people in rural settings were both the highest prevalence and proportion of users.

CONCLUSION:

While Alaska Native race, low SES status and community of residence can be considered alone when developing tobacco control interventions, creating "population segments" based on combinations of factors may be helpful for tailoring effective tobacco control strategies and messaging. Other countries or states may use a similar approach for describing and prioritizing populations.

Smoking-related knowledge, attitudes and behaviors among Alaska Native people: a population-based study.³

BACKGROUND:

Several studies have shown that Alaska Native people have higher smoking prevalence than non-Natives. However, no population-based studies have explored whether smoking-related knowledge, attitudes, and behaviors also differ among Alaska Native people and non-Natives.

OBJECTIVE:

We compared current smoking prevalence and smoking-related knowledge, attitudes, and behavior of Alaska Native adults living in the state of Alaska with non-Natives.

³ Rohde K, Boles M, Bushore CJ, Pizacani BA, Maher JE, Peterson E. Smoking-related knowledge, attitudes and behaviors among Alaska Native people: a population-based study. 2013. Full text article available at <http://www.ncbi.nlm.nih.gov/pubmed/23984275>

METHODS:

We used Alaska Behavioral Risk Factor Surveillance System data for 1996 to 2010 to compare smoking prevalence, consumption, and cessation- and second-hand smoke-related knowledge, attitudes, and behaviors among self-identified Alaska Native people and non-Natives.

RESULTS:

Current smoking prevalence was 41% (95% CI: 37.9%-44.4%) among Alaska Native people compared with 17.1% (95% CI: 15.9%-18.4%) among non-Natives. Among current every day smokers, Alaska Natives were much more likely to smoke less than 10 cigarettes per day (OR = 5.0, 95% CI: 2.6-9.6) than non-Natives. Compared with non-Native smokers, Alaska Native smokers were as likely to have made a past year quit attempt (OR = 1.4, 95% CI: 0.9-2.1), but the attempt was less likely to be successful (OR = 0.5, 95% CI: 0.2- 0.9). Among current smokers, Alaska Natives were more likely to believe second-hand smoke (SHS) was very harmful (OR = 4.5, 95% CI: 2.8-7.2), to believe that smoking should not be allowed in indoor work areas (OR = 1.9, 95% CI: 1.1-3.1) or in restaurants (OR = 4.2, 95% CI: 2.5-6.9), to have a home smoking ban (OR = 2.5, 95% CI: 1.6-3.9), and to have no home exposure to SHS in the past 30 days (OR = 2.3, 95% CI: 1.5-3.6) than non-Natives.

CONCLUSION:

Although a disparity in current smoking exists, Alaska Native people have smoking-related knowledge, attitudes, and behaviors that are encouraging for reducing the burden of smoking in this population. Programs should support efforts to promote cessation, prevent relapse, and establish smoke-free environments.

What we recommended

The detailed analyses conducted showed that (1) Alaska Native people have relatively positive knowledge and attitudes about tobacco control; (2) tobacco use is especially high in some regions of the state, particularly Iqmik in the Southwest region and cigarette smoking in the North Slope and interior regions; (3) tobacco type, gender, and SES were all considerations in identifying Alaska Native populations at risk.

It may be useful to monitor trends in a variety of indicators (including knowledge, awareness, and also prevalence in high-risk subgroups) to identify subtle patterns of change not detected when examining only state-level prevalence of tobacco use among Alaska Native people. This could help to identify early progress.

Next steps could include analysis of existing surveillance data (including new YRBS data) to summarize trends in tobacco use among Alaska Native vs. non-Native people in different communities, including contrasting trends in “covered” communities (part B) with “uncovered” communities.

New analysis of BRFSS “community norms measures” data (from Part D above) may reveal differences in social norms measures for urban/rural communities & a descriptive report on Alaska Native/low SES/Urban-Rural associations (for example, to describe “urban Natives”)

F. Identifying model programs: *What does research say is effective in serving Alaska Native people with tobacco control?*

What we studied

We wanted to describe the research base for successful interventions in Alaska Native communities, both in tobacco control and *other than* tobacco control. Specifically, we were interested in wellness or holistic health interventions vs. topic-specific interventions. We examined published studies and “gray literature” to identify reports of successful approaches.

What we learned

A substantial amount of literature exists that documents the problem of tobacco use within the Alaska Native/American Indian population and provides guidance on how to approach public health interventions within the Alaska Native/American Indian community.^{4 5 6 7} Unfortunately, there is almost no literature on strategies that have been successful in reducing smoking prevalence within the Alaska Native/American Indian population. Many studies that did report success were isolated reports, and did not include representation from Alaska Native communities (most often, studies reported on interventions conducted in American Indian communities of the “lower 48.”)

In the TPC report *What State Surveys Tell Us About Tobacco Use Among Alaska Natives: Implications for Program Planning*, which was published in 2007, an extensive literature review was conducted to identify any published research available to describe effective tobacco control interventions for Alaska Native people. Several key themes were identified:

- Very little research was available to describe Alaska Native-specific interventions
- There was little if any historical use of tobacco in Alaska Native communities prior to introduction by European explorers in the 1700-1800s
- A unique smokeless tobacco variant called “Iqmik” is well-entrenched in some Southwest Alaska Native cultures
- Tobacco is culturally embedded in some ways, such as sharing at a potlatch
- Some cultures avoid “telling someone what to do” and this extends even to childrearing, where young people are taught by example
- There have been documented barriers to providing mental health and other counseling in some Alaska Native cultures, in addition to geographic and healthcare access barriers, which are substantial, and lack of trust in counselors who do not come from the community or culture). Western-style counseling that strictly adheres to “clock time,” is delivered at a fast pace, and in a directive style, may be very ineffective.

⁴ Oberly J, Macedo J. The R word in Indian country: Culturally appropriate commercial tobacco-use research strategies. *Health Promot Pract.* 2004;5:355-361

⁵ Chino M, Debruyne L. Building true capacity: indigenous models for indigenous communities. *Am J Public Health.* 2006;96:596-599.

⁶ Warne D. Research and educational approaches to reducing health disparities among American Indians and Alaska Natives. *J Transcult Nurs.* 2006;17:266-271.

⁷ Unger JB, Soto C, Thomas N. Translation of health programs for American Indians in the United States. *Eval Health Prof.* 2008;31:124-44.

Since that original literature review, some additional studies have been published specific to Alaska Native communities and health, although many describe health problems rather than successful interventions.

Two studies in Southwest Alaska reported on lack of effectiveness of culturally-based tobacco interventions with pregnant women⁸ and adolescents⁹ Several studies have reported on new genetic research indicating that Alaska Native people (especially Yupik people) are differentially vulnerable to physical addiction and cancer outcomes.¹⁰

One study showed benefit from clinical reminders to implement preventive screenings in a Tribal clinic primary care setting (Kodiak Area Native Association – screenings for tobacco use, intimate partner violence, alcohol use, depression and cardiovascular risk).¹¹

What we recommended

A more extensive review of literature may be useful, including updating on a routine basis (perhaps every two years). Additionally, publishing results of the TPC program in successful (or unsuccessful) support of Alaska Native communities may generate discussion with other groups that have similar interests.

G. Understanding how communities work: *What are social norms around tobacco in Alaska villages, and how do social norms change?*

What we studied

Originally, the project concept included a plan for conducting interviews with Alaska Native community residents and leaders to identify and better understand Alaska Native culture and community structures relevant tobacco control, and opportunities for community-level action. However, upon further review, information collected during a previous interview project conducted by Alaska TPC staff contained much of the information that was desired. Rather than begin a new interview series, a new analysis of the existing interview data was conducted. A comprehensive report titled *Strengthening Tobacco Control in Alaska Native Communities and Cultures* was developed based on the synthesis of interviews.

What we learned

We confirmed that there are multiple factors in the context of Alaska communities, Alaska Native culture and Alaska Native community structures that are valuable to consider when planning tobacco prevention and control programs.

The Alaskan context is unique and factors in planning community-based programs

⁸ Patten CA. Tobacco cessation intervention during pregnancy among Alaska Native women. J Cancer Educ. 2012;27 Suppl1:S86-90.

⁹ Patten CA, Fadahunsi O, Hanza MM, Smith CA, Decker PA, Boyer R, Ellsworth L, Brockman TA, Hughest CA, Bronars CA, Offord KP. Tobacco cessation treatment for Alaska Native adolescents: a group randomized pilot trial. Nicotine Tob Res. 2014;16(6):836-45.

¹⁰ For example: Binnington MJ, Zhu AZ, Renner CC, Lanier AP, Hatsukami DK, Benowitz NL, Tyndale RF. CYP2A6 and CYP2B6 genetic variation and its association with nicotine metabolism in South Western Alaska Native people. Pharmacogenetic Genomics. 2012;22(6):429-40.

¹¹ Onders R, Spillane J, Reilley B, Leston J. Use of electronic clinical reminders to increase preventive screenings in a primary care setting: blueprint for a successful process in Kodiak, Alaska. J Prim Care Community Health. 2014;5(1):50-4.

- Alaska is different than the “lower 48”
- Alaska’s regions are different from one another
- Rural Alaskan communities are isolated and independent

Alaska Native people have strong cultural values relevant to program plans or services

- Family, extended family and future generations are highly important
- Introductions and names are important
- Communication style matters
- Knowledge, skills and values are taught by demonstration (not lecture)

Alaska Native community structures are relevant to tobacco control plans and programs

- Tobacco use is acceptable in some communities or contexts
- Substance use threatens traditional activities and values
- Competing health and wellness issues exist, particularly alcohol use
- Communities are struggling to retain culture in changing times
- Communities and their members are highly independent and skeptical of “outsiders”
- Communities value prevention above cessation
- Technical, lifestyle and cultural factors are barriers to telephone-based services (such as the Quit Line)
- Non-tribal or government-sponsored efforts are suspect
- Local capacity-building takes sustained time and effort
- Small communities aren’t set up to implement programs categorically
- Reporting systems may not effectively capture successes

Cultural or community factors are potential strengths in tobacco control

- Elders are powerful community leaders
- There is universal support for youth development
- Tobacco control can be relevant to cultural or community practices
- Communities can think holistically
- Capitalize on unacceptable tobacco use in some communities or contexts
- Tobacco control can be implemented in a culturally responsive way.

People working to serve Alaska Native and rural communities with interventions for tobacco prevention, or to support quitting and reducing exposure to secondhand smoke, should consider these findings. Respectful inclusion of Alaska Native partners in program planning and implementation will help to assure that these and other factors are addressed so that programs are culturally relevant and effective.

What we recommended

For Alaska Native stakeholders, none of this was new information. However, the advisory team agreed that having this information collected and formally documented was validating and could provide a

sustainable resource for educating new partners working in Alaska tobacco control. We recommend having the report – or some version of the information included in the report – available for new staff or partners in Alaska tobacco control, to provide grounding in important context, culture and community factors.

H. Understanding how communities change: *What does successful community-level work to change social norms look like?*

What we studied

We worked to document the story of what happened in a few communities that successfully implemented social sector policy or systems change in rural Alaska. We wanted to identify “tipping points” that get community leaders energized about policy or norms changes or “key ingredients for success” to share with other communities.

What we learned

We documented two case studies of successful tobacco control efforts in Alaska Native communities: the Southeast Regional Health Corporation (SEARHC) and Aleutian Pribilof Islands Association (APIA) – see appendices for copies of these detailed stories. In both cases, programs were consistent with “best practice” approaches, with consideration for community culture, values and structure.

What we recommended

Further documentation of “success stories” in Alaska Native communities could provide concrete examples, foster discussion and illustrate “Alaska Native best practices” and especially effective methods for engaging community leaders.

What were the immediate benefits of the project?

The project itself did not reduce prevalence in tobacco use among Alaska Native people, but it was valuable in improving the capacity of the TPC program to support interventions in Alaska Native communities that may be expected to reduce prevalence in the long term.

Some results of the project had positive unintended consequence for the broader TPC program. For example, the process of reviewing grantee reports to summarize information about activities in the Alaska Native community revealed that significant improvements were needed in the grantee reporting system more generally to allow for any systematic analysis of activities and performance (such as grantee coverage or reach). The improvements made will generate ability to better monitor activities in priority populations (Alaska Native and other populations), as well as general populations.

The following is a listing of specific improvements in TPC program performance and service for the Alaska Native population that were made during the period of the project. These are both direct and indirect results of the project – some may not be entirely attributable to the project, but were perhaps catalyzed by the project. Other improvements applied could have happened entirely without the stakeholder engagement and discussion.

Improve sensitivity and cultural competence of state surveillance system measures

- Modified BRFSS and YRBS questions to more appropriately capture Alaska Native tobacco use (iq'mik)
- Added “community norms” measures that reflect the context of tobacco use in a village or hub settings, which may be more relevant to measuring progress in tobacco control for these largely Alaska Native communities.

Redesign programs to support staff in smaller community settings

- Re-organizing community-based grants program (and RFP) to provide more peer support and integrated efforts, increase focus on disparities
- Re-organizing state staff deployment to support “regional” collaborative approaches

High-level commitment to ongoing efforts in serving the Alaska Native community

- Commitment to Alaska Native community policy change in Section-level Strategic Plan at DHSS
- Committed to routine reporting to stakeholders at TPC Quarterly Stakeholder meeting (benchmark & evaluation reports from new reporting systems).

Improved monitoring of program reach and performance

- Created a clearer “menu” of strategies for tobacco control in progress in Alaska
- Re-designing community grant reporting systems to better track local efforts, including in rural areas.
- Linking community grant reporting to community-level demographic information, to provide more understanding of reach/gaps in effort

Additional investigation to improve understanding of contributors to disparities in tobacco use

- Additional study of associations between SES, urban/rural, and Alaska Native race.

Final recommendations

A long version of recommendations abstracted from specific reviews (described previously) was considered by the Advisory team in March 2012. In May 2012, preliminary recommendations were presented and discussed (including with incorporation of additional information) among Alaska Native community stakeholders.

Some of the issues identified as potential problems contributing to the puzzle of continued high tobacco use rates in Alaska Native communities were already being addressed by a variety of partners, including LEAD and ATCA (such as engaging Alaska Native leaders in the statewide tobacco control movement). Some problems were addressed during the project period (such as improving surveillance system measures to be more sensitive and culturally competent). In June 2012, the advisory team met and identified highest-priority strategies for additional effort moving forward:

4. **Provide more support to create relationships among regional partners, share stories of successful approaches, and mentoring of new staff.** (*leadership on this strategy: TPC*)
Changing some meeting structures, grantee guidance, and allowing for mentoring of staff as a grantee activity may help to address the frequent staff turnover in Alaska Native/rural communities, low or varied skillsets among new or existing staff, and need for more day-to-day support, and more relationship-building to successfully engage Alaska Native people and communities within the Tobacco Control community.
5. **Assure materials, toolkits, training & support are useful, or identify needed adaptation, for use in smaller, rural, and Alaska Native communities.** (*leadership on this strategy: TPC*)
Existing tools and support strategies should be reviewed, and new ones developed with the expectation that their usefulness and relevance for Alaska Native communities will be considered. Sometimes, tailored tools may need to be provided. For example, model tribal policies for use in small tribes may need to be shorter and simpler than they currently are to be appropriate for the simpler legal structures of those organizations.
6. **Build more infrastructure and momentum for engaging Alaska Native leaders, including from small communities:** (*leadership on this strategy: LEAD & ATCA*)
Continue to test and evaluate strategies and messaging to engage more new partners and leaders in small villages, including by reaching them through non-traditional (not specifically health-related) statewide or regional Alaska Native leadership groups.

Information about the project and findings was shared with the Centers for Disease Control and Prevention (CDC) in January 2013. Program staffs from CDC were very impressed with the process, the findings, and the recommendations, calling the project a “shining star” for other disparities reduction efforts around the country.

Advice for Future Projects

This project yielded useful information for Alaska tobacco prevention and control stakeholders working to assure success of the program within Alaska Native communities. The model of engaging key informants in a thoughtful, systematic review of program reach, efficacy and opportunities for improvement may be useful for reaching other groups disproportionately affected by tobacco use and exposure (such as people experiencing poverty, other race, ethnic or sexual minority groups, or young adults). Alternatively, a similar process might be useful for improving performance of other health programs in Alaska Native communities.

The following recommendations may be useful in planning such future projects:

- **The quality of stakeholders engaged in the project is key.** More Alaska Native stakeholder input would have been valuable. For this project we engaged an advisory group of stakeholders with expertise in tobacco control in the Alaska Native community (state staff, ATCA leaders), or people in positions to influence how programs were operated (healthcare system or health policy advocacy leaders), many of whom were non-Native, and most of whom currently live in the Anchorage vicinity (although many also had family connections or history in Alaska Native communities across the state). However, we included perspectives from Alaska Native individuals from communities across the state by further mining interviews conducted previously, and through talking circles at a statewide meeting. This approach was more efficient than having direct representation of Alaska Native individuals from various cultures on the advisory team, but some information was likely lost. Other critical factors included program managers who were willing to be self-critical about program design and make changes, and committed to strong relationships with partners; as well as partners and stakeholders who were similarly willing to share their expertise and time.
- **Allow sufficient time and resources.** This project took significant time effort (contracted and staff support, as well as volunteer time). If anything, more time and resources could have been applied. If future projects have only limited time or resources, it would be advisable to choose a specific focus for study (such as one strategy, one goal area, or one specific area of the state).
- **Make a formal, public commitment, with clear process and accountability.** Making a formal, public commitment to doing something, and working with available partners and resources in an honest, open dialogue were valuable for creating trust and for assuring stakeholders that their time was worth investing. At the conclusion of the project, plans were made for annual reporting to stakeholders through existing meeting structures; however, those meetings were subsequently discontinued. Fortunately, the goal of continuing to address tobacco use among Alaska Native people had been adopted as a higher-level strategic priority for the Alaska Department of Health and Social Services, Section for Chronic Disease Prevention and Health Promotion, which assures continued accountability of the TPC program for maintaining attention to Alaska Native communities.
- **Keep flexible.** This project continuously shifted to adapt to evolving questions, needs, and what resources were at hand. For example, the initial interest in summarizing the reach of current TPC programs in Alaska Native communities revealed that reliable, systematic information on program reach was not available. This in turn led to further investigation and development of grantee

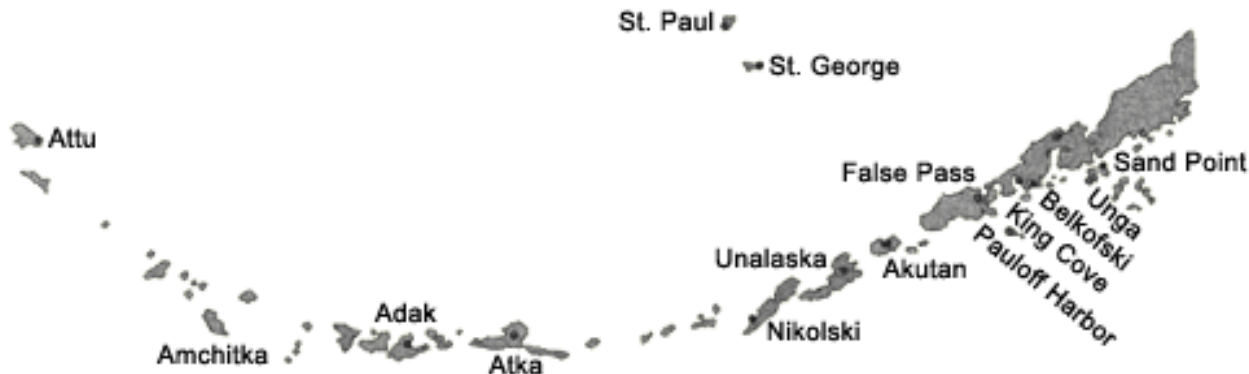
reporting systems. Flexibility of the project design allowed for better understanding of an important program gap.

- **Have realistic expectations.** Early on, the stakeholder group agreed that they were not likely to identify a single problem that was causing higher tobacco use rates among Alaska Native people, nor did they expect to find single, dramatic solutions (a “magic bullet”). Also, some efforts were already underway as the project started – such as having an Alaska Native specific leadership group in ATCA. Multiple opportunities for improving program design were identified, some of which were applied immediately. The process of this project created conversations that resulted in evolution of the TPC program design at the same time as the project was still ongoing. The final results and recommendations implemented were not dramatic, nor entirely discrete from broader program improvements. Thus, the project was associated with changes in program design and implementation, and benefits of the project were applied beyond the original purpose alone (improvement in Alaska Native communities alone).

Appendix: Case study of successful pro-health policy promotion in rural, Alaska Native villages

June 2012

Caroline Nevak is supporting tobacco control efforts as part of the Aleutian Pribilof Islands Association (APIA). Her primary goals are promoting smokefree policies, including in multi-unit housing.



Caroline is currently focusing on 5 of the 13 APIA communities, and achieved significant policy success in 3 of them. The communities are small and traveling there is difficult (both because it is expensive and due to weather conditions). Cigarettes are expensive (around \$10 per pack). There are few healthcare providers (St. Paul & St. George share one provider, Unalaska has a physician assistant, other areas have visits from community health aides - CHAPS). Most people have smokefree homes.

	St. Paul	St. George	Unalaska	Atka	Nikolski
Population (estimate)	Less than 500.	120	4,400	60	18
	80%+ Alaska Native	90%+ Alaska Native	6%+ Alaska Native	80%+ Alaska Native	69% Alaska Native

Three of these communities have made commitments to policy change within the past 2 years, associated with Caroline's efforts. Two communities had previous ordinances that Caroline works to support.

- ✓ Unalaska passed comprehensive smokefree workplace ordinance in 2009
- ✓ St. Paul passed a smokefree resolution in May 2010
- ✓ Atka Native Village passed tobacco-free workplace resolution in 2011
- ✓ St. George Island passed a tribal resolution for tobacco free workplaces on June 22, 2012

Caroline's Strategies for Success:

Policy goal: Smokefree public places (public buildings, businesses, offices, multi-unit housing). The “key Ingredients” for policy change that are promoted by Alaska’s Tobacco Prevention and Control Program can still work in rural, Alaska Native village communities. Caroline’s approaches for implementing these “key ingredients” in a culturally respectful and relevant way are summarized below.

1. Building Community-level Capacity/Local Champions

These are local people who really understand the needs of each community. They can engage others (sometimes in a coalition), disseminate messages (including campaign materials), and identify opportunities for policy action (including when a “window opens”). Caroline is working with Community Wellness Advocates (CWAs) to be the “on the ground” local champions for tobacco control (one exception, Nikolski does not have a CWA).

- Providing them with materials and supplies for local education activities (in schools, health fairs)
- Coordinating monthly phone meetings with the CWAs
- Supporting travel for CWAs to come to ATCA or grantee meetings – this travel brings them together with one another, Caroline and tobacco control movement, and it’s also seen as a benefit (trip to Anchorage) for those staff.
- Using CWAs to build local coalitions has been difficult, but this has not been a barrier to local progress and success.

2. Providing evidence of policy need

Caroline works to promote comprehensive smokefree community-wide policies but also venue-specific polices (recreation/bingo halls, school buildings and gymnasiums, businesses).

- Caroline makes personal visits to each community yearly (once per year), including with specific visits to individual policymakers and leaders (tribal and city leaders, school principals and teachers, store owners, radio reporters, business owners). CWAs provide contacts and introductions to these decision-makers.
- She asks about their current policies and educates them about the dangers of tobacco smoke, but does not try to “push” – just stating the facts, offering solutions.

3. Educating the Community about the Dangers of Tobacco

Caroline uses multiple communication strategies to assure that people are exposed to constant, fresh information about the dangers of tobacco use and exposure.

- Newsletters – on a monthly basis, wellness newsletters are emailed, and hard copies sent to clinics, that include messages about multiple health issues but tobacco is always a dominant theme.
- Poster campaigns – every other week Caroline sends new flyers about tobacco issues, which the CWAs print and post locally.
- Caroline personally has attended health fairs with “hands-on” activities that help people understand the dangers of tobacco – in a small community these events are also social and are attended by large shares of the population.

- Caroline is also working to engage her communities in the “good for health, great for business” campaign to encourage more local representation in the state campaign, and to help gain local businesses’ attention about the message of the state campaign.

4. Offering Policy Solutions and Resources

Caroline uses policy promotion resources from the LEAD group and also has developed local resources so that adopting policies can be easy.

- Caroline uses the AFN resolution and sample tribal policies/resolutions to offer clear solutions from respected sources. She also promoted the “smoke free elders events” in the region as an example of a successful policy implementation.
- Caroline also provides “smokefree” signs for places that adopt policies - clinics, schools, businesses.

5. Taking Policy Action: Educating Policymakers about the Policy Solutions for Dangers

Caroline brings together local capacity, information about the problem, community-based education efforts and policy options and presents them to policymakers (or helps local stakeholders do so):

- Caroline has made formal presentations to local policymakers that summarizes what the problem is, why a policy will help, how she knows the community supports it, and specific resources that can help with a policy change.

6. Implementation/Enforcement

Caroline checks back in with the communities that have adopted policies or resolutions, to make sure they are having success.

7. Evaluating/Describing Benefits

Caroline has not been asked to evaluate the policies’ impacts, but she does use the stories about positive experiences with the other communities as more of them consider strengthening their policies.

Lessons Learned

Caroline has learned a few lessons about what makes the work successful:

- Work with local staff (including outside of community health aide and behavioral health aide systems such as CHWs) to build meaningful local capacity; engage those staff by providing materials, ongoing guidance, and travel support.
- Coalitions (at least formal ones) may not make as much sense in small communities where everyone is always working together, but this doesn’t seem to be a problem for achieving policy goals.
- Consistent presence of information through locally-relevant media, and also in-person interaction with communities (even health fairs) works to create community-level awareness and support for policy in small communities.
- Respectful interactions with policymakers are facilitated by local introductions and offers of solutions in a non-judgmental way.

Appendix: Cresting the mountain - SEARHC measures declines in cigarette smoking among Alaska Native adults

Smoking has declined significantly among the general population of adults in Alaska since the start of Alaska's comprehensive tobacco control program in 1996. The state of Alaska reports that there are an estimated 31,000 fewer adult smokers, 8,900 fewer tobacco-related deaths, and \$396 million in healthcare costs averted since the start of the program.¹² However, these benefits have not been distributed equally in all populations. Specifically, significant declines in smoking among the statewide population of Alaska Native adults have not been observed, and current cigarette smoking among Alaska Native adults remains more than twice the state rate (41% percent vs. 18% among non-Native adults).¹³

The SouthEast Alaska Regional Health Consortium (SEARHC) has been working to reduce the health burden of tobacco use and exposure to secondhand smoke in their region since the late 1990s. SEARHC and partners have been supporting evidence-based tobacco control interventions, tailored to reach the largely Alaska Native communities in this region, including:

- Smoke free ordinances , policies and resolutions in communities and tribes, workplaces, tribal facilities, housing facilities, tribal health centers and hospitals;
- Tobacco taxes in Juneau and Sitka (including with dedicated funding to support tobacco cessation)and the Klawock Tribal Association;
- Tobacco cessation services in tribal and community healthcare systems, including provider advice and support to quit;
- Extensive media targeting Alaska Native people and others throughout Southeast including radio, print, flyers, theatre, airport, Facebook, earned media and website ads.

This work is the most aggressive tobacco control effort in any region specifically intended to reduce tobacco use and exposure among Alaska Native people. In comparison to other areas of the state, SEARHC's regional effort has been relatively more well-funded (as the result of multiple grants), involved strong partnerships, and been sustained for a longer period of time (over ten years). Significant declines in cigarette smoking among Alaska Native adults in this region could indicate that evidence-based tobacco control programs can be effective in reducing cigarette smoking in Alaska Native communities.

¹² Alaska Department of Health and Social Services, Tobacco Prevention and Control Program. *Keeping the Promise: A Tobacco-Free Generation; Tobacco Prevention and Control in Alaska, FY12.*

¹³ 2010 Alaska Behavioral Risk Factor Surveillance System (BRFSS). Reported at http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/2012_alaska_tobacco_facts.pdf

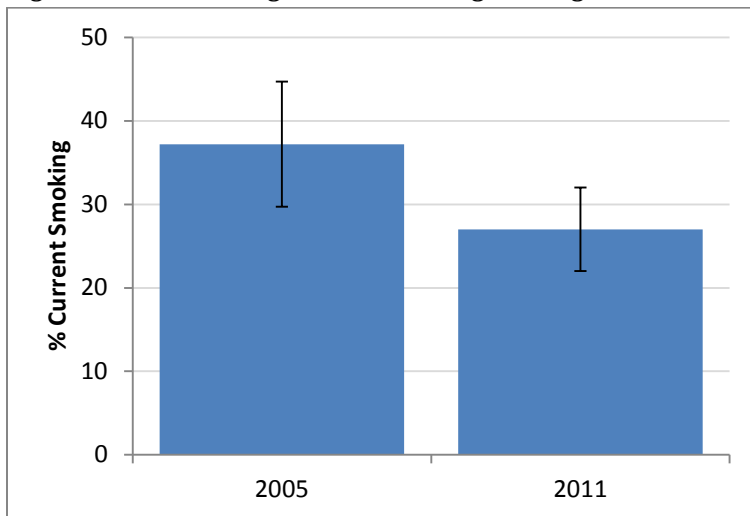
SEARHC evaluation

SEARHC worked with an independent research firm to conduct a telephone survey of Southeast Region residents from 2005 to 2011. This anonymous, random-digit dial survey used methods consistent with national surveys to ask residents of 30 communities in the SEARHC region about a variety of health factors, including current cigarette smoking. More than 400 Alaska Native adults were interviewed each year as part of this survey. The purpose of this survey was to evaluate the success of their region-specific efforts in health promotion.

A “current smoker” is defined as an adult who has smoked at least 100 cigarettes (5 packs) in their lifetime, and who reports that they currently smoke “every day” or “some days.” This is the nationally established definition for smoking among adults. We compared smoking prevalence from the first survey to the most recent survey to see whether there was a meaningful change.

In 2005, about 37% of Alaska Native adults reported currently smoking cigarettes. In 2011, only 27% reported smoking cigarettes (see figure 1). This decrease in smoking prevalence is statistically significant.¹⁴ This finding suggests that Alaska Native adults in the SEARHC region are quitting smoking.

Figure 1: Current Cigarette Smoking among Alaska Native adults in SEARHC region, 2005 and 2011



Source: SEARHC evaluation surveys conducted by Gilmore Research, 2005 and 2011

¹⁴ From a Chi-square test, $p=.004$ at 95% confidence level.

Using State Surveys to Validate SEARHC evaluation findings

The State of Alaska has used ongoing telephone surveys since the late 1990's to monitor health-related behaviors among state residents. These surveys are implemented as part of the national Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Disease Control and Prevention (CDC), and were the model for SEARHC's survey design and smoking definitions as well.

Although a relatively small number of Alaska Native adults in the SEARHC region are interviewed as part of the state phone surveys (about 100 per year), examining the statewide data can provide an independent view of the trends in smoking for that region. We compared trend over time for current smoking among Alaska Native people in the SEARHC region to Alaska Native adults from outside the SEARHC region.¹⁵

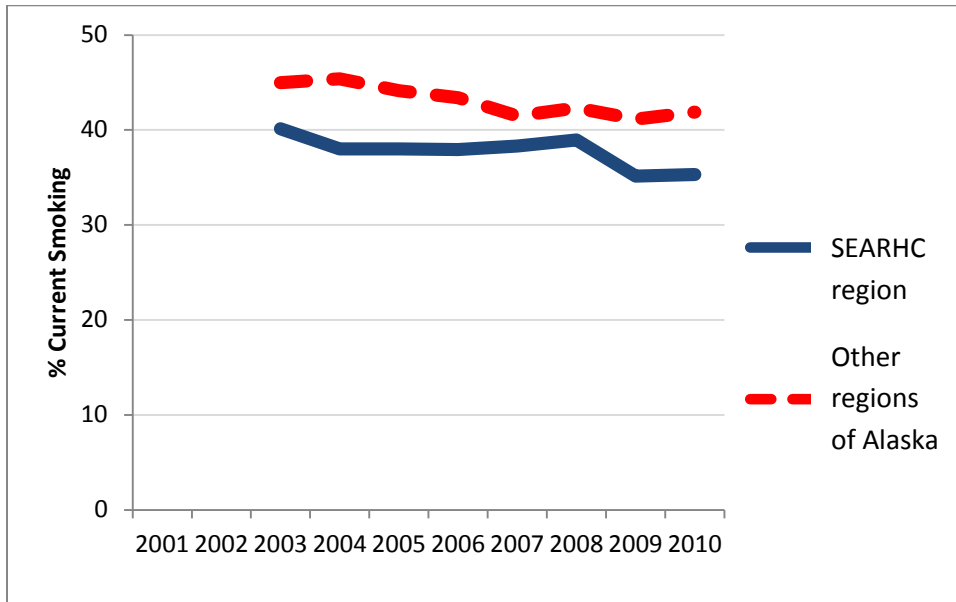
Using a regression model, we compared the trend for current cigarette smoking from 2000-2010. Figure 2 illustrates the trend for current smoking as 3-year "moving averages."¹⁶ Overall, the decline in smoking among Alaska Native adults in the SEARHC region is slightly better than for Alaska Native adults outside the region – dropping faster than the change among Alaska Native adults outside the SEARHC region.¹⁷

¹⁵ An average of 600 Alaska Native adults outside the SEARHC region were interviewed per year as part of the Alaska BRFSS.

¹⁶ "Moving averages" are prevalence estimates averaged over 3 years. This provides a simple visual image of the trend, because estimates for any single year based on small numbers tend to be unstable.

¹⁷ From a logistic regression model, the coefficient for an interaction term for trend among Alaska Native adults in the SEARHC region vs. non-Native adults and other Alaska regions is -.011 (p=.06).

Figure 2: Current Cigarette Smoking among Alaska Native adults, 3-year “moving averages” for 2000-2010, SEARHC region vs. other Alaska Regions



Source: Alaska BRFSS, 2000-2010

Conclusion

Two independent studies of trends in cigarette smoking among Alaska Native adults in the SEARHC region indicate that cigarette smoking is declining. Smoking among Alaska Native adults appears to be declining to a greater extent in the SEARHC region vs. in other regions of the state of Alaska.

Stakeholders in the State of Alaska are concerned about the lack of progress in reducing cigarette smoking among Alaska Native adults in the state. Alaska Native communities are diverse, often rural and small. One possible explanation for the lack of observed program effectiveness among Alaska Native adults to date is that statewide efforts have not sufficiently penetrated rural communities, including with approaches that are grounded in the evidence base, but adapted to be relevant to unique community cultures and structures. Another possibility is that changing community cultures around tobacco may take more time than in the general population; like climbing Alaska’s mountains, it takes perseverance, resources, knowing and respecting the environment, and steady movement forward to reach new heights.

The results of these evaluations of SEARHC’s effort suggest that evidence-based tobacco control interventions focused on reaching Alaska Native communities can be effective in reducing cigarette smoking among Alaska Native adults, given sufficient time, resources and effort.

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Appendix: Tribal resolution progress

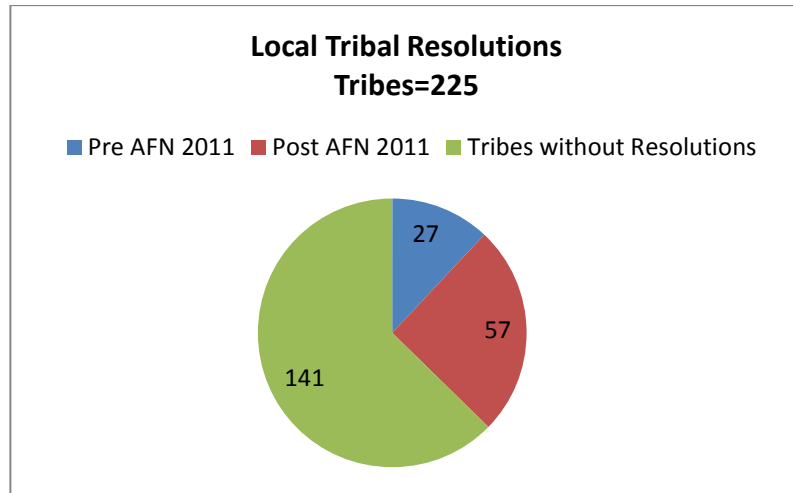
[Fact Sheet distributed by LEAD workgroup.]

Alaska Native Tribal Resolutions

Updated February 19, 2014

Congratulations!!!

As of January 9, 2014, **84** out of **225** Federally Recognized Tribal Entities in Alaska - more than a third - have passed local **tobacco-free** or **smokefree workplace** resolutions.



Tribes with POST AFN 2011 Model Resolutions

KEY: TF = Tobacco-free SF = Smokefree

1	Hydaburg Cooperative Assoc	Apr-12	SF	31	Chignik Bay Tribal Council	Feb-13	TF
2	Saint George Island	Jun-12	TF	32	Native Village of Port Heiden	Feb-13	TF
3	Native Village of Point Hope	Jul-12	TF	33	Village of Atmautluak	Feb-13	TF
4	Native Village of Buckland	Jul-12	TF	34	Native Village of Goodnews Bay	Feb-13	TF
5	Native Village of Kobuk	Jul-12	TF	35	Native Village of Shungnak	Feb-13	TF
6	Nenana Native Association	Aug-12	TF	36	Levelock Village	Mar-13	TF
7	Skagway Village	Aug-12	SF	37	Village of Aniak	Mar-13	TF
8	Chilkat Indian Village	Sep-12	SF	38	Native Village of Port Lions	Mar-13	TF
9	Cheesh-Na Tribe	Oct-12	TF	39	Native Village of Aleknagik	Mar-13	TF
10	Native Village of Akhiok	Oct-12	TF	40	Native Village of Afognak	Mar-13	TF
11	Native Village of Kotzebue	Oct-12	TF	41	Nome Eskimo Community	Apr-13	SF
12	Village of Clarks Point	Nov-12	TF	42	Ekwok Village	Apr-13	TF
13	Village of Iliamna	Nov-12	TF	43	Tangirnaq Native Village	Apr-13	TF
14	Native Village of Tuntutuliak	Nov-12	SF	44	King Island Native Community	Apr-13	TF
15	Kaguyak Village	Nov-12	TF	45	Newhalen Village	Apr-13	TF
16	Native Village of Deering	Nov-12	TF	46	Noorvik Native Community	Apr-13	TF
17	Village of Kotlik	Dec-12	SF	47	Native Village of Noatak	May-13	TF
18	Newtok Village	Dec-12	SF	48	Native Village of Napakiak	Aug-13	SF
19	Nunakauyarmiut Tribe	Dec-12	SF	49	Native Village of Kongiganak	Aug-13	TF
20	Native Village of Kiana	Dec-12	TF	50	Kasigluk Traditional Elders Council	Aug-13	TF
21	Native Village of Selawik	Dec-12	TF	51	Native Village of Ambler	Aug-13	SF
22	Petersburg Indian Association	Dec-12	SF	52	Emmonak Village	Sep-13	TF
23	Ivanoff Bay Village	Jan-13	TF	53	Native Village of Hooper Bay	Sep-13	TF
24	Curyung Tribal Council	Jan-13	TF	54	Holy Cross Village	Nov-13	TF
25	Igiugig Village	Jan-13	TF	55	Native Village of Savoonga	Nov-13	TF
26	Manokotak Village	Jan-13	TF	56	Twin Hills Village	Dec-13	TF

27	Nondalton Village	Jan-13	TF	57	Native Village of Chignik Lagoon	Feb-14	TF
28	Traditional Village of Togiak	Jan-13	TF	58	Hoonah Indian Association	Jan-14	TF
29	Ugashik Village	Jan-13	TF				
30	Village of Old Harbor	Jan-13	TF				

Tribes with PRE AFN 2011 Resolutions

KEY: TF = Tobacco-free SF = Smokefree

1	Native Village of Koyuk	Mar-03	SF	16	Organized Village of Kwethluk	No copy
2	New Koliganek Village Council	May-04	TF	17	Native Village of Eyak	No copy
3	Pedro Bay Village	Feb-05	TF	18	Kenaitze Indian Tribe	No copy
4	Chignik Lake Village	Apr-05	TF	191	Koyukuk Native Village	No copy
5	Egegik Village	Apr-05	TF	20	Nulato Village	No copy
6	Native Village of Pilot Point	May-05	TF	21	Sun'aq Tribe of Kodiak	No copy
7	Native Village of Chenega	Jun-07	SF	22	Chilkoot Indian Association	No copy
8	Saint Paul Island	May-10	SF	23	Central Council Tlingit and Haida	No copy
9	Native Village of Atka	Jun-11	TF	24	Klawock Cooperative Association	No copy
10	Native Village of Saint Michael	Aug-11	TF	25	Metlakatla Indian Council	No copy
11	Village of Solomon	Sep-11	TF	26	Sitka Tribe of Alaska	No copy
12	Native Village of Gambell	No copy		27	Ketchikan Indian Corporation	No copy
13	Akiachak Native Community	No copy				
14	Native Village of Chuathbaluk	No copy				
15	Akiak Native Community	No copy				

Support for a Statewide Smokefree Workplace Law

On January 11, 1964, – a Saturday so to not roil the stock market, then Surgeon-General Luther Terry released a 387-page document entitled Smoking and Health. Ten scientists (all men; half smokers) analyzed 7,000 studies to assess the effects of tobacco on the human body and concluded that cigarette smoking is causally related to lung cancer in men and women. The adult smoking rate in the country at that time was 42%. This report triggered a long but gradual decline. In the 50 years since the report, smoking rates were cut by half. In 2010, 21% of Alaska adults and 41% Alaska Natives were smokers. In 2010, 85% of Alaska adults and 71% of smokers reported that they believe smoking should not be allowed in work areas.

As stated in the letter sent to Tribal Health Directors last month, we are making tremendous progress toward protecting Native people from secondhand smoke and discouraging young people from starting but there is more work to be done. More than half of Alaska Native people are not protected from secondhand smoke in their workplaces. You can help by bringing the attached resolution to your board to sign their support for Statewide Smokefree Workplaces.

So far, out of **24** Tribal Health Consortiums, **8** Health Consortiums have passed resolutions in support of a **Statewide Smokefree** Workplace Law. They are:

1. Tanana Chiefs Conference (TCC)
2. Yukon-Kuskokwim Health Corporation (YKHC)
3. Aleutian Pribilof Island Association (APIA)

4. Alaska Native Tribal Health Consortium (ANTHC)
5. Southeast Alaska Regional Health Consortium (SEARHC)
6. Bristol Bay Area Health Corporation
7. Copper River Native Association
8. Kodiak Area Native Association

16 Tribes have also passed Resolutions in support of a **Statewide Smokefree** Workplace Law. They are:

1. Organized Village of Kasaan
2. Native Village of Koyuk
3. Village of Solomon (based out of Nome)
4. Qutekcak Native Tribe
5. Chilkoot Indian Association
6. Native Village of Kotzebue
7. Native Village of Saint Michael
8. Native Village of Brevig Mission
9. Native Village of Bill Moore's Slough
10. Native Village of Eek
11. Native Village of Emmonak
12. Native Village of Kwinhagak
13. Native Village of Marshall
14. Native Village of Nunam Iqua
15. Native Village of Tununak
16. Nenana Native Village

ATCA has over **400** business supporters statewide that signed resolutions to support a Statewide Smokefree Workplace Law. Grantees are continuing to gather signatures on ACSCAN postcards for individuals who want to support statewide smokefree legislation.

It's time for a smokefree Alaska! Together we can get this done!

Appendix: References

- ¹ Alaska Department of Health and Social Services, Division of Public Health. Healthy Alaskans 2010, Volume I: Targets for Improved Health. Chapter 3: Tobacco Use. December 2001. Available at http://dhss.alaska.gov/dph/Director/Documents/ha2010/PDFs/03_Tobacco.pdf (last accessed 4/22/14).
- ² Peterson E, Fenaughty A, Eberhart-Phillips JE. Tobacco in the Great Land, A Portrait of Alaska's Leading Cause of Death. Alaska Department of Health and Social Services, Division of Public Health, Section of Epidemiology. Anchorage, AK. 2004.
- ³ Alaska Department of Health and Social Services. *Fiscal Year 2013: Alaska Tobacco Prevention and Control Program Annual Report*. <http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/TobaccoARFY13.pdf> (last accessed 4/22/14); *Alaska Tobacco Prevention & Control Timeline* http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/2013_TPC_Timeline.pdf (last accessed 4/22/14)
- ⁴ Alaska Department of Health and Social Services, Tobacco Prevention and Control Program. *What State Surveys Tell Us About Tobacco Use Among Alaska Natives: Implications for Program Planning*. Anchorage, AK: Section of Chronic Disease Prevention and Health Promotion, Division of Public Health, Alaska DHSS. March 2007. Available at <http://dhss.alaska.gov/dph/Chronic/Pages/Tobacco/factsheets.aspx>
- ⁵ Boles M, Rohde K, He H, Maher JE, Stark MJ, Fenaughty A, O'Connor T. Effectiveness of a tobacco quit line in an indigenous population: a comparison between Alaska Native and other first-time quit line callers who set a quit date. *Int J Circumpolar Health*. 2009;68(2):170-81. Abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/19517876>