Building Coalitions for Tobacco Control and Prevention in the 21st Century

This editorial is based on the author's keynote address to the American Legacy Foundation's Second Annual Grantee Training Conference, "Expanding the Dialogue for Cultural Competencies and Social Justice: Highlighting Our Successes and Expanding Our Circles," Washington, DC, September 30, 2003. The author serves as a member of the American Legacy Foundation's Low Socioeconomic Status Steering Committee for Priority Populations, a member of the resource team for Community Voices, and a peer reviewer for Small Innovative Grants.

The goal of expanding the dialogue for cultural competencies and social justice with regard to tobacco control and prevention entails both challenges and opportunities. The first challenge is to create unity, to both transcend and celebrate our differences. The second is to assemble concrete guidance rather than merely deliver oratory to the committed practitioners who, day in and day out, conduct the essential work of public health. The third and fundamental challenge is to build up tobacco control and prevention programs and policies while also supporting other essential goals of a just society, including providing a living wage to every worker, safe and affordable housing to every individual, and quality education to every child.

EMBRACING OPPORTUNITIES

In addressing these notable challenges, we would be remiss if we failed to embrace the opportunities afforded by having such a wide array of creative and skilled public health leaders and advocates dedicated to the cause of tobacco control and prevention. In building coalitions around tobacco control and prevention in the 21st century, we need to be mindful of the changing demographics of US society. In particular, we must strive to ensure that Latino, Asian, and African migrants are included in our coalitions. We also need to remember that hard-won gains in the labor movement, the civil rights movement, the women's movement, the environmental and environmental justice movements, and the gay rights movement came about because members of these different groups recognized commonalities in their struggles against discrimination and oppression. Finally, we need to renew the scientific basis for decisionmaking[1] and ensure that the research and practice conducted on behalf of marginalized and oppressed constituencies is unassailable.[2]

CULTURAL COMPETENCIES, SOCIAL JUSTICE, AND HUMAN RIGHTS

To create unity, I propose expanding our dialogue on cultural competencies and social justice to include health as a human right. The language and vision of human rights pervades much of our practice and writing; still, it helps to explicitly name health as a human right and to be clear about using this framework to advance tobacco control and prevention.

According to Gruskin and Tarantola, the Universal Declaration of Human Rights that was adopted by the United Nations in 1948 serves as the cornerstone of the modern human rights movement.[3] Its preamble claims that human rights and dignity are self-evident, the "highest aspiration of the common people," and the "foundation of freedom, justice, and peace."[4] For historic reasons, the rights described in this and subsequent human rights documents were artificially divided into civil and political rights—which were championed by the United States—on the one hand, and economic, social, and cultural rights—which were championed by the former Soviet Union—on the other hand. Since the end of the Cold War, the indivisibility and interdependence of civil, political, economic, social, and cultural rights has once again been recognized.[3] This reintegration provides an opportunity for us as health and health care advocates to use the human rights framework to both expand and revitalize the US civil rights movement for the 21st century.

Gruskin and colleagues have argued convincingly that the violation of human rights can increase the threat of poor health.[5] In doing so, they have conceptualized *vulnerability* as a limitation on the extent to which people are capable of making and implementing free and informed decisions,[3] thus focusing attention on

the social context in which individual experiences are embedded. For example, public health researchers and practitioners employing a health and human rights model might posit that the ongoing marginalization of poor and working-class people in US society results in scarce resource allocation to the communities in which they live and work, thereby leading to inadequate educational and employment opportunities, few tobacco prevention programs for young people and limited tobacco cessation programs for adults, and increased reliance on those who sell or use tobacco and other substances for economic and social support.[5] Research questions might then be posed and interventions purposefully designed to address the higher burden of tobacco use and exposure to environmental tobacco smoke among poor and working-class populations.

CREATING UNITY

By invoking the health and human rights framework, I do not mean to imply that it should oppose, supplant, or be merged with other essential frameworks for understanding and addressing health disparities.[6] Cultural competencies are essential in reaching out to and serving *all* members of society, including both the migrant and native-born residents of our diverse communities. Language, literacy, and social ties do indeed matter in the programs and policies we devise around tobacco control and prevention. Rather, social justice—as the foundation of public health[7]—may augment and reinforce other perspectives, as explained by Krieger:

> Understanding of what prompts violation of human rights and sustains their respect, protection, and fulfillment is, in turn, aided by social justice frameworks, which explicitly analyze who benefits from—and who is harmed by—economic exploitation, oppression, discrimination, inequality, and degradation of "natural resources."[8(p695)]

ASSEMBLING CONCRETE GUIDANCE

The concrete guidance I hope to provide relates to documenting our findings in the public health record so that others may benefit from our triumphs and setbacks. Publishing in peer-reviewed journals is more than a requirement of funding agencies, organizations, and institutions: it is our ethical responsibility to the communities we serve. Best practices, wisdom gained through reflection on experience (what worked, what didn't, and why), and pointers on how to sustain interventions delivered in real time are essential to changing the current distributions of tobacco-related diseases and eliminating disparities in health.[9]

Two departments were designed for the Journal with practitioners expressly in mind. Field Action Reports promotes sharing of experiences among practitioners and favors reports of programs that have been sustained long enough to permit rigorous evaluation (see http://www.ajph.org/misc/Far). Government, Politics, and Law seeks to promote understanding between the public health community and these "often misunderstood disciplines" by allowing contributors to "sound off" on essential public health topics, with arguments grounded in critical analysis.[10] Many other peer-reviewed journals regularly publish findings on tobacco control and prevention initiatives; these journals include *American Journal of Health Behavior*, *American Journal of Health Promotion*, *American Journal of Preventive Medicine*, *Health Promotion Practice*, *Journal of Public Health Management and Practice*, *Journal of Tobacco and Nicotine Research*, *Public Health Reports*, and *Tobacco Control*.

While there are no shortcuts to the writing process, here I list 12 strategies—1 for every year that I have been publishing (and editing) in peer-reviewed journals—that may prove useful to other public health practitioners.

1. Decide on authorship up front, and choose a lead author who will be accountable for ensuring that the paper is written *and* published.
2. Respect the rules of authorship, and list only authors who fulfill the 3 criteria of conceptualization, writing, and approval of the final draft, as per the International Committee of Medical Journal Editors (see http://www.icmje.org).
3. Be clear in your thinking before you begin to write, but recognize when it is time to stop talking and start writing.
4. Give credit to those who informed your ideas and be certain to cite the seminal work of others.
5. Carve out space and time for writing in practical and sustained ways to promote reflection, creativity, and honing of writing skills.
6. Hire practitioners who are skilled writers and value their contributions as essential to the success of your program.
7. Choose appropriate formats and journals to reach your intended audience and be prepared to respond to calls for papers that actively seek practice reports.
8. Interpret data with care and sensitivity, and uphold your duty as socially responsible practitioners to advance the cause of underserved communities.
9. Ask for constructive feedback from other practitioners, community partners, and evaluators *before* submission.
10. Tap your inner core to infuse your writing with passion and purpose, then direct your energies toward careful analysis and thoughtful policy recommendations.
11. Capture the richness and immediacy of your daily work in your written reports, and avoid the "drudgery" that too often is equated with public health practice.[9]
12. Be prepared to rethink, rework, and rewrite your paper, but never relinquish ownership or responsibility for its content.

PROMOTING A JUST SOCIETY

The recent upsurge in public health research and practice that addresses disparities in tobacco use and the targeting of certain communities, including lesbian, gay, bisexual, and transgender (LGBT) youths,[11] didn't just happen. Rather, the contemporary focus on, for example, LGBT health[12] can be traced to the Stonewall Rebellion of June 26, 1969, in Greenwich Village, New York City, which gave birth to the modern gay rights movement. This rebellion occurred against "the backdrop of an era in which critique of Western culture was growing, fueled by the worldwide anti–Vietnam War movement, and civil rights and anti-racism movements in many

countries, plus the advent of second wave feminism."[13(p529)]

As public health practitioners and researchers, we need to remember the larger backdrop against which we carry out our daily activities. By careful documentation in the peer-reviewed literature of the contribution of smoking to excess mortality,[14] we can assemble an evidence base that may be resolutely directed toward eliminating disparities in health and health care. Building coalitions for tobacco control and prevention in the 21st century will be abetted by acknowledging health as a human right and working in solidarity with those in the civil rights and related social movements in the ongoing struggle to realize a just US society, with equitable opportunities and hope for all. ■

Mary E. Northridge, PhD, MPH
Editor-in-Chief, AJPH

About the Author

Requests for reprints should be sent to Mary E. Northridge, PhD, MPH, Mailman School of Public Health, Columbia University, 722 W 168th St, Room 1123.6, New York, NY 10032 (e-mail: men11@columbia.edu).

This editorial was accepted October 2, 2003.

Acknowledgments

The author thanks (in alphabetical order) Mary Bassett, Benjamin Frey, Lyndon Haviland, Nancy Krieger, Helen Lettlow, Karen Martin, Kenneth McLeroy, Adin Miller, Marguerite Ro, and Gabriel Stover for helpful comments on drafts of this editorial and for their ongoing support and collaboration to ensure that the findings and experiences of practitioners conducting tobacco control and prevention initiatives are part of the public health record.

References

1. Northridge ME, Sclar E. A joint urban planning and public health framework: contributions to health impact assessment. *Am J Public Health.* 2003;93:118–121.

2. Northridge ME. Partnering to advance public health: making a difference through government, community, business, and academic vocations. *Am J Public Health.* 2003;93:1205–1206.

3. Gruskin S, Tarantola D. Health and human rights. In: Lamptey P, Gayle H, Mane P, eds. *HIV/AIDS Prevention and Care Programs in Resource-Constrained Settings: A Handbook for the Design and Management of Programs.* Arlington, Va: Family Health International. 2001.

4. Universal declaration of human rights. GA Resolution 217A (III), UN GAOR, Resolution 71, UN Document A/810. New York, NY: United Nations; 1948.

5. Gruskin S, Plafker K, Smith-Estelle A. Understanding and responding to youth substance use: the contribution of a health and human rights framework. *Am J Public Health.* 2001:91:1954–1963.

6. Krieger N, Gruskin S. Ecosocial and health and human rights perspectives on disparities in women's health: the case of tuberculosis. *J Am Med Womens Assoc.* 2001:56:137–142.

7. Krieger N, Birn AE. A vision of social justice as the foundation of public health: commemorating 150 years of the Spirit of 1848. *Am J Public Health.* 1998;88:1603–1606.

8. Krieger N. A glossary for social epidemiology. *J Epidemiol Community Health.* 2001;55:693–700.

9. Stover G, Bassett MT. Practice is the purpose of public health. *Am J Public Health.* 2003;93:1799–1801.

10. Colmers J. Why "Government, Politics, and Law"? *Am J Public Health.* 2002;92:1217.

11. Washington HA. Burning love: Big Tobacco takes aim at LGBT youths. *Am J Public Health.* 2002;92:1086–1095.

12. Meyer IH. Why lesbian, gay, bisexual, and transgender public health? *Am J Public Health.* 2001;91:856–859.

13. Dowsett GW. Gay communities. In: Christensen K, Levinson D, eds. *Encyclopedia of Community: From the Village to the Virtual World.* Thousand Oaks, Calif: Sage Publications; 2003.

14. Northridge ME, Morabia A, Ganz ML, Bassett MT, Gemson D, McCord C. Contribution of smoking to excess mortality in Harlem. *Am J Epidemiol.* 1998;147;250–258.