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**Minutes of the Thursday, December 17, 2020  
PHAC Meeting  
5:30 – 7:00 p.m.  
Fourth Floor Conference Room  
Alexandria Health Department**

<b>Present</b>	Chair, Daniel Hawkins (DH), Vice Chair, Andrew Romero (AR), Stacy Biddinger (SB), Richard Merritt (RM), Elaine McSorley-Gerard (EMG), Allen Lomax (AL), Michael Millman (MM), Dr. Michael Trahos (DMT), Patricia Rodgers (TR), Dr. Jessica Hill (JH) Brian Hricik (BH), Patrick Killeen (PK), Kathleen Hicks, (KH)
<b>Absent (Excused)</b>	
<b>Absent (Unexcused)</b>	
<b>AHD Representatives</b>	Dr. Anne Gaddy(5:30 to 6:20pm), Dr. Stephen Haering (6:20 to 6:52pm) Natalie Talis, Casey Colzani
<b>Guests</b>	

**I. Establishment of a Quorum**

- Meeting called to order at 5:35 p.m. Daniel Hawkins (DH), Chair read the Virtual Meeting Notice. Attendance taken. Quorum established.

**II. Approval of the November 2020 Minutes**

- Dr. Michael Trahos (MT) motioned approval of November 2020 meeting minutes. Allen Lomax (AL) Seconded. All in Favor. Minutes Approved.

**III. Introductions**

**IV. Health Department Updates**

- Dr. Anne Gaddy (AG) Gave Update on Contact Investigation and Contact Testing. Recent surge in cases post-Thanksgiving has dramatically increased workload of staff. AHD is still conduction Contact Investigation and Tracing

with a priority on those most at risk and instruction positive cases how to trace and notify their close contacts

- Natalie Talis (NT) and AG gave update on COVID-19 Testing. Health Department continues to support Neighborhood Health in targeted community testing. As well as large capacity testing events preformed with Virginia National Guard assistance. There continues to be a increase need for testing. Previously each event would test 80-100 persons, now events are testing 150-200 persons. Neighborhood Health has conducted 15,000 tests today. Neighborhood Health and AHD continue to plan strategy for testing during winter months.
- AG gave update on COVID-19 Vaccination. Hospitals have begun vaccination hospital workers, LTCF worker and residents are being supported through CVS and Walgreens pharmacy program. AHD continues to prepare for COVID-19 vaccine distribution. AHD will be following VDH and CDC priority phases, beginning with Phase 1a Healthcare Workers. AHD is in the process of obtaining ultra-cold freezers. AHD staff is preparing for Vaccination PODs to support Non-Hospital Health Care Workers. AHD being supported by MRC, City of Alexandria staff and EMS, CERT volunteers for staffing of PODs.

**V. Consideration of Health Equity Workgroup’s Report, *Advancing Racial and Health Equity by Reducing Tobacco Use and Exposure to Secondhand Smoke***

- Andrew Romero (AR) presented, see Attachment A. Discussion held on priorities. Reviewed and discussed each recommendation of the Health Equity Workgroup.
- Richard Merritt (RM) moved to approve Objective One, Patrick Killeen (PK) Second. All in Favor. Motion Passed
- PK moved to approve Objective Two, Michael Millman (MM) second. All in favor. Motion Passed
- AR moved to approve Objective Three, Patricia Rodgers (PR) second. All in foavor. Motion Passed
- PK moved to approve Objective Four, RM second – AL opposed. Motion passed by majority.

**VI. Updates from the Chair**

- StacyBiddinger (SB) gave update on 2020 Flora K Casey Award. City press release sent through e-news and social media today. January 15 2021
- Dr. Hill will process preliminary review for vote on January 21 2021 meeting

**VII. Announcement**

- AL 3 tactics in CHIP for PHAC as owners will be presented at a later meeting

- AL- Substance Abuse Prevention Coalition of Alexandria presented five anti-vaping PSAs created by Youth in Alexandria one geared towards parents and four for youth.
- AL -Governor will be releasing legislation on legalization of Marijuana.
- PR -VA Foundation for Healthy Youth proposal for Tobacco Prevention Grants. More information on Vfhy.org

### **VIII. Adjournment**

- Meeting Adjourned at 6:52 p.m.

# ***ADVANCING RACIAL AND HEALTH EQUITY BY REDUCING TOBACCO USE AND EXPOSURE TO SECONDHAND SMOKE***

***By***

***The Health Equity Workgroup  
Alexandria Public Health Advisory Commission***

December 10, 2020

## **ABSTRACT**

This *Health Equity report* examines the relationship between tobacco use and exposure to secondhand smoke to premature death and poor health and identifies some of the key inequities that contribute to disparities in premature mortality and poor quality of life among racial and ethnic groups within the City of Alexandria. Tobacco use is the only behavioral factor that is identified as a major risk factor for the top three causes of death in the U.S., viz., heart disease, cancer and chronic lower respiratory disease. Several recommendations are offered for reducing and eliminating disparities among groups most adversely affected by tobacco use and exposure to secondhand smoke. Chief among them is to increase the cigarette tax at the state and city levels and apply most of the new revenues toward increasing the availability and affordability of comprehensive smoking cessation services for low-income minority communities.

## **INTRODUCTION**

### **A Brief History of City of Alexandria's Leadership In Reducing Tobacco Use and Exposure to Secondhand Smoke**

The City of Alexandria has been a leader in the Commonwealth in the quest to reduce tobacco use and exposure to secondhand smoke among its residents and visitors. The history goes way back to 2004, when the Alexandria Health Department's "Proud to Be Smoke Free" program was launched under a grant from the Centers for Disease Control (CDC). The program encouraged restaurants in the City to voluntarily adopt a 100 percent smoke-free policy for both indoor and outdoor seating. Restaurants who joined the program received a certificate of commendation signed by the Health Director and a decal, a 2-sided laminate sign, to advertise their participation in the program. During its first year of operation, more than 100 restaurants joined the program; by 2007, almost three years prior to the state's prohibition of smoking in restaurants and bars, almost 95 percent of the restaurants had voluntarily enrolled.

In 2007, Mayor Bill Euille, frustrated over the failure of the General Assembly to ban smoking in bars and restaurants, convinced the City Council to sidestep the Dillon Rule (prohibiting the city from adopting a direct ban on smoking in restaurants or bars), by

using the city's zoning authority to mandate smoke-free restaurants. Too much outcry from restaurant owners and threats of expensive litigation over the approach eventually won the day. But the city would have to wait only a couple of more years before it would become one of the first in the Commonwealth to implement regulations pursuant to state authority to ban smoking in restaurants and bars.

At the behest of an Alexandria Public Health Advisory Commission (APHAC) resolution in 2011, City Council authorized the placement of signs discouraging smoking in each of the City's playgrounds, parks and bus shelters. The City was the first in the Commonwealth to discourage smoking in all three public venues. (See photo of Mayor Bill Euille and Councilwoman Del Pepper placing the first sign in a City bus shelter, near the campus of T. C. Williams High School, in 2012.) It must be pointed out that several members of the Advisory Commission, along with the new director of the Alexandria Health Department, Dr. Stephen Haering, took responsibility for placing the signs in the remaining scores of bus shelters around the City. (The Department of Recreation, Parks and Cultural Activities was tasked with mounting the signs in all City-owned parks and playgrounds.)

In 2013, again upon a recommendation by the Advisory Commission – this time in cooperation with the Clean and Smoke Free Air Coalition of the Partnership for a Healthier Alexandria – City Council allocated \$35,000 toward collaboration with the Alexandria Redevelopment and Housing Authority (ARHA) to (1) adopt a smoke-free housing policy for ARHA housing; (2) offer tobacco cessation services to those ARHA residents seeking to quit smoking, and (3) evaluate the effectiveness of the effort in reducing exposure to secondhand tobacco smoke among ARHA residents.

One of the common denominators among most of the initiatives described above was the importance of the authority granted to Alexandria and other cities and towns (but curiously not to counties) with general taxing powers to impose a cigarette tax with no rate limitations. (Only two counties, Arlington and Fairfax, are authorized to impose a cigarette tax, which is limited to the amount of the state cigarette tax rate – currently at 30 cents per pack.) The 2020 General Assembly made major changes in its authorization of the local cigarette tax. Senate Bill 588 authorized counties to tax cigarettes at up to 40 cents per pack. The bill also limits the cigarette tax rate of cities and towns to 40 cents per pack or the rate in effect on January 1, 2020. (Alexandria's rate as of January 1, 2020 was \$1.26 per pack.)

Alexandria first authorized a tax on cigarettes in 1992 at a rate of \$.20 per pack of 20. Between 1992 and 2020, the tax was increased only on eight occasions, the last time in 2016. The 2016 rate became \$1.26 per pack, making Alexandria the highest cigarette taxing jurisdiction in the Commonwealth. The closest to Alexandria's rate is \$. 85 per pack. (In FY 2017, the tax generated approximately \$3 million; in FY 2018 about \$2.8 million and in FY 2019 an estimated \$2.5 million.) It should be noted that reductions in revenue generated over those three years should be regarded as evidence that the tax and other abatement policies are reducing smoking in the City.

It is quite clear that few of the initiatives described above would have even been attempted, much less enacted, if it wasn't for the power of City Council to raise the cigarette tax to finance in whole or in part the program initiative under consideration. It is almost certain that Alexandria was the first city in the Commonwealth to increase the tax and allow part or all of the new revenues to be deposited somewhere other than the General Fund. In most cases, revenues were devoted to priority public health concerns – usually identified by the Advisory Commission – namely, reducing smoking among vulnerable populations and/or mitigating exposure to secondhand smoke, predominately among low-income children. With the most recent increase in 2016, substantial revenues were devoted to increasing Neighborhood Health's capacity for serving the primary care needs of more than 800 very low-income uninsured residents in the City. (That authorization continues to this day.)

At its February 2020 meeting, the last one due to Covid until November 2020, the Advisory Commission endorsed two key policy recommendations, both anticipating an increase in the cigarette tax to help finance:

- Increase the local cigarette tax by 10 cents per pack and devote new revenues toward the foundation of a comprehensive Tobacco Control, Prevention and Cessation program, housed within the Alexandria Health Department, aimed at the needs of the low-income Black/African American and Latinx/Hispanic communities; and,
- Increase the cigarette tax by an additional 5 cents per pack to support Neighborhood Health's Prenatal Care Program.

The Commission endorse another important policy but chose not to identify any financing mechanism for it:

- Support increased capacity of Neighborhood Health to provide a medical home for all low-income (at or under 200% of federal poverty level), uninsured residents who are without a routine source of primary care.

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## BACKGROUND

Tobacco use is the leading cause of preventable death in the United States. Each year, smoking kills 480,000 Americans, including about 41,000 from exposure to secondhand smoke. Smoking causes cancer, heart disease, stroke, diabetes, and lung diseases such as emphysema, bronchitis, and chronic airway obstruction (COPD), and can lead to lung cancer and heart disease in those exposed to secondhand smoke. On average, smokers die 10 years earlier than nonsmokers.

The economic costs of smoking total approximately \$300 billion per year, with medical expenditures amounting to \$130 billion. Additionally, the effects of smoking cause a loss

of productivity equaling \$150 billion a year. More than 16 million Americans are currently living with a disease caused by smoking. Smoking is one of the leading causes of cancer deaths, responsible for approximately a third of all cancer fatalities; in the US, smoking causes 87 percent of lung cancer deaths, 32 percent of coronary heart disease deaths, and 79 percent of all cases of chronic obstructive pulmonary disease (COPD).

Further, smoking is also responsible for causing liver and colorectal cancer, as well as dramatically diminishing a patient's prognosis for survival. The risk of developing diabetes is 30-40% higher for smokers than nonsmokers; smokers with diabetes also have greater risk of cardiovascular disease. Compared to the general population, the HIV-positive population is 2 to 3 times more likely to smoke. Smoking while HIV-positive increases the risk of developing infections and long-term side effects of HIV disease and treatment. Tobacco use increases the risk for oral cancer and periodontal disease. Overweight smokers have a shorter average life expectancy than nonsmokers. Smoking during pregnancy increases the risk for early delivery and low-birthweight babies.

In addition to serving as a primary agent for causing serious conditions, cigarette smoking diminishes overall health status, impairs immune function, and reduces quality of life.

Smokeless tobacco, while less lethal than smoked tobacco, can lead to various cancers, gum and teeth problems, and nicotine addiction. Almost 6% of young adults use smokeless tobacco and half of new users are younger than 18.

Tobacco use has real economic impacts for individuals and communities. It costs the nation about \$170 billion annually to treat tobacco-related illnesses, and another \$156 billion in productivity losses.

It is widely accepted that health equity is the opportunity for everyone to reach their full health potential, regardless of any socially or economically determined circumstances. Health equity in tobacco prevention and control is the opportunity to live a healthy, tobacco-free life, regardless of one's race, level of education, gender, employment, income, sexual orientation, or neighborhood they live in.

Health disparities are differences in health outcomes between population groups based on characteristics like income, race, geography or education. CDC's *Best Practices User Guide: Health Equity in Tobacco Prevention and Control* defines tobacco-related disparities as: "Differences that exist among population groups with regard to key tobacco-related indicators, including patterns, prevention and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness; and capacity, infrastructure, and access to resources; and secondhand smoke exposure."

Tobacco-related disparities affect many different population groups based on a number of socially determined circumstances and characteristics. Despite overall declines in smoking prevalence in the U.S., significant differences still exist among population subgroups. These groups have a higher prevalence of tobacco use, lower cessation rates

and poorer health outcomes. For example, higher smoking prevalence has been reported in the LGBT community and among populations living in poverty, those with mental health disorders and substance abuse conditions, and those living in the South and Midwest. The American Indian and Alaska Native population has the highest smoking prevalence than any other racial or ethnic group.

Cigarette smoking disproportionately affects the health of people with low socioeconomic status (SES). Lower income cigarette smokers suffer more from diseases caused by smoking than do smokers with higher incomes. Moreover, low SES populations are far more likely to suffer the harmful health consequences of exposure to secondhand smoke.

According to the *Truth Initiative* – a nonprofit tobacco control organization, formerly the American Legacy Foundation, dedicated “to achieving a culture where all youth and young adults reject tobacco” -- nearly 3 in 4 smokers (72%) are from lower-income communities. And it claims that this statistic “reveals a tobacco industry strategy to appeal to lower-income, less-educated consumers. Tobacco companies have targeted low-income populations in many ways over many years, creating smoking rate disparities that did not previously exist. In fact, the smoking rate was higher among those with more years of education in 1940, before the health effects of smoking became widely known and before the industry started targeting low-income individuals.”

The *Truth Initiative* documents the many ways the tobacco industry has targeted low-income communities over the past sixty years: (1) handing out free cigarettes to children in housing projects; (2) issuing tobacco coupons with food stamps; (3) giving away financial products like prepaid debit cards; (4) discounting practices or lowering the cost of cigarettes; (5) expanding the retailers and marketing (there are an estimated 375,000 tobacco retailers in the U.S. and they are disproportionately located in low-income communities).

Moreover, the *Truth Initiative* reminds us that the surgeon general’s 2014 report found that the cigarettes today pose an even greater risk of death and disease – specifically lung cancer – than the cigarettes sold when the first surgeon general’s report on smoking was issued in 1964. The primary reason, according to the *Truth Initiative*, is that over the last 50 years, “the tobacco industry has genetically engineered cigarettes to have twice the amount of nicotine and be even more addictive. Targeting people in low-income communities with an even more addictive product ensures that they will continue to buy it.”

Research continues to show how various social and economic determinants of health contribute to and maintain tobacco-related disparities. For example, people that lack quality housing may be at greater risk of exposure to secondhand smoke, and people with limited health care access may lack information about the dangers of tobacco use and available cessation options.

One of the few bright spots with respect to black-white cancer disparities – with blacks experiencing sharply higher mortality rates -- is the fact that they have narrowed significantly during the past several years. A 2019 American Cancer Society study showed that the “excess risk” of cancer death in blacks, compared with whites, fell from 47 percent in 1990 to 19 percent in 2016 for men, and from 19 percent to 13 percent for women. According to the chief medical officer of the Cancer Society, “ the biggest factor in narrowing the gap has been more rapid decreases in smoking and lung cancer over the past four decades in blacks than in whites.” He also added that “early evidence suggests the Affordable Care Act (aka Obamacare), which expanded health insurance coverage, made a difference in narrowing cancer disparities....”

The Cancer Society echoed the point made by the Truth Initiative, viz. that cancer death rates were lower in blacks than in whites during the 1950s. But the African American rate increased sharply after that, peaking in the 1990s. Disparities developed as whites, but not blacks, benefited from gains made in improved cancer detection and treatment. The chief medical officer pointed out that back then African Americans were less likely to have insurance and access to early diagnosis, while at the same time black communities were being “overwhelmingly targeted in advertising by cigarette manufacturers and the alcohol folks.”

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Health equity can be achieved in tobacco prevention and control by eliminating differences in tobacco use and exposure to secondhand smoke between certain groups. Experience has shown that well enforced, comprehensive tobacco control policies can result in a reduction in disparities among groups.

According to the CDC, comprehensive tobacco control policies help achieve health equity in three important ways:

- *Reducing disparities among groups most affected by tobacco use and secondhand smoke.* Multiple, coordinated efforts can reduce tobacco-related disparities among groups with the highest rates of use and secondhand smoke exposure. These efforts can include implementing comprehensive smoke-free laws, increasing tobacco product prices, reducing targeted tobacco industry advertising and offering comprehensive cessation services.
- *Addressing the factors that influence tobacco-related disparities*  
Tobacco-related disparities are challenging problems created and affected by a complex mix of factors, including social and economic determinants of health, tobacco industry influence, a changing U.S. population, and a lack of comprehensive tobacco control policies.... Comprehensive, well-enforced policies help address these factors by changing social norms about tobacco use, increasing protections against exposure to secondhand smoke, and improving

access to cessation services among populations most affected by tobacco use and exposure.

- *Creating a return on investment*  
Because populations experiencing health disparities make up a significant portion of health care costs, policies that focus on protecting these groups have the potential to significantly reduce overall health care costs.

Researchers estimate that tobacco control policies have saved the lives of at least 8 million Americans. Yet about 18% of adults still smoke. Each day, nearly 3,200 youth smoke their first cigarette, and 2,100 transition from occasional to daily smokers.

Continuing to adopt and implement tobacco control policies can motivate users to quit, help youth choose not to start, and improve the quality of the air we all breathe.

## I. TOBACCO USE AMONG ADULTS

### TOBACCO USE AND TOBACCO RELATED INEQUITIES

- Among U.S. Adults in 2017, 19.3% (estimated 47.4 million) currently used any tobacco product, down from 21.3% in 2013, and 41.1 million or 86.7% of current tobacco users used any combustible tobacco product;
- Current tobacco use prevalence breaks down according to the following age groups: ages 25-44 yrs. (22.5%); 45-64 yrs. (21.3%); 18-24 yrs. (18.3%) and ages 65 and older (11.0%);
- Among racial and ethnic groups, the prevalence is highest among non-Hispanic American Indian/Alaska Natives (29.8%), followed by multiracial adults (27.4%), whites (21.4%), blacks (20.1%), Hispanics (12.7%) and non-Hispanic Asians (8.9%);
- In 2013, prevalence was highest among adults with annual household income of less than \$20,000 (29.8%) and lowest among those with incomes above \$100,000 (12.8%);
- Prevalence was higher among those who were uninsured (31%), insured by Medicaid (28.2%) or had some other public insurance (26.8%) than among those with private insurance (16.2%) or Medicare only (11.0%)
- A much higher prevalence was found among those who had serious psychological distress (40.8%) than among those who did not (18.5%)

**Source:** “Tobacco Product Use Among Adults – United States, 2017” *MMWR Weekly*, November 9, 2018/67(44):1225-1232.

## **II. EXPOSURE TO SECONDHAND SMOKE**

***“There is no risk-free level of secondhand smoke exposure; even brief exposure can be harmful to health.”***  
***-Surgeon General of the United States***

Secondhand smoke is a serious health hazard causing more than 41,000 deaths per year. It can cause or make worse a wide range of damaging health effects in children and adults, including lung cancer, respiratory infections and asthma. Moreover, the U.S. Surgeon General declared in 2014 that secondhand smoke is a definitive cause of stroke. The Surgeon General also declared that there is “no risk free level of exposure to secondhand smoke” and even short-term exposure can potentially increase the risk of heart attacks.

In a landmark report, *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, the Institute of Medicine confirmed that there is conclusive evidence that secondhand smoke causes heart disease, including heart attacks. The Institute further concluded that “it is biologically plausible for a relatively brief exposure to secondhand smoke to precipitate an acute coronary event.” According to the report, “experimental studies have found that secondhand smoke exposure causes adverse changes in the cardiovascular system that increase the risk of a heart attack.”

Secondhand smoke causes approximately 7,330 deaths from lung cancer and 33,950 deaths from heart disease each year. Data show that patients with non-small cell lung cancer (the most common type of lung cancer) who are exposed to secondhand smoke have worse outcomes, including reduced overall survival and reduced progression-free survival (the length of time during and after treatment when the cancer does not grow or spread).

Secondhand smoke is especially harmful to young children. It is responsible for between 150,000 and 300,000 lower respiratory tract infections in infants and children under 18 months of age, resulting in between 7,500 and 15,000 hospitalizations each year. It also causes 430 sudden infant death syndrome (SIDS) deaths in the U.S. annually.

### III: DISPARITIES IN TOBACCO USE AND EXPOSURE TO SECONDHAND SMOKE IN THE CITY OF ALEXANDRIA

*Significantly, Tobacco Use was identified as one of the top 10 health issues in the City by those who participated in the Health Department's Community Health Assessment survey and community meetings.*

In 2015, the Alexandria Health Department reported that the percentage of adults that smoke in Alexandria is lower than the U.S. median. Moreover, Alexandria ranked first out of 43 peer counties. (Range: 9.1-24.0) and currently met the Healthy People 2020 goal of 12.0% of adults who are current cigarette smokers.

It also reported that the percentage of students that smoke in Alexandria is lower than national estimates for students in both grades 10 and 12. CHSI peer county comparisons are not available for this adolescent smoking indicator. Alexandria students in both grades 10 and 12 currently meet the Healthy People 2020 goal of 16.0% of adolescents in grades 9 through 12 who smoke cigarettes. (See "HEALTH PROFILE 1", Alexandria Health Department, August 2015.)

More recent data (see Table 4) from the County Health Rankings Survey and Roadmaps indicate that with respect to adult smoking, Alexandria failed to meet the Healthy People 2020 goal of 12% for each of the previous four years.

According to the 2016 Alexandria Youth Risk Behavior Survey the percent of 10<sup>th</sup> and 12<sup>th</sup> grade students smoking dropped dramatically from 16.1% in 2011 to 9.0% in 2014 and to 3.9% in 2016. On the other hand, the percent using e-cigarettes rose from 5.4% in 2014 to 7.5% in 2016.

2016 YRBS yielded some interesting data on youth (Grade 8) smoking by race and ethnicity;

- With respect to "ever tried smoking", 16.3% of Blacks and 16.1% of Asians said Yes, followed by 11.8% of Hispanics and only 1.7% Whites
- As to "current cigarette use", 9.7% Hispanics replied Yes, followed by 4.2% Asians, 3.5% Blacks, and 0.6% Whites
- As to "current e-cigarette use", 12.9% of Asian 8<sup>th</sup> graders said Yes, followed 8.0% of Hispanics, 5.9% Blacks, and 1.2% Whites.

White students reported statistically significant *lower* proportions of ever having smoked or current e-cigarette use when compared to Black, Hispanic or Asian students.

**TABLE 4**

**Adult Smoking in Alexandria and Neighboring Jurisdictions**

	<b>VA</b>	<b>Alex.</b>	<b>Arl.</b>	<b>Falls Church</b>	<b>Fairfax Co.</b>	<b>Fairfax City</b>	<b>PW Co.</b>	<b>Loud'n</b>
<b>2013</b>	10%	11%	4%	12%	6%	18%	12%	18%
<b>2014</b>	9%	10%	NA	11%	NA	17%	10%	18%
<b>2015</b>	9%	10%	NA	11%	NA	17%	10%	18%
<b>2016</b>	14%	13%	15%	12%	13%	15%	13%	20%
<b>2017</b>	15%	12%	13%	11%	11%	13%	12%	17%
<b>2018</b>	15%	12%	13%	10%	12%	15%	11%	15%
<b>2019</b>	14%	12%	13%	10%	12%	15%	11%	15%

**Source: County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, National Center for Health Statistics**

What is most noticeable about the comparisons of adult smoking across seven jurisdictions in Northern Virginia is that Alexandria is the only one that has failed to make any progress in reducing adult smoking over the six-year period. In fact, adult smoking increased by almost 50% over the first three years, from 9-10% to 15%. No other jurisdiction compares to that. Most others either remained flat (e.g. Arlington hovered in the 11% to 12% range) while Fairfax County showed some progress downward, from 12% to 10%. The jurisdictions that made the most progress were Prince William County and the Commonwealth of Virginia – both demonstrating a reduction of 20% in adult smoking over the six years.

Furthermore, during the last four years under consideration, ie. 2016, 2017, 2018, and 2019, Alexandria’s adult smoking rate was third highest among eight in 2016, the highest in 2017, the second highest in 2018, and dropped to the third highest among eight in 2019.

While no breakdowns of adult smoking in Alexandria by race and ethnicity are available\*, if we apply the 17.1% Blacks v. 11.4% White differential in smoking rates in Virginia, add in further evidence of the inverse relationship between level of education and level of income and those who smoke, and mix in the racial and ethnic disparities in Age-adjusted Hospitalization Rate due to COPD in table above – a not unreasonable proxy measure for adult smoking – one can reasonably conclude that low-income, not beyond high school educated African American adults account for the great majority of the adult smoking in the City.

Furthermore, data on exposure to secondhand smoke is not collected by the Virginia Department of Health, and even if it was, it would not be broken down by race/ethnicity; however, some glimpse of the extent of the problem may be discerned from the Model-based estimates from current smoking among adults aged  $\geq 18$  years (2016) below.

\*According to Sarah Conklin, PhD, with the Virginia Department of Health, “data for Alexandria by race/ethnicity is suppressed to protect participant confidentiality.” (email response to Richard Merritt, April 10, 2019)

**FIGURE 1**

**MODEL-BASED ESTIMATES FOR CURRENT SMOKING AMONG ADULTS  
AGED  $\geq 18$  YEARS IN CITY OF ALEXANDRIA– 2016  
AN INTERACTIVE MAP**

**Current smoking among adults aged  $\geq 18$  years  
by census tract, Alexandria, VA, 2016**

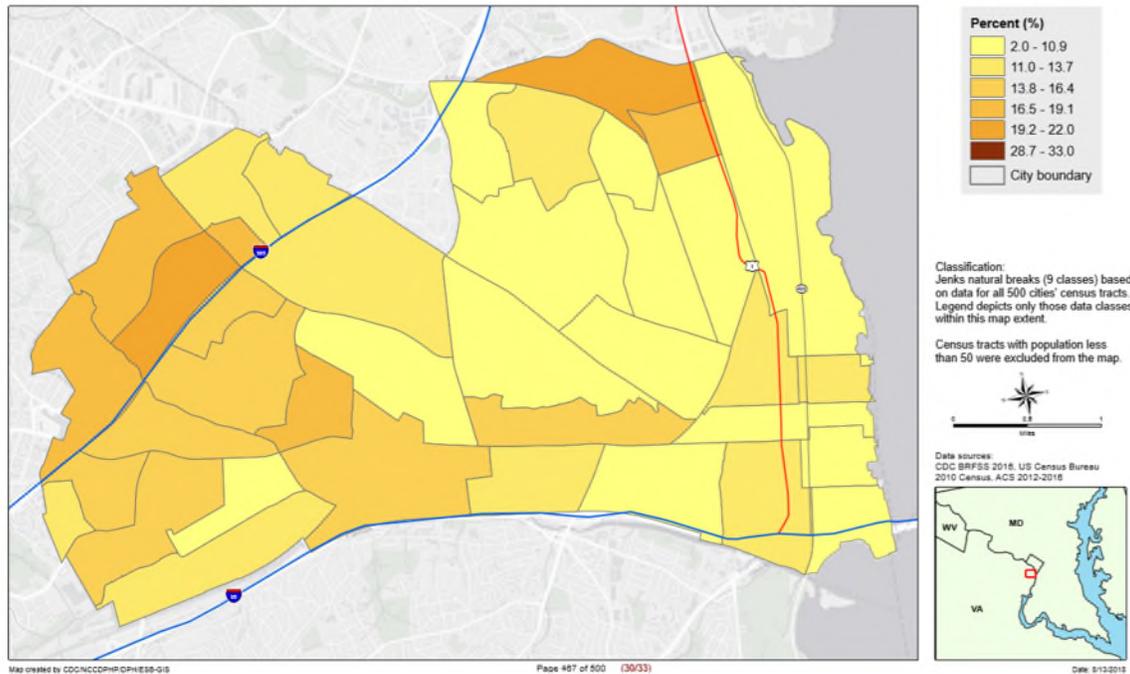
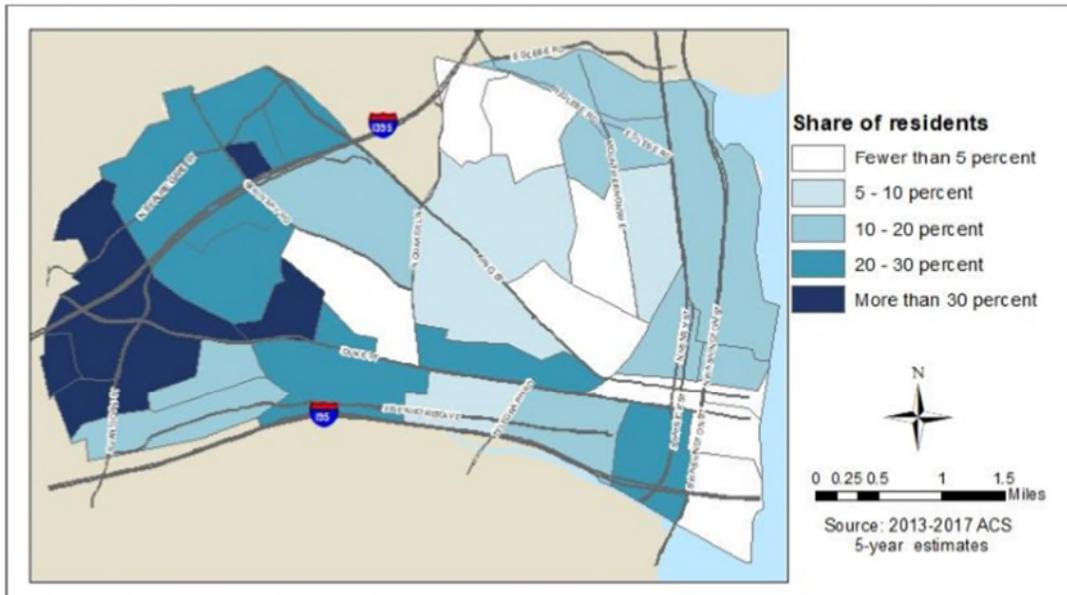


Figure B12. Share of Black or African American, non-Hispanic Residents by Census Tract, City of Alexandria (2017)



In addition, given that approximately 85 to 90 percent of all Chronic Obstructive Pulmonary Disease (COPD) cases -- a long-term lung disease that is the third leading cause of disease-related death in the U.S. -- are caused by cigarette smoking, COPD is a more than acceptable proxy for smoking prevalence.

When a cigarette burns, it creates more than 7,000 chemicals, many of which are harmful. The toxins in cigarette smoke weaken the lungs' defense against infections, narrow air passages, cause swelling in air tubes and destroy air sacs -- all contributing factors for COPD.

Table 4 below suggests there are significant differences in the prevalence of smoking among African Americans in Alexandria compared to Hispanics and Whites.

**TABLE 4**

**Age-Adjusted Hospitalization Rate due to COPD by Race/Ethnicity**

Black or African American	23.6
Hispanic	5.6
White	6.8
Overall	10.1

**Source: Disparities Dashboard, *Health Matters Alexandria***

Evidence clearly points to a close association between low-income, less-educated uninsured African American adult tobacco users in Alexandria and increased risk for premature death and poor health status. Twenty years of data from the County Health Rankings Survey confirm significant disparities in premature death rates per 100,000 population comparing Black adults (ages 15- 64) to White adults in the City of Alexandria.

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## **OVERVIEW OF KEY EVIDENCE-BASED INTERVENTIONS TO REDUCE TOBACCO USE AND EXPOSURE TO SECONDHAND SMOKE**

**The Centers for Disease Control and Prevention (CDC) has identified four evidence-based strategies, together dubbed the Tobacco Control Vaccine, which when implemented, provide robust population-level protection for communities and drive down racial disparities in tobacco use and exposure to secondhand smoke.**

- 1. Tobacco price increases**
- 2. Access to smoking cessation**
- 3. Smoke-Free Policies**
- 4. Hard Hitting Media Campaigns**

### **1. Tobacco price increases**

Even though rates of tobacco use have been declining across the U.S. (and including in Alexandria), not all populations experience that decline, and the corresponding health benefits in the same way. Smoking rates (and exposure to secondhand smoke) are disproportionately high among racial and ethnic minority individuals.

Since 2012, the Community Preventive Services Task Force has recommended interventions that increase the unit price of tobacco products based on strong evidence of effectiveness in reducing tobacco use. Evidence is considered strong based on findings from studies demonstrating that increasing the price of tobacco products:

- Reduces the total amount of tobacco consumed
- Reduces the prevalence of tobacco use
- Increases the number of tobacco users who quit
- Reduces initiation of tobacco use among young people
- Reduces tobacco-related morbidity and mortality

With respect to the later, a 2015 study published in the journal PEDIATRICS reported “increases in cigarette taxes are associated with decreases in infant mortality in the U.S., with a stronger effect among non-Hispanic African American infants.” The researchers concluded that **“policymakers may consider cigarette tax increases as a primary prevention strategy for infant mortality.”**

Evidence also shows that increasing the price of tobacco products can reduce tobacco-related disparities among different income groups and may reduce disparities among different racial and ethnic groups.

Studies have found that sensitivity to tobacco prices is highest among Hispanics, followed by African Americans and whites (regardless of differences in income). Low-income smokers, certain lower-income occupational groups, and youth are also more responsive to price increases. Research indicates a 20 percent increase in the unit price of tobacco could reduce tobacco consumption by 10%, adult tobacco use by 4% and youth initiation by 9%.

Numerous economic studies in peer-reviewed journals have documented cigarette taxes or price increases reduce both adult and under-age smoking. The consensus among many research studies is that every 10% increase in the real price of cigarettes reduces adult smoking by approximately 2.0%, smoking among young adults by 3.5%, the number of minors who smoke by at least 6.0%, and overall cigarette consumption by at least 3.0%. ([www.tobaccofreekids.org/assets/factsheets/0146.pdf](http://www.tobaccofreekids.org/assets/factsheets/0146.pdf))

## **2. Access to Smoking Cessation**

Long-standing research confirms that quitting smoking before the age of 35 years greatly diminishes the risk of death resulting from a smoking related disease; however, quitting at any age confers health benefits.

A 2020 Report of the Surgeon General on Smoking Cessation declared that “most adult smokers want to quit. Less than 10% successfully quit each year, however, largely because cigarettes are designed to create and sustain nicotine addiction....Tobacco dependence is a chronic, relapsing condition and should be treated accordingly.” The report goes on to add: “Effective cessation treatments are available. Individual, group, and telephone-based counseling increase success rates, as does each of the seven smoking-cessation medications approved by the Food and Drug Administration (FDA). Combining counseling and medication is the most effective approach.”

The Surgeon General Report further points out that many smokers face obstacle to obtaining care, are unaware of available resources, or have misconceptions about cessation treatments. Hence, according to the Surgeon General, “increasing cessation rates will require removing barriers to care and connecting smokers with evidence-based cessation treatments.”

One major barrier singled out by the Surgeon General was that “four out of every nine adult cigarette smokers who saw a health professional during the past year did not receive advice to quit.” (This was based on 2015 survey data.)

The Community Preventive Services Task Force has found compelling evidence that reducing out-of-pocket cost for tobacco cessation therapy increases access to and use of cessation treatment and increases quit rates.

Medicaid enrollees smoke cigarettes at a significantly higher rate than do privately insured residents (25.3% versus 11.8%), placing Medicaid enrollees at increased risk for smoking-related disease and death. Comprehensive state Medicaid cessation coverage has the potential to reduce smoking, smoking-related disease, and health care expenditures among Medicaid enrollees.

Approximately 8 million adult smokers were estimated to be enrolled in Medicaid in 2016. The disproportionately high cigarette smoking prevalence among Medicaid enrollees imposes a substantial health burden on society and is a major driver of federal and state health care expenditures. Smoking-related diseases accounted for approximately 15% of annual Medicaid spending between 2006-2010. Evidence based research shows that reductions in the health and financial burden of Medicaid enrollees who smoke can be obtained by covering all evidence-based cessation treatments, removing barriers that impede access to these treatments, promoting covered treatments to Medicaid enrollees and their health care providers to increase use of these treatments, and monitoring use of covered treatments.

States with expanded Medicaid coverage for tobacco cessation therapies have higher levels of cessation treatment and higher quit rates than states with lower levels of coverage. Cessation therapies may be underutilized even when Medicaid covers cessation treatment. Wisconsin and Massachusetts based studies suggest that collaborative education campaigns by public health and Medicaid officials regarding the availability of smoking cessation therapy may improve cessation treatment usage rates. When Massachusetts expanded its Medicaid cessation benefit in 2006 to include comprehensive cessation coverage, smoking prevalence decreased from 38% to 28% among Medicaid recipients. Hospitalizations for cardiovascular conditions were cut in half, saving \$3.12 for every dollar spent on the benefit.

According to the American Lung Association, a comprehensive Medicaid smoking cessation benefit would include coverage for a total of nine cessation treatments: individual counseling, group counseling, and seven FDA-approved cessation medications. As of late 2017, only 10 states covered all nine; Virginia was not among them. ALA also identified seven major barriers to accessing covered treatments employed by the states, e.g. copayments, prior authorization. Most states, including Virginia, employ at least three of those barriers. (Missouri is the only state that removed all seven barriers.)

### **3. Smoke-Free Policies**

Information and policy recommendations will be forthcoming

### **4. Hard Hitting Media Campaigns**

This strategy will not be addressed in this report

## **RECOMMENDED INTERVENTIONS TO PROMOTE HEALTH EQUITY AND REDUCE TOBACCO-RELATED DISPARITIES AMONG THE MOST AT-RISK MINORITY POPULATIONS IN THE CITY OF ALEXANDRIA**

**GOAL: Achieve sustained reductions in tobacco-related health disparities and in tobacco-related morbidity, mortality and economic cost.**

### **OBJECTIVE 1: INCREASE THE PRICE OF TOBACCO (AND E-CIGARETTE) PRODUCTS**

#### **STATE LEVEL**

1) **Recommend the General Assembly increase the state cigarette tax to \$1.20 a pack (a 300% increase over current level of \$0.30 a pack – the 49<sup>th</sup> lowest rate in the nation, Fifty percent of the increased revenue should be rebated back to community health centers and local health departments for the purpose of increasing access to comprehensive primary care services (including behavioral, mental health and oral health) for low-income, uninsured residents and making comprehensive smoking cessation services and treatment more affordable and available to low-income African Americans and Hispanics/Latinos.**

**[This policy was adopted by the Commission in 2019.]**

**RATIONALE:** Evidence-based research confirms that further increases in the unit price of cigarettes will lead to reduced smoking among low-income African American and Hispanic adults and youth and contribute to lowering infant mortality among African American infants. Part of the revenue raised through the increased tax can help finance a part-to-full time professional smoking cessation counselor tasked with conducting group and individual smoking cessation clinics within the low-income minority communities.

**(2) Recommend the General Assembly tax e-cigarettes at a rate of 40 percent of the wholesale price, and request that cities and counties be authorized to tax e-cigarettes in the same manner they are currently authorized to tax cigarettes.**

RATIONALE: The 2018 National Youth Tobacco Survey found the number of U.S. high school students who reported being current e-cigarette users increased 78 percent between 2017 and 2018 to 3.05 million (or 20.8 percent). Numbers among middle school students rose 48 percent to 570,000 (or 4.9 percent). “The markedly accelerating rate of e-cigarette use among U.S. youth within the past year is a cause for grave concern,” said CDC Director Robert R. Redfield, MD.. “E-cigarette use is unsafe among youth, and it’s critical that we implement proven strategies to protect our Nation’s youth from this preventable health risk.”

By 2019, a quarter of 12<sup>th</sup> graders were vaping nicotine, nearly half of them daily, according to a national survey Monitoring the Future. Daily vaping rose in all three grades surveyed – 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> – with accompanying increases in the proportions of youth who are physically addicted to nicotine. In the 2019 Youth Risk Behavior Survey of 4.9 million high school students, 6 percent reported smoking conventional cigarettes while 33 percent smoked e-cigarettes in the past 30 days. All this evidence led CDC Director to declare, ‘Youth e-cigarette use remains an epidemic.’”

From a public health perspective, the number one concern is the addiction power of nicotine. Research shows that the younger you are when exposed to nicotine, the more likely it is that one will become highly addicted to it. Dr. Richard Miech, the principal investigator of the Monitoring the Future survey declared, “We’re stepping backward from all the advances we’ve made in tobacco control. I’m worried that we will eventually return to the tobacco situation of yore. There’s evidence that kids who vape are four to five times more likely the next year to experiment with cigarettes for the first time.” (emphasis added)

Several studies have shown that young people are “significantly more likely” to become addicted to nicotine than adults. Other research shows that nicotine exposure in kids is also linked to development in mood disorders, attention disorders, and other drug-seeking behaviors.

A 2019 international study conducted at University of Katowice, Poland found that the use of e-cigarettes among young adults was shown to result in higher nicotine dependence levels than nicotine dependence related to tobacco cigarette use. In addition, a stronger dependence on the e-cigarette compared to the traditional cigarette identified in dual users indicates that e-cigarettes may be highly addictive.

A 2018 Study by Rand Corp. surveyed more than 2,000 people in California, ages 16 to 20, over a three-year period, and found that the longer they used e-cigarettes, the more likely they were to also start smoking regular cigarettes. Researchers have long known that nicotine in cigarettes can raise blood pressure, but it’s only recently been shown to have the same effect when it’s in e-cigarettes too.

Finally, research by the Stanford University School of Medicine concluded that vaping may be associated with a five to seven times increased risk of covid-19 among U.S. teenagers and young adults.

**(3) Seek authority to adopt additional pricing policies that can complement excise tax increases and thereby counteract pernicious industry practices that keep prices low.**

RATIONALE: Research suggests that for every 10% increase in the price of cigarettes, adult smoking decreases by 3-5% and youth smoking decreases by 6-7%.,Some studies have found even greater reductions. However, the tobacco industry knows that cheap prices help to lure new users and keep current users hooked, so they spend billions of dollars each year on price discounts and coupons to reduce prices. Price discounts are the tobacco industry’s single largest marketing expenditure.

Smoking rates among low-income populations are significantly higher than among those with higher incomes, in large part due to the industry’s targeted marketing and discounting practices in low-income communities. The City of Alexandria has clear authority to increase taxes on tobacco, however it has no authority to adopt so called Point of Sale policies such as setting a minimum price for all tobacco products or prohibiting the redemption of coupons, price discounts, and promotions, in order to counteract industry practices that keep prices low.

**CITY LEVEL**

**(1) Increase the local cigarette tax by 10 cents a pack (current rate is \$1.26) and devote new revenues toward the foundation of a comprehensive tobacco control prevention and cessation program aimed at the needs of the low-income Black/African American and Latino/Hispanic communities.**

RATIONALE: Even though rates of tobacco use have been declining across the U.S. (including in Alexandria), not all populations experience that decline, and the corresponding health benefits in the same way. Smoking rates (and exposure to secondhand smoke) are disproportionately high among racial and ethnic minority individuals. Local tobacco-control legislation has historically played an important role in reducing the impact of tobacco use. As a strong Dillon rule state with preemption on adopting stronger clean indoor air laws, Virginia’s cities and counties are limited in their options for adopting effective tobacco control measures. The exception to these limitations is the ability for several Virginia localities, including the City of Alexandria, to levy local cigarette taxes with no ceiling on the amount. (Counties, however, are limited to the amount the state taxes cigarettes, currently at \$0.30 a pack.)

**Increasing the price of tobacco through higher taxes is the single most effective way to encourage tobacco users to quit and prevent children from starting to smoke.**

Studies have found that efficacy of tobacco price increases is highest among Hispanics,

followed by African Americans and whites (regardless of differences in income.) Low-income smokers, certain lower-income occupational groups, and youth are also more responsive to price increases. Other research has shown that increases in the cigarette tax is associated with reductions in infant mortality among African American infants.

Virginia is currently ranked 50<sup>th</sup> in the U.S. for its cigarette tax of 30 cents per pack (enacted July 2005), compared to the national average of \$1.81. (The District of Columbia has the highest tax at \$4.50 and Missouri has the lowest at 17 cents.) For reasons explained above, plus additional reasons that follow, the Health Equity Workgroup believes that strong consideration should be given to increasing the local cigarette tax.

The City has been a leader in the use of the cigarette tax to finance significant public health measures, e.g. to support ARHA's board in adopting a No Smoking policy for most public housing residents, as well as for expanding capacity of Neighborhood Health to provide primary care services for an additional 800 low-income uninsured residents.

The most recent increase in the local tax took place in 2015; Council raised the rate by 11 cents a pack to a total of \$1.26 – more than three times the levy at the state level. Alexandria is currently the highest cigarette taxing jurisdiction in the Commonwealth, followed by \$0.85 in Fairfax and a few other cities. (See companion document, *History of Smoking Abatement and Reduction of Exposure to Secondhand Smoke in the City of Alexandria*)

City budget personnel estimate that a 4 cent increase in the cigarette tax will yield approximately \$90,000 in revenue; a 9 cent increase would generate approximately \$200,000 in revenue. New revenues could be devoted toward hiring a part-to-full-time professional tobacco cessation counselor/therapist with responsibility for conducting evidence-based group (and individual) smoking cessation training programs aimed at the needs of low-income minority residents, and for subsidizing the costs of FDA-approved cessation drugs for those with the greatest need. Moreover, an increase in the cigarette tax gives the city a “double barreled” approach toward reducing tobacco-related racial disparities in that evidence-based research confirms that increases in the unit price of cigarettes will lead to reduced smoking among low-income African American and Hispanic adults and youth and contribute to lowering infant mortality among African American infants.

**Note: The above recommendation is contingent on the General Assembly's recession of the limitation it placed on the City's cigarette tax rate during its 2020 session to the rate in effect on January 1, 2020.**

## **OBJECTIVE 2: PREVENT INITIATION OF TOBACCO USE AND E-CIGARETTE USE AMONG YOUTH AND YOUNG ADULTS**

### **STATE LEVEL**

**(2) Recommend General Assembly increase the state cigarette tax to \$1.20 a pack and support Senator Adam Ebben’s bill to tax e-cigarettes at 40 percent of the wholesale price**

**RATIONALE:** Evidence-based research strongly shows that these two measures will lead to a reduction in initiation of tobacco use and e-cigarette use by youth and young adults.

**(3) Recommend the General Assembly ban the sale of menthol cigarettes.**

**RATIONALE:** Use of mentholated cigarettes is disproportionately high among African Americans. While African American smokers have comparable smoking rates to Whites, more than 77 percent smoke menthol cigarettes, which make it easier to start smoking and more difficult to quit, compared with 23 percent of White smokers. Almost 84 percent of African American smokers aged 12 years or older reported smoking a mentholated brand of cigarette compared to 24 and 32 percent of their Caucasian and Hispanic counterparts, respectively. (According to CDC, nationally, 88.5% of Black smokers prefer menthol cigarettes.) More than half of youth smokers – including 70% of African American youth smokers – use menthol cigarettes.

As smoking declines among the white non-Hispanic population, tobacco companies have targeted both African Americans and Hispanics with intensive merchandising, which includes advertising in media oriented to these communities and sponsorship of civic groups.

The tobacco industry has a long history of targeting the African American community with menthol cigarette marketing and making large financial contributions to African American groups and political leaders. In 2018, the NAACP pushed back by making menthol a part of its national platform, endorsing a resolution supporting state and local efforts to restrict the sale of menthol cigarettes and other flavored tobacco.

Research shows that while cigarette consumption has declined by 26 percent over the past 7 to 8 years, menthol cigarettes have thrived in this declining market. The menthol market share has been increasing as 91 percent of the overall decline in cigarette consumption is attributed to non-menthol cigarettes. It’s important to note that preferences for menthol are not limited to Black smokers; it is also disproportionately high among lesbian, gay, and bisexual smokers, smokers with mental health problems, socioeconomically disadvantaged populations and pregnant women.

In a Commentary, “The FDA Can and Should Act Now to Address Health Disparities by Banning Menthol Flavorings in Cigarettes,” Georges Benjamin, M.D., the Executive Director of the American Public Health Association and Cheryl Heaton, DrPH, Chief

Executive Officer of the American Legacy Foundation, wrote: “Banning menthol flavored cigarettes is truly a life and death issue. One model estimates that if menthol was prohibited as a characterizing flavor in cigarettes between 2010 and 2020, more than 2.2 million people (predominately African Americans) would not start smoking and about 17,000 premature deaths could be prevented. By 2050, the cumulative number of people who would not start smoking would be nine million, and more than 300,000 deaths could be prevented. .... Cigarette smoking remains the leading cause of preventable death and disease in the United States. ...Minority populations are especially affected by tobacco use. Tobacco use is a well-known cause of various cancers, heart disease and stroke, diseases that result in disproportionately higher rates of death in African Americans than Whites. “

## **LOCAL LEVEL**

**(1) Seek authority to restrict the sale of menthol cigarettes in the absence of a state-wide ban.**

RATIONALE Same as for recommendation to ban menthol cigarettes at the state level.

## **OBJECTIVE 3: PROMOTE TOBACCO USE CESSATION AMONG ADULTS AND YOUTH**

### **STATE LEVEL**

**(1) Encourage General Assembly to expand state Medicaid tobacco cessation benefit.**

RATIONALE: Medicaid enrollees smoke cigarettes at a significantly higher rate than privately insured residents (25% vs.12%), placing Medicaid enrollees at increased risk for smoking-related disease and death. Comprehensive coverage for smoking cessation under Medicaid has a real potential to reduce smoking, smoking-related disease and health care expenditures among Medicaid enrollees. (See more extensive explanation above.)

### **LOCAL LEVEL**

**(1) Expand the availability and accessibility of effective cessation services for low-income populations affected by tobacco-related disparities, primarily African Americans and Hispanics/Latinos.**

RATIONALE: In the same way that comprehensive coverage for cessation under Medicaid can lead to a reduction in smoking related death and disease in Medicaid enrollees, similar expanded coverage for smoking cessation for low-income uninsured residents should yield similar results.

Comprehensive cessation services are understood to include all seven FDA-approved cessation medications along with individual, group and telephone counseling.

An effective cessation benefit for low-income uninsured residents should include at a minimum: coverage (with no co-pay, cost sharing or deductible) of two cessation treatments per year. Treatment consists of 1) four cessation counseling sessions, which the beneficiary may attend in person or by telephone or other communication device and individually or in a group, as she or he prefers and 2) a 90-day treatment regiment of any FDA-approved tobacco cessation drug without a prior authorization requirement.

City Council should increase the cigarette tax by \$0.xy a pack and devote new revenues to hiring a part-to-full time professional smoking cessation counselor for Neighborhood Health with responsibility for conducting group (and individual) cessation counseling sessions (based on the American Lung Association's *Freedom from Smoking*, which is regarded as the "gold standard") around the City. (e.g. Neighborhood Health clinics, Health Department and ARHA facilities).

## **OBJECTIVE 4: REDUCE AND ELIMINATE EXPOSURE TO SECONDHAND SMOKE**

### **STATE LEVEL**

**(1) Seek authority from the General Assembly to ban smoking in public spaces, including playgrounds, parks, bus shelters and in and around public recreation facilities.**

**RATIONALE:** In 2012, at the urging of the Public Health Advisory Commission and the Partnership for a Healthier Alexandria, City Council authorized the placement of signs in all playgrounds, parks and bus shelters. The signs for parks and playgrounds read:



City Council was persuaded by the evidence presented by the Commission and Partnership that such an effort would contribute to the overall public health and well-being of the City. The resolution referred to such as evidence as:

- Exposure to secondhand smoke causes disease and premature death in children and adults who do not smoke;
- The Surgeon General of the United States declaration, “*There is no risk-free level of exposure to secondhand smoke. Even small amounts of secondhand smoke exposure can be harmful to people’s health.*”
- Even brief exposure to secondhand smoke places children at greater risk for: atherosclerosis, decreased lung function, increased rates of bronchitis, pneumonia and respiratory functions; lung disease, build up of fluid in the inner ear, and behavioral problems.
- Exposure to secondhand smoke is a trigger for asthma and responsible for preventable emergency visits and hospitalizations at Inova Alexandria Hospital.

Additional arguments that were persuasive to City Council included:

- Public spaces, such as playgrounds and parks, exist for the very purpose of fostering good health and recreation, and therefore those who frequent such spaces ought not to be exposed to the dangers of unnecessary and harmful air contaminants such as secondhand smoke.
- City-owned and maintained bus shelters exist for the primary purpose of protecting citizens and visitors from the dangers of inclement weather while waiting to board a bus, and therefore those who depend on such public transportation should not, at the same time, be exposed to other, far more dangerous threats to their personal health and safety or the safety of their children such as secondhand smoke.

It is worth noting that seven years later, those arguments are still compelling and argue for consideration of requiring people to refrain from smoking while in a City park, playground or bus shelter – and within or around recreation facilities. But such consideration can only follow a change in state law permitting such actions by cities and counties.

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## **POSTSCRIPT**

Early into the advent of the coronavirus, a number of assertions were made about the relationship between smoking and Covid-19. The tobacco industry was supportive in spreading claims that nicotine helped lessen the impact of coronavirus exposure or Covid-19 symptom control. However, those assertions have not withstood the rigor of peer-reviewed data. There has also been a lot of anecdotal evidence that Covid has led to a significant increase in smoking, much like that with alcohol consumption and substance abuse. A very recent budget estimate for FY 2021 from the City depicts the first increase (almost 11 percent) in cigarette tax revenues in three years – from \$2,321,507 in FY 2020

to a budgeted amount of \$2,600,000 for FY 2021 – which could suggest a modest uptick in smoking behavior. (The Northern Virginia Cigarette Tax Authority had no information it could share regarding the last six months or so.)

Meanwhile, key takeaways by the American Nonsmokers Rights Foundation should be helpful:

- Cigarette smoking can suppress the immune system and cause heart and lung diseases.
- A person who smokes may be at greater risk for, and may have a harder time recovering from, COVID-19.
- The relationship between the use of e-cigarettes, or vaping products and risk of COVID-19 is uncertain.

The Health Equity Workgroup will continue to monitor this issue over the next several months and report on any significant new developments.