The National Latino Tobacco Control Network (NLTCN) recognizes that the burden of tobacco addiction has taken its toll on Hispanic/Latino communities. The purpose of this report is to shed light on the prevalence of tobacco use among Latinas, historical smoking trends, patterns, health effects and recommendations for action.

This is the continuation of a report series produced by NLTCN which are useful resources for agencies, advocates and researchers who are working on tobacco control initiatives in Hispanic/Latino communities.

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In the United States, an estimated 24.8 million men (23.1 percent) and 21.1 million women (18.3 percent) are smokers. Figure 1 demonstrates current smoking prevalence by sex and race/ethnicity. These people are at higher risk of heart attack and stroke. Among Hispanics, 20.7 percent of men and 10.7 percent of women smoke.\(^5\)

Prevalence of current smoking was highest among non-Hispanic American Indians/Alaska Natives, followed by non-Hispanic whites and non-Hispanic blacks, and lowest among Hispanics and non-Hispanic Asians. The aggregated smoking rate among Asians is substantially lower than that of other races due to the low rate of smoking among females (4.7%). Smoking rates among females are lower than males with black females tending to smoke less than white females.\(^6\)\(^7\)\(^8\)

This report sheds light on the problem of tobacco use among Hispanic/Latina women and provides recommendations for data collection, research, policies and programs designed to reach this community in a culturally and linguistically appropriate manner in order to reduce tobacco use, promote cessation and protect communities from environmental tobacco smoke.
Historical Trends in Smoking Among Women

What caused women to smoke? The data on women smoking before 1935 is anecdotal. The Fortune magazine published a discussion of the medical implications of smoking. It concluded that: “This much can be said: That the possible benefit to be derived from tobacco is always less than the possible harm.” The systematic surveillance of smoking behavior did not begin in the United States until 1965. Surveys before 1965 were often done for commercial purposes.

Women and girls in colonial New England and the wives of Presidents Andrew Jackson and Zachary Taylor reportedly smoked pipes. The primary form of tobacco used in the early 1800’s was chewing tobacco and was used predominantly by men however women did use snuff. The use of chewing tobacco declined in the United States after 1890 when strict laws were enacted that prohibited spitting. The introduction of blended and flue-cured cigarettes and the invention of an automated machine to produce cigarettes set the stage for widespread adoption of cigarette smoking. In New York, a law was passed in 1908 making it illegal for women to smoke in public. However, smoking among women began to increase, and some women smoked openly in the 1920s, as social and cultural changes lessened the taboos that discouraged tobacco use by women. While Grace Coolidge is believed to have been the first Lady to smoke cigarettes, Eleanor Roosevelt was the first to smoke in public.

Women started smoking in the 1930’s and very few smoked because it was socially unacceptable for a woman to smoke in public and it was against the law. It was not until World War II that smoking among women increased dramatically. The 1980 U.S. Surgeon General report “The Health Consequences of Smoking for Women” was the first report that acknowledged women and related diseases caused by smoking.

How Common is Smoking in Women?

A smoker is anyone who has smoked 100 cigarettes in his or her lifetime and who still smokes one or more cigarettes a day. More than 20 million American women smoke. In the 1970s, smoking levels began to decline in US adults, but the decline among women did not decrease significantly until the 1990’s (Figure 2).

<table>
<thead>
<tr>
<th>Levels of Smoking Among Women</th>
<th>Source: American Heart Association Heart Disease &amp; Stroke Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>People in the US who smoke</td>
<td>44.3 million</td>
</tr>
<tr>
<td>Women in the US who smoke</td>
<td>20.2 million</td>
</tr>
</tbody>
</table>

**WOMEN WHO SMOKE (by race)**

<table>
<thead>
<tr>
<th>Race</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>20%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>17%</td>
</tr>
<tr>
<td>Hispanic or Latina*</td>
<td>11%</td>
</tr>
<tr>
<td>Asian*</td>
<td>5%</td>
</tr>
<tr>
<td>American Indian/Alaska Native*</td>
<td>29%</td>
</tr>
</tbody>
</table>

Figures for adults 18 years and older, 2004; *1999-2001
Nearly 80% of smokers begin before age 18. Currently, about 25% of American girls in grades 9 to 12 smoke. Prevalence estimates of regular cigarette smoking among females between 1935 and 1979 continued to increase while men’s prevalence rates declined (Figure 3).

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935</td>
<td>18.1</td>
<td>52.5</td>
</tr>
<tr>
<td>1955</td>
<td>24.5</td>
<td>52.6</td>
</tr>
<tr>
<td>1965</td>
<td>33.3</td>
<td>51.1</td>
</tr>
<tr>
<td>1970</td>
<td>31.1</td>
<td>43.5</td>
</tr>
<tr>
<td>1974</td>
<td>31.9</td>
<td>42.7</td>
</tr>
<tr>
<td>1976</td>
<td>32.0</td>
<td>41.9</td>
</tr>
<tr>
<td>1978</td>
<td>29.9</td>
<td>37.9</td>
</tr>
<tr>
<td>1979</td>
<td>28.2</td>
<td>36.9</td>
</tr>
</tbody>
</table>

Unfortunately women’s smoking prevalence rates have almost become equal to that of men. According to data from the Centers for Disease Control and Prevention, the 2008 adult smoking prevalence for women was 16.2% compared to men with 20.7% (Figure 4). In 2001 a second Surgeon General report focused on smoking among women and further advanced the understanding of women and tobacco. The Surgeon General’s Report highlighted trends in women smoking, the negative effects of tobacco use and secondhand smoke, and the unique role of the tobacco industry in marketing tobacco to women.

Tobacco Industry Targeting of Women

The tobacco industry has historically targeted women and girls as early as the 1920s. Women have been extensively targeted in tobacco marketing, and tobacco companies have produced brands specifically for women. Such marketing towards women is dominated by themes of social desirability and independence conveyed by advertisements featuring slim, attractive, and athletic models. The tobacco industry reaches the Latina population through magazines. Research showed that in 2003, the tobacco brands with the highest advertising expenditures were in African American magazines (Ebony, Essence, Jet and Vibe) and in Hispanic magazines (Latina, People en Español).

A Virginia Slims ad campaign launched by Phillip Morris (now ALTRIA) in 1999 targeted women with a slogan “Find Your Voice”. This campaign included beautifully photographed ethnic women, some in traditional/cultural clothing, giving women the impression that smoking would help them “find their voice” and independence. The tobacco industry also continues to have promotional giveaways. In January 2007,
R.J. Reynolds ran ads for a new cigarette (Camel No. 9) in women’s magazines and included giveaways such as lip balm, cell phone jewelry, tiny purses and wristbands, all in hot pink. More recently, Phillip Morris announced a makeover of Virginia Slims cigarette packs into “purse packs” that contains super slim cigarettes. The industry also continues to have promotional giveaways.

Cigarette Use Among Hispanic Women

Menthol Cigarettes

Menthol use is becoming more and more popular among women and Hispanics. Data from the Federal Trade Commission (FTC) showed that 20% of cigarettes sold in the U.S. in 2006 were mentholated. Research has has showed that Hispanics are the second largest group of menthol cigarette smokers. Among menthol smokers, 68% are African American, 26% are Hispanic, 23% are Asian and Pacific Islander, 21% American Indian and Alaskan Native and 20% White. In terms of gender differences, 31% of menthol smokers are female and 22% are male.

Research has shown that one in four Hispanic smokers uses menthol and Kool and Newport campaigns are deliberately placed in Spanish language magazines. In fact, the tobacco industry documents reveal a clear grasp of regional differences in target marketing of leadership groups and events. Furthermore, lower income and less acculturated Latinos may associate their traditional beliefs about menthol with advertising messages, thus thinking menthol is medicinal or less harmful. Unfortunately, women are the largest group of menthol users. In fact, the largest tobacco advertising expenditures in women’s magazines are for menthol brands.

Nearly half of Hispanic smokers in high school (47%) usually smoke menthol cigarettes. Menthol cigarettes are also preferred by 76% of African American smokers, 62% of Asian American smokers and 29% of White smokers. Combined 2004 to 2008 data indicate that nearly one third (32.%) of past month smokers aged 12 or older smoked menthol cigarettes. Rates of menthol cigarette use in high school students varied greatly by race/ethnicity, with 82.6% among African Americans, 32.3% for Latino and to 23.8% among whites smoking menthol in the past month. Data from the Tobacco Use Supplement to the Current Population Survey (2006/07) shows the current menthol use among adults 18 and older by ethnicity (Figure 5).
A recent study looked at the quit rates among African American and Latino menthol cigarette smokers compared to quit rates of non-menthol cigarette smokers. The researchers found that African American and Latino smokers smoked significantly fewer cigarettes per day than non-menthol smokers. At 4-week follow up of patients attending smoking cessation services, the African American and Latino menthol smokers have lower odds of quitting compared to their non-menthol counterpart. Thus, despite smoking fewer cigarettes per day, the menthol smokers experienced less success in quitting when compared with non-menthol smokers of the same racial/ethnic group.

**Light Cigarettes**

There is no safe level of tobacco use. Light cigarettes are no less harmful than regular cigarettes. Unfortunately, more women than men smoke “light cigarettes”, mostly due to advertising that is targeted to women.

Because of cigarette design, light cigarette smokers may actually be inhaling as much tar and nicotine from the so-called “light cigarettes” as they would from regular or full flavored cigarettes. Light cigarette filters are ventilated which help to dilute smoke with air and thus reduce tar, nicotine and carbon monoxide intake. However, many smokers block the vents while smoking light cigarettes thus inhaling more tar and nicotine than is measured by machines. Smokers get as much tar and nicotine from light cigarettes as they do from regular cigarettes. Thus, light cigarettes are no less dangerous than regular cigarettes and may actually be more hazardous to one’s health.

Researchers have found that the tobacco industry uses advertising strategies that promote the use of light cigarettes as a safer alternative to regular cigarettes and to reassure smokers, thereby discouraging them from quitting. Seven percent (7%) of Hispanic adults smoke light cigarettes compared to 80% of Whites and 8% African Americans.
Acculturation

Is acculturation making Hispanic/Latinos sick? Research has shown that acculturation plays a major role in health behaviors of immigrant populations throughout the United States. The continuum of acculturation leads to behavior changes and can ultimately lead to psychological and sociocultural adaptations. Overall, as Hispanic/Latinos acculturate their health habits begin to mirror that of non-Hispanic Whites. Acculturation level is a longitudinal process and is likely to impact lifestyle, smoking rates health outcomes, food security, feelings of depression, lack of leisure time and frequency of physical activity.

Although Hispanic/Latina women have the second lowest smoking prevalence rate (10.7%), as they acculturate into the mainstream culture, their smoking patterns begin to increase to that of non-Hispanic Whites. A review of studies showed that that as women begin to acculturate, their smoking prevalence increases and that women in low acculturation groups had significantly lower prevalence rates for both smoking and total tobacco use.55

Another study looked at the differences in smoking prevalence in terms of Hispanic/Latino women who speak mostly English at home compared to those who speak mostly Spanish. The results showed that the current smoking prevalence between Hispanic/Latino women who spoke mostly English at home, versus those who spoke mostly another language was more than double.56 Seventy-eight percent of Hispanic/Latinos aged 5 and older speak Spanish at home.57

Health Effects and Mortality Trends

Smoking is responsible for approximately one in five deaths in the United States. From 2000 to 2004, smoking killed an average of approximately 443,000 people each year in the United States alone. This includes an estimated 269,655 male and 173,940 female deaths annually. Among adults, most smoking-attributable deaths were due to lung cancer (125,522), coronary heart disease (80,005) and chronic obstructive pulmonary disease and others. Like their male counterparts who smoke, women smokers are at increased risk of cancer, cardiovascular disease, and pulmonary disease. Women smokers experience unique risks related to menstrual and reproductive function.58

In terms of women’s health, cigarette smoking kills an estimated 178,000 women in the United States annually. The three leading smoking-related causes of death in women are lung cancer (45,000), heart disease (40,000), and chronic lung disease (42,000).59 Ninety percent of all lung cancer deaths in women smokers are attributable to smoking. Since 1950, lung cancer deaths among women have increased by more than 600 percent. By 1987, lung cancer had surpassed breast cancer as the leading cause of cancer-related deaths in women.60

Women who smoke have an increased risk for other cancers, including cancers of the oral cavity, pharynx, larynx (voice box), esophagus, pancreas, kidney, bladder, and uterine cervix. Women who smoke double their risk for developing coronary heart disease and increase by more than tenfold their likelihood of dying from chronic obstructive pulmonary disease.61,62

Cigarette smoking impacts women’s health overall. Postmenopausal women who smoke have lower bone density than women who never smoked. Women who smoke have an increased risk for hip fracture than those who never smoked.63

90% OF ALL LUNG CANCER DEATHS IN WOMEN SMOKERS ARE ATTRIBUTABLE TO SMOKING.
Heart Disease and Tobacco Use

Smoking also appears to increase a woman’s risk of heart disease more so than a man’s. In one study, smoking increased the risk of having a heart attack 57% more in women than in men. In general, women—especially younger women—have a lower risk of heart disease than men. Smoking seems to cancel out this natural protection. The chemicals in cigarettes damage the walls of the arteries around your heart. This causes the buildup of fatty plaque that can harden and narrow the arteries. Smoking can also trigger these fatty plaques to burst and block the artery, causing a heart attack.

Smoking makes the blood more likely to thicken and clot, increasing your risk of a heart attack. Smoking may trigger coronary spasms where the blood vessels of the heart are pinched or narrowed, causing chest pain or a heart attack.

The nicotine in cigarettes stimulates the release of chemicals that can raise your blood pressure. Smokers tend to have high levels of LDL (bad) cholesterol and triglycerides—two types of blood fat that increase your risk of heart disease. Smoking also lowers HDL (good) cholesterol.

Pregnancy and Tobacco Use

Research has shown that cigarette smoking increases the risk of infertility, preterm delivery, stillbirth, low birth weight, and sudden infant death syndrome (SIDS).

Women smokers tend to take longer to conceive than women nonsmokers, and women smokers are at high risk of not being able to get pregnant at all. The more cigarettes a woman smokes is associated with decreased fertility.

Women who smoke during pregnancy have double the rate of premature delivery compared to nonsmoking mothers. Hispanic women were more likely to give birth than their non-Hispanic counterparts. In 2005-2006, Hispanic women had 84 births per 1,000 women compared with 63 births per 1,000 non-Hispanic women.

Studies have shown that many women quit smoking when they decide to conceive or learn they are pregnant. However, many of these women resume smoking within 3 months of postpartum. One study looked at low-income Black and Hispanic women and showed that 22% of former smokers resumed smoking approximately three months postnatal.

Poverty and Health

In the United States interest has grown in reducing tobacco-related disparities between and among populations. The low socioeconomic status of women and girls characterized by one or more social conditions increased their risk for tobacco, thus they have higher rates of smoking and lower rates of quitting than do women of higher socioeconomic status.

Poverty rates have increased in United States since 2001, and women and women-headed families are more likely than men to live in poverty.

Recommendations

**Policy**

- Support increases in state and federal taxes on tobacco products.

- Utilize tax income from these tax hikes to increase tobacco prevention, cessation and control efforts in Latino communities.

- Eliminate the sale of cigarettes in all Tax Free stores, the DOD’s PXs and in border communities in order to reduce access to cheap cigarettes.
Support strict regulation of all tobacco products by the FDA including cigars, cigarillos, menthol cigarettes, and all new tobacco products.

Eliminate vending machines from all settings.

Secondhand Smoke

Support comprehensive state and local Clean Indoor Air legislation and ordinances that include casinos, bars, restaurants and all indoor work places.

Support local and state policies to achieve that all workplaces become smoke-free including construction sites, agricultural sites, landscaping sites, mining and other outdoor-based activities.

Support local and/or state ordinances that create smoke-free parks, beaches, bus stops, cars, vehicles used for work purposes, fairgrounds, amusement parks, entertainment venues, stadiums, ballparks, rodeos, prisons, juvenile detention centers, immigration centers, homeless shelters, and all places where people congregate.

Support smoke-free multi-unit housing construction and regulation of apartments built with state or federal funds.

Support smoke-free multi-unit apartment dwellings and rental properties.

Promote model advocacy campaigns such as “Regale Salud” to help community organizations or community groups address secondhand smoke issues in multi-unit housing. The Regale Salud Toolkit is available at www.tecc.org.

Support policies to assure that all substance abuse treatment settings are smoke-free and incorporate smoking cessation as an integral component to their substance abuse addiction protocols.

Data Collection

Collect disaggregated data by Hispanic/Latino ethnic subgroups in all federal, state and local governments surveys (BRFSS, NYTS, ATS, NHANES, NHIS, CPS, MTFS, NHSDA, YTS, PRAMS, etc.) Mexican Americans, Puerto Ricans, Cubans, Central and South Americans and further disaggregated data by localities with other large populations such as Dominicans, Salvadorans, Colombians, etc. When sample numbers are too small, additional surveys should be conducted.

Collect primary language data in accordance with recommendations made by The Institute of Medicine report released August 31st, 2009, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, available at http://iom.edu/datastandardization.

Collect LGBT data in all surveys and assure that this data is collected also by Hispanic/Latinos.

Collect data by Hispanic/Latino subgroups and primary language in all health care providers interventions including community health centers, Quitlines & other cessation providers.

Collect and report all Puerto Rico’s data as part of the Latino data collected by the U.S. Census Bureau. In states with large Puerto Rican communities, special efforts need to be made to collect their data and correlate it to the Puerto Ricans living in the Island.

Include in all surveys the questions of “low and intermittent smokers” and “how many cigarettes do you smoke per day?”

Conduct special surveys with Hispanic/Latinos of Afro-Latino and Indigenous heritage in order to identify patterns and design specific prevention and cessation program for these populations.
Conduct comprehensive surveys to analyze how Federal and Puerto Rican based policies have impacted tobacco prevalence rates and illnesses in Hispanic/Latino populations.

Research

Research needs to be conducted in a culturally and linguistically appropriate manner. Training is needed for non-minority researchers in appropriate research methodologies.

Research is needed to understand the differences between Latinos from the first, second, and third generations to determine how acculturation plays a role on smoking behaviors and which promising practices should be used to reach the various groups.

Because of high school drop out rates among Latinos, special surveys need to be conducted with young adults to capture the smoking rate of this at risk population.

Fund research to collect data by occupation in order to target interventions, specifically in the following industries: construction, hospitality, casino, landscaping, agriculture and services where Hispanic/Latinos are over-represented and on specific Hispanic/Latino groups at risk such as migrant workers, young pregnant women, second and third generation youth and the elderly.

Provide funding to evaluate promising practices so that they can be replicated and turned into CDC certified best practices.

Fund research that links tobacco and other chronic diseases such as diabetes, heart disease, asthma, mental health issues, HIV/AIDS and obesity in Latino communities.

Fund grants for local groups to carry out “local tobacco prevention and control” efforts that can be replicated and supported in the various Hispanic/Latino communities.

Prevention

Create, identify, disseminate and fund the implementation of prevention programs and materials geared toward serving Latino families as units, in various settings: schools, day care centers, after-care programs, colleges and universities, vocational schools, and all educational settings and institutions.

Assure that there are effective tobacco prevention curricula integrated into the school curriculums, so as to assure that this topic will not be cut, and institutionalize prevention especially in middle schools.

Fund leadership training and capacity building for tobacco prevention and control at the local level so that communities can effectively engage in supporting tobacco policies such as higher taxes and smoke-free air ordinances.

Incorporate tobacco addiction and cessation curriculum in all medical, dental, nursing and all allied health professions schools, making it a requirement for certification and quality measures.

Fund culturally and linguistically appropriate multi-media campaigns, materials and messages to inform about industry tactics and the dangers associated with tobacco use, including “harm reduction” options offered by the tobacco industry and secondhand smoke policies.

Fund “Promotora” programs (community health workers) to take the tobacco prevention, cessation, and control messages and programs to the latino community and advocate for change.
Cessation

- Support the incorporation of cultural and linguistically appropriate services in all QUITLINE services.
- Support inclusion of counseling and comprehensive cessation services in all private and public health insurance plans.
- Provide free and/or reduced NRT and/or medications to all of those who wish to use them to quit smoking.
- Review the Public Health Guidelines in light of the high rate of Hispanic/Latinos who are low and intermittent smokers.
- Fund locally based cessation services at community-based organizations, community health clinics and Hispanic/Latino and minority and/or all providers who serve Latino communities.
- Fund multi-media campaigns in Spanish and English, including TV ads to promote cessation and the value of quitting.
- Include tobacco education and cessation interventions as part of the “quality control” measures for all health care professionals and health care services.
- Include tobacco questions in the Electronic Medical Records and/or Health Records of all patients.
- Include in all cessation surveys and Quitlines DMS if people smoke mentholated cigarettes, “low and intermittent” smoking and questions on “dual usage” of cigarettes and other products, including the use of cigarettes and nicotine replacement therapy.
References

2. Ibid.
10. Ibid.
References


30. Ibid.


32. Ibid.


35. Ibid.


38. Ibid.


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47-48. Ibid.

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64-68. Ibid.


71. Ibid.


The Centers for Disease Control & Prevention (CDC) Office on Smoking and Health (OSH) funds selected organizations to lead six networks (www.tobaccopreventionnetworks.org). These national networks educate, mobilize, and connect communities in an effort to strengthen tobacco control initiatives for specific populations. The lead agencies and the corresponding networks for these priority populations are:

**African American** — National African American Tobacco Prevention Network
NAATPN [www.naatpn.org](http://www.naatpn.org)

**American Indian / Native Alaskan** — Intertribal Council of Michigan
National Native Commercial Tobacco Abuse Prevention Network [www.keepitsacred.org](http://www.keepitsacred.org)

**Asian / Pacific Islanders** — Asian Pacific Partners for Empowerment, Advocacy & Leadership
APPEAL PROMISE [www.appealforcommunities.org](http://www.appealforcommunities.org)

**Hispanic / Latinos** — The Indiana Latino Institute, Inc.
National Latino Tobacco Control Network (NLTCN) [www.latinotobaccocontrol.org](http://www.latinotobaccocontrol.org)

**Lesbian / Gay / Bisexual / Transgender / Queer** — The Fenway Institute at Fenway Health
National LGBTQ Tobacco Control Network [www.lgbttobacco.org](http://www.lgbttobacco.org)

**Low Socio Economic Status** — The Health Education Council
Break Free Alliance [www.healthedcouncil.org](http://www.healthedcouncil.org)

### NATIONAL NETWORKS FOR TOBACCO CONTROL AND PREVENTION

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### NATIONAL LATINO TOBACCO CONTROL NETWORK

NLTCN started operating in July 2008 through a five year cooperative agreement as part of the National Network Initiative. The Network’s goals are to become an effective catalyst, build leadership, inform, energize and support a National Network of tobacco control experts and activists working with Latino communities, states and coalitions to address the health burdens created by tobacco consumption. NLTCN achieves its goals by promoting policies and programs that prevent youth initiation, increase quit rates and assure smoke-free environments, as well as training and supporting communities to achieve policy changes and de-normalize tobacco use.

The expertise of the NLTCN network is built upon the collaboration of organizations and agencies involved with comprehensive tobacco control policies and programs; promising and best practices; faith and health based community mobilization; publication of tobacco control outreach materials in Spanish and English; promotion of effective cessation programs; utilization of Promotoras (Health Promoters) for tobacco control; capacity building, training and technical assistance in local communities; participatory research, evaluations, assessments and analysis; as well as, youth mobilization and media advocacy.

Although NLTCN focuses on tobacco disparities affecting the Hispanic/Latino communities, our network is enriched by the efforts and accomplishments of all the other networks collaborating with the National Tobacco Control Program (NTCP) which includes the CDC’s OSH, Network members, Network partners, States, and other local and national tobacco control organizations to advance the science and practice of tobacco control in the United States for all members of their populations.