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Smoke-free Coalition Cohesiveness in Rural Tobacco-growing Communities

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Abstract

Promoting tobacco control policies in rural tobacco-growing communities presents unique challenges. The purpose of this study was to assess smoke-free coalition cohesiveness in rural communities and identify coalition members' perceived barriers or divisive issues that impede the development of smoke-free policies. A secondary aim was to evaluate differences in coalition cohesiveness between advocates in communities receiving stage-based, tailored policy advocacy assistance vs. those without assistance.

Tobacco control advocates from 40 rural Kentucky communities were interviewed by telephone during the final wave of a 5-year longitudinal study of community readiness for smoke-free policy. On average, five health advocates per county participated in the 45-minute interview.

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Participants rated coalition cohesiveness as not at all cohesive, somewhat cohesive, or very cohesive, and answered one open-ended question about potentially divisive issues within their coalitions.

The mean age of the 186 participants was 48.1 years ($SD=13.3$). The sample was predominantly female (83.6%) and Caucasian (99.5%). Divisive concerns ranged from rights issues, member characteristics, type of law, and whether or not to allow certain exemptions. Three of the divisive concerns were significantly associated with their rankings of coalition cohesiveness: raising tobacco in the community, the belief that smoke-free would adversely affect the economy, and government control.

Educating coalition members on the economics of smoke-free laws and the actual economic impact on tobacco-growing may promote smoke-free coalition cohesiveness. More resources are needed to support policy advocacy in rural tobacco-growing communities as well as efforts to reduce the divisive concerns reported in this study.

Keywords

Tobacco control; community readiness; coalitions; smoke-free laws

Introduction

Coalitions can build community capacity for prevention programs and policy change by developing members' leadership and advocacy skills and knowledge about the topic at hand (1). Successful coalitions are effective in promoting and implementing change within communities. They are able to recruit a cross-section of community members and organizations that help inform, influence, and support the development of public policy, promoting the health, education, safety and welfare of the overall community (2, 3). Coalition members combine resources to affect population-based change that none of them could achieve independently (4). In fact, coalitions accomplish positive changes more effectively than individuals and groups working alone (5), and are foundational for community-based prevention through mobilization to address complex public health issues (6).

Tobacco control coalitions form to decrease the burden of tobacco use and reshape norms so that tobacco becomes less desirable, acceptable, and accessible in a community (7). They are able to establish greater credibility than a single individual because they represent multiple partners focused on improving the health of the community (8). These coalitions can enhance government tobacco control efforts by advocating for policy change and focusing community values on health by decreasing pro-tobacco influences (9). Tobacco control coalitions bring political, professional and skill diversity to prevention efforts and they can expand public support for smoke-free policy. Tobacco control advocacy efforts have resulted in the protection of nearly 49% of Americans from secondhand smoke through implementation of comprehensive smoke-free workplace laws (10), increased tobacco taxes (11), and exposure of the tobacco industry for deceptive marketing (12, 13).

In order for coalitions to be successful, cohesion among members is necessary. Coalition cohesiveness is defined as the ability of a coalition to work together effectively and comfortably to address a specific issue (14). For cohesion, there must be clear, relevant, attainable goals with strong leadership to maintain focus (15). Members must be knowledgeable, able to trust and interact with each other based on equality, and feel appreciated and valued. Effective group process and dynamics are essential (i.e. active listening, communication of core messages, and consensus building). Cohesive coalitions persevere despite setbacks and present a united front against opposition. Barriers to coalition cohesiveness include vague or unrealistic goals, inability to engage community leaders and partners and/or reach group consensus, and having an authoritarian leader. Non-cohesive coalitions have difficulty presenting a united front using core messages and they may be anxious about advocating for policy change. There may be interpersonal conflicts among the members, resulting in member burnout (8, 16, 17).

Promoting smoke-free coalition cohesiveness in tobacco-growing communities introduces unique challenges. Historically, politicians, community leaders and residents in these communities have resisted tobacco control efforts because they were believed to be a threat to the local economy (18). There is little evidence in the literature about how the changing role of tobacco in local economies impacts attitudes about tobacco use and tobacco control policies (13). The purpose of this study was to: 1) assess smoke-free coalition cohesiveness in rural communities; and 2) identify coalition members' perceived barriers or divisive issues that impede the development of smoke-free policies in tobacco-growing communities. A secondary aim was to evaluate differences in coalition cohesiveness between advocates in communities receiving stage-based, tailored policy advocacy assistance vs. those without assistance.

Methods

Design

This study was part of 5-year randomized controlled trial with 22 treatment and 18 control counties to test a stage-based, tailored intervention to promote comprehensive smoke-free workplace policies in a rural, tobacco-growing state. Community advocates participated in annual telephone interviews to determine community readiness for smoke-free policy. The intervention provided stage-based, tailored technical assistance to help health advocates develop capacity including coalition building, building demand for smoke-free policy, and translating and disseminating the science of secondhand smoke and smoke-free policy. A yearly leadership exchange conference with advocates from the treatment counties supported coalition leadership, and small grants (\$2500 per community per year) were provided to support evidence-based and tailored advocacy interventions to promote smoke-free workplace policy.

This paper reports data collected and analyzed related to coalition cohesiveness and perceptions of coalition cohesiveness from the Year 5 annual readiness survey. For the purposes of this paper, data from advocates in both treatment and control groups were combined to assess coalition cohesiveness and common divisive concerns among smoke-

free coalitions in rural, tobacco-growing communities. The study was approved by the institution's Office of Research Integrity.

Sample

Tobacco control advocates from 40 tobacco-growing Kentucky communities (Figure 1) were interviewed by telephone using snowball sampling. An average of five advocates per county participated in 45-minute telephone interviews ($N=186$). Of the 186 participants, 117 (63%) were from the treatment group and 69 (37%) were from the control group. Mean age of the participants was 48.1 ($SD=13.3$) with a range of 23 to 99 years. The sample was predominantly female (83.6%) and Caucasian (99.5%).

Measures

Participants were asked to rate coalition cohesiveness on an ordinal scale in response to this question: "What is the current climate within your group or coalition including morale, team commitment, and trust among employees, volunteers, leaders and/or board members? Is your group or coalition: not at all cohesive, somewhat cohesive, or very cohesive?" One open-ended question assessed potentially divisive issues within their coalition: "Thinking about your group or coalition, please describe any issues or potentially divisive concerns related to smoke-free laws that potentially cause division among your members." Each of the seven divisive concerns most often reported by participants was coded on a binary scale (yes/no).

To analyze responses to the open-ended question on divisive concerns, a codebook was developed using an iterative process to identify themes. All responses were imported into Atlas.ti and each was coded independently by two research staff using codebook themes. Inter-coder reliability and kappa statistic were used to evaluate the degree of agreement among the two independent coders on 10% of the randomly selected responses. Inter-coder reliability was 98.8% with a kappa statistic of .74.

Data Analysis

Descriptive analysis of study data consisted of frequency distributions. Chi-square tests (or Fisher's exact when appropriate) were used to evaluate the relationships between presence of each of the seven divisive concerns and the ratings of coalition cohesiveness. SAS version 9.3 was used for the analysis (19); p -values less than .05 were considered statistically significant.

Results

Overall, 50.8% viewed their coalitions as very cohesive; 44.3% rated their coalitions as somewhat cohesive. Only 4.9% reported that their coalition was not at all cohesive. Over half (56%) of the participants stated there were no divisive concerns or the meaning of the response could not be interpreted.

The most common divisive concern reported by participants in both study groups was a history of raising tobacco in the community or coalition members who raise tobacco,

followed by the belief that smoke-free ordinances would have a negative impact on the community's economy, and that business owners should make the decision whether or not to go smoke-free. Other cited concerns were individual rights, coalition members or family who smoke, government control, and enforcement concerns (Table 1).

Coalition cohesiveness was associated with three of the reported divisive concerns (Table 2). First, coalition cohesiveness was associated with the view that a history of raising tobacco was a divisive concern ($\chi^2=6.4, p=.04$). Of those who indicated a "very cohesive" coalition, 6.5% indicated that raising tobacco was a divisive concern compared to 17.3% who reported their coalition was "somewhat" or "not at all cohesive." Second, coalition cohesiveness was related to the belief that smoke-free legislation adversely affects the economy ($\chi^2=8.0, p=.02$). Of those who indicated a "very cohesive" coalition, only 2.2% indicated that smoke-free policies would adversely affect the economy vs. 12.4% who said their coalition was "somewhat cohesive". Third, coalition cohesiveness was associated with the view that government control was a divisive concern ($\chi^2=14.0, p=.001$). Of those who indicated a "somewhat cohesive" coalition, only 4.9% indicated government control as a divisive concern vs. 22.2% who said their coalition was "not at all" cohesive. No one who rated their coalition as "very cohesive" indicated that government control was a divisive concern.

Of the 115 participants in the treatment group who rated coalition cohesiveness, 65 (56.5%) rated their coalitions as "very cohesive;" 42 (36.5%) rated their coalitions as "somewhat cohesive;" and 8 (7%) indicated that their coalitions were "not at all cohesive." Among the 68 participants in the control group, 28 (41.2%) rated their coalitions as "very cohesive;" 39 (57.4%) rated their coalitions as "somewhat cohesive;" and 1 (1.5%) indicated his/her coalition was "not at all cohesive." There was a statistically significant relationship between coalition cohesiveness rating and group type (treatment vs. control) ($\chi^2=8.8, p=0.01$). The treatment group was more likely to indicate that their coalition was "very cohesive" compared to the control group (56.5% vs. 41.2%). Six of 10 (61%) treatment group participants stated there were no divisive concerns or the meaning of the response could not be interpreted. Of those in the control group, 49% stated there were no divisive concerns or the meaning of the response could not be interpreted.

Discussion

Half of the tobacco control advocates in rural communities rated their coalitions as "very cohesive." Over half reported that there were no perceived barriers or divisive issues that impede the development of smoke-free policies in rural, tobacco-growing communities. This finding is promising as prior research has indicated that promotion of smoke-free coalition cohesiveness in tobacco-growing communities has been challenging (13, 18). One reason for this relatively high coalition cohesiveness in the full sample may have been the fact that six of 10 participants were from treatment counties that received tailored technical assistance over five years. Future studies need to examine the factors that support coalition building for tobacco policy change in rural, tobacco-growing communities.

A secondary aim was to evaluate differences in coalition cohesiveness between advocates in communities receiving stage-based, tailored policy advocacy assistance vs. those without

assistance. Indeed, coalition cohesiveness was greater in treatment communities. Nearly six of 10 treatment group participants indicated that their coalition was “very cohesive” compared to only four in 10 control group advocates. The intervention was effective in terms of building capacity and developing coalition cohesiveness. Proactive technical assistance and frequent contacts (20) over the 5 years of the study allowed time for coalition ‘buy-in’ (15) in the treatment counties. Several high functioning treatment group coalitions that had endured pain and frustration and defended each other from attacks developed a true sense of ‘we-ness’, as described by King & Beckham (17). The treatment counties received ongoing, stage-specific technical assistance and training in leadership and advocacy. They also were afforded additional opportunities to work together on advocacy projects as a result of small grant funding. These additional opportunities may have contributed to improved trust between coalition members, as evidenced by the greater sense of cohesiveness reported by treatment vs. control group participants.

Smoke-free advocates in both study groups identified raising tobacco as a divisive concern. However, those in very cohesive coalitions were less likely to report raising tobacco as a divisive concern compared to those in less cohesive coalitions. The tobacco-growing tradition in rural communities is particularly emotional because of the historical involvement of numerous small family farms and cooperation among family, friends, and neighbors to accomplish the labor intensive work of raising and harvesting tobacco. The tobacco buyout (21) has changed this landscape, but tobacco is still deeply rooted in the rural culture (13). In order to reach a shared perception of coalition goals, finding a common objective and communicating it to the community is needed (3). In rural, tobacco-growing communities, it is critical to communicate that secondhand smoke exposure not only damages health, but also reinforces the culture of continued tobacco use, generation after generation (13). To be effective, coalitions must convey the message that the goal of reducing tobacco-related disease and premature death in no way dishonors the farmer or the work, family, and community ethic involved in raising tobacco. Self-reliance, individualism, and working with neighbors to overcome obstacles, which are common qualities among rural residents, can be harnessed to change the pro-tobacco culture to instill the expectation that each child deserves a healthy, tobacco-free life (13).

Smoke-free advocates also expressed as a divisive concern the belief that a smoke-free ordinance or regulation would adversely affect the economy. However, those in very cohesive coalitions were less likely to identify this concern compared to those in less cohesive coalitions. The tobacco industry has promoted the myth that smoke-free businesses will lose profits, but there is strong evidence that this is not the case (22). Smoke-free coalitions need to identify misconceptions such as the economic myth (3) and expose deceptive practices of the tobacco industry and their allied front groups (8). Coalitions in the treatment group in this study were exposed to training and strategies used to correct misconceptions about economic issues related to smoke-free policies. Technical assistance introduced coalition members in treatment communities to industry tactics such as using the hospitality industry as a front group to scare small businesses about their economic futures. They also gained the knowledge and skills to refute bogus economic studies and incidental, misleading reports stating that businesses have suffered in smoke-free communities as well as opinion pieces about what individuals believed would happen. Coalitions must change the

local 'script' perpetuating the myth that smoke-free policy will negatively affect the economy, and instead communicate the true economic impact of continuing to hand down nicotine addiction from generation to generation. Coalition advocates might share examples of restaurants that gained new families as patrons once smoking was not allowed, or bingo halls with smoke-free policies that report more patrons.

Tobacco control advocates also expressed the view that government control was a divisive coalition concern. However, those in cohesive coalitions were less likely to identify this divisive concern compared to those in coalitions that were not at all cohesive. Although clean indoor air laws are essentially no different than regulations for clean water or food, some people view such policies as government intrusion. Coalitions need to recruit members who value prevention to promote common understanding about the benefits of smoke-free laws among coalition members (20). Training and technical assistance must include a strong public health rationale and detailed knowledge about how smoke-free laws prevent initiation and support cessation as well as protect workers and the public from secondhand smoke exposure (20). Smoke-free coalition efforts must help the community understand that smoke-free policy can change the social norms to reduce morbidity and mortality from tobacco use (8).

There are a number of limitations of this study. First, we report cross-sectional findings at Year 5 of a longitudinal community intervention trial. Because we did not have data over time from advocates in all 40 communities, we were unable to determine change in coalition cohesiveness and divisive concerns over time. Treatment group participants, many of whom had participated in annual phone interviews over five years, may have felt that previously identified divisive issues had been resolved or that other issues had become more important to their coalition. Newer coalitions may face divisive concerns than more experienced coalitions experience earlier in their development. It is important to note that a few treatment group communities remained fairly uninterested in technical assistance, never developing strong coalitions, perhaps due to continued low readiness for smoke-free policy and/or other health priorities. Second, determining the exact nature of the relationship between coalition cohesiveness and divisive concerns was not possible due to the cross-sectional nature of the study reported here. Research is needed to determine whether coalition cohesiveness reduces the chance of divisive concerns or whether divisive concerns erode the ability of coalitions to develop trust, and promote morale and commitment.

Although community health advocates in rural, tobacco-growing communities expressed barriers to building cohesive coalitions for smoke-free policy, they can work systematically and collaboratively with community leaders to promote respect for all community members. A major strength of rural communities is their strong sense of self-reliance and individualism that promote rural neighbors working together to overcome major obstacles, thus promoting high levels of trust and civic engagement by those who have lived in rural communities for generations (13). Many community-level approaches are needed to end the epidemic of tobacco-related illness in rural tobacco-growing areas; everyone must help change the culture for the health of future generations (13). It will take strong, committed, local people, efforts, capacity, and resources (23) to challenge the status quo with place-based strategies tailored to their own unique needs.

Government, private, and voluntary agencies must be dedicated to providing technical assistance and other resources to support coalition building, particularly in rural tobacco-growing communities. Technical assistance and modest monetary resources made a positive difference in coalition cohesiveness in this study. Advocates need time, support and evidence-based materials to fully educate a community and its policymakers in order to counter myths from opposition forces. These resources will help the community learn the key aspects needed to enact policy change: translating and disseminating scientific knowledge to the community; building community capacity; and building demand for health policy.

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References

1. Cramer ME, Atwood JR, Stoner JA. A conceptual model for understanding effective coalitions involved in health promotion programming. *Public Health Nursing*. 2006; 23(1):67–73. doi: 10.1111/j.0737-1209.2006.230110.x. [PubMed: 16460423]
2. Brieger, W. [October 30 2013] Community Coalitions. 2006. <http://ocw.jhsph.edu/courses/socialbehavioralfoundations/PDFs/Lecture14.pdf>.
3. Marchand L, Fowler KJ, Kokanovic O. Building successful coalitions for promoting advance care planning. *American Journal of Hospital Palliative Care*. 2006; 23(2):119–26.
4. Brown, CR. The art of coalition building: A guide for community leaders. American Jewish Committee; New York, NY: 1984.
5. Boydell KM, Volpe T. A qualitative examination of the implementation of a community–academic coalition. *Journal of Community Psychology*. 2004; 32(4):357–74.
6. Center for Prevention Research and Development. Evidence-Based Practices for Effective Community Coalitions. Center for Prevention Research and Development, Institute of Government and Public Affairs, University of Illinois; Champaign, IL: 2006.
7. California Department of Health Services Tobacco Control Section. A Model for Change: The California Experience in Tobacco Control. California Department of Health Services; Sacramento, CA: 1998.
8. Centers for Disease Control and Prevention. [June 12 2013] Best Practices User Guide: Coalitions. 2007. http://www.cdc.gov/tobacco/stateandcommunity/bp_user_guide/pdfs/user_guide.pdf.
9. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; Atlanta, GA: 2000.
10. Americans for Nonsmokers' Rights Foundation. [October 1 2013] Overview list--how many smokefree laws?. 2013. <http://www.no-smoke.org/pdf/mediaordlist.pdf>.
11. Lynch, B.; Bonnie, R., editors. Growing Up Tobacco-Free: Preventing Nicotine Addiction in Children and Youth. Committee on Preventing Nicotine Addiction in Children and Youths, Institute of Medicine (IOM), The National Academies Press; Washington, DC: 1994.
12. Centers for Disease Control and Prevention. Guide to community preventive services: Reducing tobacco use and secondhand smoke exposure. 2009. <http://www.thecommunityguide.org/tobacco/default.htm>
13. American Lung Association. [June 12 2013] Cutting tobacco's rural roots: Tobacco use in rural communities. 2012. <http://www.lung.org/assets/documents/publications/lung-disease-data/cutting-tobaccos-rural-roots.pdf>.

14. Cheah YN, Chong YH, Neoh SL. A framework for cohesive healthcare coalition formation. *Studies in Health Technology and Informatics*. 2006; 124:575–80. [PubMed: 17108579]
15. Department of Transportation. Community how-to guide on coalition building. 2001. http://www.nhtsa.gov/people/injury/alcobol/community%20guides%20html/Book1_CoalitionBldg.html
16. Butterfoss, FD. Coalitions and partnerships in community health. Jossey-Bass; San Francisco, CA: 2007.
17. King, J.; Beckham, K. [June 12 2013] Communication in Coalitions, CDFS-5. <http://ohioline.osu.edu/bc-fact/0005.html>.
18. Ferketich AK, Liber A, Pennell M, Nealy D, Hammer J, Berman M. Clean indoor air ordinance coverage in the Appalachian region of the United States. *American Journal of Public Health*. 2010; 100(7):1313–8. doi:10.2105/ajph.2009.179242. [PubMed: 20466957]
19. SAS Institute I. SAS for Windows: 9.3. Cary; NC: 2011.
20. Greenberg MT, Feinberg ME, Meyer-Chilenski S, Spoth RL, Redmond C. Community and team member factors that influence the early phase functioning of community prevention teams: the PROSPER project. *Journal of Primary Prevention*. 2007; 28(6):485–504. doi:10.1007/s10935-007-0116-6. [PubMed: 18058234]
21. Southern Legislative Conference. Southern Legislative Conference of the Council of State Governments. Atlanta, GA: Jan. 2005 SLC Regional Resource.. https://www.slcatlanta.org/Publications/AgRD/tobacco_buyout.pdf. [November 2013]
22. Hahn EJ. Smoke-free legislation: a review of health and economic outcomes research. *American Journal of Preventive Medicine*. 2010; 39(6 Suppl 1):S66–76. doi:10.1016/j.amepre.2010.08.013. [PubMed: 21074680]
23. York NL, Rayens MK, Zhang M, Jones LG, Casey BR, Hahn EJ. Strength of tobacco control in rural communities. *Journal of Rural Health*. 2010; 26(2):120–8. doi:10.1111/j.1748-0361.2010.00273.x. [PubMed: 20446998]

Figure 1.
Study Counties by Group

Table 1

Divisive Concerns Most Often Reported by Respondents in Both Study Groups

Divisive Concern	Codebook Definition	Sample Quotes
History of raising tobacco (n=20)	History of raising tobacco in the community or coalition members who raise tobacco	<i>"There are some members who feel betrayed by smoke-free laws because the county has a strong history in tobacco and a lot of [people] have raised their family that way. They feel as if they are turning their back on where they are from."</i>
Smoke-free adversely affects economy (n=12)	Belief that smoke-free ordinances would have a negative impact on the community's economy	<i>"Given the state of the economy, establishments are reluctant to enforce a smoke-free policy for the fear that 'they will lose business.'"</i>
Business rights (n=11)	Business owners should make the decision whether or not to go smoke-free	<i>"Members are often divided about business owners having to implement smoke-free laws. Some members believe that business/restaurant owners should be able to determine on their own whether or not to implement a smoke-free policy. The argument was that if they are paying taxes they should be able to decide."</i>
Individual rights (n=8)	Individuals have the right to smoke anywhere	<i>"Many local business members are on the coalition and they have caused disagreements about freedom to smoke and owners' rights to enact smoke-free laws."</i>
Members who smoke or family members who smoke (n=7)	Coalition members smoke or have family members who smoke creating a conflict of interest	<i>"Some members are using tobacco; hard to address smoke-free issues when people use."</i>
Government control (n=6)	Government enacting smoke-free laws	<i>"There are some civil liberties issues where people do not want to be told when or where they can or cannot smoke."</i>
Enforcement (n=5)	Who should be responsible for enforcing smoke-free ordinances	<i>"When police are trying to control substance abuse at the football stadium, they don't feel that it is as important to control who is smoking."</i>

Table 2

Divisive Concerns and Coalition Cohesiveness Rating

Divisive Concerns	Coalition Cohesiveness Rating			<i>p</i> -value
	Not at all Cohesive	Somewhat cohesive	Very cohesive	
	(<i>n</i> =9)	(<i>n</i> =81)	(<i>n</i> =93)	
History of raising tobacco	0 (0.0%)	14 (17.3%)	6 (6.5%)	0.04
Smoke-free adversely affects economy	0 (0.0%)	10 (12.4%)	2 (2.2%)	0.02
Business rights	0 (0.0%)	6 (7.4%)	5 (5.4%)	0.63
Individual rights	0 (0.0%)	6 (7.4%)	2 (2.2%)	0.19
Members who smoke or family members who smoke	0 (0.0%)	3 (3.7%)	4 (4.3%)	0.81
Government control	2 (22.2%)	4 (4.9%)	0 (0.0%)	0.001
Enforcement	0 (0.0%)	2 (2.5%)	3 (3.2%)	0.84