Published in final edited form as:

Mil Behav Health. 2018 ; 6(1): 102–107. doi:10.1080/21635781.2017.1374221.

Veterans' views on military tobacco use and tobacco control policy

E.A. Smith¹, W.S.C. Poston², C.K. Haddock², S.A. Jahnke², and R.E. Malone¹

¹Department of Social & Behavioral Sciences, Box 0612, University of California, San Francisco, San Francisco, CA 94143

²National Development and Research Institutes, Inc., HOPE Health Research Institute 2336 SW Feather Ridge, Lee's Summit, MO 64082

Abstract

National military and veteran service organizations (MVSOs) have the potential to be advocates for stronger military tobacco control. This study consisted of qualitative analysis of interviews with 5 MVSO leaders (or their designees) and 6 focus groups conducted with veterans, to explore the opinions of MVSO leaders and veterans about military tobacco use and tobacco control policy, and to assess their current knowledge, attitudes, and likelihood of engaging with civilian tobacco control. Themes discussed include the impact of tobacco use on the military mission and on veterans; the possibility of stronger military tobacco control policies; and the idea that such policies would affect the rights of military personnel. Participants considered whether tobacco use impacts the military mission in the most literal sense (e.g., giving away patrol locations), ignoring larger scale effects on long term health and costs. While familiar with tobacco's impacts on veterans' health, MVSO leaders did not endorse stronger policies, although some veterans did. Participants were largely unaware of the impact of tobacco use on military readiness. Establishment of better alliances among MVSOs and civilian public health groups for mutual education about tobacco's many negative effects on the military's mission may be necessary to achieve a tobacco-free military.

Tobacco use prevalence is unacceptably high in the U.S. military, exceeding rates in the civilian population (Barlas, Higgins, Pflieger, & Diecker, 2013). Among all personnel, 49.2% reported using any nicotine product (including cigarettes, smokeless, pipes, cigars, and e-cigarette devices) in the past 12 months, with the highest percentage in the Marine Corps (60.8%) and the lowest percentage in the Air Force (40.4%) (Barlas et al., 2013). Military tobacco use is associated with training injuries (Altarac et al., 2000), premature discharge (Klesges, Haddock, Chang, Talcott, & Lando, 2001), lower cardiorespiratory fitness (Macera et al., 2011), and reduced troop readiness and increased costs for the Department of Defense (DoD) (Klesges et al., 2001). Elevated rates of tobacco use persist when personnel transition to civilian life. Smoking prevalence (age adjusted) is 27.0% among veterans and 21% among non-veterans (Brown, 2010).

Correspondence to: E.A. Smith.

The authors declare that there are no conflicts of interest.

Tobacco control policies in the military include tobacco-free basic training, smoke-free housing policies (these vary by service) (Smith, Rojo, & Malone, 2015), and tobacco cessation programs that include in-person and online elements, as well as availability of nicotine replacement therapy (details of these programs also vary by service and installation) (Smith, Poston, Haddock, & Malone, 2016). Most workplaces are smokefree. Tobacco products are sold in commissaries and exchanges, where they are not taxed; prices are supposed to be within 5% of community prices, but this policy appears to be poorly enforced (Haddock et al., 2014; Poston et al., 2016).

Stronger tobacco control measures have been considered recently among some military branches. For example, the U.S. Navy prohibited smoking entirely on its submarine fleet (Lando et al., 2015), and also announced that it will comply with Hawaii's new law establishing 21 as the minimum legal age for tobacco sales and use (Bussewitz, 2015). However, other efforts have been stymied by Congressional interference. In 2014, when Secretary of the Navy Ray Mabus proposed eliminating tobacco sales from Navy and Marine Corps installation stores (Mabus, 2012), Congress intervened, inserting language in the Defense Authorization bill to compel military stores to continue to carry any items currently in stock (Mechanic, 2014). Because the military cannot lobby Congress on its own behalf, it can be at a disadvantage when it crosses powerful interests such as the tobacco industry.

Military and veterans' service organizations (MVSOs) frequently represent military voices in public policy debates. Historically, MVSOs have been considered a powerful lobby (Camacho & Sutton, 2007). Some MVSOs monitor and take positions on legislation and policy affecting both veterans and active duty personnel; for instance, on voting rights of active duty members, and post-deployment health assessment policies (American Legion, 2009). Much of the impetus for organized veteran activity on tobacco issues appears to have come from the tobacco industry (Offen, Smith, & Malone, 2013). Despite these relationships, MVSOs have not always supported tobacco industry positions. For example, MVSOs lobbied in favor of a ruling that veterans' tobacco-related disabilities should be eligible for pensions (Offen, Smith, & Malone, 2010). In general, MVSO websites and newsletters rarely address tobacco use in their content. For example, tobacco comprised only 1.4% of all health content of 24 active MVSO websites (Poston, Haddock, Jahnke, & Jitnarin, 2013). Similarly, MVSO newsletters rarely mention tobacco, with only 1.0% of covers, 5.9% of general magazine content, and no leadership messages mentioning tobacco use in any way (Jahnke, Haddock, Poston, & Jitnarin, 2014; Jitnarin, Poston, Haddock, & Jahnke, 2015).

Veterans and MVSOs could be a powerful voice for stronger tobacco policy in the military, but have not been active on these issues. Civilian public health organizations also have remained largely silent on issues of military tobacco control, and have not formed alliances with veterans (Grundy, Smith, & Malone, 2014; Smith, Grundy, & Malone, 2015; Smith & Malone, 2013). We sought to explore the opinions of MVSO leaders and veterans about military tobacco use and tobacco control policy, and to assess their current knowledge, attitudes, and likelihood of engaging with tobacco control.

Methods

Key Informant Interviews with MVSO National Leadership

We previously conducted a study of the content of MVSO websites to examine how they provide health information to their members (Poston et al., 2013). In this study, we reviewed lists of all chartered and unchartered MVSO from the US Department of Veterans Affairs (<https://www.va.gov/vso/>) and those listed by the Veterans Coalition (<http://veterans-coalition.org/members.html>) to determine whether they provided current communications to members and had functioning websites. Organizations were included if they: 1) were national organizations; 2) had a functioning website; 3) had broad memberships (e.g., not limited to a particular ethnic or religious group); 4) were not primarily social organizations; 5) had some interest in physical and/or mental health issues affecting veterans; and 6) were primarily focused on veterans' and military issues (Poston et al., 2013). Twenty four (N=24) MVSOs were selected based on these criteria. Next, for our study on legislative activity among MVSOs, we narrowed this list to 20 organizations that had legislative or government affairs sections on their websites or if they referenced such work in Washington D.C. which may have included legislative priorities, resolutions, and/or fact sheets (Jahnke et al., 2014). From this group of 20 we selected the nine MVSOs that addressed the highest number of legislative priorities related to veterans and military members (i.e., active duty, reserve, Guard), the US Veterans Administration, and general military concerns (Jahnke et al., 2014). One group with a high number of legislative priorities was excluded because it was an umbrella group for other MVSOs already on the list and only had organizational members. The nine groups were the Air Force Sergeant's Association, the American Legion, the American Military Society, AMVETS, Disabled American Veterans, the Fleet Reserve Association, the Iraq and Afghanistan Veterans of America, the Retired Enlisted Association, and Veterans of Foreign Wars. Descriptions of each of these organizations missions and the legislative priorities endorsed can be found elsewhere (Jahnke, et al., 2014).

We also limited our target organizations because of the challenge involved in "cold calling" the national offices of these organizations and securing permission to interview their national commander, executive director, or appointed designee. Arranging leadership interviews took nearly six months, starting with sending solicitation letters to the headquarters of each of the nine MVSOs and following up with numerous phone calls to the leadership. No organization gave us access to leadership initially; we typically were screened over several teleconferences by a designee. After this screening process, designees provided us with a scheduled telephone appointment with the MVSO leader or designee (n=5), informed us via email that the MVSO leader declined our request (n=2) or ceased communication (n=2). Interviews were conducted telephonically and digitally recorded and then professionally transcribed verbatim.

Focus Groups with MVSO Members

We solicited 20 MVSO local posts and state leadership offices to conduct focus groups in states with large numbers of veterans or those with populations representing a larger than average proportion of veterans. After an initial phone request, usually to the Sergeant at

Arms and Adjutant, the request was elevated to the State or Post Commander or Vice Commander to whom we sent study materials and provided a telephone briefing about the study. After the briefing, they generally requested a period of up to a month to consider participation. Thus, for each MVSO post or State leadership office, the initial recruitment process typically included 4–5 phone calls spaced over several weeks just to reach an initial point of contact and another 3–4 weeks to work our way up the command structure.

We gained approval from six MVSOs and conducted focus groups in California, Florida, Hawai'i, Massachusetts, New York, and Texas with a broad spectrum of veterans (ranging from those serving in Korea and Vietnam to those who recently completed service in either Operation Iraqi Freedom or Operation Enduring Freedom) and settings (e.g., three with state MVSO offices and three with local posts) and some among MVSOs representing the largest numbers of individual post members nationally (i.e., the American Legion, Disabled American Veterans, and Veterans of Foreign Wars) (Jahnke et al., 2014). Once each of the six MVSO leaders approved us to conduct focus groups, they posted information about the study and when the focus groups would be conducted. Focus groups were held with veterans at MVSO meeting rooms.

Two researchers (including at least one of the veteran authors at all groups) with extensive experience in facilitating focus groups, used a standardized protocol with a low moderator involvement approach, which allowed for the spontaneous emergence of unanticipated information. The co-moderators, prior to commencement of the focus group, obtained informed consent individually. Participants consented to audiotaping; identifying information was deleted in transcripts. The co-moderators took field notes and prepared debriefing memos following each group. Participants completed a brief demographic questionnaire (Table 1). Following this, participants were asked to discuss their perceptions of military tobacco use, military tobacco control, and what, if any, role MVSOs might play in the development of military tobacco control policy. Focus group digital audiotapes were professionally transcribed.

The researchers coded verbatim interview and focus group transcripts into thematic categories. Two authors (EAS and REM) reviewed the transcripts and together generated a set of preliminary codes. EAS then coded all transcripts to identify additional codes and through discussion with REM, refined existing codes. NVivo software was utilized to manage textual data. By iteratively reviewing data under each code, the research team developed an interpretive account that captured patterns and variations in the data. The interpretive account was refined through writing memos, which were developed with the research team. Quotes are identified as coming from a focus group [FG] or leader interview [LI].

Results

No participants reported that their organizations had worked on military tobacco control policy issues (a few referenced their local posts' smokefree policies), so results reported here focus on issues that suggest whether MVSOs and their memberships are adequately informed and prepared to support such initiatives. These issues include participants' ideas

about the effects of tobacco use on the military mission; the impact of tobacco use on veterans; opinions about strengthening military tobacco control policies and the concept of a tobacco-free military; and whether tobacco control policies impinge on the rights of military personnel.

Military mission

Most respondents considered the question of whether tobacco use impacts the military mission in the most literal and immediate sense. For example, one participant pointed out that on patrol “the smoke can give your position away, and especially the glow at night.” [FG] Another reported personal experience with this situation in Vietnam: “a guy did light up when ...we were playing border guard. No lie. He got popped [shot]. And from then on, they said, ‘No smoking up on line.’ You come down to the tent below the hill, and you’d light up in your tent. And it better be quick light, ‘cause they’ll see that flash of light.” [FG] A few veterans raised other, similar issues, for instance, “you’re out somewhere and they’re trying to keep quiet. And somebody that smokes got the coughs . . .” [FG] Another said that when he was in the Navy, smoking was restricted to certain areas on ship, “and people would leave their assigned working spaces to go someplace they could smoke.” [FG] Some issues were more hypothetical: “It’s hard to quantify, but it’s got to have some effect, especially if you ...have to be somebody who has to run, like a Navy SEAL or something, and your lung capacity is less, then it’s got to have an effect.” [LI]

Larger scale impacts on the military were largely unaddressed, such as the issues of the costs and logistics of making tobacco available to deployed personnel, supporting an addictive behavior (i.e., tobacco dependence) in organizations where substance addiction is generally not tolerated or condoned, or the costs of healthcare for active duty personnel or veterans. Only one leader brought up this issue, remarking that “somebody’s paying for their health care, whether it’s the Veterans’ Administration or it’s the Medicare-B budget or something else Tricare [the military healthcare system] provides.” [LI]

Impact on veterans

Veterans for the most part thought smoking had significant impacts on veterans’ lives. As one leader put it, “All you have to do is go into an old American Legion post and hang around the bar. You can observe ...the smoking and coughing and smoking and coughing. It’s bad for their health.” [LI] A focus group participant noted that “The physical effects of smoking are well documented. We see cases of people – generally it’s Vietnam vets and older who come to us with chronic obstructive pulmonary disease, pulmonary emphysema, carcinoma of the lung. And you look at their record, and they were smokers. And the evidence is clear.” [FG] Others had personal stories, such as one who said, “We lost a very good friend of ours ...he had to smoke. He had to have that cigarette. And ultimately, it did kill him. It contributed to his heart failing. So is it an ongoing problem? Oh, hell, yes.” [FG] A few were vaguer about the connection. One participant described “impacts on some older veteran friends that I knew ...They came down with what they call it – COPD or whatever it is – and going around with an oxygen bottle nowadays ...and they smoked through their military years and continued afterwards.” But he continued, “Now whether they would have

still had problems had they not smoked, I don't know. But I think it might have – certainly didn't help the situation.” [FG]

Strengthen military tobacco control/Tobacco-free military

Despite this, veteran leaders did not endorse stronger military tobacco control policies, generally regarding smoking as an individual behavior choice rather than an organizational problem. Some simply said that they were not sufficiently aware of current regulations to take a position. One felt that the question was “a political hot potato. That's just like choice of religion.” [LI] He declined to elaborate. Others were definite that they were not in favor of more regulation. One said that his “perception is that [tobacco control regulations] are about right. I do not believe in strict prohibition against smoking for anyone.” [LI] Another acknowledged the health hazards of smoking, and suggested that “communication efforts should be strengthened. But ultimately, it's that service member's decision on whether they want to quit.” [LI] Similarly, in answer to a question about abolishing tobacco use altogether for service members, one said, “I strongly disagree.... If we outlaw it as a country, then sure. But we haven't.” [LI]

Focus group participants also were asked about making the military tobacco-free. Somewhat surprisingly, a number of them supported this idea, including all members of one group. A participant said, “There's nothing beneficial about it. And if you want to be a good fighting machine or pilot, you know, what the hell are you doing? ...it's not good for you . It shouldn't be allowed.... if you're going to join the military, quit.... If you're already in and you're smoking, stop it.” [FG] Some said that such a policy should be instituted gradually, starting with new recruits. One participant suggested that “they could start with, ‘okay, we're giving you all this money to get in the service. So you can't smoke.’ Do I sign the contract and get the money and join the service? ‘You won't be a smoker.’ ...Eventually, everybody would be a nonsmoker.” [FG] Another agreed, saying, “I think if it was pre-known before you went in the service, you can't smoke, then ...the impact wouldn't be severe...Because they probably would throw like a grandfather rule in. If you're in the service now, you can still smoke. Any new recruitments, no smoking.” [FG] Current members could be given time to adjust: “If you're an alcoholic, they put you through a program.... And you are out if you don't go through the program. They can do the same thing with cigarettes.... Go through the program. If you don't quit smoking within a certain period of time, you're out of the military.” [FG]

Others foresaw problems. One commented, “I think the universe should be smoke-free. However, is it realistic? Probably not.... And how you would all of a sudden say that all of the military is smoke-free. That sounds very good. But once again – and I would absolutely support it – but the devil is in the detail.” [FG] Another thought that given such a policy, “Somebody's going to come up and say, ‘Well, you're being prejudiced against me because I'm a smoker.’” [FG] One participant questioned the efficacy of regulating tobacco use: “I guess you can make rules and things, you know, say that no one in the military's gonna smoke, or something. But that's not gonna stop smoking.” [FG]

Participants suggested there would be problems with recruitment; for instance, one said “Well, I was a smoker when I joined, so if they said I can't smoke, I wouldn't have joined.”

[FG] Another agreed, saying, “If I had a real smoking problem, I wouldn’t go there. I wouldn’t put my name in.” But he continued, “I quit smoking pot because I wanted to keep working in construction. I mean, that was my choice. I had to quit. And I don’t miss it,” [FG] perhaps suggesting that the policy was neither as draconian nor as likely to reduce enlistment as he first thought. Another also mentioned re-enlistment particularly: “I can see reenlistment going down dramatically, because if ...I can't smoke when I'm doing my four years or however long my enlistment is, that's going to be a determining factor on whether on whether I re-up.” [FG] One participant thought a tobacco-free requirement was inevitable, saying, “I think there'll be a time when you won't be able to smoke. It won't be sold on base. And if you do, this ain't where we want you.” [FG]

Rights

The issue of rights emerged when participants were asked about abolishing smoking. That would be “taking away a privilege, too, though, somebody's right.” [FG] Even those who supported the idea in general had some second thoughts. One participant said, “you give up civil rights that every citizen in this United States has, when you join the military.... Being a member of the military, for all intents and purposes, Uncle Sam owns your body. And to him, it's a ...tool to get the mission accomplished. Should he be able to sit here and say, ‘You can’t smoke anymore’? That’s a tough call.” [FG]

Even when participants recognized that tobacco use was detrimental to the military mission, the idea of abolishing its use and sale disturbed them. One commented, “We give up some basic rights when you go into the military.... But, you know, to take that away completely -- you know, here you are in a combat zone, and you can't smoke? You know, yeah, that has a negative on the mission and stuff, but you're also taking away a basic human privilege.” [FG] But for others, the idea that smoking was a right was just an argument that would be deployed to oppose stronger rules. One participant said that, if the military stopped selling cigarettes, the political fallout would be challenging: “ACLU [American Civil Liberties Union] would probably come out of the woodwork and all kinds of civil rights activists would swarm all over the command structure, and there'd be a lot of political stuff and a lot of posturing on the hill, a lot of oversight hearings. And there'd be a lot of furor.” [FG]

Discussion

This study has limitations. It was challenging to get MVSO leaders to participate in the study at all; therefore the leadership of some large MVSOs is not represented. Interviews and focus groups do not represent the same set of organizations, so it is unknown whether the leaders interviewed represent the views of their organization members better than do the focus group participants. Veterans of different generational profiles also may have very different perspectives and our study was not designed to explore these. The research is qualitative and exploratory in nature, so generalization is not possible. However, this study is the first to examine attitudes and opinions about tobacco control issues among veterans and MVSO leaders.

MVSO leaders were somewhat more aware than individual veterans of the larger costs of tobacco use by military personnel to the military and the Department of Veterans Affairs.

Most veterans and MVSO leaders were not eager to strengthen military tobacco control or establish a tobacco-free military, regarding the issue primarily as a matter of individual behavior choices. Some veterans described tobacco use as a right, an idea widely held in the military (Smith & Malone, 2012) and promulgated by the tobacco industry (Givel, 2007; Smith & Malone, 2007), though it lacks legal or jurisprudential basis (Graff, 2005). However, a minority of veterans was enthusiastic about the idea of ending tobacco use in the military, and some regarded it as inevitable, suggesting that perhaps MVSO leaders may be more cautious on this issue than veterans at large. Those who supported a tobacco-free military characterized the issue as a matter of military fitness and therefore an organizational issue. This suggests that those working to address tobacco in the military may need to develop stronger messaging about its effects on the military as a whole, not merely on individuals, to disrupt the “individual choice” framing that often predominated conversations.

Conclusions

Our data suggest that veterans and MVSOs currently are not well-positioned to be advocates for military tobacco control. Previous research has found that public health and tobacco control advocates also are ill-equipped and reluctant to address these issues, because of their lack of knowledge about the military and uncertainty about their possible role in policy change (Grundy et al., 2014; Smith, Grundy et al., 2015; Smith & Malone, 2013). These knowledge gaps leave military tobacco control advocates without the civilian support necessary to protect policy change from congressional interference. Better alliances among MVSOs and civilian public health groups for mutual education may be necessary to achieve a tobacco-free military.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

We would like to thank Naphtali Offen for conducting focus groups.

Funding: This work was supported by the National Institutes of Health, grant numbers CA157014/DA036509. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Cancer Institute, the National Institute on Drug Abuse, or the National Institutes of Health.

References

- Altarac M, Gardner JW, Popovich RM, Potter R, Knapik JJ, Jones BH. Cigarette smoking and exercise-related injuries among young men and women. *American Journal of Preventive Medicine*. 2000; 18(3 Suppl):96–102. [PubMed: 10736545]
- American Legion. Issues & legislation: current legislation. 2009. Retrieved December 11, 2009, from <http://legion.capwiz.com/legion/issues/bills/>
- Barlas, FM., Higgins, WB., Pflieger, JC., Diecker, K. 2011 Health Related Behaviors Survey of Active Duty Military Personnel. 2013. Retrieved 12 September, 2014, from http://www.murray.senate.gov/public/_cache/files/889efd07-2475-40ee-b3b0-508947957a0f/final-2011-hrb-active-duty-survey-report.pdf

- Brown DW. Smoking prevalence among US veterans. *J Gen Intern Med*. 2010; 25(2):147–149. [PubMed: 19894079]
- Bussewitz, C. Hawaii raises smoking age to 21; military supports new law. 2015. Retrieved 6 January, 2016, from http://hosted.ap.org/dynamic/stories/U/US_HAWAII_SMOKING_AGE?SITE=AP&SECTION=HOME&TEMPLATE=DEFAULT&CTIME=2015-12-31-12-52-25
- Camacho PR, Sutton P. A sociological view of the Vietnam veterans' lobby. *Armed Forces & Society*. 2007; 33(3):316–336.
- Givel MS. Consent and counter-mobilization: the case of the National Smokers Alliance. *Journal of Health Communication*. 2007; 12:339–357. [PubMed: 17558787]
- Graff, SK. There is no constitutional right to smoke. 2005. Retrieved 23 May, 2012, from http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-syn-constitution-2008_0.pdf
- Grundy Q, Smith EA, Malone RE. "Like throwing a rock at their armored tank": Civilian authority and military tobacco control. *BMC Public Health*. 2014; 14:1292. [PubMed: 25518726]
- Haddock CK, Hyder ML, Poston WS, Jahnke SA, Williams LN, Lando H. A Longitudinal Analysis of Cigarette Prices in Military Retail Outlets. *Am J Public Health*. 2014; 104(4):e82–87.
- Jahnke SA, Haddock CK, Poston WSC, Jitnarin N. Priorities of legislatively-active veteran services organizations: A content analysis and review for health promotion initiatives. *Military Medicine*. 2014; 179(11):1331–1338. [PubMed: 25373063]
- Jitnarin N, Poston WSC, Haddock CK, Jahnke S. Health in the news: an analysis of magazines coverage of health issues in veterans and military service organizations. *Mil Med*. 2015; 180(5): 539–546. [PubMed: 25939108]
- Klesges RC, Haddock CK, Chang CF, Talcott GW, Lando HA. The association of smoking and the cost of military training. *Tobacco Control*. 2001; 10(1):43–47. [PubMed: 11226360]
- Lando HA, Michaud ME, Poston WS, Jahnke SA, Williams L, Haddock CK. Banning cigarette smoking on US Navy submarines: a case study. *Tob Control*. 2015; 24(e3):e188–192. [PubMed: 25163466]
- Mabus, R. Memorandum for Chief of Naval Operations and Commandant of the Marine Corps: Tobacco cessation in the Department of the Navy. 2012. Retrieved 11 Aug, 2015, from <http://projectuniform.org/wp-content/uploads/2015/01/SECNAV-Memorandum.pdf>
- Macera CA, Aralis HJ, Macgregor AJ, Rauh MJ, Han PP, Galarneau MR. Cigarette smoking, body mass index, and physical fitness changes among male navy personnel. *Nicotine Tob Res*. 2011; 13(10):965–971. [PubMed: 21624940]
- Mechanic, M. Is the world's most powerful military defenseless against big tobacco?. May 22, 2014 2014, Retrieved 1 October, 2014, from <http://www.motherjones.com/politics/2014/05/military-tobacco-cigarette-sales-navy-congress>
- Offen N, Smith EA, Malone RE. "Willful misconduct": How the U.S. government prevented tobacco-disabled veterans from obtaining disability pensions. *American Journal of Public Health*. 2010; 100(7):1166–1173. [PubMed: 20466954]
- Offen N, Smith EA, Malone RE. "They're going to die anyway": smoking shelters at veterans' facilities. *Am J Public Health*. 2013; 103(4):604–612. [PubMed: 23409899]
- Poston WSC, Haddock CK, Jahnke SA, Jitnarin N. What do veterans service organizations' web sites say about tobacco control? *Am J Health Promot*. 2013; 28(2):88–96. [PubMed: 23631454]
- Poston WSC, Haddock CK, Jahnke SA, Smith EA, Malone RE, Jitnarin N. Cigarette prices and community price comparisons in US military retail stores. *Tobacco Control*. 2016
- Smith EA, Grundy Q, Malone RE. "It's not a priority when we're in combat": public health professionals and military tobacco control policy. *American Journal of Public Health*. 2015; 105(4):660–664. [PubMed: 25713938]
- Smith EA, Malone RE. 'We will speak as the smoker': the tobacco industry's smokers' rights groups. *European Journal of Public Health*. 2007; 17(3):306–313. [PubMed: 17065174]
- Smith EA, Malone RE. Why strong tobacco control measures "can't" be implemented in the US military: a qualitative analysis. *Military Medicine*. 2012; 177(10):1202–1207. [PubMed: 23113448]
- Smith EA, Malone RE. Military exceptionalism or tobacco exceptionalism: How civilian health leaders' beliefs may impede military tobacco control efforts. *American Journal of Public Health*. 2013; 103(4):599–604. [PubMed: 23409898]

- Smith EA, Poston WS, Haddock CK, Malone RE. Installation tobacco control programs in the U.S. military. *Military Medicine*. 2016; 181(6):596–601. [PubMed: 27244072]
- Smith EA, Rojo R, Malone RE. Tobacco use policy in military housing. *Military Medicine*. 2015; 180(6):612–614. [PubMed: 26032376]

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 1

U.S. Veteran and MVSO leader participant demographics

	N = 33	%
Male	27	82
Female	6	18
AI/AN	6	18
Asian	2	6
Native Hawaiian/PI	1	3
African-American	2	6
White	21	64
No data	1	3
Hispanic/Latino	2	6
Focus group only	N= 28	
Age		
40s	3	10.7
50s	9	32.1
60s	8	28.6
70s	6	21.4
80s	2	7.1
Conflict era of service		
Korea	2	7.1
Vietnam	19	67.9
Gulf Wars	3	10.7
Non-conflict era	4	14.3