Disparate King County African American Adult Smoking Rate

Public Health—Seattle King County Tobacco Prevention Program

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Table of Contents

Executive Summary

Public Health—Seattle King County (PHSKC) and the community have made huge strides in decreasing the overall adult smoking rate in King County. The rate has shown a steady decline over the past ten years, and has dropped nearly 7% since 2001,[1] resulting in King County having one of the lowest rates in the state. Unfortunately, not all racial/ethnic groups have equally benefited from these declining rates, which have actually caused an increase in the disparities that exist between subpopulations living in the county. This had led to an adult African American smoking rate that is nearly twice that of the adult Caucasian rate.

These smoking rate disparities within King County have led PHSCK to search for the root causes behind them, as well as potential solutions. Working as a practicum student for PHSCK's Tobacco Prevention Program, I analyzed county level Behavioral Risk Factor Surveillance System (BRFSS) data and conducted interviews with leaders in King County's African American community. My purpose was to gain some insight into the possible etiology of these smoking disparities, and some potential next steps that the county to take in order to ameliorate these imparities.

Key Informants outlined six main reasons why the smoking rates may be so much higher among African American's in King County:

1. more pressing competing priorities than quitting smoking
2. smoking as copping, stress-relief, and/or self-medication
3. tobacco advertising targeted at this community
4. lack of resources—or barriers that prevent accessing resources that are available
5. a lack of culturally appropriate tobacco prevention efforts
6. higher exposure to tobacco products

Interviewees also highlighted some innovated ideas on how to work toward bringing this rate down, some of the next steps, and how information from this report should be shared with the community.

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I. Introduction

King County, Washington has one of the lowest adult smoking rates in the nation. According to data from the Behavioral Risk Factor Surveillance System (BRFSS) survey, in 2010 King County's adult smoking rate was 12.0% (95% CI 11 to 12%)—a lower smoking rate than 31 of Washington's 39 counties.[2] Both the Washington State adult smoking rate (15.2% [95% CI 14.4 to 16.0%])[3] and the King County smoking rate are below the average United States adult rate of 19.3% (95% CI 18.7 to 19.9%).[4]

Public Health—Seattle King County (PHSKC) and the community have made huge strides in decreasing the adult smoking rate in King County. The rate has shown a steady decline over the past ten years, and has dropped nearly 7% since 2001.[1] Unfortunately, not all racial/ethnic groups have equally benefited from these declining rates, which have actually caused an increase in the disparities that exist between subpopulations living in the county (Appendix A). In 2010 the African American population had an adult smoking rate of 22.0% (95% CI 18-27%), nearly twice that of the crude King County rate.[1] In a county that fairs far better than both Washington State and the United States on *crude* smoking rates, King County has an African American smoking rate that is actually **higher** than the national African American smoking rate (Table 1).

Table 1. 2010 County, State, and National Smoking Rates

2010	King County[1]	Washington State[3]	United States[4]
Black	22.0% (95% CI 18-27%)	19.1% (95% CI 12.5-25.7%)	20.6% (95% CI 19.1-22.1%)
White	11.0% (95% CI 11-12%)	14.9% (95% CI 14.1-15.8%)	21.0% (95% CI 20.2-21.8%)
Total	12.0% (95% CI 11-12%)	15.2% (95% CI 14.4-16.0%)	19.3% (95% CI 18.7-19.9%)

Sources: Adapted from Washington Tobacco Facts: 2011. Washington State Department of Health; Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System data and Morbidity and Mortality Weekly Report (MMWR).

These smoking rate disparities within King County have led PHSCK to search for the root causes behind them, as well as potential solutions. Working as a practicum student for PHSCK's Tobacco Prevention Program, I analyzed county level BRFSS data and conducted interviews with leaders in King County's African American community. My purpose was to gain some insight into the possible etiology of these smoking disparities, and some potential next steps that the county to take in order to ameliorate these imparities.

II. Background

In order to gain a better understanding of why smoking rates are higher among African Americans in many areas of the nation, as well as to inform the development of the interview tool for this project, I conducted a literature review on smoking disparities nationally. Studies exploring the possible reasons for high smoking rates among the African American population in Washington and nationally have pointed to a number of associations.

The Washington State Department of Health (WA DOH) convened the Cross Cultural Workgroup on Tobacco to conduct a multicultural review from 2001 to 2003. They interviewed ten key informants whom identified six potential causes of high smoking rates among the African American populations in King and Pierce Counties[5]:

1. having more pressing competing priorities than quitting smoking
2. not being fully aware of the harms and addictive nature of cigarettes
3. tobacco companies' support of African American organizations and events
4. cigarette advertising targeted at this community,
5. the cost of nicotine replacement as a barrier
6. a lack of culturally appropriate tobacco prevention efforts

Competing priorities, such as searching for a job, paying rent and other bills, and caring and providing for one's family, often push quitting smoking to the bottom of the list, even among those that want to quit.[5] Individuals of low socioeconomic status (SES), or those who are members of racial/ethnic minority groups, have been shown to experience more frequent stressful or traumatic events[6] which may be leading to a lower prioritization of quitting among current smokers. The poverty rate among African Americans is unfortunately higher than that of any other racial/ethnic group in the United States;[7] which means that this population is likely experiencing a disproportionate number of the stress-inducing events associated with having low SES.

High stress is associated not only with *events* in an individual's life, but also with the home and work *environments*. A study conducted by Reitzel et al. found that a greater perception of neighborhood problems, and a greater perceived need to be on-guard and vigilant in the home neighborhood, is associated with many African American smoker's tobacco dependence. [8] Work environment may also play a fundamental role in lowering smoking rates. The Community Preventive Services Task Forces recommends smoking bans and restrictions in the workplace based on strong evidence of their effectiveness in both decreasing exposure to environmental tobacco smoke and in reducing tobacco use among workers.[9] While smoke free workplaces may be effective in reducing tobacco use and exposure, several studies have indicated that Black employees are less likely than White employees to work in places with a smoke-free policy.[10,11] This may be one component contributing to a faster decline in smoking rates among the Caucasian population than among the African American population. According to composite National Health Institute Survey Data from 2004 to 2010, the industry groups with the highest age-adjusted smoking rates were mining, accommodation and food services, and construction. [12] These may be industries, then, worth targeting for smoking cessation interventions.

Tobacco companies may also play a substantial role in the high African American smoking rates. Both their financial support of Black organizations and events, as well as target marketing may be contributing to an uneven playing field for this population. The relationship between the tobacco companies and the African American community actually has very deep historical roots. The cultivation of tobacco is closely tied to the slave trade, as by the beginning of the 1600s tobacco had become very profitable, and settlers exploited free human labor to grow their crops cheaply. After the abolition of slavery following the Civil War, many former slaves continued to work in the tobacco industry in the factories and the fields, and eventually as landowners of

tobacco fields. This relationship persisted throughout history, and in the 1930s, nearly half of the tobacco manufacturing industry was African American. Tobacco was one of the only industries providing industrial jobs for African Americans at that time.[13]

Tobacco companies during this decade began to "reach out" to the African American community through target marketing and through funding Black hospitals and newspapers (complete with cigarette advertisements), securing their grasp on a future market. Through the decades, cigarette companies have continued to pour money into the African American community, both through advertising and through sponsoring community events, scholarships, and even elected officials. They have successfully built relationships with Black organizations and political leaders, further inserting themselves into the Black culture.[13]

Though tobacco companies work to make their efforts appear philanthropic rather than self-interested, the court ordered release of the private tobacco company documents reveals the true intentions behind this community outreach. Letters and recorded comments document intense marketing targeted toward the African American community, often coated with belittling comments or signs of distain toward their target markets.[14] This corporate disease promotion has been largely exposed, but the relationships and the addiction are in many ways already deeply rooted.

Another factor that may be leading to the differences in rates, are disparities in medical care. Evidence suggests that those that receive advice from a doctor to quit smoking are more likely to actually quit. The Center for Disease Control and Prevention (CDC) has even listed a ten minute intervention conversation with a doctor as one of the effective methods to quit smoking.[15] Not all populations are getting equal access to this type of beneficial recommendation though. Cokkinides et al. analyzed 2005 National Health Interview Survey data and found that Black and Hispanic patients who had a healthcare encounter in the last year were less likely than White patients with an encounter to be asked about their tobacco use, be advised to quit, or have used tobacco-cessation aids in the past year in an attempt to quit.[16] This is a disparity in doctor advice among individuals that **did** see a doctor within the past year. This disparity becomes even more evident after considering who has access to a physician to begin with. According to the CDC's *Health Disparities and Inequalities Report*, in the United States in 2008, low-income, young (18-34 years old), Hispanic, Black, American Indian/Alaska Natives, and low-education populations were the **least** likely to have health insurance of any kind.[17] Other studies have also found that few African Americans are receiving cessation counseling from health care providers despite recommendations that this is effective in successfully quitting.[18]

Another interesting concept that is being explored is the role of stigmatization around smoking in decreasing smoking rates. There is some evidence that smokers that perceive high levels of stigma around smoking are more likely to quit. Stuber et al., in there study on stigmatization and smoking, had a number of interesting findings. They found that respondents who had less education, who felt that family and friends thought smoking was acceptable, or who reported that all or most of their neighborhood smoked, reported low levels of stigma. African Americans and Latinos also perceived less stigma around smoking than did Caucasians.[19] This is interesting as the acceptability of smoking in many African American neighborhoods may be playing a role in the plateau in the adult smoking rate.

Despite the plethora of studies done at the national level on tobacco disparities, there is very little research that has been conducted looking at King County specifically. The work done by the Cross-Cultural Workgroup on Tobacco from 2001-2003 highlighted some very interesting findings, and greatly informed the process of this report. The past decade has seen huge changes in smoking rates, interventions, and community involvement around this issue though. It is important to explore if the results uncovered in 2003 are still applicable to today. This report intends to explore this, and help to fill this gap in the literature.

III. Methods

I analyzed King County level BRFSS composite data from 2007 to 2011 in order to gain a better understanding of what is happening in King County, both in relation to smoking trends and to factors that may be influencing these trends. BRFSS data is collected monthly through random telephone surveys.[20] Respondent self-identify their race/ethnicity during the survey, and have the opportunity to select as many race groups as they feel apply, with "Black or African American" being grouped together under once heading.[21]

In order to fill in some of the gaps in understanding still left after analyzing the data, I conducted Key Informant interviews with leaders in the African American community in King County. I created an interview tool, and then had it reviewed by experts in qualitative research. Their feedback was incorporated into the final draft of the interview tool which can be found in Appendix B.

I interviewed five Key Informants during the process. They were selected based on their expertise in smoking or other disparities in King County, their current and past work on this topic, and their relationship to the African American community. Key Informants included physicians, leaders in community-based organizations, and a public health expert that works on disparities in King County. I identified Key Informants based on past PHSCK relationships, as well as through contacting organizations that work closely with the African American community and/or have done work in smoking cessation. After identifying preliminary contacts, I made further contacts through snowball sampling. Dozens of individual contacts or organizations were identified, ten were contacted, and five responded and were interviewed. I audio recorded and transcribed all of the interviews, and then coded and analyzed them with ATLAS.ti software. I offered a draft of the report to all Key Informants, and those who were interested provided feedback which informed the final draft of the report.

IV. Results

A. Behavioral Risk Factor Surveillance System Data

The composite BRFSS data indicates that, as previously mentioned, the adult smoking rates are higher among the African American sub-population than the county average. These data sets allow us to tease out some of the other factors that are correlated with race/ethnicity or smoking rates. Unfortunately, many of the potential associations of interests do not have a large enough

sample size to allow for analysis. Some areas that did allow for analysis though, highlighted some interested correlations and trends.

Based on the opinion upheld by the CDC that advice to quit from a doctor is a helpful factor in successfully quitting, it is of interest to see if all sub-populations have equal access to a health care provider. In fact, in King County, those that have a personal doctor or healthcare provider are **less** likely to smoke, and are **more** likely to be former smokers (indicating that they have quit successfully). This relationship is outlined in more detail in Table 2. This suggests that, though we cannot be sure if this correlation is attributable to some confounding factor, that those with a personal provider are less likely to smoke, and more likely have successfully quit smoking.

Table 2. Smoking Status by Personal Provider Status (2007-2011 composite data)

	Have a personal provider	**Do not have a personal provider**
Smoking Status		
Every day smoker	6.5% (95% CI 6.0-7.1%)	13.0% (95% CI 11.3-15.0%)
Someday smoker	2.9% (95% CI 2.6-3.3%)	5.0% (95% CI 4.0-6.3%)
Former smoker	27.2% (95% CI 26.4-28.1%)	17.4% (95% CI 15.5-19.3%)
Non-smoker	63.4% (95% CI 62.7-64.5%)	64.6% (95% CI 62.1-67.1%)

Source: Behavioral Risk Factor Surveillance System

The data indicates that access to a healthcare provider is not equal, with 89.6% (95% CI 88.7-90.4%) of the White population having some form of health care coverage, while only 73.4% (95% CI 66.9-79.0%) of the Black population does. 'Some form of coverage" includes health insurance, prepaid plans such as HMOs, or government plans such as Medicare, Medicaid or Indian Health Services. This indicates that African Americans in King County are more likely to be paying for health care out-of-pocket. In this same stream, African Americans are less likely than Caucasians to have a personal doctor or health care provider (Table 3). Though the BRFSS questionnaire does ask if the individual has received advice to quit from a provider in the past 12 months, unfortunately the sample size (once stratified by race/ethnicity) was too small for analysis.

Table 3. Access to Care by Race/Ethnicity (2007-2011 composite data)

	Have Insurance	**Have personal doctor/health care provider**
Black	73.4% (95% CI 66.9-79.0%)	73.6% (95% CI 67.6-78.9%)
White	89.6% (95% CI 88.7-90.4%)	82.6% (95% CI 81.6-83.5%)
Total	87.3% (95% CI 86.4-88.1%)	80.4% (95% CI 79.5-81.3%)

Source: Behavioral Risk Factor Surveillance System

BRFSS data also indicates that there is a strong desire to quit among African Americans. There is actually no statistically significant difference in the percent of people that want to quit between any of the racial/ethnic subpopulations. Though the desire to quit is similar between sub-populations, **unsuccessful** quit attempts are actually highest among African Americans. Current smokers were asked if they had stopped smoking for one or more days in the past twelve months. 74.5% (95% CI 64.2-82.7%) of African American smokers had tried to quit, while only 53.4% (95% 50.4-56.8%) of Caucasian smokers had tried to quit. This shows that African Americans are trying to quit, with nearly 75% making an effort to stop smoking. So, the high smoking rate

among this population cannot be attributed to a lack of desire to quit. We can attempt to evaluate how successful this sub-population has been in quitting by also considering the number of former smokers. While over 80% of African Americans expressed a desire to quit, and nearly 75% attempted to quit, the percentage of former smokers is actually quite low, while the percentage of current smokers is high among this population. The inverse is true of the White population, where the percentage of former smokers (successful quitters) is high, and the percentage of current smokers is rather low. These figures are further outlined in Table 4.

Table 4. Desire/Attempts to Quit and Smoking Status by Race/Ethnicity (2007-2011 composite data)

	Would like to quit using tobacco	Smokers that attempted to quit in the past 12 months	Percent of population that are former smokers	Percent of population that are current smokers
Black	81.1% (95% CI 66.7-90.2%)	74.5% (95% CI 64.2-82.7%)	14.1% (95% CI 11.2-17.7%)	21.1% (95% CI 16.9-26.0%)
White	70.4% (95% CI 64.3-75.9%)	53.4% (95% CI 50.0-56.8%)	27.5% (95% CI 26.6-28.4%)	11.1% (95% CI 10.4-11.8%)
Asian	51.4 % (95% CI 28.5-73.8%)	65.1% (95% CI 49.4-77.8%)	13.2% (95% CI 11.1-15.8%)	7.4% (95% CI 5.5-9.8%)
All Other	47.5% (95% CI 28.0-67.8%)	63.3% (95% CI 51.0-74.0%)	18.4% (95% CI 15.4-21.9%)	11.6% (95% CI 9.1-14.6%)
Total	68.7% (95% CI 63.1-73.8%)	56.1% (95% CI 53.1-59.1%)	25.3% (95% CI 24.5-26.1%)	11.1% (95% CI 10.5-11.8%)

Source: Behavioral Risk Factor Surveillance System

B. Key Informant Interviews

The Key Informants provided very valuable insights and ideas. The time that they took to speak with me was invaluable, and the information that they provided will be essential in informing PHSKC's next steps. This section highlights some of information provided by Key Informants during their interviews, with a special emphasis on concepts that were brought up by multiple interviewees. All of the material in this section was presented by one or more of the Key Informants. All quotes were taken word-for-word from transcriptions of their interviews. I also want to point out that with a project such as this one, I am at serious risk of overgeneralizing. So I want to preface this with an apology for making generalizations about a population that is made up of very unique individuals. Unfortunately, in order to craft community level interventions, it is necessary to concede to some level of generalization.

1. Reasons for the Disparate Rate

Though Key Informants highlighted numerous possible reasons for the disparate smoking rate, six reasons were mentioned several times by all or most of the Key Informants. Several of these reasons overlap with those highlighted by the Cross Cultural Workgroup on Tobacco. The six reasons highlighted during my interviews were:

1. more pressing competing priorities than quitting smoking
2. smoking as copping, stress-relief, and/or self-medication

3. tobacco advertising targeted at this community
4. lack of resources—or barriers that prevent accessing resources that are available
5. a lack of culturally appropriate tobacco prevention efforts
6. higher exposure to tobacco products

More pressing competing priorities

All of the Key Informants talked about the competing priorities that the African American community often faces. They indicated that this population is unfortunately disproportionately represented among low income groups, which means that paying rent or feeding ones family often becomes a priority over quitting smoking. Several examples of competing priorities were highlighted: paying rent or finding housing, a job, or childcare, feeding their family, quitting other addictions (e.g. alcohol or drugs), or the instant gratification of the cigarette being prioritized over the long-term consequences of smoking. Another component of this that was highlighted during interviews is that successfully quitting smoking may mean distancing yourself from friends and family who smoke—but it is very difficult to prioritize quitting smoking over your relationships and the support and other benefits that they provide.

> *"Or if they are giving up drugs and alcohol, than [to them] this one cigarette, or smoking, is not that big of a deal."*

> *"We have so many other issues, other priorities—single parents, teen moms who smoke because they are stressed, but they are also looking for housing, and they are in a transitional home…you know so that is not their priority right now, their priority is you know, trying to find a place for themselves and their child."*

Competing priorities may be playing out at a larger level than the individual as well. Key Informants mentioned that the African American community as a whole may not be prioritizing this as an issue because they have other more pressing issues that they are trying to address, such as disproportionate unemployment rates or incarceration rates. A community may not feel the need to focus on eliminating tobacco advertisements in their neighborhood, for example, if this is not the most serious concern in their eyes.

Smoking as copping, stress-relief, and/or self-medication

The concept of competing priorities is closely connected to the idea of smoking being used as a way to cope with high levels of stress. Whether cigarettes actually work as a physical anxiety suppressant, or simply perceived stress relief, cigarettes are often used to self-medicate against stress. In a community that is dealing with competing priorities such as those mentioned above, stress is a very real emotion, mental, and physical harm. Finding ways to cope with this stress is essential. Four of the five Key Informants indicated that the role that cigarettes play in stress relief makes it harder for a population that is under higher levels of stress to successfully quit. Several of the Key Informants also indicated that on top of these daily stressors that are largely experienced by individuals of low SES, African Americans must also contend

> *"You have to have almost everything else in your life right if you are going to quit smoking."*

with "the stress of being Black." The very real presence of covert and overt discrimination and institutional racism often contribute another layer of stress to this population that makes quitting smoking even harder, and starting the habit even easier.

> *"When you watch your family members imprisoned in inordinate rates, when you watch adult family members die of chronic diseases in rates that are really out of proportion, when you see family disillusioned in ways that are really painful, when you enter into the world even in very stressful ways, when you watch people of great heart and spirit constantly facing challenges that seem to knock them back, you might seek out different forms of self-therapy, whether you are consciously aware of it or not. And I think sometimes that makes you also, maybe, not as open to hearing somebody say, 'You should stop this one thing.'"*

Tobacco advertising targeted at this community

All of the Interviewees strongly emphasized that tobacco companies heavily target marketing at African American communities, and felt that this is a very real contributor to the higher smoking rates. While **some** Key Informants felt that the content of advertisements is targeting this population (using imagery and iconography that is very specific to the African American population) **everyone** indicated that the volume of cigarette advertisements is higher in predominantly African American neighborhoods. This seems to be most pervasive in mini-mart-type stores (mom and pop stores, corner stores, gas stations, convenience stores, drug stores, etc.). One Key Informant had even conducted a youth Photovoice project in which they took pictures in two demographically different neighborhoods and found that there was a higher count of tobacco ads in the neighborhood with a higher African American population. Another interviewee emphasized that among chain convenience stores, which are so consistently set up the same, that you notice the small inconsistencies. One of these inconsistencies is the presence of a greater volume of cigarette options in predominantly African American communities. Part of why this target marketing has been allowed to persist ties back to the concept of competing priorities for a neighborhood: *"I think in other, more affluent communities it would be considered inappropriate to have that advertisement out where children and other people could see it, and so there would be laws or some kind-of ordinance to keep that from happening. Where I think that in a lot of communities where you are dealing with so many other issues…that it is not the first thing that people are thinking that they want to focus on, unfortunately."*

> *"They do target our community. In the Mom and Pop stores, you see the posters and the flyers…there is definitely the cigarettes."*

It is important to point out, as one interviewee did, that targeting advertising at the African American community is not a new strategy, but that there is rather a history of this. This means that branding happened during a time when cigarette companies could create a feeling that they were identifying with the African American community, reaching out to a group that is often times marginalized or discriminated against. This branding may have led many African

Americans to feel loyal to a brand that they were then pulled into feeling a sense of connection with.

Lack of resources—or barriers that prevent accessing resources that are available

A lack of resources is another component that all of the Key Informants talked about. These include resources that are specifically designed to help with cessation such as support groups, therapy, and nicotine replacement therapy, or access to a health care provider and insurance, but also resources to help address the root causes of smoking such as stress. Some Key Informants felt that the resources were simply not there, while others indicated that resources are available (such as services through the American Heart Association, the American Diabetes Association, workplace intervention programs, or hospital intervention programs) but that they are not necessarily accessed by African Americans.

> *"But usually people don't necessarily go out and say, 'I want to quit smoking I am going to call the American Heart Association.'"*
>
> ***
>
> *"I think, interestingly, the people that I know that try to quit, they usually try to do it on their own. They usually try to do that solo."*

Even if there may resources available, there are often barriers that prevent African Americans from really accessing these resources. Some of the barriers highlighted by key informants were that these programs and interventions are not always culturally appropriate, but rather they are designed with a majority culture in mind, cost (either real financial and time costs or perceived costs such as the assumption that the program will not be free), or that individuals don't have anybody to watch their children while they access these resources. Another very important barrier is a lack of trust: *"I think that there is lots of distrust in government in general by communities of color. I think that, unfortunately, whether we want to acknowledge it or not, people still feel like the government does and has done research on communities of color."*

> *"There is nowhere for them to go to be honest…and I shouldn't say nowhere, because African Americans tend to want to get help from other African Americans. So let's say that the Public Health Department says, 'We have these resources,' a lot of them would not access that because of the trust."*

Another barrier that may be preventing African Americans from accessing, or even knowing about smoking cessation resources, is that they may not be having the conversation with their doctor. As mentioned above, studies at the national level have indicated that among those that **do** see a health care provider, African Americans are less likely to be recommended to quit than their Caucasian counterparts. Though there are no empirical studies indicating that this is also a problem in King County, all of the Key Informants felt that it is very probable that this disparity exists in King County as well. Though there was no real certainty around this topic, there were several attempts to understand why this might be happening. One explanation ties back to competing priorities yet again. This time, it is the competing priority of the health care provider:

"I think that people…are taking on some other series of messages and are choosing. You know, 'I have ten important messages, and does cigarette smoking always get onto them?'" Because African Americans are disproportionately affected by many health issues, their providers often have to decide which issues are the most important to tackle with limited time. This may mean that smoking just doesn't make it to the top of the priority list. There were also some indications that the African American population may not be as honest with their doctors about their smoking habits, whether this is due to a lack of trust, a desire to please the provider, or even a feeling that smoking cessation is not the prevue of the doctor. Another possible reason is that providers may make assumptions about their patients based on their race/ethnicity, or unconsciously feel that they are less effective with their African American patients. There also may not be enough diversity in the medical field that allows for African Americans to be treated by African American providers.

Lack of culturally appropriate tobacco prevention efforts

As mentioned above, a lack of culturally appropriate tobacco prevention efforts often acts as a barrier for many African American in accessing support: "*The intervention may have been a nice general overview, but it didn't really speak to the challenges that this specific group is facing*." Four of the Key Informants indicated that this was partially an explanation for why the rates have not been declining as fast in the African American population as they have for the county as a whole, or for the Caucasian population. One example of this was that school-based interventions are often considered successful, and may be getting the awareness out to all racial/ethnic groups, but may not be affecting actual cigarette use equally. Part of this is that there is "*a potential for children to actually positively influence the adults around their health habits. That I also think is a little bit more burdensome to an under-empowered young child than a boisterously, very strong-willed, very empowered, very privileged child to say, 'Mommy, don't smoke.'"* So the intervention may not be taking into account a need to also teach self-efficacy to both youth and adults to help them feel confident in their ability to quit, or to talk to their families about quitting. Another aspect of this is that some messaging may actually be positively influencing children or even parents, but if there is intergenerational smoking in the family and the message doesn't permeate deep enough, than the children are still exposed to smoking by their grandparents.

Higher exposure to tobacco products

When you are part of a population with a higher smoking rate, the chances are higher that those around you will smoke—your parents, siblings, aunts and uncles, grandparents, and likely your peers as well. This means that it is more difficult to decrease the rate among this group because the exposure it higher from the time that you are born (or even earlier in many cases). Several Key Informants also pointed out that this means that your support network is more likely to smoke, making it hard to turn to them for help in quitting. Some of the main places that interviewees felt that African American adults are exposed to smoking or tobacco related triggers are: in places where African American's tend to congregate, homes, drug stores, workplaces, and work release facilities. All of those interviewed indicated that youth had

> *"I think that it's possible that the support network that you rely on for many things may be more likely to include people who smoke."*

the greatest and earliest exposure in the home. Schools and other youth hang out places were cited as the place of the second greatest exposure.

2. Commonly Cited Intervention Ideas

Key Informants provided insightful and creative ideas on what type of interventions would be most effective for this population. Some of these ideas were commonly cited in several of the interviews. It was strongly supported that interventions need to start dealing with the root causes of why people smoke, such as dealing with stress and the factors that lead to high stress: income and home insecurity, discrimination, lack of access to resources, and other social determinants of health. These are very difficult structural issues to tackle, something that Public Health works toward constantly. Some ideas on how to start tackling this issue (which would make huge changes in many health indicators even beyond smoking rates) were mentioned: *"Making sure that all young people have access to high quality education, so that they have an opportunity to go to college or trade school or get good paying jobs. It's making sure that we live in communities that are safe and have the resources that people need to feel like they can live healthy lives…whether it's open spaces, parks, community centers, places where they feel like they can go, and there is a sense of healthiness in the community."*

An opinion that was supported by all of the Key Informants was that it will be essential that any intervention should use multiple avenues. Again, the African American community is diverse, and we cannot hope to reach everyone through one avenue. Something that many of the Key Informants stressed as essential, is that the intervention is coming from the within the community, not from the government level. So it will be important to mobilize the community to make change. Suggestions included educating people in the community to provide counseling, Nicotine Replacement Therapy, and referral to organizations that can help people quit smoking, find housing, work, etc. It is important that the community is permeated with these resources, and that they are all giving the same message about quitting, so that the message is being heard often and from trusted sources. Key Informants mentioned some groups in the community that should be included in this effort. Among them were: churches and other faith based organizations, doctors, community-based organizations, schools, barber shops and beauty salons (which were mentioned often, and have been used in the past for interventions such as blood pressure screenings), fraternities and sororities, gilds and unions, work-release facilities, corner stores, community groups, and people already working in the community (especially people working with children and pregnant women such as doulas or midwives). This strategy actually very closely mirrors what the Center for MuliCultural Health was working toward before they lost funding for tobacco cessation. They were working to educate and provide cessation toolkits to churches, food-banks, work-release facilities, community organizations and other places in the community that could then work together to provide access and support for the African American community.

> *"I hope that what the interviewers myself included, have conveyed is the sense of the importance of making sure that this is a community led approach and not a Public Health led, or some other entity led, but that this is really something that is coming from a community that has a lot of stuff that it is dealing with."*

"There are lots of informal leaderships and informal message deliverers, and it's possible that in a community that is a little bit limited in size, like King County's African American community, that maybe there is a threshold number of people that need to deliver a message in the same exact way, with the same exact words, with the same exact tone, that would actually have a critical effect. My barber, and my minister, and my…grocery store person, and my auntie and my school teacher, and the person I think is cool who lives around the corner, they all said the same thing in the exact same way."

Nearly everyone I interviewed indicated that African Americans were, in general, aware of the addictiveness of cigarettes and the risks to themselves, but that they were much less aware of the risks that smoking poses to their families. Based on this, several suggestions for interventions included educating people on the risks to their families as this could help incentivize people to quit. One key informant pointed out that this is a population that is used to making sacrifices for their families, so it is not a far stretch to do an intervention that uses children and loved ones as leverage, and that it may even be counterproductive to put too much energy into stressing the risks to themselves—considering that family often takes precedent over self.

3. Unique Intervention Ideas

There were also some ideas that were not highlighted by such a large majority of the Key Informants, but that were innovative and deserve mention. Dovetailing on the idea of using the effects of smoking on children and families as leverage, was the idea that with limited resources an intervention could be targeted toward parents of children with asthma, as it is easy to see the direct effect of smoking on their child's health. Another idea was to start to bring workplace interventions and smoking cessation programs into workplaces where they are less traditionally used, such as unions (masons, carpenters, etc.). This could help access workers that have not yet seen the benefits of workplace interventions and also that work outside and are therefore likely have higher exposure to smoking. The advantage of working with a union is that, "*because they are negotiating with the employer to keep the healthcare costs low for the people that they represent…they may joyfully sponsor programs related to smoking cessation."*

Energy could also be put into advocating to limit target marketing. This connects to the importance of mobilizing the community, as there will not be any push for change if the community does not feel that this is an issue that they **can** change. A suggestion for how to really start to make change around this and mobilize the community is to target community leaders. One Key Informant pointed out the importance of working with grandmothers and other female leaders, as many African American communities are matriarchal. Interventions tend to target those with the highest rates (young men), but perhaps working with female leaders would encourage them to start making the changes in their homes and communities.

On the other end of the generation spectrum, many interviewees pointed out the importance of putting energy toward preventing youth from starting smoking in the first place so that they never have to contend with the difficulty of quitting. Creative methods were suggested, such as

"The No Smoke Rap."
"Hip Hop Without a Cigarette"

incorporating messages into school music and plays. Perhaps school-based programs could be infused with some level of teaching media literacy (where youth are taught to critically analyze media, the sponsors' motives, and be less effected by media) with an emphasis on tobacco advertising. Key Informants emphasized that interventions, especially with youth, work outside of the box and think beyond what has already been done as that is obviously not having enough effect in the African American population.

4. Complications

Key Informants mentioned some conundrums within interventions that make an already complex issue even more complicated. These thoughts don't suggest that these interventions or channels are not successful or appropriate, but rather that it is important to always consider the possible unintended consequences of an intervention. Though it was widely suggested that the churches be involved in any intervention, one Key Informant pointed out that it is important to consider, that while the churches are a great asset, there is a limitation to using churches as a place to talk about vices. Some people may not feel comfortable admitting their vices in a place where they are trying to be their best. It will then be important to take this into consideration when planning any program in the faith-based community.

> *"That is kind-of a two edged sword when it comes to vices, because people don't want to admit that they have a vice…and so, in a church or a faith setting people feel guilty because they feel like they are not living up to what someone's standards may be."*

Interviewees also seemed to feel that smoke free housing, bars, restaurants, and parks have been great progress, but several people pointed out that there are some perhaps hidden issues surrounding these as well. Part of this is that smoke free bars may have driven smoking in some ways into more visible areas. Those that were not inspired to quit by these restrictions then go out into the street to smoke, making it a more visible activity at the street level. Making smoking zones in largely smoke-free areas may also have created a subculture of smokers, where people congregate to smoke. So these groups get together to smoke outside of buildings, and then the subculture starts to set roots in these areas.

There was also some discomfort around the idea of the cigarette tax. Though it is widely felt that this has decreased the overall smoking rate, this also means that those that have a harder time quitting not only continue to smoke, but now have more of their income dedicated to the habit. Discomfort was also expressed around the concept that these taxes often go toward funding cessation programs. This has its benefits, but it also puts programs in a situation where they are depending on people to continue smoking in order to be able to continue receiving funding.

Smoke-free housing is another intervention of contention. Several Key Informants talked about issues surrounding this intervention. One comment was that there might be an equity issue around this policy, in which you create smoke-free public housing, but you have certain groups who smoke at higher rates and are therefore restricted from accessing resources that could be beneficial to them. Another side to this is that within any disenfranchised population, people

often feel that they are not in control of very much in their world, so making restriction on their home may be more disempowering from some groups than for others

V. Next steps

When considering next steps, more formative research will be essential. This report outlined ideas and insights from five Key Informants, but it will be important to hear from more leaders in the community and experts in the field to develop a greater perspective of the big picture. Part of this will be actually hearing from African Americans in King County who smoke, through surveys, interviews, or focus groups, in order to gain a better understanding of this issue.

There is also more information to be mined from the BRFSS data. Unfortunately, even after compiling the data from several years, the sample sizes just aren't large enough to analyze some relationships after stratifying by race/ethnicity. There are still some relationships that were not addressed in this report that could be analyzed through the data though, that would perhaps shed more light on this issue. Another aspect that will be important to consider, are youth smoking rates. It was out of the scope of this report, as the focus here were adult smoking rates, but several Key Informants raised questions about if the rates are higher simply because lower successful quit rates, or because higher initiation into smoking among youth as well. The Healthy Youth Survey could be used to try to tease this out, which would further inform where interventions should be targeted in King County.

Another important step will be asset mapping. Key Informants mentioned many important assets within the African American community: the communities ability to celebrate, survival skills that are not often enough celebrated or reinforced, informal networks that connect the community, a strong sense of family and community, trust, peer-group support, and the strong role of churches, community groups, and community-based organizations. If the intervention is to come from the community, it will be essential to recognize and inventory these strengths, and then move toward mobilizing the community to start making a change.

Part of mobilizing the community is sharing information about the high rates of smoking. Parts of this report, as well as other data can be shared to spark an interested in the community to make a change. Key Informants provided some important suggestions that must be taken into consideration when sharing this information. It will be important to use several channels, as people receive information differently. A few suggestions for channels and vehicles included:

- Community forums through partnership with church or community based organization that provide a natural gathering place
- Getting the information out to community leaders who can spread the information
- Bringing the information to people (barber shops, beauty salons, etc.)
- Getting the information out to people that don't already know about smoking as an disparate issue (don't just 'preach to the choir')
- Give reports/write-ups/newsletters etc. to community organizations (such as the Center for MultiCultural Health, the Central Area Chamber of Commerce, the National Association of Black Journalists, the Commission on African American Affairs, and the Mary Mahoney Professional Nurses Organization) and let them disseminate it
- Post online

- Get into the media: the Medium, the FAQ, talk shows (e.g. *Community Potpourri*)
- Church bulletins
- Through the schools through creative means such as music and plays

There were also suggestions on the tone and language with which this information should be presented to the community. Though there was a feeling that it is important that accurate information concerning the high rates and what is unique about this community that puts it at risk is presented clearly and without ambivalence; it was also pointed out that it is important when telling a community that they have a disparately high smoking rate, that there "*be some logical next steps, and people need to be engaged in making those next steps work…and work with the community to come up with solutions."* It is important to highlight the assets within the community that can be used to combat this issue so that people aren't left feeling that is just more bad news with no solutions. A helpful technique that was suggested is to present the positive side first. For example, start an article by saying that the community is working together to improve health, or areas that the community is doing well or have made improvements, rather than by jumping straight into the negative statistics.

> *"And whether you write it up as a report and do it that way, or do it as a presentation to the Board of Health, I think that you want to make sure is that you are [not only] preaching to the choir, but that you are* ***also*** *talking to people that this is not a part of their everyday life. I don't know that people in the field of education, or in economic development, or in other arenas, are aware of this disparity in smoking rates. And then why should they care? How does this impact their work, and their field? So making sure that not just the folks that know this information already get to hear it, but that people that don't often get to hear it get exposed to it."*

VI. Limitations

The Interviewees that informed this report offered great insight and wonderful ideas, but five Key Informants is a very limited number, so it will be important to further this formative research. If future interviews are conducted it would be beneficial to try to hear from arenas that were not represented in this report—such as church leaders, representatives from schools, unions (and other segments of the workforce), sororities, fraternities, and other community groups. It will also be important to try to draw Key Informants from all parts of King County. Many of the Key Informants for this report have experience living and working in different parts of King County, but most of them are currently stationed in Seattle. This is a limitation as Seattle is obviously not representative of the whole county.

There are also limitations to using BRFSS data. As previously mentioned, the sample size is often two small to analyze certain relationships. This data set is also collected through random telephone surveys, so anyone without a stable telephone number does not have the opportunity to be sampled. This dataset also does not capture very much information on youth, which means that another data source will have to be incorporated in order to see the smoking trends among the youth population.

VII. Conclusion

There are many possible reasons for the disparate smoking rates, but there are numerous possible solutions as well. Hearing from and working with the African American community in King County in order to come up with more ideas will start making progress towards decreasing the smoking rate. There are many leaders in the community that are invested in making changes around these smoking trends, and many assets in the community that can work together to actually make these changes.

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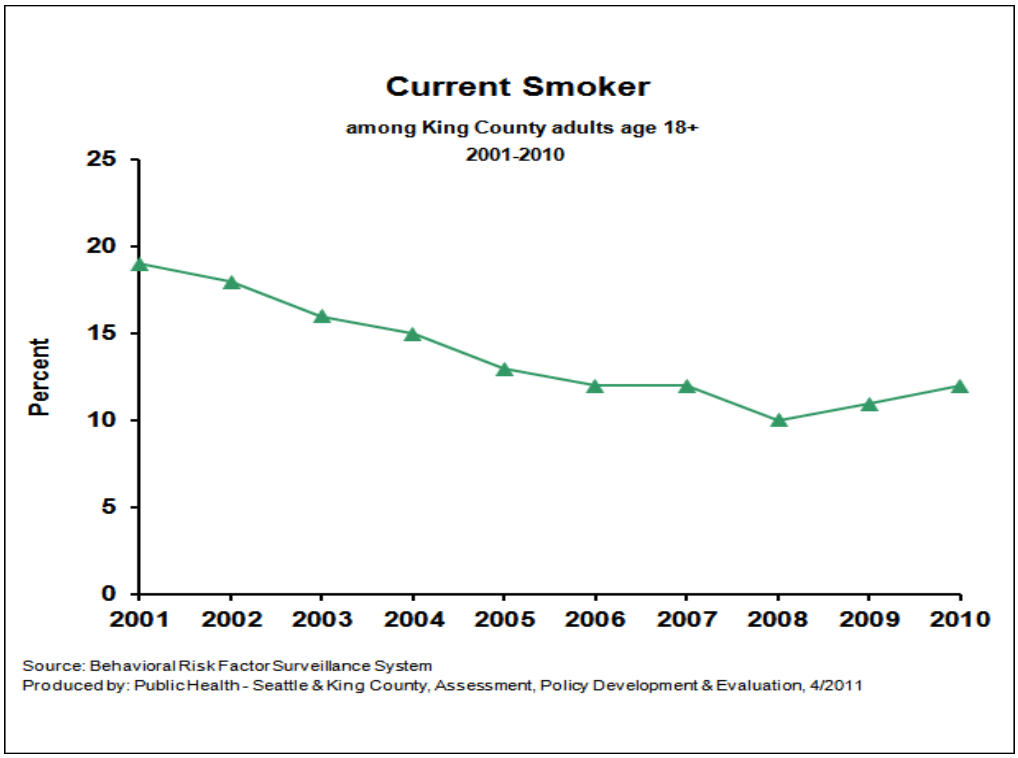
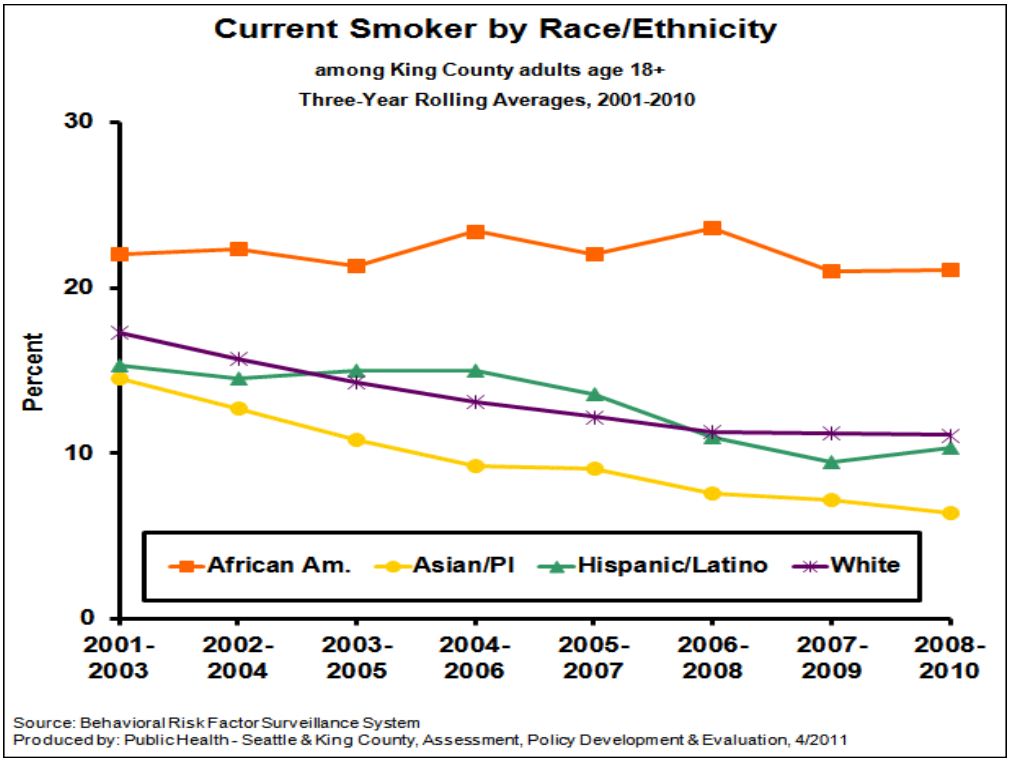
VIII. Appendices

Appendix A. Increasing Disparities





Appendix B. Interview Tool

King County Smoking Disparities Key Informant Interview

Introduction:

I am a graduate student at the University of Washington, and I am doing my practicum with Public Health Seattle and King County's Tobacco Prevention Program. The purpose of this project is to gain a better understanding of why King County's smoking rates are not declining at the same rate in the African American population as they are in King County as a whole; as well as to hear some ideas of what interventions would be most effective in addressing this disparity. Though we may touch on tobacco products in general during our conversation, I am specifically looking at cigarette smoking, so all of my questions are centered around cigarette use, and I would like to try and keep this as the main focus.

Your participation in this interview is strictly confidential. I would like to record this interview in order to make sure I'm accurately recording the information. Subsequently the tape will be destroyed. Do you agree to have our interview audio recorded? ____Your participation in this interview is greatly appreciated, and very important; however if at any time you wish to stop the interview, or if you do not want to answer a question, you are free to do so. Also, please feel free to ask me any questions concerning the interview or the study at any time. Do you have any questions now? ____Are you ready to begin?____

Questions:

1. Do you think smoking is a problem for the African American population in King County?
    a. What makes you feel that smoking is *[or is not]* a problem?
2. County-wide health surveys find that African Americans smoke at almost twice the rate of Whites in King County. What are some of the possible reasons that smoking rates in this population are higher than the county average?
3. In King County, where are some of the main places that African Americans may be exposed directly to smoking or things that make people think about smoking?
    a. In what ways are children being exposed to the presence of smoking: such as through their parents, their peers, advertising, the presence of tobacco products in their neighborhood stores, etc.?
4. Do you think tobacco companies target advertising at the African American community locally?
    a. Can you think of any examples?
5. Are there unique challenges to an African American person on King County who wants to quit?
    a. Do they have the same things pushing them to quit as others in King County?
    b. Do they have the same support in quitting as others: such as support from family, friends, churches, doctors, or others?
6. If an African American in King County wants to quit using tobacco, where can they go for help?
    a. Do you feel that people know about these resources?
    b. Do people trust these resources?

7. Some evidence in the literature suggests that among those that receive medical care, African Americans are less likely than Whites to have a doctor, nurse or other health care provider recommend that they quit smoking. Do you think that this is an issue that exists in King County?
8. In general, how do you think African Americans in King County perceive the risks that smoking presents to their health?
    a. How do you think African Americans in King County perceive the risks that smoking presents to their family's health?
    b. What makes avoiding this risk a priority, or not a priority?
9. In general, how do you think African Americans in King County perceive the addictiveness of smoking?
    a. Is this any different than the way that other populations in King County perceive the addictiveness of smoking?
10. Are you aware of any past county level tobacco interventions, and if so, which ones?
    a. Are you familiar with any of the following local interventions (*if not already mentioned*)?
        i. Tobacco-free parks and campuses.
        ii. Tobacco-free workplaces, bars, restaurants, and housing.
        iii. Compliance checks with retailers to identify sales to minors.
        iv. Trainings for health and social service providers to help people with quitting.
        v. Ads urging adults to quit tobacco, and to encourage youth not to use tobacco.
        vi. School-based tobacco prevention activities.
        vii. KCQuits, the King County Facebook forum to provide support for people that are trying to quit smoking.
    b. Which past county level tobacco interventions have effectively reached the African American population?
    c. Why have these interventions been especially effective?
    d. What are some interventions that you feel have not been effective, and why?
11. Are you familiar with any of the following State or Federal interventions *(if not already mentioned)*?
        i. The Washington State Tobacco Quitline
        ii. Tax increases on tobacco products
        iii. FDA regulation of tobacco products

    a. How have these State and Federal interventions effected the African American population in King County?

12. What ideas do you have to decrease the smoking rate?
13. Which people or organizations should be involved in order to make changes around tobacco use in the African American population?
14. What are the strengths within this community that could be used to help decrease tobacco use?
15. How would you like to see us go about sharing the information from this study and other studies with the King County community?

    a. How would you like us to go about sharing this information with the King County African American population in particular?
16. Is there anything else that you would like to speak about that we haven't addressed yet?
17. Are there any other community leaders or experts that you would recommend that I speak with?