TOBACCO USE IN THE BLACK COMMUNITY

Strategies to Increase Tobacco Cessation

One of the pernicious hallmarks of the commercial tobacco[1] epidemic is its disproportionate burden on priority populations — many members of which are struggling with socio-economic and related challenges in addition to chronic health issues resulting from tobacco use.[2]

Communities of color have experienced the impact of generations of targeted tobacco advertising and marketing campaigns. A notable example is the industry's long history of promoting menthol tobacco products to Black youth and adults — products that have been proven to increase smoking initiation, decrease successful quitting, and lead to greater addiction.[3] As a result, even though Black Americans smoke at lower or similar rates compared with other racial or ethnic groups, they are disproportionately affected by tobacco use.[4]

This fact sheet presents an overview of the problem of tobacco use among Black youth and adults, challenges in addressing use and cessation[5] in this population, and effective tobacco dependency treatment options and considerations for Black tobacco users.

Overview of Problem

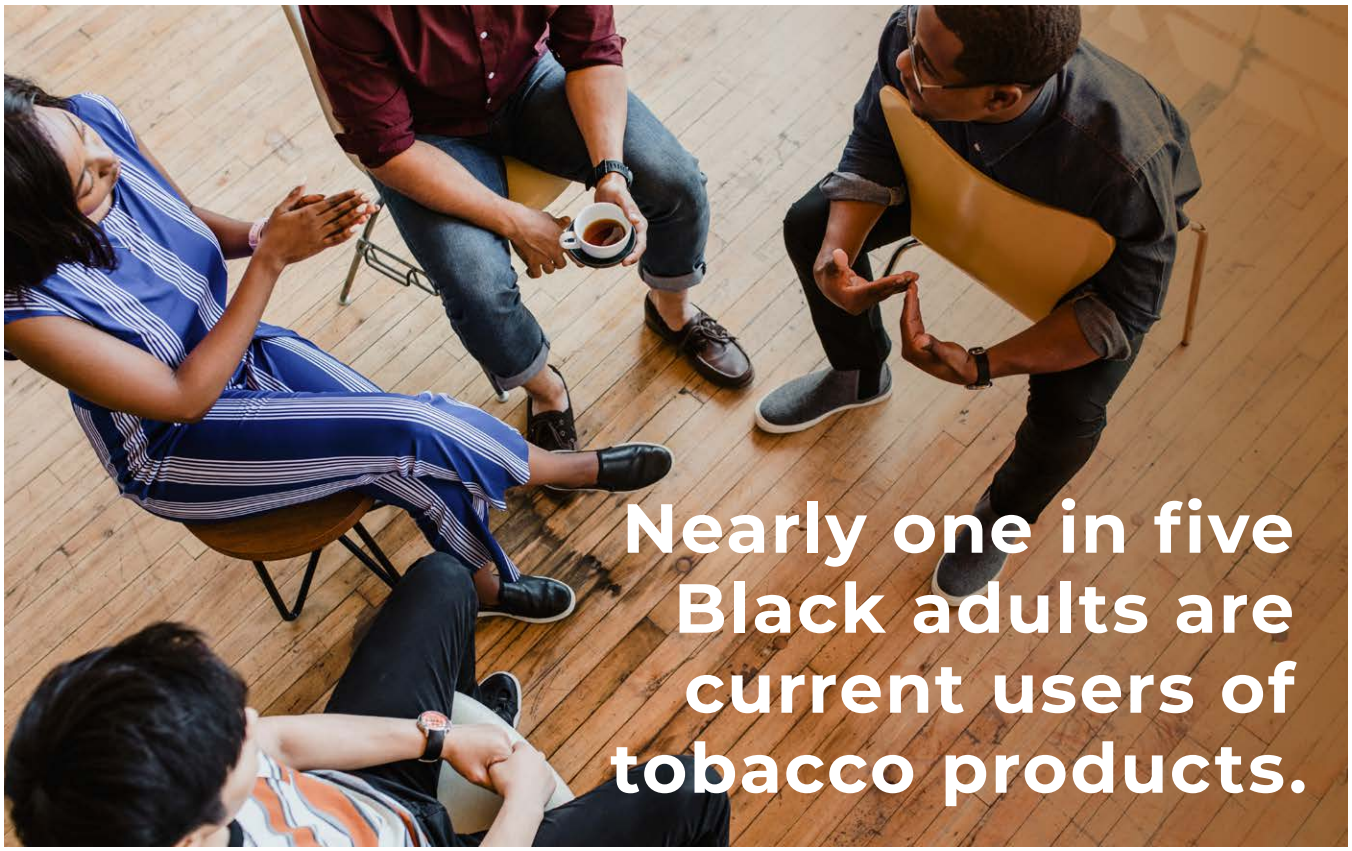
Despite the relative decline in U.S. tobacco use over the last several decades, Black Americans have continued to bear a disproportionate tobacco-related health impact compared to other ethnic and racial groups in the U.S. While approximately 11.5 percent of U.S. adults are current smokers, nearly one in five (18.1 percent) Black adults are current users of tobacco products.[6] Approximately 85 percent of all Black American smokers smoke menthol cigarettes today, compared to 29 percent of all White smokers.[7] Black adults also have the highest prevalence of cigar smoking of all major American racial/ethnic groups — 5.1 percent of all Black adults are current cigar smokers, compared to 3.5 percent of adults overall.[8]

Smoking is a major cause of heart disease, cancer, and stroke — the three leading causes of death for Black Americans in the U.S.[9] Smoking also results in a disproportionate number of other tobacco-related diseases in Black communities, including COPD and emphysema, which only exacerbates existing health disparities.

The statistics on cancer alone are striking. Tobacco use is the cause of at least twelve different cancers.[10] Of all racial and ethnic groups in the U.S., Black Americans have the highest rates of tobacco-related cancer, with more than 72,000 Black Americans diagnosed with a tobacco-related cancer each year.[11] Black Americans also have the shortest survival rates of any racial or ethnic group in the U.S. for most cancers and higher death rates from tobacco-related causes than any other racial or ethnic groups.[12] Approximately 39,000 Black Americans die from tobacco-related cancers annually.[13]

Lung cancer, which is the leading cause of cancer death in the United States,[14] is the second most common cancer in both Black men and women.[15] Black individuals in the U.S. in general experience a disproportionate amount of lung cancer (both in terms of incidence and mortality), with Black men approximately 12 percent more likely to develop lung cancer than White men.[16]

In addition, Black children and adults are more likely to be exposed to secondhand smoke than any other racial or ethnic group.[17] Studies have shown that Black nonsmokers tend to have higher cotinine levels (a chemical in the body that indicates recent exposure to tobacco smoke) than nonsmokers of other races and ethnicities.[18] Deaths caused by secondhand smoke exposure have a disproportionately heavy impact on Black Americans, as well as Hispanic/Latino Americans.[19]



Reasons Behind the Disparities

Some experts believe that differences in smoking habits, socioeconomic factors, and the metabolism of tobacco carcinogens may play a role in the prevalence of tobacco use, and its significant health impact in Black communities.[20] One of the most commonly cited causes for tobacco use in this population is the way tobacco companies have historically inundated communities of color with cigarette advertising and promotions, focusing in particular on the marketing of menthol cigarettes to Black communities. Studies consistently show a greater number of tobacco advertisements in African American neighborhoods compared to other areas.[21] These marketing campaigns, which often appropriate Black culture, feature multiple tobacco product coupon deals and discounted prices — which are appealing to low socioeconomic consumers, as well as young people, who are especially price-sensitive.

The tobacco industry also funds Black publications, cultural events, and educational institutions, and recruits well-known civic leaders to amplify its messages, making large financial contributions to Black groups and political leaders.[22] Recently, the industry has co-opted racial justice talking points and bought political influence directly and indirectly —

particularly regarding the long-awaited federal rule banning the sale of menthol cigarettes.[23] Given the amount of funding and influence behind the industry's marketing to Black communities, the prevalence of tobacco use in this population is not surprising.

Longstanding, evidence-based public health policies, in tandem with aggressive education marketing campaigns, are proven ways to reduce tobacco use and (in the case of smoke-free policies) exposure to second-hand smoke. These measures include restrictions of the sale of flavored tobacco products — particularly menthol cigarettes; policies that prevent tobacco retailers from congregating in neighborhoods and areas near schools, playgrounds, and places frequented by youth and children; policies that raise tobacco product prices and prohibit coupons and other pricing methods that discount these products; and comprehensive smoke-free / tobacco-free policies that prohibit the use of tobacco products in all public areas, including multi-unit housing.

Whenever tobacco control policies are adopted, public health authorities and related community organizations, such as housing and social service providers, should simultaneously adopt measures to ensure the ready availability of cessation services and resources to those interested in quitting.

Benefits of Cessation

Quitting the use of tobacco products has multiple health benefits. According to the U.S. Surgeon General, cessation can enhance one's quality of life at any age, regardless of how long or how heavily a person has smoked.[24] For example, quitting the use of tobacco can —

- Reduce one's risk of premature death while adding as much as ten years to life expectancy
- Reduce one's risk for many adverse health effects, including cardiovascular diseases, chronic obstructive pulmonary disease (COPD), cancer, and poor reproductive health outcomes
- Lower the risk for those already diagnosed with coronary heart disease or COPD
- Benefit the health of pregnant women and their fetuses and babies
- Reduce the financial burden that smoking places on those who smoke, health care systems, and society in general.[25]

Types of Cessation Services & Support

Effective cessation services include assessment and a combination of counseling and medication.

Assessment. An assessment (or screening) of tobacco use by a clinician or counselor, treatment specialist, or other health care provider, is often a critical first step in tobacco cessation. The main goal of such an assessment is to connect the individual with the resources needed, regardless of how many times the person has tried to quit. A careful ongoing assessment identifies the type and extent of a person's tobacco use, level of nicotine dependence, and readiness to quit, and then connects the individual to resources and/or treatment.[26]

Tobacco cessation counseling. Treating tobacco use helps individuals recognize underlying habits or triggers associated with their tobacco use. For those ready to quit, the goal of treatment is cessation; for those not yet ready to quit, the goal of treatment is to increase motivation. Treatment is typically delivered in three ways: group and individual counseling, peer mentorship, and quitlines (including mobile apps and online programs).[27]

- **Group and individual strategies.** Providers can use a variety of evidence-based counseling strategies to treat tobacco dependence, which range in intensity and complexity. Simple, brief advice from a provider during a routine exam or visit can have a significant impact. Another approach is group or individual therapy sessions, usually delivered weekly, which can provide more intense and sustained support as patients make a quit attempt.

- **Peer support.** This refers to a wide range of interactions between people who have shared experiences and those who are experiencing nicotine addiction. Peer mentors act as role models, advocates, educators, and sources of motivation to current tobacco users. One example of a peer support model is Nicotine Anonymous, a group support and recovery program for anyone who wants to stop using nicotine. Nicotine Anonymous uses an adapted version of the 12 steps from Alcoholics Anonymous, and is led by peer facilitators with a history of nicotine addiction.[28] There is no cost to join or attend meetings.

- **Online and telephone support.** These tobacco cessation options have grown in recent years. Because most tobacco users (over 93 percent) report owning a mobile phone, these resources are easy to access.[29] Quit lines, websites, and mobile applications have many advantages for tobacco users: they are free, available 24 hours a day/7 days a week, and are not dependent on insurance coverage. Telephone counseling is also associated with positive outcomes. In addition to phone counseling, most quitlines offer free online coaching and text and email messages, and refer people to local programs.

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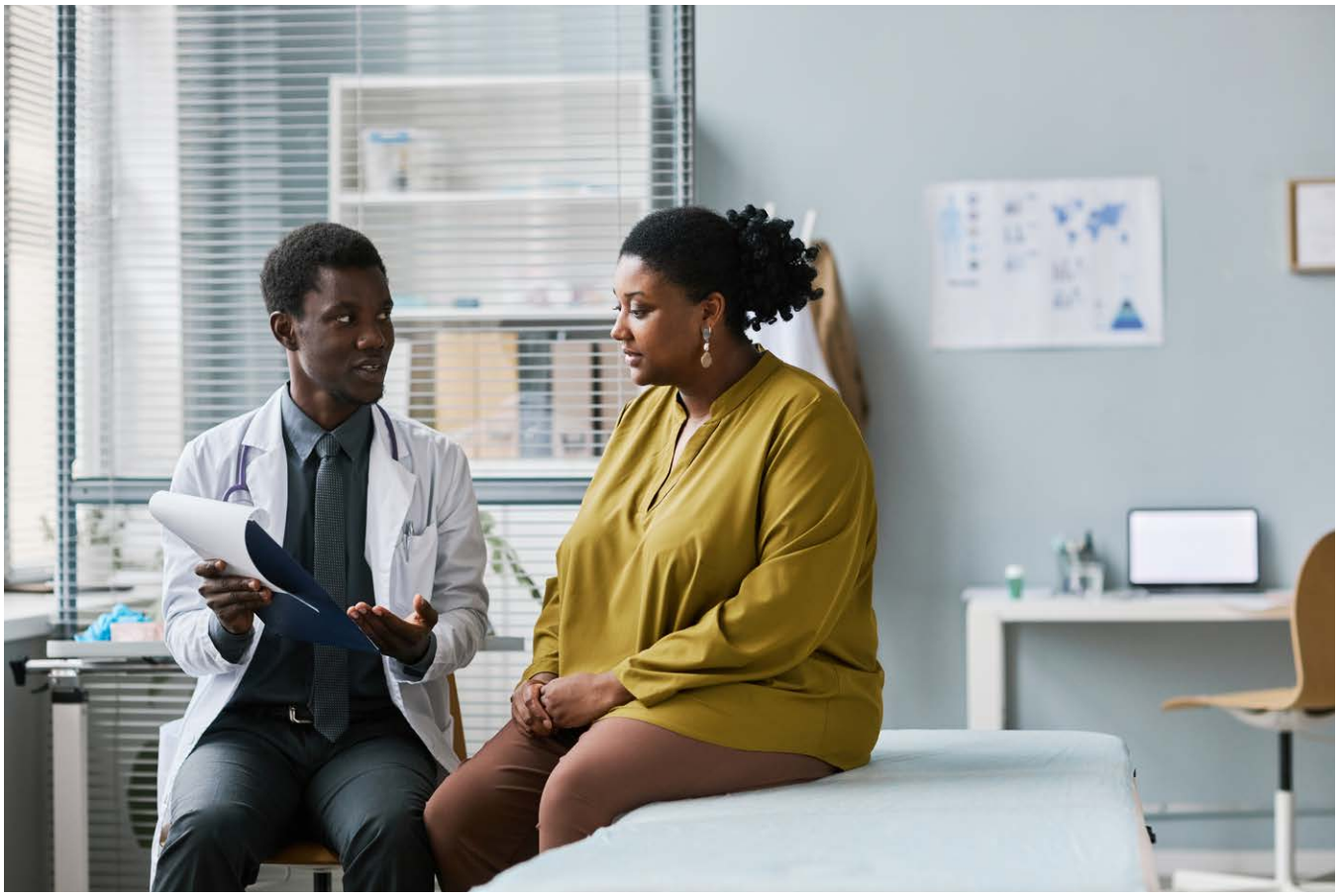
According to recent research, while phone-based support only may not achieve high smoking abstinence rates, it is much more effective when combined with nicotine replacement therapy.[30] The popularity of smart phones among young people makes it easy to reach them using text messages. This is also true of members of underserved populations who may not seek treatment in other settings.[31]

Smokefree.gov

This website, provided by the National Cancer Institute, provides evidence-based quit support to tobacco users across a variety of platforms, including text message programs and smartphone apps. Programs are targeted at veterans, women, seniors, and teens. Most services are also offered in Spanish. Resources are also available for providers to download and use. Providers/peers can enroll tobacco users online at https://smokefree.gov/tools-tips/text-programs, or tobacco users can enroll directly.

Although little research has been published on the use of quitlines or their success rate in the Black population, one study of three states and the District of Columbia did find that Black Americans tended to use a quitline in greater proportions than their proportional representation in the smoking communities in these states and the District. Black Americans were also more likely to request counseling than non-Hispanic Whites; Black quit rates were equivalent to those of non-Hispanic Whites; and the levels of satisfaction with the service and number of counseling sessions completed were equivalent as well.[32] The study concluded that telephone counseling is a promising tool for addressing health disparities related to smoking among Black Americans.

Tobacco cessation medication. Medication is a key component of most successful tobacco cessation programs. In fact, the U.S. Preventive Services Task Force — an independent group of experts in primary care and evidence-based medicine that evaluates preventive care services and makes clinical recommendations — has determined that pharmacotherapy interventions for tobacco cessation are highly beneficial.[33]



Several medications, including nicotine replacement therapy (NRT), have proven effective in managing withdrawal symptoms and supporting quit attempts. The U.S. Food and Drug Administration currently approves seven first-line medications for tobacco cessation: five NRT products and two prescription medications — varenicline and bupropion — that do not contain nicotine.[34] On their own, each of these medications has been evaluated for safety and effectiveness.

Nicotine replacement therapy products provide a controlled dose of nicotine, the main addictive substance in tobacco products, to help individuals manage the cravings and withdrawal symptoms associated with quitting tobacco use. Several NRT products (gum, lozenges, skin patches, and nasal sprays) are on the market, each with different doses and mechanisms of delivery. These products allow tobacco users to gradually wean themselves off nicotine as they make a quit attempt. Each product has distinct advantages or disadvantages that can be matched to individual preferences and needs. Evidence from clinical trials consistently shows that NRT products improve rates of cessation, both alone and in combination with other treatments.[35]

Cessation Barriers for Communities of Color

Even with strong evidence for the safety and effectiveness of cessation medications and counseling, access to these cessation resources often is limited for individuals in communities of color who are interested in quitting. Research has found that Black Americans are less likely to receive smoking cessation advice from a healthcare provider[36] and less likely to use prescription smoking cessation medications than White smokers.[37] There is substantial evidence that racial/ethnic minorities are in general less likely to be prescribed NRT or to use NRT to quit smoking.[38]

Interestingly, Black smokers in both metropolitan and non-metropolitan areas are more likely than White smokers to report making a quit attempt.[39] At the same time, population-based studies have shown that Black Americans are only half as likely to successfully quit smoking as non-Hispanic Whites, despite reports citing lower cigarette consumption.[40]

Michigan-Specific Study

Note: A 2020 survey of tobacco use behavior among African Americans in one state — Michigan — unearthed several interesting findings:

- 27 percent of African Americans preferred over-the-counter NRT to quit smoking, while 25 percent preferred using medications prescribed by their physicians when they quit smoking
- 66 percent of African Americans started using tobacco with menthol flavored tobacco products, and 53 percent of current smokers use menthol cigarettes only
- 62 percent of African American smokers are ready to quit now, when appropriate resources are available
- 42 percent of African Americans who smoke have another smoker in the household[41]

Although research is limited on methods that different racial/ethnic minority groups use to stop smoking, especially younger smokers, it seems clear that increasing access to affordable cessation resources can help support quit attempts by all tobacco users — particularly those in socioeconomically challenged communities that are (and have been for generations) targeted by the tobacco industry.[42]

Options to Overcome Cessation Barriers in Black Communities

As mentioned earlier, public health policies that restrict the sale and use of tobacco products are most effective in reducing the disparate health impact of tobacco in priority populations when coupled with easy access to affordable tobacco dependency treatment and resources. Obvious public health policy changes, such as a federal rule eliminating the sale of menthol flavored cigarettes — products that are alone responsible for so much nicotine addiction in the Black population — are long overdue. Rather than wait for federal measures to occur, states and local communities can adopt their own comprehensive tobacco control policies, while also enacting measures to provide cessation treatment for tobacco users most affected by these measures.

Removing barriers to cessation services, coverage, and treatment options is one of the most critical ways to ensure the effectiveness of tobacco control measures. Below are a few ways to overcome these barriers:

Need for assessment: All providers involved in an individual's treatment should consider tobacco use and dependence a primary medical problem. Given the higher incidence of lung cancer among Black smokers, it is critical that healthcare providers counsel all patients — particularly Black patients — on the health benefits of quitting all tobacco products, not just cigarettes. Providers should be trained to give tobacco-related assessments and screenings automatically in all health care and mental health intake settings, and to provide clear and immediate information about access to evidence-based treatment options available to their patients.

Ensuring Awareness of Coverage: Health care providers, including pharmacists and treatment specialists, as well as patients themselves, need to be aware of available cessation treatment options and insurance coverage. Cessation coverage varies depending on an individual's insurance — whether it is provided by the government (e.g., Medicaid, Medicare, VA benefits, or TriCare), by an employer, or purchased through the individual marketplace. Additional considerations should be made for uninsured patients.

Addressing No Insurance/No Prescription Drug Coverage: Individuals without insurance coverage may be able to receive free or discounted cessation medications through a pharmacy assistance program. For instance, Pfizer offers over 60 medications for free through its Patient Assistance Program, including Chantix (varenicline), Nicotrol Inhaler and Nicotrol NS (nasal spray) for cessation.[43] Patients qualify if they have a prescription, live in the United States, have no prescription coverage or not enough prescription coverage, and meet income limits. For more information, call 1-844-989-PATH or visit https://www.pfizerrxpathways.com. Some uninsured individuals may also obtain cessation medication through state quitlines. For

instance, uninsured Michigan residents may get free nicotine patches, gum, and lozenges by enrolling with the Michigan Tobacco Quitlink.

Increasing Access to Cessation Counseling and Medication: To ensure that individuals are aware of the availability of cessation counseling and medication options, health care providers should consider networking with other providers involved in an individual's treatment, such as mental health or addiction specialists.

Pharmacists are providers that play a unique role in community settings — a role that a growing number of states are now expanding to enable them to provide tobacco cessation assistance and FDA-approved medications for patients who are ready to quit. In 2004, New Mexico was the first state to grant pharmacists the authority to prescribe all cessation medications under a statewide protocol.[44] The number of states with pharmacist prescriptive authority for tobacco cessation medications has increased substantially since 2018, with at least 17 states to date enabling pharmacists to prescribe all medications for cessation.[45] Significantly, no complaints have been registered or safety concerns raised during the years pharmacists have had the ability to prescribe all medications for cessation.[46]

Allowing pharmacists to prescribe cessation medication may have a positive impact in communities where residents tend to have limited interactions with other health care professionals. State associations, boards of pharmacy, and state legislatures might thus want to consider exploring ways to expand the prescriptive authority of pharmacists in their states and enable them to provide more cessation assistance than they currently are trained to provide.[47]

Conclusion

Quitting tobacco use is challenging for everyone, but for a variety of reasons, tobacco users in some priority populations tend to have less success in quitting than others. One of the most effective ways to reduce tobacco use and its disparate health impact in the Black community is to ensure that a wide range of affordable, easily accessible tobacco cessation resources and treatment options is available and that health care providers and related organizations provide consistent, non-judgmental support and encouragement at every stage of the cessation process.

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Endnotes

1 The Public Health Law Center recognizes that traditional and commercial tobacco are different in the ways they are planted, grown, harvested, and used. Traditional tobacco is and has been used in sacred ways by Indigenous communities and tribes for centuries. Comparatively, commercial tobacco is manufactured with chemical additives for recreational use and profit resulting in disease and death. For more information visit: http://www.keepitsacred.itcmi.org. When the word "tobacco" is used throughout this document a commercial context is implied and intended.

2 *See, e.g.*, U.S. Dep't Health and Human Servs., *Social Determinants of Health* (2024), https://health.gov/healthypeople/priority-areas/social-determinants-health.

3 Public Health Law Center, *The Tobacco Industry and the Black Community: The Targeting of African Americans* (2021), https://www.publichealthlawcenter.org/sites/default/files/resources/Tobacco-Industry-Targeting.pdf.

4 American Cancer Society, *Cancer Facts and Figures for African American/Black People 2022–2024* (2022), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/2022-2024-cff-aa.pdf.

5 In this fact sheet, "tobacco cessation" or "cessation" is used in lieu of the term "tobacco dependency treatment."

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8 *Tobacco Use Among Adults*, *see supra* note 6.

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11 *Id.*

12 Rony Arauz et al., *Racial Disparities in Cigarette Smoking Behaviors and Differences Stratified by Metropolitan Area of Residence*, 19 INTN'L J. ENV'T RESEARCH AND PUBLIC HEALTH 2910 (2022), https://www.mdpi.com/1660-4601/19/5/2910.

13 Henley, *Vital Signs*, *supra* note 10.

14 *Key Statistics for Lung Cancer*, *supra* note 9.

15 Am. Lung Assoc., *Lung Cancer's Impact on Black Men and Women* (2020), https://www.lung.org/getmedia/87a67675-a8ff-450f-bc82-f9a4631c84cd/infographics-lung-cancer-and-black-men-final.pdf.

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18 *Id.*

19 *Id.*

20 Henley, *Vital Signs*, *supra* note 10.

21 *See, e.g.*, Natl' Public Radio, *How the Tobacco Industry Targeted Black Americans With Menthol Smokes* (2022), https://www.npr.org/2022/04/29/1095291808/tobacco-industry-targeted-black-americans-with-menthols.

22 *See, e.g.*, *The Tobacco Industry and the Black Community*, *supra* note 3.

23 *See, e.g.*, Public Health Law Center, *Urging Quick Action: Meeting on Menthol and Cigar Rule* (2024), https://www.publichealthlawcenter.org/commentary/240118/1/18/24-urging-quick-action-meeting-menthol-and-cigar-rules; *see also The Tobacco Industry and the Black Community*, *supra* note 3.

24 Ctrs. for Disease Control & Prevention, *Benefits of Quitting Smoking* (2024), https://www.cdc.gov/tobacco/about/benefits-of-quitting.html.

25 U.S. Dept Health and Human Services, Smoking Cessation: A Report of the Surgeon General (2020), https://www.cdc.gov/tobacco-surgeon-general-reports/reports/2020-smoking-cessation/index.html.

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35 *See, e.g.*, Nieves Gómez-Coronado et al., *Current and Emerging Pharmacotherapies for Cessation of Tobacco Smoking*, 38 Pharmacotherapy 235-38 (2018), doi:10.1002/phar.2073; Matthew J. Carpenter et al., *Clinical Strategies to Enhance the Efficacy of Nicotine Replacement Therapy for Smoking Cessation: A Review of the Literature*, 73 Drugs 407-26 (2013).

36 Vilma Cokkinides et al., *Racial and Ethnic Disparities in Smoking-Cessation Interventions: Analysis of the 2005 National Health Interview Survey*, 34 Am. J. Preventive Med. 404-12 (2008), https://pubmed.ncbi.nlm.nih.gov/18407007.

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42 *See* Seven Fu et al., *supra* note 37.

43 Pfizer Inc., Pfizer Pathways (2024), https://www.pfizerrxpathways.com.

44 Katy Ellis Hilts et al., *Update and Recommendations: Pharmacists' Prescriptive Authority for Tobacco Cessation Medications in the United States* 62 J. AM. PHARM. ASSOC.1531-37 (2022), https://pubmed.ncbi.nlm.nih.gov/35953378.

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