National Medical Association

INTRODUCTION

Cigarette smoking is a major contributor to the three most prevalent causes of death in African Americans--heart disease, cancer, and stroke. All people, regardless of race and ethnicity, can become addicted to nicotine and damaged by the harmful effects of smoking. However, health-related factors specific to African Americans must be addressed in any smoking cessation program. This briefing paper summarizes research and data on the adverse effects of smoking and describes characteristics of the specific effects smoking has on African Americans.

The National Medical Association, a leader in African American health issues, represents over 30,000 African American physicians and health professionals and the patients they serve. The NMA has historically taken an active role in promoting smoking cessation among African Americans, participating in programs to support tobacco control such as the Stop Active Smoking and Take Charge project funded by the CDC. This paper is meant to brief members of the Smoking Cessation Panel on tobacco-related issues and to provide background for the December 2006 meeting.

BACKGROUND

Cigarette smoking remains the leading preventable cause of death in the United States, accounting for approximately 1 of every 5 deaths (438,000) people each year. Approximately 20.9% of all American adults (45.1 million people) smoke cigarettes. [1]

After years of progress in reducing adult smoking rates, a recent study issued by the CDC indicates that among adult smokers the cessation effort has stalled with no observed change between 2004 and 2005.[2] Factors possibly responsible for the lack of decline in smoking may include smaller increases in the price of cigarettes, a reduction in funding for state programs of tobacco control and prevention, and a doubling of tobacco-industry advertising and promotional expenditures.

In addition, although secondhand smoke exposure has declined, more than 126 million nonsmoking Americans continue to be exposed to secondhand smoke.[2] Although progress has been made in recent years to reduce the level of secondhand tobacco smoke exposure, the decline has been greater among adults than among children.[5]

Along with the significant health risks due to smoking, the financial costs of tobacco-related deaths and diseases are enormous. The estimates of smoking-attributable costs approach $100 billion dollars per year.[3]

Although the number of high school seniors who smoke has been reduced (from 36.5 percent in 1997 to 24.4 percent in 2003), the rate of decline has slowed in recent years.[5]

EPIDEMIOLOGICAL CONSIDERATIONS: Smoking harms nearly every organ of the body, causing many diseases, including cancer, cardiovascular diseases, and respiratory diseases, and adverse reproductive effects. Quitting smoking has immediate as well as long-term benefits. [5]

According to a recent report of the Surgeon General on the health effects of smoking:

> Smoking caused an estimated total of 263,600 deaths in males and 176,500 deaths in females (total 440,100) in the United States each year from 1995-1999. For men aged 35 years and older, annual smoking attributable deaths were 105,700 for cancers, 87,600 for cardiovascular diseases (CVDs), and 53,700 for respiratory diseases. For women aged 35 years and older, the annual SAM was 53,900 for cancers, 55,000 for CVDs, and 44,300 for respiratory diseases. Among adults, the most smoking attributable deaths were from lung cancer (124,800), ischemic heart disease (IHD) (82,000), and chronic airways obstruction (64,700). Smoking during pregnancy was estimated to result in 560 deaths in infant boys and 410 deaths in infant girls annually. Excluding adult deaths from secondhand smoke, the estimated SAM (Smoking Attributable Mortality) was responsible for a total annual YPLL (Years of Potential Life Lost) of 3,319,000 for males and 2,152,600 for females. [5]

Smoking can be blamed for many forms of cancer, including lung, laryngeal, oral cavity and pharyngeal, pancreatic, bladder and kidney, cervical, endometrial, stomach, and acute leukemia cancers. Smoking has also been linked to cardiovascular diseases, including subclinical atherosclerosis, coronary heart disease, cerebrovascular disease, and abdominal aortic aneurysm.

A causal relationship can be inferred between smoking and acute respiratory illnesses and many forms of chronic respiratory disease, including but not limited to maternal smoking during pregnancy, which leads to a reduction of lung function in infants, smoking and impaired lung growth during childhood and adolescence, and asthma. Smoking affects the reproductive process, including causing reduced fertility in women, premature rupture of the membranes, placenta previa, and placental abruption and low fetal birth weight. It is also linked to sudden infant death syndrome. Other effects of smoking include adverse surgical outcomes related to wound healing and respiratory complications, low bone density in postmenopausal women, hip fractures, periodontitis, some eye diseases, and some forms of peptic ulcer disease.

For chronic diseases such as asthma, for which African Americans have a higher prevalence and a higher hospitalization rate, smoking exacerbates the already high incidence of asthma. Tobacco smoke is a leading environmental asthma trigger and has been linked to development of asthma in children and adults. Cigarette smoking decreases lung functioning, increases the risk for asthma-related hospital admissions, increases asthma-related health care use, and increases the risk of death from asthma. Cigarette smoking has also been associated with an impaired therapeutic response to corticosteroids among people with chronic asthma. Smoking cessation and reduced exposure to secondhand tobacco smoke are key components of asthma management.[9]

SMOKING AND AFRICAN AMERICANS
The Surgeon General's report on *The Health Consequences of Smoking* states:

> No single factor determines patterns of tobacco use among racial/ethnic minority groups; these patterns are the result of complex interactions of multiple factors,

such as socioeconomic status, cultural characteristics, acculturation, stress, biological elements, targeted advertising, price of tobacco products, and varying capacities of communities to mount effective tobacco control initiatives.

Rigorous surveillance and prevention research are needed on the changing cultural, psychosocial, and environmental factors that influence tobacco use to improve our understanding of racial/ethnic smoking patterns and identify strategic tobacco control opportunities. The capacity of tobacco control efforts to keep pace with patterns of tobacco use and cessation depends on timely recognition of emerging prevalence and cessation patterns and the resulting development of appropriate community-based programs to address the factors involved.

Although the smoking rate for African Americans is at 21.5%, slightly less than for whites at 21.9%, 1 African Americans bear a great health burden from smoking-related disease and death. African Americans suffer disproportionately from chronic and preventable diseases, to which smoking is a major contributor.

In the United States, approximately 45,000 African Americans die each year from smoking-related diseases. If this situation is not remedied, approximately 1.6 million African Americans now under the age of 18 will become regular smokers and about 500,000 of those smokers will die of a smoking-related disease.[7]

Smoking rates within the African American community vary according to gender and age. In 1997, African American men (32.1%) smoked at a higher rate than white men (27.4%), while African American women (22.4%) and white women (23.3%) smoked at a similar rate.3 Although the National Youth Tobacco Survey (NYTS) found that the smoking prevalence rate was

higher among white high school students (32.8%) than among African American high school students (15.8%), recent surveys have shown that smoking rates among African American high school students are starting to increase. [7]

As with white men, African American men who were high school graduates showed a greater decline in smoking prevalence than did those with less formal education. Generally, rates of illness have differed across racial/ethnic groups. Although some genetic factors may be involved, culture, degree of acculturation, and socioeconomic factors are considered more significant in explaining differences in health between groups. Socioeconomic characteristics in particular often affect health-care access and quality, and minority groups are less likely than whites to be insured and to receive adequate health care.[6]

Commenting on a study reported in the July 24 Journal of the American Medical Association (Vol. 288, No. 4: 468-474), in which researchers looked at accepted treatments for smoking cessation and how they worked in the African-American community, an online article included the following points:

The authors concluded that one way to improve the "quit rates" for African Americans would be through increased access to medications as part of health insurance programs, especially Medicare and Medicaid. This would make an investment in reducing the differences in access to health care that exist in the US, they said.

Just as important, the study noted, is to reach the goals of Healthy People 2010 set by the US government. Significant decreases in smoking among "special populations" such as African Americans must occur.

In an editorial in the same journal, Neal Benowitz, MD, from the University of California in San Francisco, raised the question about the value of trials such as these in racial and economic groups. "The adverse health effects of smoking are even greater in African Americans, who have a higher risk of lung cancer compared with whites, and also are increased among the poor, who are much more likely to be smokers and to have other risk factors, such as hypertension, diabetes, and obesity that interact with cigarette smoking to promote cardiovascular disease."[10]

Smoking is the most common cause of lung cancers (87%). African American men are at least 50% more likely to develop lung cancer than white men and have higher mortality rate of cancer of the lung and bronchus (100.8 per 100,000) than do white men (70.1 per 100,000). The risk of cerebrovascular disease, associated with stroke, is elevated by smoking. Cerebrovascular disease is twice as high among African American men (53.1 per 100,000) as among white men (26.3 per 100,000) and twice as high among African American women (40.6 per 100,000) as among white women (22.6 per 100,000).[7]

Levels of serum cotinine (metabolized nicotine) are higher among African American smokers than among white or Mexican American smokers for the same number of cigarettes, possibly because of differing patterns of smoking behavior, rates of nicotine metabolism, and brand mentholation. [6] Another risk factor specific to African Americans is the fact that three out of four African American smokers smoke menthol cigarettes, as compared to one fourth of white smokers. There is some evidence that menthol cigarettes may facilitate absorption of harmful constituents of cigarette smoke.[6] One study found that people who smoke menthol cigarettes may have a more difficult time quitting smoking. [10]

Other important factors are associated with the promotion of tobacco use among African Americans. Tobacco companies have specifically targeted tobacco advertising toward African Americans, placing ads in stores, on billboards, and at special events.[8] Advertising targeted to African Americans often does not describe the harmful effects of tobacco. A study found that African American publications Ebony, Jet, and Essence received higher profits from cigarette advertising than did other magazines. It has been found that cigarette companies also support cultural events and donate to minority higher education institutions, elected officials, civic and community organizations, and scholarship programs. [6]

A 2002 study found "The tobacco industry established relationships with virtually every African American leadership organization and built longstanding social connections with the community, for three specific business reasons: to increase African American tobacco use, to use African Americans as a frontline force to defend industry policy positions, and to defuse tobacco control efforts. "

It concluded, "As the tobacco industry expands its global reach, public health advocates should anticipate similar industry efforts to exploit the vulnerabilities of marginalized groups…. Helping groups anticipate such efforts, confront industry co-optation, and understand the hidden costs of accepting tobacco industry largesse should be part of worldwide tobacco control efforts."[11]

PERTINENT LEGISLATION AND LEGISLATIVE HISTORY

Three important developments in the 1990's began to influence the way in which tobacco was regulated and used in the U.S. The FDA issued final regulations in 1996 to restrict the sale, distribution, advertising and promotion of cigarettes and smokeless tobacco. In 1997 a group of state attorneys general presented a tobacco settlement proposal, representing 41 of the 50 states. This initial proposal eventually led to an agreement in 1998 between U.S. tobacco companies to settle pending and prospective lawsuits by states to recover Medicaid

expenditures from tobacco use. These national settlements also led to provisions similar to public health regulations. These important regulatory measures included state-wide restrictions on tobacco related activities such as a ban on outdoor advertising, advertising to minors and to call for statewide restrictions on vending machines. [5]

Recently, the Public Health Service targeted reductions in youth and adult smoking rates in its Healthy People 2010 objectives. Its goals were to reduce current smoking from 35% (1999) to 16% among high school youth 14-17 years of age and to reduce current smoking from 24% (1998) to 12% among adults aged 18 years and older. [5]

RELATED NMA POLICY

Since 1975, the Association has participated in a wide variety of externally funded projects. Our programs, funded by federal, state, and local governments, private foundations, pharmaceutical companies, and private corporations range from topics such as AIDS, bioterrorism, and cultural competence to health literacy, immunization, lupus, and prostate cancer. In addition, the NMA has worked with research institutes at the National Institutes of Health, including the National Cancer Institute, the National Eye Institute, the National Institute on Deafness and Other Communication Disorders, and the National Heart, Lung and Blood Institute. The NMA has also collaborated with the Centers for Disease Control and Prevention, the Public Health Service, Health and Human Services Department, and Healthcare Research and Services Administration.

Our tobacco program highlights include the following:
1. The Stop Active Smoking and Take Charge Program, funded for 3 years (1994-1997) by the CDC and also by the Robert Wood Johnson Foundation, created a national community-based

leadership coalition that participated in the development and promotion of a tobacco control agenda and media campaign for black Americans.

2. In 1997, the National Medical Association, under the auspices of the SASATAC Project ("Stop Active Smoking and Take Charge"), launched a dissemination initiative, which began with a series of strategic planning sessions held at NMA headquarters and other locations in Washington, DC, and Rockville, MD. Staff of the NMA/SASATAC Project met with AHRQ and NMA leaders to finalize plans for implementing project activities, including:

• Modification of existing AHRQ point of sale and provider information to insure ethnic/cultural relevance and appropriateness.

• Subsequent strategic planning meetings with AHRQ staff, NMA leadership, and administrative staff.

• Recommendations for modifying and customizing the guideline supplemental materials (a quick reference physician pocket guide and posters).

• Video production and on-site training.

• Massive dissemination of clinical practice guidelines and associated materials.

• Establishment of a tentative regional training schedule for NMA state and local organizations.

3. In 2002, the NMA worked with the CDC to endorse a guide for African American patients titled "Pathways to Freedom: Winning the Fight Against Tobacco."

4. Recently the Association has been working with Glaxo Smith Kline on the NMA physician education program, implementing clinical practice guidelines for treating tobacco dependence and educating patients about tobacco cessation via public service announcements.

5. The NMA, along with other nonprofits such as Tobacco Free Kids, is an active member of the Washington, DC, Independent Tobacco Commission Coalition, which tracks tobacco prevention efforts and develops and participates in tobacco control activities. Recently the Commission submitted its Evidence Based Control and Prevention Recommendations to the CDC, which included community-based youth education programs.

CONCLUSION

The NMA has the capacity to organize and mobilize organizations, communities and constituents to promote tobacco control among African Americans. The goal is to use NMA resources to significantly decrease the disproportionate impact that smoking and the use of other tobacoo products plays in the African-American community.

REFERENCES

1. Centers for Disease Control, Adult Cigarette Smoking the US: Current Estimates.
2. Centers for Disease Control, Decline in Adult Smoking Rates Stall Millions of Nonsmoking Americans Remain Exposed to Secondhand Smoke

3. Treating Tobacco Use and Dependence: A Systems Approach. A Guide for Health Care Administrators, Insurers, Managed Care Organizations, and Purchasers, November 2000. U.S. Public Health Service, http://www.surgeongeneral.gov/tobacco/systems.htm

4. "Smoking: epidemiology, cessation, and prevention - Task Force on Research and Education for the Prevention and Control of Respiratory Diseases," BR Flay, JK Ockene, and IB Tager, CHEST, Sep 1992; 102: 277 - 301.

5. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

6. U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups - African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. 1998.

7. Centers for Disease Control. African Americans and Tobacco, 2005.

8. National Medical Association. Tobacco Control. National Colloquium on African American Health.

9. Rebanal RD, Leman R. Collaboration between Oregon's chronic disease programs and Medicaid to decrease smoking among Medicaid-insured Oregonians with asthma. Prev Chronic Dis [serial online] 2005 Nov [date cited].

10.   "Medication and Counseling Help African Americans Quit Smoking," Victor Linjoco, Discover.com online article, July 24, 2002.

11.   "African American leadership groups: smoking with the enemy," V. B. Yerger and R. E. Malone, Tobacco Control 11:336-345, 2002.