FACT SHEET

American Heart Association.

Structural Racism & Tobacco

BACKGROUND

Structural racism is the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that advantageously benefit White people while producing adverse outcomes for people of color.[1] As a result, communities of color are limited in their opportunities for social, economic, and financial advancement ultimately cultivating negative health consequences and inequities, particularly among Black Americans who are also subjected to anti-Black racism.[1] U.S public policies have systematically displaced and destabilized communities of color, most notably Black and Indigenous communities. Exclusionary policies such as redlining, the Indian Relocation Act of 1956, and the formation of Chinatowns resulted in racially segregated, under resourced, environmentally hazardous, and poverty-concentrated neighborhoods that continue to persist today.[1,2]

The experience of racism results in chronic discrimination and stress that adversely impacts the health of individuals from historically racially marginalized populations.[1] The use of tobacco products can further exacerbate these negative health consequences resulting in even worse health outcomes among these populations. One study demonstrated that adolescents that had interpersonal experiences with racism were more likely to initiate smoking, regardless of gender, ethnicity, or socioeconomic status.[3] Racially or ethnically marginalized communities are less likely to have access to affordable health care, lower medical access and coverage for tobacco cessation, and live in areas with higher tobacco retailer density.[4,5,6] The tobacco industry has an extensive history of targeting historically under-resourced communities with tactics that use racial profiling, neighborhood demographics, and cultural elements to promote tobacco sales.[7,8,9] Additionally, tobacco companies have heavily marketed menthol products to Black communities and low-income neighborhoods.[8] Strategic targeting by the tobacco industry in combination with structurally racist policies has resulted in disproportionate rates of tobacco use and exposure in historically under-resourced communities. The American Heart Association is committed to a tobacco endgame that ultimately leads to an end to all tobacco and nicotine addiction in the US for all communities. We support first minimizing the use of all combustible tobacco products, while combating the structural barriers that continue to inhibit equitable health outcomes. We aim to ensure the next generation of youth and adolescents do not become addicted to harmful nicotine products.

KEY FACTS

- American Indian/Alaska Native (29.3%) adults had the highest prevalence of tobacco use compared to White (23.3%), Black (20.7%), Hispanic (13.2%), and Asian (11.0%) adults in 2019.[10]
- Sovereign tribal status and cultural practices are important factors when considering strategies to address the high prevalence of tobacco use among American Indians/Alaska Natives. Tobacco companies have historically targeted these communities by tactics such as price reductions, giveaways, promotions, charitable contributions, and sponsorships.[11]
- Black and Hispanic communities have been traditionally pursued by the tobacco industry. These communities experience high levels of tobacco retailer density, price discounts, availability of little cigar and cigarillo, and advertising.[7,12]

- Menthol cigarettes are used at disproportionately higher rates by racial and ethnic minority smokers, including African Americans (84.6%), Hispanics or Latinos (46.9%) and Asian Americans (38%), compared to White smokers (28.9%). At least half of all teen smokers use menthol tobacco products, including more than 70% of adolescent African American smokers and more than half of all adolescent Latino smokers.[13]

- A 2018 study examining the promotion of alternative tobacco products in New York City found that inexpensive, combustible, and most harmful tobacco products are disproportionately more accessible and advertised in non-White and low-income neighborhoods. Black and Hispanic neighborhoods were more likely to carry inexpensive products such as 99-cent cigarillos.[14]

- Disproportionately high distribution of tobacco retailers in Black and Hispanic neighborhoods provides increased availability of tobacco products in these communities contributing to existing tobacco disparities. Historical factors such as redlining, racially biased retailer decisions to invest (or not invest) in resources, and neighborhood segregation could all be contributing factors to high retailer density in these communities.[15]

- It is important to consider the traditional and cultural difference among population subgroups when targeting different tobacco cessation and control strategies as smoking behavior can vary widely. For example, Asian Americans have the lowest prevalence of cigarette use among racial groups; however, 20% of Koreans smoke cigarettes compared to 7.6% of Chinese individuals.[16]

- Between 2014 – 2017, Native Hawaiian/Other Pacific Islander (23.4%) and American Indians/Alaska Natives (20.6%) youth had the highest prevalence of current tobacco use compared to Multiracial (16.5%), White (15.3%), Hispanic (14.6%), Black (11.5%), and Asian (5.0%) youth.[17]

- Between 2014-2017, cigars are more frequently used among Black youth, whereas e-cigarettes are the most common product for all other racial/ethnic youth.[17]

- Historically marginalized racial communities are less likely to be screened for tobacco use, receive physician advice to quit smoking, and receive tobacco cessation treatment.[18,19] These disparities in cessation behaviors could possibly be associated with difference in tobacco use behaviors, health care access, access to cessation treatments, and lack of awareness of these treatments.[20]

- In 2014, the CDC estimated that 50.3% of Black non-smokers are exposed to secondhand smoke compared to 21.4% of White non-smokers and 20.0% of Mexican American non-smokers.[21] Additionally, 66.1% of Black children (aged 3-11 years) are exposed to secondhand smoke compared to 37.8% of White children and 22.2% of Mexican American children of the same age.[21]

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