Article:
Pearson, Jennifer, Waa, Andrew, Siddiqi, Kamran et al. (2021) Naming racism, not race, as a determinant of tobacco-related health disparities. Nicotine & tobacco research. pp. 885-887. ISSN: 1469-994X

https://doi.org/10.1093/ntr/ntab059

Naming racism, not race, as a determinant of tobacco-related health disparities

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Funding source:

This issue of *Nicotine & Tobacco Research* includes articles investigating how commercial tobacco product use varies by 'race/ethnicity' in the USA[1-4] and a systematic review of factors influencing smoking cessation among pregnant Indigenous women in Australia.[5] These articles highlight how, as people engaged in nicotine and tobacco research, we can improve how we engage stakeholders and conceptualize, conduct, and report research exploring racial/ethnic disparities. In this editorial, 'tobacco' refers only to commercial tobacco products, recognizing that the tobacco plant is sacred for many Indigenous peoples. We use 'race/ethnicity' to broadly represent socio-political constructs, recognizing that there are many dimensions to racial/ethnic identity that this conceptualization does not include.

There are many important topics that fall broadly under 'health disparities research' that we could explore. Examples include how researchers' racial/ethnic identities affect study design, study conduct, methodologies, and reporting, or how to ensure that the research team and its leadership reflect the Indigenous or racial/ethnic groups under study. Each of these topics merit individual editorials. However, in this editorial, we focus on the importance of studying the structural causes of racial/ethnic disparities in commercial tobacco use and health outcomes. We begin by explaining why explicitly or implicitly framing race/ethnicity as a causal determinant of tobacco-related health disparities is problematic and may impede progress towards health equity. Then, we highlight approaches to investigating the multilevel mechanisms that drive these disparities. We close with brief suggestions for modifying how we conduct research in tobacco-related health disparities.

Framing race/ethnicity as a causal determinant impedes progress towards health equity

Readers are no doubt familiar with studies concluding that people of a certain race/ethnicity are 'at greater risk' of negative commercial tobacco-related behaviours or outcomes compared to individuals from other racial/ethnic groups, without further investigation into the source of these disparities. Whilst such comparisons can highlight inequity and hence support arguments for prioritising interventions to reduce disparities, it can also frame race/ethnicity as a causal determinant of health disparities, impeding our understanding of *why* these inequities exist. This approach may lead to erroneous assumptions that the cause of disparities is either biological and hence not modifiable, or cultural and therefore the 'fault' of group members themselves.[6,7] For example, governing authorities may frame tobacco-related behaviours as 'entirely cultural' to absolve themselves of responsibility to regulate commercial tobacco products, as is arguably the case of the failure to regulate smokeless tobacco products, which are disproportionately used by South Asians in the UK. [8] Even the endeavour of identifying racial/ethnic disparities without considering the underlying mechanisms driving them risks framing the wider group as "normal" and the racial/ethnic group as "substandard."

Rather than conceptualizing racial/ethnic categories as 'risk factors', we encourage thinking of race/ethnicity as a socially constructed proxy for structural determinants such as degree of disadvantage, marginalisation, colonisation, and the pervasive effects of racism at the intrapersonal,

interpersonal, institutional, and structural levels.[6,9] Across cultures and contexts, the effects of racism are associated with poor heath and increased likelihood for commercial tobacco use initiation, maintenance, and relapse.[10-13] For example, experiences of discrimination are associated with heightened psychosocial stress and increased risk for smoking among Black Americans.[14] Adjusting for socioeconomic factors rarely fully explains inequity.[6] For instance, while commercial tobacco use prevalence varies by socioeconomic status (SES) in Aotearoa/New Zealand, Māori are more likely to smoke than non-Māori at every SES.[15] Thus, using an intersectional lens and assessing racism's pervasive effects in combination with SES is necessary to understand why disparities persist even after adjusting for material disadvantage.[6]

Approaches to measuring the underlying mechanisms driving racial/ethnic inequity

There are many approaches available to nicotine and tobacco researchers to investigate the manifestations of racism in the lived experiences of racial/ethnic minority and Indigenous groups. At the individual level, measures such the Major Experiences and Everyday Discrimination Scales assess both exposure to and the frequency of experienced racism.[16 17,18] At the interpersonal level, assessing the degree of healthcare providers' implicit bias or cultural competency may help explain racial/ethnic differences in intervention engagement and outcomes. Similarly, assessing differential healthcare access, experiences, or treatment outcomes could measure the degree of institutional racism perpetuating health inequity. Possible measures of structural racism related to commercial tobacco use disparities include residential segregation and the density of tobacco retailers within locations. More broadly, understanding the role of structural racism in tobacco-related health disparities requires shifting from study designs focusing on individual-level determinants to designs that focus on population-level factors that impact health across the lifecourse.[19]

Moving the field forward

To move the field of nicotine and tobacco research towards work that is more inclusive of our racially/ethnically diverse global communities and that provides the knowledge base for eliminating health disparities, we offer the following suggestions when designing, conducting, and reporting studies. We recognize that there are many other actions we should take in addition to those listed below.

1. Development and application of methods grounded in theory: Use theory (e.g., Minority Stress Model, intersectionality, US National Institute on Minority Health and Health Disparities framework, or decolonizing theory, among others) to guide study design, particularly to incorporate multilevel measurement of the experience, mechanisms, and consequences of racism. In reporting and disseminating findings, researchers should explain how they assessed race/ethnicity and justify why they took this approach. For example, as highlighted by the diversity of backgrounds, cultures, and lived experiences encompassed by the "Hispanic" label in the USA, researchers should consider the

shortcomings of using racial/ethnic labels as set of mutually exclusive categories in explanatory analyses, which gloss over people's self-defined multiple identities. At the same time, we also recognize that racial/ethnic labels make disparities visible, and thus are useful for purposes like surveillance.

2. Attention to appropriate study design, methods, and reporting. This suggestion includes many facets. For example, study designs should adhere wherever feasible to the principle of "equal explanatory power," which requires that research be as useful for improving the health of racial/ethnic minority and Indigenous subpopulations as it is for the overall population.[20] A major component of this principle is designing studies with adequate sample sizes to explore differences by race/ethnicity. If collecting adequate samples is not possible (e.g., in a secondary analysis), consider how aggregating racial/ethnic groups may mask key differences and reduce the utility of examining race/ethnicity as proxy for lived experience. Researchers should also consider how they use race/ethnicity in analyses. Some approaches could yield misleading results due to faulty categorization and comparisons, or inappropriate use of race/ethnicity as an adjusting variable.
3. Research management and conduct: On a broader level, researchers should also reflect on their role in the research process, particularly if they are not members of the groups included in the study. Research should be led by or at least with the participation of researchers from the groups studied. We encourage researchers to avoid deficit framing in their interpretation of results and to disseminate findings to communities from where participants were drawn.

Beyond improving study design and measurement, our field must also critically reflect on how structural racism constrains and shapes our research endeavours. The basic metrics of success in academia encourage focus on the total population rather than subpopulations, which translates to more citations, name recognition, grant funding, and ultimately career progress. As individuals and as a field, we must actively engage in dismantling racism in all its manifestations, including within our own institutions and practices by ensuring that research investigating topics of importance to Indigenous or racial/ethnic groups is prioritised and is carried out using appropriate designs, methods and practices.

We intend this editorial to encourage additional conversation in our field on eliminating disparities and achieving equity in our own research activities. The journal welcomes discussion pieces about issues raised here and will soon issue a call for papers for an upcoming special issue, entitled 'Identifying and Eliminating Inequities in Commercial Tobacco Use and Related Health Outcomes.'

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