UNIVERSITY of York

This is a repository copy of *Naming racism, not race, as a determinant of tobacco-related health disparities*.

White Rose Research Online URL for this paper:
https://eprints.whiterose.ac.uk/172900/

Version: Accepted Version

Article:

Pearson, Jennifer, Waa, Andrew, Siddiqi, Kamran orcid.org/0000-0003-1529-7778 et al. (3 more authors) (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

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

White Rose university consortium
Universities of Leeds, Sheffield & York

eprints@whiterose.ac.uk
https://eprints.whiterose.ac.uk/

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

Jennifer L. Pearson, MPH, PhD

Division of Social and Behavioral Health/Health Administration and Policy, School of Community Health Sciences, University of Nevada, Reno

Andrew Waa, MPH

Department of Public Health, University of Otago, Wellington, New Zealand

Kamran Siddiqi, PhD

Department of Health Sciences, University of York, York, UK

Richard Edwards, MPH, MD

Department of Public Health, University of Otago, Wellington, New Zealand

Patricia Nez Henderson, MD, MPH

Black Hills Center for American Indian Health

Monica Webb Hooper, PhD

National Institute on Minority Health and Health Disparities, National Institutes of Health, Bethesda, MD

Corresponding author contact:

Jennifer Pearson

Assistant Professor

School of Community Health Sciences

Mail Stop 274

University of Nevada

Reno, NV 89557

775-682-5005

© The Author(s) 2021. Published by Oxford University Press on behalf of the Society for Research on Nicotine and Tobacco. All rights reserved. For permissions, please e-mail: journals.permissions@oup.com.

Accepted Manuscript

Downloaded from https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntab059/6208270 by guest on 07 April 2021

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,

Accepted Manuscript

Downloaded from https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntab059/6208270 by guest on 07 April 2021

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. <u>Development and application of methods grounded in theory</u>: 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

Accepted Manuscript
Downloaded from https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntab059/6208270 by guest on 07 April 2021

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.'

Accepted Manuscript

Downloaded from https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntab059/6208270 by guest on 07 April 2021

REFERENCES

1. Kcomt L, Evans-Polce RJ, Engstrom CW, West BT, McCabe SE. Racial/ethnic discrimination, sexual orientation discrimination, and severity of tobacco use disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *Nicotine Tob Res.* 2020. 10.1093/ntr/ntaa197
2. Mills SD, Hao Y, Ribisl KM, Wiesen CA, Hassmiller Lich K. The relationship between menthol cigarette use, smoking cessation and relapse: Findings from Waves 1 to 4 of the Population Assessment of Tobacco and Health Study. *Nicotine Tob Res.* 2020. 10.1093/ntr/ntaa212
3. Stokes A, Wilson AE, Lundberg DJ, et al. Racial/ethnic differences in associations of noncigarette tobacco product use with subsequent initiation of cigarettes in us youths. *Nicotine Tob Res.* 2020. 10.1093/ntr/ntaa170
4. Sakuma KK, Pierce JP, Fagan P, et al. Racial/ethnic disparities across indicators of cigarette smoking in the era of increased tobacco control, 1992- 2019. *Nicotine Tob Res.* 2020. 10.1093/ntr/ntaa231
5. Rahman T, Eftekhari P, Bovill M, Baker A, Gould G. Socioecological mapping of barriers and enablers to smoking cessation in Indigenous Australian women during pregnancy and postpartum: A systematic review. *Nicotine Tob Res.* 2021. 10.1093/ntr/ntab003
6. Phelan JC, Link BG. Is racism a fundamental cause of inequalities in health? *Annu Rev Sociol.* 2015;41(1):311-330. 10.1146/annurev-soc-073014-112305
7. Borrell LN, Elhawary JR, Fuentes-Afflick E, et al. Race and genetic ancestry in medicine - a time for reckoning with racism. *N Engl J Med.* 2021;384(5):474-480. 10.1056/NEJMms2029562
8. Siddiqui F, Khan T, Readshaw A, et al. Smokeless tobacco products, supply chain and retailers' practices in England: A multimethods study to inform policy. *Tob Control.* 2021. 10.1136/tobaccocontrol-2020-055830
9. Nichter M. Smoking: What does culture have to do with it? *Addiction.* 2003;98:139-145. 10.1046/j.1360-0443.98.s1.9.x
10. Oh H, Glass J, Narita Z, Koyanagi A, Sinha S, Jacob L. Discrimination and multimorbidity among black americans: Findings from the National Survey of American Life. *Journal of Racial and Ethnic Health Disparities.* 2021;8(1):210-219. 10.1007/s40615-020-00773-z
11. Harris R, Cormack D, Tobias M, et al. The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Soc Sci Med.* 2012;74(3):408-415. 10.1016/j.socscimed.2011.11.004
12. Read UM, Karamanos A, João Silva M, et al. The influence of racism on cigarette smoking: Longitudinal study of young people in a British multiethnic cohort. *PLoS One.* 2018;13(1):e0190496. 10.1371/journal.pone.0190496
13. Unger JB. Perceived discrimination as a risk factor for use of emerging tobacco products: More similarities than differences across demographic groups and attributions for discrimination. *Subst Use Misuse.* 2018;53(10):1638-1644. 10.1080/10826084.2017.1421226 PMC7392176

Accepted Manuscript

Downloaded from https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntab059/6208270 by guest on 07 April 2021

14. Cuevas AG, Reitzel LR, Adams CE, et al. Discrimination, affect, and cancer risk factors among african americans. *Am J Health Behav.* 2014;38(1):31-41. 10.5993/ajhb.38.1.4
15. Cormack D, Stanley J, Harris R. Multiple forms of discrimination and relationships with health and wellbeing: Findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health.* 2018;17(1). 10.1186/s12939-018-0735-y
16. Williams DR, Yan Y, Jackson JS, Anderson NB. Racial differences in physical and mental health. *J Health Psychol.* 1997;2(3):335-351. 10.1177/135910539700200305
17. Atkins R. Instruments measuring perceived racism/racial discrimination: Review and critique of factor analytic techniques. *Int J Health Serv.* 2014;44(4):711-734. 10.2190/hs.44.4.c
18. Aotearoa/New Zealand Manatū Hauora/Ministry of Health. Racial discrimination. https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-awe-o-te-hauora-socioeconomic-determinants-health/racial-discrimination. Published 2018. Accessed 21 March, 2021.
19. McMichael AJ. Prisoners of the proximate: Loosening the constraints on epidemiology in an age of change. *Am J Epidemiol.* 1999;149(10):887-897. 10.1093/oxfordjournals.aje.a009732
20. Te Röpü Rangahau Hauora a Eru Pömare. *Mana whakamārama - equal explanatory power: Māori and non-māori sample size in national health surveys.* Wellington: Ministry of Health;2002. Accessed 21 March 2021

Accepted Manuscript

Downloaded from https://academic.oup.com/ntr/advance-article/doi/10.1093/ntr/ntab059/6208270 by guest on 07 April 2021