Moving Toward Health

Achieving Parity through Tobacco Control for All Communities

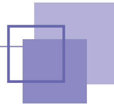
This educational toolkit is designed to provide guidance to individuals, community-based organizations, coalitions, health departments, local, state and national organizations on how to work toward parity in tobacco control.

Parity (păr ˈĭ-tē)
“the state or condition of being the same

This toolkit is an introductory document that can engage tobacco control advocates and other interested parties in a dialogue on parity — a dialogue that will hopefully lead to action and the elimination of tobacco disparities. It is not intended to cover all of the issues of parity or provide a recipe for achieving parity. The goals of this toolkit are:

1) To provide a framework for understanding the specific tobacco-related problems of heterogeneous communities of color (African Americans, Asian Americans, Native Hawaiians, Pacific Islanders, Hispanic/Latinos, Native Americans, Alaskan Natives), and other priority populations (lesbians, gay, bisexuals, transgenders (LGBTs), low socioeconomic status, women, youth);
2) To raise and respond to key questions regarding the background and challenges of working toward parity;
3) To suggest some specific steps to move towards achieving parity for all communities; and
4) To provide a list of some community organizations that can help provide technical assistance, referrals and resources on working with respective communities on tobacco control issues.

in power, value, rank, etc. — equality."



We Must Move Towards a Common Vision . . .

... to build a tobacco control movement that is responsive to the history, culture, language, geography, socioeconomic status, gender and sexual orientation of our growing and heterogeneous communities. A movement that embraces diversity and inclusivity and strives for parity is essential to building effective local, state and national coalitions and organizations that can achieve policy, environmental and behavioral changes necessary to reduce the burden of disease and disability caused by commercial tobacco consumption. Every organization and advocate is needed to make parity a reality. Together we can!

Tobacco disparities continue to exist for communities of color and other priority populations. For example, African Americans have the highest lung cancer incidence and mortality rates and American Indians and specific AAPI subgroups have some of the highest prevalence of tobacco use. The increasing targeting of communities of color, the poor, LGBTs and youth by the tobacco industry has contributed greatly to these tobacco disparities.

However, with some exceptions, the tobacco control movement at national, state and local levels has not historically embraced nor adequately addressed tobacco issues for communities of color and other priority populations. Although efforts to begin addressing parity are slowly increasing, many of the disparities and inequities are built into our system (whether in our political system, health care system or our tobacco control organizations) that has been institutionally biased.

Whether it's a disparity issue related to tobacco-related morbidity and mortality, capacity building opportunities and infrastructure, tobacco control and health resource allocation, or how representatives from key impacted communities are involved in the decision-making process, the end result is the same — the inability to eliminate disparities and achieve parity for all of our communities.

The term "parity", while similar to the term "disparities", is preferred because it presents a vision that is framed in a positive way and focuses on what we need to do to achieve parity rather than "who has more" and "who has less". However, we cannot ignore the unbalanced nature of the current equation and the consequences it has had for communities of color and priority populations. But we must move beyond that historical reality towards a "parity" process where all organizations and communities can take part to achieve a "parity" outcome.

To be successful in tobacco control, we need to recognize that our approach must be comprehensive and all-inclusive. We must recognize the need to understand tobacco and health holistically within the context of each heterogeneous community — to understand each community's history, culture, context and diversity. We must understand and address other barriers to achieving tobacco and health parity including economic, social and political inequalities and institutional inequalities.

If we are not strategic, explicit, persistent, and vocal about moving toward parity in tobacco control and health, we risk the danger of inadequately confronting the tobacco and health disparities that will continue to plague many of our communities, weaken the movement and prevent us from reaching our ultimate goal of building a healthy nation.

Questions and Answers

◆ **What is the difference between diversity, inclusivity and parity?**

Having a diverse group is often thought of as the end goal for many tobacco control coalitions and organizations. However, ***diversity*** is only the representation of the heterogeneity of a community in a meeting, activity or program. Diversity achieves the short term objective of having a person or a "token representative" in the room, but this is only a very small step toward achieving parity or equity.

Inclusivity refers to actively involving representatives from heterogenous communities in a substantive way, in the planning and decision making process of any organization's mission, goals and objectives. True inclusivity, as opposed to diversity, works more closely towards parity and equity.

Parity can be defined as being equal in the process, as well as the outcomes attained in tobacco control. It can also be defined as the ability of representatives from heterogeneous communities to equally participate in the planning and implementation of key activities, programs and policies. As stated by the Out of Many, One coalition, "In order to achieve the fullest health potential for our communities and ourselves, we must begin by achieving health parity with the best level of health achieved by any group."

◆ **What inequities exist around tobacco?**

There is a higher prevalence of tobacco use in low socioeconomic status groups, communities of color and other priority populations (e.g. blue collar workers). There is also a greater exposure of individuals to secondhand smoke in communities of color. This higher prevalence and exposure often results in an excess burden of tobacco-related diseases like stroke, heart disease, lung cancers, oral cancers, other cancers and respiratory diseases. Lack of access to medical care and inequities in how patients from different communities are treated in the health care system may also play a role in overall negative outcome of the tobacco-related diseases.

Studies have also shown that tobacco use is also related to heavy and disproportionate tobacco industry targeting of communities of color, women and youth, LGBT and low socioeconomic status communities through advertising and promotion. For example, LGBT communities suffer from very high smoking prevalence among youth because of the combined targeting of the tobacco industry and the pressures of discrimination and ostracism they endure.

We must also recognize the co-optation of community leaders, organizations and decision makers through corporate sponsorship that can effectively silence the community's voice. Tobacco products are

the only products that when used as intended are harmful; in essence, the industry targeting of specific communities with these products makes tobacco a social justice issue.

◆ What are some other tobacco inequities faced by communities of color?

The inequities described above have helped to create a disparity in the ability of communities to respond to tobacco issues, thereby limiting the capacity building and infrastructural development efforts. In addition, the historic unequal and inadequate distribution of funds and resources from tobacco control organizations and the tobacco settlement has also helped to perpetuate the widening disparity in capacity and infrastructural levels for communities of color relative to the mainstream.

As a result, communities of color and other priority populations have lower institutional capacity, core funding and infrastructure to develop a comprehensive approach that allows for a continuum of competent services to take place in each community, for example, from prevention and cessation to policy development. Ethnic-specific and priority population networks and a few leadership programs have recently been funded to help build the skills, collaboration, capacity and leadership of heterogeneous communities to respond to tobacco and move toward parity.

◆ Why should all groups become more inclusive, competent and proficient in addressing issues for communities of color and work more toward parity?

The burden of tobacco use and tobacco-related diseases in these communities is compounded by

African Americans and Tobacco

African Americans bear a disproportionately heavy health burden from tobacco-related diseases. Our community remains among the ranks of one of the populations most heavily targeted by tobacco industry marketing, including advertising, promotions and philanthropy.

Tobacco use is an affirmative action killer, that targets people of African descent for special treatment. Tobacco can rob the African American community of its existence, present and future at any given point. The data below highlights the impact of tobacco-related disease on the African American community —

- Each year, approximately 45,000 African Americans die from a preventable smoking-related disease.
- If current trends continue, an estimated 1.6 million African Americans who are now under the age of 18 years will become regular smokers.
- About 500,000 of those new youth smokers will die of a smoking-related disease
- Approx. 3 out of 4 African American smokers prefer menthols, and among Black youth who smoke, more than 9 out of 10 choose menthols.
- Smokers of menthol cigarettes can have as much as three times the exposure to toxic and cancer-inducing agents as smokers of non-menthol cigarettes.

lack of health care access, social and economic inequities, immigration status, sovereignty issues, historic and contextual issues and cultural and linguistic differences. On the one hand, parity is only achievable through substantive policies and mechanisms to secure diversity and inclusivity. Similarly, tobacco control has not been a priority in many communities of color because of the multitude of issues they face and the lack of tobacco control resources. Empowering these communities to mobilize their own constituencies is at the core of preventing the exponential deaths expected from this preventable disease.

◆ What are tobacco control organizations doing to respond to disparities and move toward parity?

Some national, state and local tobacco control organizations have begun to address disparity issues. For example, the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health's fourth priority area is to Eliminate Health Disparities and was one of the first national organizations to have tobacco control initiatives specifically for communities of color and other priority populations.

The Robert Wood Johnson Foundation has also been key in funding tobacco control leadership and policy initiatives for communities of color. And more recently, the American Legacy Foundation has launched their Priority Populations Initiative which has provided funding for tobacco control in diverse communities of color, low SES and the LGBT community.

On the statewide level, California has led by example, providing continuous funding to four ethnic tobacco education networks and to numerous community-based organizations as local competitive grantees since the inception of the Tobacco Control Program in 1990. More recently, several other states have begun

Native Americans and Alaskan Natives

There are over 550 federally recognized American Indian tribes in the US, including 200 village groups in Alaska. There are 2.4 million Native Americans, with each tribe and village embracing their respective unique and rich cultural traditions, language, heritage and spiritual and medicinal relationship with tobacco.

It is critical that a distinction be made about the traditional uses of native tobacco and the current abuse and addiction to commercial tobacco being manufactured and sold by tobacco companies.

It is vital to address tobacco issues, including the traditional, ceremonial use of tobacco in our native communities across the United States within the context of respecting the sovereign status of American Indian/Alaska Native tribes and villages since Native Americans have the highest prevalence of tobacco use than any other group.

Approximately 39% of American Indians /Alaskan Native adults are smokers, and 3 out of every 5 deaths in our native communities can be attributed to tobacco use.

to address tobacco disparities and either developed ethnic networks (e.g. Minnesota, Wisconsin, Oklahoma) or provided funding for tobacco control programs for communities of color. One example is Indiana whose statewide program has made efforts to be more inclusive of diverse communities and provide funding for community programs.

While these are important steps forward, the action steps toward eliminating these disparities and institutionalizing parity measures still need to happen. Efforts need to better address the historical context and stages of readiness of these heterogeneous communities to respond to tobacco.

In addition, there is a dearth of information about what local communities of color and other priority populations are already doing to address health disparities and tobacco control. Their successful efforts in tobacco control are rarely publicized or evaluated for replication. In terms of tobacco control resources and program development, communities of color are playing catch-up. Only when more resources and attention is given to these communities will they be more on an equal footing with the mainstream.

Some organizations have created "minority-focused" departments or programs, however they are most often understaffed with limited resources and authority. There is a danger that these may foster and perpetuate a "separate minority" mentality when it is not a representation from each of the four major communities of color that ultimately counts. It is the commitment to address the needs of all of the diverse people living in a community that should be the focus of tobacco control efforts.

Asian Americans and Pacific Islanders (AAPIs) and Tobacco

AAPIs are the fastest growing racial group in the U.S. and are a very heterogeneous group comprised of more than 50 diverse ethnic and language groups. Geographically, AAPIs are located in the 50 states and six Pacific Island jurisdictions. This diversity is also seen in terms of disparate poverty rates and other socioeconomic characteristics.

Unfortunately, there is a lack of good data on tobacco use among AAPIs although some local studies have revealed alarmingly high prevalence of tobacco use for specific ethnic subgroups including a range of 33% - 71% for Cambodian males, 48% - 72% for Laotian males, and 42% for Native Hawaiian males. In addition, some of the highest smoking rates for youth are among Native Hawaiian and Pacific Islander girls.

Other barriers to tobacco control for AAPIs have included a low capacity to respond to tobacco use and an increasing marketed targeting of AAPI communities by the tobacco industry in the U.S. and overseas.

Our AAPI communities have been responding to tobacco through the development of networks and coalitions, mobilization of youth, capacity building and leadership development activities and other tobacco prevention, cessation and policy interventions tailored for specific communities.

◆ How can we help our board members, staff, coalition members, and affiliates understand more about inclusivity from diverse communities?

Diversity and inclusivity need to be a priority to the organization or coalition — with real commitment from the leadership of the organization. There needs to be an inclusion of issues of communities of color throughout the decision-making process. Efforts need to ensure that tobacco issues for communities of color, the poor and LGBT communities are integral in the strategic agenda planning and development process of each organization. A long term cultural or community-competency plan, that includes a parity training component for staff, volunteers and organizational leadership, needs to be developed. To implement these systemic changes, we need to show what is at stake and what will be lost if inclusivity and parity does not get advanced or achieved.

◆ Don't we need to understand and study these communities more?

Yes, data collection and research for ethnic-specific subgroups and priority populations that covers the

Hispanic/Latinos and Tobacco

By 2005 this group will be the largest ethnic group in the US, second only to Whites. The majority are of Mexican descent, 58.5%, 9.6% Puerto Rican, 4.8% Central American, 3.8% South American, 3.5% Cuban, 2,2% Dominican, and ,3% Spaniard. In the aggregate, 26.2% men and 14.3% of women smoke though this data is misleading since specific data on smoking rates of these subgroups is still scarce.

Nationally, Hispanics have the largest number of individuals under 18 years of age. In 1999, an alarming 70.4% of Latinas in grades 9-12 reported ever trying smoking or ever smoking. Approximately, one in three high school boys smoke. More acculturated Hispanics smoke more than immigrants, making these groups a prime target for pro-tobacco promotion and advertising.

Lung cancer is the leading cause of cancer deaths for Hispanics, and coronary heart disease is the leading cause of death. Many lack health insurance and are not given advice to quit. Latinos are not as protected by smoke-free workplace laws than is necessary even though the majority support such laws.

full spectrum of tobacco issues (i.e. prevalence, initiation of use, tobacco control interventions, tobacco industry influence, policy analysis and transdisciplinary research approaches) is necessary. Furthermore, studies that examine capacity building indices and initiatives are critical to understanding the readiness of communities to respond to tobacco.

However, we need to prioritize what type of research needs to be done and how it's done. We need scientifically rigorous and validated research while also conducting more informal assessments when they are more appropriate for communities. We need to value and fund community participatory action research approaches where communities are equal partners with academic institutions such as with the Community-Academic Research Awards (CARAs) funded by California's Tobacco-Related Disease Research Program. And we also must ensure adequate representation of communities of color and priority populations on Independent Review Boards (IRB) and on proposal review committees.

◆ **Ultimately, who knows most about communities of color and other priority populations and who should be involved?**

There are many groups who reach out to communities of color and priority populations such as community-based organizations, community-specific medical, nursing, public health, educational and housing groups, labor organizations, churches, faith communities, indigenous groups and tribal councils. All communities need to expand the involvement of leaders and advocates beyond traditional tobacco control leaders and involve other sectors of our community impacted by tobacco. Community groups also need to be accountable to their communities. Just because an organization says that they work with different communities of color does not necessarily mean that they are the most competent or proficient in working with them.

Representation from diverse sectors of the community should be involved in discussions, activities and programs that would inform the strategic planning, policy agenda and funding decisions of all organizations. For example, we should involve elected and appointed officials and tribal leaders. And we need to support initiatives that have meaning to the communities, for example, supporting programs that make linkages with other health care issues of importance to our communities such as asthma, health care access, diabetes, obesity, alcohol abuse and HIV/AIDS.

◆ How can communities of color and priority populations help with this process?

There needs to be a recognition that each community has existing leadership and key decision makers who have experience with many different health and community issues. For native communities and other communities of color, this may be the traditional tribal leader, elder or village leader.

These key established and emerging community leaders can serve as spokespersons, advocates and provide technical assistance with training and support. But there also needs to be funding to support capacity building and leadership development efforts for community stakeholders to further develop as tobacco control advocates and form linkages between their communities and the tobacco control movement.

Priority populations need to set an example themselves by becoming culturally and community competent themselves. All communities need to take responsibility for addressing these issues. Sometimes communities of color and priority populations may not always be inclusive or effective in reaching all sectors and subgroups, so inclusivity has to be the goal for all communities.

There also needs to be a mechanism to regularly convene representatives of communities of color and priority populations for discussions of tobacco issues and forums or mechanisms to provide feedback to mainstream organizations (e.g. funding for and planning of community town hall-style meetings.)

Organizations composed of communities of color and priority populations should be adequately funded to address tobacco issues comprehensively at both the national, state and local levels.

◆ What should be the priority of these organizations in tobacco control?

For communities that are at early stages of readiness to address tobacco control, capacity building, infrastructure and leadership development are critically important. Efforts to create social norm changes have focused on tobacco control policies. Communities of color and other priority populations need to be more involved in these policy change activities. While some states have emphasized tobacco control policy efforts, communities of color also need low-cost cessation services that are culturally, linguistically and community-competent and provide coverage for cessation services and nicotine replacement therapy.

We should also recognize the global impact of tobacco and the connection between immigrant communities in the U.S. and the tobacco industry marketing campaign in developing countries. This highlights the need for a focus on transnational tobacco control and the advertising, smuggling and policy issues that surround this issue.

◆ Will these efforts at diversity, inclusivity and parity really achieve anything?

Diversity, inclusivity and parity efforts take time, commitment, leadership, action and courage. But by working together with a collective consciousness, commitment and action, we can better move toward advancing and reducing tobacco use, attaining smoke free environments, and achieving health parity for all communities.

The following steps are only suggestions on how an organization may proceed toward parity. They are not meant to be a recipe of how to do all parity work.

Steps we will take

to make our organization more responsive to the needs of communities of color and priority populations

1. Conduct Self Assessment of Organizational Diversity and Inclusivity

Have we assessed the composition of our organization's Board of Directors, staff, and volunteers, and do they reflect the racial, ethnic and priority populations in our community, state, and the nation? Do our organization's policies, funding streams, strategic plans, and programs address the needs and concerns of communities of color and other priority populations? What strategies and steps will we take to address this discrepancy?

2. Increase community knowledge

Do we have the knowledge about all the priority population groups that exist in our community? Do we have knowledge about their concerns? If no, what methods will we use and what do we want to learn about? For example, have we conducted focus groups, key informant interviews, surveys, canvassing and town meetings to provide opportunities for in-depth knowledge of the community?

3. Build Relationships

Have we identified members of community-based organizations, clinics, associations and other community leaders from communities of color and LGBT and visited these institutions, neighborhoods and communities? If yes, what were key events that can build relationships with these communities? If no, who are some of our contacts that we can collaborate with? What are local community events that our organization can support and participate in? What groups can we reach out to be part of our organization, coalition and partner with us in order to build comprehensive tobacco control programs in our community?

4. Make Tobacco Relevant

Have we found ways to relate tobacco to the community's concerns? Do we know what the impact of tobacco has been on communities of color and

other priority populations? If yes, which issues were successfully related to tobacco (e.g. cancer)? If no, for each group that we work with, which issues can we start with to incorporate tobacco? Have we provided information about tobacco control in a way that will interest the various groups? If yes, how have we done this? If no, what specific information is appropriate for the groups that we have selected? Have we received cultural competency training that could assist us in these efforts?

5. Become Inclusive in Process

Have we included communities of color and priority populations in our organization or department's strategic planning process? Have we provided adequate funding to support these tobacco control efforts in priority populations? Have we included communities in the prioritization of policies? When we were assessing whether to put together a coalition, or launch a major policy initiative, we must ask who we need to garner support to win. Communities of color and priority populations are able to understand and move the policy debate in a way that is effective. Have we included them in our policy efforts?

6. Develop Measurable Goals and Objectives and Conduct Evaluation

Have we set up goals and objectives for our organization in terms of concrete outcomes that can measure whether we are achieving inclusivity and parity for all the groups in our community, our state and our nation? What evaluation tools have we designed to assure that our goals, objectives and strategies are working and result in concrete programs, policy changes and outcomes? Are we being evaluated in accordance with those goals?

"Diversity, inclusivity and parity efforts take time, commitment, leadership, action and courage. But by working together . . . we can better move towards achieving health parity for all communities."

Lesbian, Gay, Bisexual, and Transgender

Research indicates that prevalence rates among lesbian, gay, bisexual, and transgender individuals exceed those of the general population. Using a household-based sample, Stall, et.al., (1999) found 41.5% of gay adults to be smokers, a rate far in excess of the national rate of tobacco use by men in general (28.6%). Results from this study identified co-factors for smoking which included alcohol consumption, an AIDS-related loss, and a higher frequency of gay bar visits. Variables that were associated with nonsmoking included a higher education level, a seronegative status, and an exercise routine.

Other studies on LGBT tobacco use indicate similar risk co-factors. Durant (1998) found young men who have sex with men to have higher rates of tobacco use correlated with drug use, victimization, and use of violence. Remafedi (in review) found that among the young men who have sex with men that received services at the Youth and AIDS Project (YAP) in Minnesota since 1989, 81% reported trying tobacco, and 56% smoked in the past month.

Unfortunately, very little is known about tobacco prevalence among LGBT communities of color. A secondary analysis of the Stall (1999) data indicated that Latino gay and bisexual men had the highest prevalence rate (43.2%) among the four ethnic groups identified for the study. There is a need to conduct research that specifically identifies the prevalence rate among our LGBT communities of color in addition to prevention strategies that would work well with these populations.

Some USEFUL Community Organization Websites:

African American
www.naatpn.org
www.healthedcouncil.org
www.naaapi.org
www.cbhn.org

Native American and Alaskan Native
www.npaihb.org
www.crihb.org

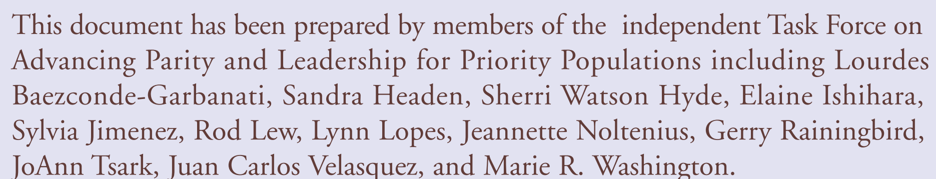
Asian American and Pacific Islander
www.appealforcommunities.org
www.apiahf.org/programs/apiten5.html
www.imihale.org

Lesbian, Gay Bisexual and Transgender
www.llego.org
www.lgbtcenters.org

Hispanic/Latino
www.nlcatp.org
www.hispanichealth.org
www.latinotobaccoeducation.com

Low Socioeconomic Status
www.healthedcouncil.org

Multiethnic resources
www.iccnetwork.org
www.thepraxisproject.org
www.outofmany1.org
www.nmci.org



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