Achieving Health Equity
in Tobacco Control

December 8, 2015—Version 1

This report is a joint publication of a consortium of organizations working to coordinate efforts around the 50th anniversary of the Surgeon General's report on smoking and health.

Organizations endorsing this report are the African American Tobacco Control Leadership Council; the American Cancer Society; American Heart Association; American Lung Association; Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL); Campaign for Tobacco-Free Kids; the Intercultural Cancer Council; LGBT Healthlink at CenterLink: The Community of LGBT Centers; NAATPN, Inc.; National Latino Alliance for Health Equity; the Smoking Cessation Leadership Center; Truth Initiative; and the University of Southern California Keck School of Medicine.

INTRODUCTION

We believe that further efforts in tobacco control should recognize and give priority to the well-understood fact that smoking and tobacco use, and therefore disease, affect certain specific populations within the United States differently, with some suffering disproportionately from the tobacco epidemic.

This paper sets forth our reasoning and conclusion that in order to improve America's health, we must find and treat tobacco use and tobacco-related diseases where they are most prevalent.

Tobacco control efforts have seen great successes since the first Surgeon General's report on tobacco more than 50 years ago. Nationally, since 1964 smoking prevalence has plummeted and now over half of the U.S. population is protected by laws banning smoking in public places.[1,2] Despite these monumental achievements, programs and services designed to eliminate the burden of tobacco related-diseases among our nation's diverse populations have reached an impasse and, in some cases, such as those with low socio-economic status, tobacco disparities are worsening. The data presented below show that smoking continues to disproportionately affect lower-income and less-educated communities; racial and ethnic populations; and the lesbian, gay, bisexual, and transgender (LGBT) communities. Predatory marketing practices targeting these communities are no longer covert, but palpable, and technological advances have made both the development and sale of new tobacco products seem an indomitable challenge to overcome.

Population-based tobacco control efforts, such as policy change, are effective, have made an enormous difference and must be continued, but also must be complemented by new efforts designed to eliminate existing disparities. The February 2015 Vital Signs Report released by CDC lauded national efforts to protect the U.S. population from secondhand smoke; however, as the report states, 7 in 10 Black children remain exposed. Heart disease and cancer, both smoking-related illnesses, are the top two leading causes of death among African Americans. Although Hispanic/Latinos are a growing population in the U.S., they are the least likely of any racial/ethnic group to have health insurance. Unsurprisingly, heart disease and cancer are also the first and second leading causes of death among Hispanics/Latinos. In 2013, smoking prevalence among American Indians and Alaskan Natives was the highest among all racial/ethnic groups. Native Hawaiians, Pacific Islanders and some Asian American ethnic subgroups have very high rates of tobacco use, including smokeless products, and continue

to require culturally and linguistically tailored tobacco prevention and cessation programs. Similarly, the National Adult Tobacco Survey data show LGBT people smoke at rates 50% higher than others, yet there are few programs designed to reach and speak to this population. Lower-income and less-educated populations are particularly burdened by tobacco use. Smoking is directly correlated with income level and years of education. Since the release of the Surgeon General's first report on smoking in 1964, smoking has become ever more concentrated among populations with lower incomes and fewer years of education. People with mental illness also face a higher prevalence—and greater challenges—than those without mental illness. Mental illness affects nearly 1 in 5 adults and, of that group, 36% smoke cigarettes. People with mental illnesses face issues that can make it more challenging to quit, such as low income, stressful living conditions, and lack of access to health insurance and healthcare. Just as our communities are diverse with assorted histories, social environments, value systems and mental health factors, so too must our efforts to combat health disparities be varied. Additionally, adequate resources must be appropriated to develop local capacity and build an empowering infrastructure if these efforts are to be sustained.

We need to continue the population based policies and programs that have produced such dramatic results, including results that have benefited many racial and ethnic populations, but also expand efforts that incorporate and embrace fundamental principles of health equity that afford equal treatment of all individuals/groups (horizontal) and provide supplementary support for individuals/groups that are marginalized (vertical). Health equity, as understood in public health literature and practice, is when ideally everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of his or her social position or other socially determined circumstance."[I] Making advances towards health equity requires institutions to invest in infrastructure for national public health policy agendas that break from orthodox practices. A practice of imposing solutions on communities without involving them in their development can frustrate grassroots efforts. Implementation of authentic principles of health equity will require institutional changes as well as a substantial investment of both time and resources in our communities.

[I] Whitehead M, Dahlgren G. Levelling Up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health. World Health Organization. Available at http://www.euroho.int/document/ e89383.pdf

A commitment to addressing health equity can be demonstrated in many ways; for example, internal practices. Organizations and institutions committed to health equity should have internal hiring practices that appropriately reflect the populations they want to serve; strategic planning processes that involve key community stakeholders at the outset; and financial resources allocated to local communities or organizations serving those communities.

Additionally, organizational priorities should address specific disparities. For instance, since the LGBT communities have higher rates of smoking than other communities, efforts are needed to reach this often-marginalized population and support its need for cessation and prevent uptake by the young. Since an estimated 88% of African American smokers use mentholated tobacco products,[3] governing agencies should exercise their authority to proscribe the sale of mentholated tobacco products to address this glaring disparity. While data collection systems do not adequately represent the diversity of the Asian American, Native Hawaiian, and Pacific Islander communities, we should rethink how data is being collected, disaggregated and portrayed for these groups. As tobacco taxes are lower and secondhand smoke policies oftentimes do not encompass those in rural areas in Southern and Midwestern states,[4] regional and state efforts should be emphasized to address the unequal burden of tobacco-related diseases in that region. Finally, tobacco cessation should be made part of an overall mental health treatment strategy.

Eliminating tobacco-related disparities can only occur if we collectively advance principles of health equity. Governments, national organizations and agencies must be willing to concede some control of the policy making process to the communities most impacted by the policies. Local communities, supported by organizations committed to health equity, should be sufficiently empowered to advocate for policies that address barriers to health equity. Researchers should conduct surveillance in partnership with communities, as opposed to having the community be a target for their research. Finally, everyone should share ownership and accountability for the success or failure of efforts to incorporate a health equity frame of reference in the quest to eliminate tobacco-related disparities.

THE EVIDENCE

Overview

Tobacco use is not an equal opportunity killer. Smoking disproportionately affects those most in need such as the poor, the homeless, racial minorities, LGBT persons and those suffering from mental illness and substance use disorders.

While there have been declines in both youth and adult tobacco use in America, gaps in health equity persist. These trends are well documented, having been the subject of many policy statements, academic analyses, and the subject of the 1998 Surgeon General's report, ***Tobacco Use among U.S. Racial/Ethnic Minority Groups***. Excellent analyses on this issue have been conducted by many groups, such as the Tobacco Research Network on Disparities, and tobacco control advocacy groups continue to provide updated data on this issue. The Centers for Disease Control and Prevention (CDC) continues to fund national networks of groups committed to addressing the ongoing disparate impact of tobacco.

The facts are compelling. Americans with lower levels of education and income are significantly more likely to smoke than more affluent or educated Americans. Smoking prevalence is 50% higher among LGBT Americans compared with other Americans. Those grappling with mental illness comprise nearly a third of all adult smokers. Even among populations who smoke ***less*** than the general population (such as African American adults), death and disease is greater than among the general population, partially due to lack of cessation resources and treatment options. Moreover, those groups most impacted by the tobacco epidemic have consistently been targets of marketing by the tobacco industry designed to hook them on their deadly product.

This document addresses only the highlights of the problem, but even these highlights make the case that in order to appropriately address and eventually end the tobacco epidemic in America, ***all*** populations must be included in developing policies and practices designed to reduce tobacco use, increase cessation, and improve access to treatment for tobacco-related disease. Below we summarize key facts on prevalence, cessation, health effects, and marketing among demographic groups most severely impacted by the tobacco epidemic.

Low Socioeconomic Status (SES)

Smoking Prevalence: In 2013, smoking prevalence was higher among persons living below poverty (29.2%) than those living at or above poverty (16.2%).[5]

- Among adults under age 65 in 2012, 30.1% of Medicaid enrollees and 29.6% of uninsured individuals smoke, compared to 15.2% with private insurance coverage.[6]
- A study of cigarette smoking prevalence in U.S. counties found that, while the U.S. as a whole has made significant progress in reducing smoking from 1996–2012, rates vary dramatically between counties with different income levels, even within the same state. Counties with higher average incomes experienced more rapid declines than counties with lower average incomes.[7]

Cessation: People living below the poverty line are less likely to successfully quit smoking (5.1%) than those living at or above poverty (6.5%).[8]

Health Effects:

- Among the primary causes of death in the U.S., the diseases with the strongest gradients in SES are those related to smoking, such as chronic obstructive pulmonary disease and lung cancer.[9]
- Occupational exposures place low SES employees in blue collar or working class sectors (i.e., industrial, service professions) at increased risk of tobacco-related health outcomes, including lung cancer and restrictive and chronic obstructive lung disease, due to secondhand smoke or chemical and other agents that are synergistic with tobacco smoke in contributing to health outcomes.[10]

Marketing: An analysis of previously secret tobacco industry documents found that tobacco companies strategically marketed their products to low SES women by distributing coupons with food stamps, discounting cigarettes, developing new brands, and promoting luxury images to low SES, African-American women.[11]

Education Level

Smoking Prevalence: 2013 smoking prevalence was higher for those with a GED (41.4%) or high school diploma (22.0%) compared with those with an undergraduate degree (9.1%) or graduate degree (5.6%).[5]

- Smoking among non-college bound high school seniors is more than twice that of college-bound high school seniors (25.3% vs. 10.8%, respectively).[12]
- Evidence suggests widening disparities in prevalence over time. National Health Interview Survey data from 1940 to 2000 finds that smoking prevalence in 1940 was lowest among those with less than a high school degree (35.8%). Prevalence was higher for those with a high school degree (39.4%), some college education (40.8%) or a college degree (40.4%). By 2000, there was a clear negative gradient between smoking prevalence and education: 29.6% of those with less than a high school degree smoked, compared with 28.4% of those with a high school degree, 25.6% of those with some college and 14.2% of those with a college degree only.[13]

Cessation:

- According to data from 2012, quit attempts increase as education level rises, with only 40% of adult smokers with a high school diploma making a quit attempt versus 49.0% of those with a college degree.[14]
- According to data from 2010, successful quitting also increases as education level rises. 11.4% of adult smokers with an undergraduate degree have quit successfully compared with only 3.2% of those with less than 12 years of education.[8]

Health Effects: A 14-year follow-up study found that lower education was associated with greater ischemic stroke incidence, a condition exacerbated by smoking.[15]

Race/Ethnicity

African American

Smoking Prevalence: Survey data from 2013 reported that 18.3 % of African American adults are current smokers. Smoking among African American men is higher than among African American women (21.8% vs. 15.4%).[5]

- African American high school students smoke at lower rates than their White and Hispanic/Latino peers. A 2014 survey found that 4.5% of African American high school students smoke cigarettes, compared to 10.8% of White high school students and 8.8% of Hispanic/Latino high school students.[16]

Cessation:

- Although African Americans tend to be lighter smokers, they have more difficulty quitting compared with other racial/ethnic groups. While more African American adult smokers want to quit and more make quit attempts than White smokers, African Americans successfully quit at a lower rate. Every year, 59.1% of African Americans make a quit attempt, but only 3.3% succeed in quitting compared with 6.0% of Whites.[8] African American adults are 10–11 times more likely to smoke menthol cigarettes than Whites,[17] with the highest rates of menthol smoking among African American youth aged 12–17.[3] Despite starting smoking later and smoking fewer packs per day, African American menthol smokers successfully quit at a lower rate than non-menthol smoking African Americans.[18]
- Data from California examining the population-level distribution of smokers along the quitting continuum from 1999 to 2008 found that although both Whites and African Americans had achieved progress along the continuum, successful cessation was lower among African Americans and the gap widened between 2002 and 2008 for African Americans compared with non-Hispanic whites.[19]

Health Effects:

- Heart disease and cancer, both tobacco-related diseases, are the top two leading causes of death among African Americans.[20] African Americans, and particularly males, have experienced lung cancer at higher rates than Whites for many years. Experts believe that racial differences in smoking behaviors, socioeconomic factors, and the metabolism of tobacco carcinogens may all play a role.[21,22]
- Lung cancer kills more African Americans than any other type of cancer.[23] In 2013, more than 24,000 new cases of lung cancer were estimated to occur among African Americans and more than 16,000 African Americans were estimated to die from the disease.[23]
- Data from Missouri show the estimated number of smoking-attributable deaths and years of potential life lost among Whites and Blacks indicate that the average annual smoking-attributable mortality rate is 18% higher for Blacks (338 deaths per 100,000) than for Whites (286 deaths per 100,000).[24]
- Menthol cigarettes produce a greater increase in carbon monoxide concentrations than non-mentholated cigarettes, which may increase the risk of both lung and bronchial cancer more than regular cigarettes.[25,26]

Hispanic and Latino

Smoking Prevalence: In 2013, smoking prevalence among Hispanic/Latino American adults was 12.1% compared with 19.4% among Whites.[5] However, wide variations exist in smoking prevalence across Hispanic/Latino subgroups. While data is limited, national surveillance from CDC collected between 2002 and 2005 found that Puerto Ricans had the highest rates of smoking at 31.5%, followed by Cubans (25.2%), Mexicans (23.8%), and Central and South Americans (20.2%).[27]

- In 2014, 8.8 % of Hispanic/Latino high school students reported smoking cigarettes. Current smoking rates for Hispanic/Latino high school students were higher than smoking rates for African American students but lower than the rates of White students.[16]

Cessation: Though Hispanic/Latino smokers have high motivation to quit, with concern for health effects on children and the family as a primary motivator, they mostly rely on themselves for cessation, with little use of cessation medication and healthcare provider advice.[28] Some research suggests that Hispanic/Latino smokers also experience lower levels of practitioner inquiry regarding patient's interest in quitting and are less likely to receive instruction on how NRTs work relative to non-Latino smokers.[29]

Health Effects: Hispanics/Latinos have among the lowest rates of health insurance compared with other racial/ethnic groups, such as non-Hispanic whites[30,31] and African Americans.[30] Cancer and heart disease are the first and second leading causes of death among Hispanics/Latinos, and tobacco use is a major risk factor.[32,33]

- In 2012, over 8,000 new cases of lung cancer were expected to occur among Hispanics/Latinos; and more than 5,000 Hispanics/Latinos are expected to die from this disease.[31]

American Indian/Alaska Native

Smoking Prevalence: 2013 smoking prevalence among American Indians and Alaskan Natives was 26.1% compared to 19.4% among Whites, and was the highest among all racial/ethnic groups.[5]

- According to the National Survey on Drug Use and Health (NSDUH) 2008–2010, among both adolescents and young adults, American Indians/Alaska Natives had the highest prevalence of current smoking.[34]

Cessation: According to the National Health Interview Survey (NHIS) in 2012, American Indians/Alaska Natives had one of the lowest quit ratios at 48.2% compared to Whites at 57.1%.[14]

Health Effects: Smoking contributes to a disproportionate excess of mortality and disease among American Indian/Alaska Natives compared with Whites.[35]

- From 2001 to 2009, age-adjusted death rates, smoking-attributable fractions, and smoking-attributable mortality for all-cause mortality were higher among American Indian/Alaska Native men and women than among White men and women.[35]
- Recent data has found that smoking causes 21% of ischemic heart disease, 15% of other heart disease, and 17% of stroke deaths in American Indian/Alaska Native men, compared with 15%, 10%, and 9%, respectively, in White men.[35]
- Among American Indian/Alaska Native women, recent data demonstrates that smoking causes 18% of ischemic heart disease deaths, 13% of other heart diseases deaths, and 20% of stroke deaths, compared with 9%, 7%, and 10%, respectively, among White women.[35]

Asian American

Smoking Prevalence: Smoking prevalence in 2013 was 9.6% among Asian American adults compared with 19.4% among Whites.[5] Asian American men smoke at a substantially higher rate—15.1%, compared with 4.8% of Asian American women.[5] Smoking prevalence varies greatly by gender, ethnicity, and language fluency across different Asian American communities. While data is limited, national surveillance from 1999–2001 found prevalence ranging from 12.3% among Chinese-American adults to 27.2% among Korean American adults.[36]

- Local community studies conducted in the 1990s have shown that males among certain Asian American ethnic groups actually have some of the highest smoking prevalence in the U.S.[37] This emphasizes the need for current research regarding non-heterogeneous Asian American populations.

Health Effects:

- Cancer was the leading cause of death for Asian Americans or Pacific Islanders as of 2010.[38]
- A study in California found that Chinese people had the highest mortality rates for lung and bronchial cancer among all Asian subgroups.[39]

Native Hawaiians and Pacific Islanders

Smoking Prevalence: Data have also shown very high smoking prevalence among Native Hawaiian and Pacific Islanders, particularly among men. National data find smoking rates of 41.9% among Native Hawaiian/Pacific Islander men and 27.0% for Native Hawaiian/Pacific Islander women.[27]

- Statistics among Native Hawaiian and Pacific Islander youth are also disconcerting. Nationwide, Pacific Islander youth smokers start earlier than any other ethnic or racial group, with 31.1% starting to smoke in grade school.[40]
- The Global Youth Tobacco Survey [GYTS] conducted in the Pacific Islands revealed a smoking prevalence of 43.1% among Guam boys aged 13–15 years.[41]

Marketing to Racial and Ethnic Groups

- A recent systematic review on neighborhood disparities in point-of-sale tobacco marketing found that neighborhoods with lower income have more tobacco marketing. The study also found that there is a higher prevalence of marketing of menthol cigarettes in urban neighborhoods and neighborhoods with more African American residents, while smokeless tobacco was more prevalent in rural neighborhoods and areas with more White residents.[42]
- Several studies have found a greater number of tobacco advertisements and a larger presence of menthol cigarette advertising in African American neighborhoods.[43–47]
- A 2011 study of cigarette prices in retail stores across the U.S. found that Newport cigarettes, the top selling menthol cigarette brand in the U.S.[48] and the most commonly used among African American youth,[3] are significantly less expensive in neighborhoods with higher proportions of African Americans.[49]
- A study of neighborhoods with high schools in California found that as the proportion of African American high school students rose, the proportion of menthol advertising increased, the odds of a Newport promotion were higher, and the cost of Newport cigarettes was lower.[50]
- Some research has found that lower-income communities are more likely to have tobacco advertising within 1,000 feet of schools than higher income communities.[44] A higher density of such retailers near schools has been found to increase experimental smoking among high school students.[51–53]

- The tobacco industry has targeted African American communities by using urban culture and language to promote menthol cigarettes, sponsoring hip-hop bar nights, and targeting direct-mail promotions.[54]
- Marketing to Hispanics/Latinos and American Indians/Alaska Natives has included the promotion of cigarette brands with names such as Rio, Dorado, and American Spirit.[54]
- Hispanic and Latino neighborhoods tend to have a high concentration of retail tobacco outlets,[55,56] and these neighborhoods have significantly more businesses selling tobacco products to underage consumers.[57]
- Tobacco companies have sponsored cultural events tied to racial and ethnic culture, including Mexican rodeos; American Indian powwows; racial/ethnic minority dance companies, parades, and festivals; Tet festivals; Chinese New Year and Cinco de Mayo festivities; and activities related to Black History Month, Asian/Pacific American Heritage month, and Hispanic Heritage Month.[58]

LGBT

Smoking Prevalence: In 2012, the smoking rate was 68% higher among LGBT adults (32.8%) versus others (19.5%).[100] Smoking rates stayed at least 50% higher in subsequent waves of data collection.[5]

- Overall, sexual minorities are 1.5 to 2.5 times more likely to smoke cigarettes than their heterosexual counterparts.[59] Bisexual women are up to three and a half times more likely to be smokers than heterosexual women.[59]
- Smoking rates among LGB youth are estimated to be considerably higher (38%–59%) than those among adolescents in general (28%–35%). However this data is from a review that covers 1987–2000.[60] New research on smoking among LGB youth is needed.
- Several factors such as higher levels of social stress,[61] frequent patronage of bars and clubs,[62] higher rates of alcohol and drug use,[63] and direct targeting of LGB consumers by the tobacco industry[64,65] may be related to higher prevalence rates of tobacco use among LGB groups compared to the general population.

Cessation:

- Data on interest in quitting, quit attempts and successful smoking cessation among LGBT populations is very limited. A 2012 study using a convenience sample of LGBT smokers in Colorado found that only 47.2% had made a past year quit attempt.[66]

- Although lesbians and women who have sex with women (WSW) smoke at high rates, one study found that lesbian periodicals had the fewest cessation ads: only eight appeared over a ten-year period, compared to over 1,000 in periodicals targeted to gay men.[67]

Marketing:

- Industry documents show that tobacco companies were aware of high smoking rates among sexual minorities, and marketing plans illustrate the companies' efforts to exploit the LGBT market.[68–70] Analysis of tobacco marketing has demonstrated lesbian and gay youth as an emerging target community.[71]
- One tobacco industry document explained, "A large percentage of gays and lesbians are smokers. In order to grow the Benson & Hedges brand, it is imperative to identify new markets with growth potential . . . Gays and Lesbians are good prospects for the Benson & Hedges brand."[68]
- The tobacco industry has targeted gays and lesbians through direct advertising in LGBT publications and indirect advertising in mainstream publications, community outreach and community promotions (such as "LGBT bar nights featuring specific cigarette brands"), event sponsorships, and the provision of advertising dollars.[72]
- In 1995, a tobacco company conducted a marketing plan called "Project SCUM" (Sub Culture Urban Marketing) targeting urban San Francisco populations, including gays.[70]

Mental Illness & Substance Use Disorders

Smoking Prevalence: Data from 2009–2011 indicate that more than 1 in 3 adults (36%) with mental illness smoke cigarettes, compared with about 1 in 5 adults (21%) without mental illness.[73]

- 40% of all cigarettes are smoked by adults with mental illness and/or substance use disorders.[74]
- The 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions found approximately 46.2 million adults used both alcohol and tobacco in the past year and approximately 6.2 million adults reported both an alcohol use disorder and dependence on nicotine.[75]

Cessation:

- National data indicates that the quit ratio, or the proportion of smokers who have quit, is only 34.7% among adult smokers with any mental illness compared with 53% among non-mentally ill adult smokers.[73]

- People with mental illness are more likely to have stressful living conditions, be low income, and lack access to health insurance, health care, and help quitting.[76–78] All of these factors can make it more challenging to quit.[73]
- Less than half of substance abuse treatment centers (42%) offer tobacco cessation services.[79]
- A meta-analysis of 19 randomized controlled trials evaluating tobacco treatment interventions for individuals with substance abuse problems found a 25% greater likelihood of long-term abstinence from alcohol and drugs when nicotine dependence treatment is included with other substance use treatment.[80]

Health Effects:

- An estimated 200,000 smokers with mental illness and substance abuse disorders die from tobacco-related disease each year due to elevated smoking prevalence in this group.[81]
- People with serious mental illness die 25 years earlier on average than the general population. Top causes of these premature deaths include cardiovascular and pulmonary disease and diabetes mellitus—illnesses exacerbated by smoking.[82,83]
- Individuals in treatment for alcohol dependence are more likely to die from their tobacco use than their alcohol use.[84]
- A study of long-term narcotics addicts in the 1970s and 1980s concluded that individuals with drug problems who also smoke are four times more likely to die prematurely relative to individuals with drug problems who do not use tobacco.[85]

Marketing: The tobacco industry has marketed cigarettes to populations with mental illness, funded research to show that persons with mental illness use nicotine to alleviate negative mood, provided free or cheap cigarettes to psychiatric facilities, and supported efforts to block smoke free psychiatric hospital policies.[73,86,87]

Homeless

Smoking Prevalence: A national survey of homeless adults in 2003 indicated that smoking prevalence among homeless adults is approximately 73%[88] compared with 21.6% among the general population that same year.[89]

Cessation: A 2009 nationally representative survey found that, despite having a significantly lower quit ratio than non-homeless smokers, homeless smokers did not differ from non-homeless smokers in their rates of desire to quit.[90] More homeless episodes are found to be associated with lower odds of successful cessation.[88]

Health Effects:

- Much of the homeless population suffers from medical conditions as a result of injuries,[91] poor nutrition,[92,93] and risky behaviors,[94,95] all of which can be exacerbated by smoking.
- Homeless smokers report smoking discarded cigarette butts or used filters or sharing cigarettes to save money.[96] These behaviors put them at greater risk for infectious diseases, cancer, respiratory illness, and cardiovascular disease.[97,98]

Marketing:

- In 1994, the Phillip Morris (under the brand name Merit) donated 7,000 blankets to homeless shelters in Brooklyn, in order to "generate media coverage."[58]
- RJR directly targeted the homeless as part of an urban marketing plan in the 1990s, focused on the advertising of "value" brands to "street people."[99]
- In 1995, one tobacco company developed a marketing plan aimed at homeless people and gays. They called it project SCUM: Sub Culture Urban Marketing.[70]

ADVOCACY AND INFORMATIONAL RESOURCES

- American Cancer Society — Cancer facts and statistics
- American Heart Association — Tobacco resources, facts and figures
- American Lung Association — Lung disparities reports
- Asian Pacific Partners for Empowerment, Advocacy & Leadership — Fact sheet, tobacco resources, research and data, RAISE (Reaching Asian American Pacific Islanders through Innovative Strategies to Achieve Equity in Tobacco Control and Cancer Prevention)
- Campaign for Tobacco-Free Kids — Fact sheets on toll of tobacco on specific populations
- Counter Tobacco — Disparities in point of sale advertising and retailer density, resource page, youth targeting advertising
- Eliminating tobacco-related health disparities summary report — National Cancer Institute's national conference on tobacco and health disparities (2002)
- Fagan P, Moolchan ET, Lawrence D, Fernander A, Ponder PK. Identifying health disparities across the tobacco continuum. ***Addiction***. 2007;102 Suppl 2:5-29. http://www.ncbi.nlm.nih.gov/pubmed/17850611
- Geographic Health Equity Alliance — Tobacco, cancer and geographic disparities resources, news and scholarly articles
- LGBT Health Link — Surveillance and surveys, tobacco marketing and counter-marketing, newsletters, research and literature, resources and tools
- Moolchan ET, Fagan P, Fernander AF, Velicer WF, Hayward MD, King G, Clayton RR. Addressing tobacco-related health disparities. ***Addiction***. 2007;102 Suppl 2:30-42. — Review paper http://www.ncbi.nlm.nih.gov/pubmed/17850612
- National African American Tobacco Prevention Network — Tobacco industry targets African Americans
- National Behavioral Health Network for Tobacco and Cancer Control — Health equity, data tools, and statistics

- National Native Network — Tobacco and the American Indian and Alaskan Native population, AI-ATS (survey), resource pages
- Nuestras Voces: National Network to Reduce Tobacco-Related and Cancer Health Disparities — Facts and figures, state policies, peer-reviewed literature
- Patient Advocate Foundation — Underinsured, uninsured, unemployed, disease-specific resources
- Robert Wood Johnson Foundation — Tobacco control information, research and publications
- Secondhand Smoke — Centers for Disease Control and Prevention. Vital signs.
- Smoking out a deadly threat: tobacco use in the LGBT community — American Lung Association's health disparity report
- Smoking Cessation Leadership Center — Smoking cessation information, toolkits, webinars, resources
- Substance Abuse Mental Health Services Administration — Resources and data from National Survey on Drug Use and Health (NSDUH)
- Tobacco Industry Marketing — Centers for Disease Control and Prevention, marketing to specific population
- Tobacco Research Network on Disparities — Fast facts, research
- Truth Initiative Fact Sheets — Fact sheets on different tobacco-related issues
- U.S. Department of Health and Human Services, The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014, http://www.surgeongeneral.gov/library/reports/50-years-of-progress
- U.S. Department of Health and Human Services. Prevention Tobacco use among young and young adults: A report of the Surgeon General, 2012. http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/#Full Report
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