Editorial: Preventing Tobacco-Related Cancer Disparities: A Focus on Racial/Ethnic Minority Populations

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Cancer Disparities Prevention

Cancer is the second leading cause of death in the United States. (NCHS).[1] In 2018, cancer will claim the lives of an estimated 609,000 people.[2] While all populations are affected by cancer, some communities bear a disproportionate burden – a phenomenon known as health disparities. The National Cancer Institute (NCI) defines cancer health disparities as adverse differences in the incidence, prevalence, mortality, survivorship, and burden of cancer or related health conditions that occur among specific population groups in the United States.[3] The NCI definition describes a type of difference, yet does not explicitly recognize the strong role of social injustice that distinguishes health disparities from other forms of difference. Indeed, the definitions offered by the World Health Organization (WHO) and *Healthy People 2020* state directly that health disparities are rooted in unjust social conditions[4] and are disproportionately observed among populations that have experienced systematic obstacles and exclusion.[5]

The articles in this themed issue of *Ethnicity & Disease* focus on the prevention of tobacco-related cancer disparities. Tobacco use remains

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the largest single cause of preventable cancers in the United States, is the cause of at least 14 cancer types (eg, lung, larynx, mouth, throat, and cervix),[6] and is the primary driver of preventable disparities. Tobacco-related cancer disparities are not limited to racial/ethnic minority populations. Indeed, factors such as medical insurance status, poverty, educational attainment, sex, sexual orientation or gender identity, discrimination, and geographic location are associated with disparities. The most persistent disparities, however, are observed in comparisons between African American and White Americans. African American men have the greatest cancer incidence (all-sites) compared with all other racial/ethnic groups.[7,8] Additionally, cancer mortality rates are greatest among African American men and women compared with all other racial/ethnic groups.[7,8] Hispanics in the United States have relatively low cancer incidence and mortality, although cancer is the leading cause of death in this heterogeneous population.[9] Moreover, the health status of Hispanics tends to decline with greater years in the United States,[10] possibly due to increased tobacco use and other factors (eg, acculturative stress). The general failure to recognize the non-additive disadvantage experienced among individuals with intersecting social positions, or intersectionality, also contributes to health disparities.[11]

Preventing tobacco-related cancer disparities is a complex topic. Racial/ethnic disparity prevention requires effective strategies to reduce/eliminate tobacco use, promote early detection and screening at recommended intervals, and to maintain a "normal" body mass index. Across the health disparities literature, the focus is often on patient-level barriers (or deficits) with little recognition of the roles of researchers and providers, who develop interventions and set the standard for how we address cancer risks. Moreover, there are historical and contemporary forms of oppression and exclusion that add to the complexity of meeting these individual-level goals.

Each article in this issue seeks to enhance our collective understanding of potential targets for individual, systems-level, and policy interventions to prevent cancer disparities.

The articles within this themed issue have a common thread. Each seeks to enhance our collective understanding of potential targets for individual, systems-level, and policy interventions to prevent cancer disparities. Sheffer et al[12] focus on provider-level barriers to reducing tobacco disparities among racial/ethnic and other minority populations. They discuss the lack of specific training within the tobacco treatment workforce to implement interventions that incorporate the influences of social, environmental, economic, cultural, and health system factors that serve to maintain tobacco use disparities. They propose a competency-based curriculum and provider training to help close the research-to-practice gap, which is critical to the prevention of tobacco and cancer-related disparities. In short, they argue for intersectionality as a framework to organize empirically based, culturally informed and patient-oriented interventions that express sociocultural respect, empathy, and are absent cultural superiority. The articles in this themed issue are examples of topics that could be included in the proposed curriculum and incorporated into provider training.

Three articles in this issue highlight the importance of understanding individual-difference variables that may influence menthol cigarette and cigar smoking and point to novel intervention targets. Trapl and Koopman Gonzalez[13] highlight the high prevalence of cigar, cigarillo, and little cigar (CCLC) use, and tobacco product modification (ie, freaking and blunting) particularly among adolescent African American males. Their findings suggest risk and protective factors for CCLC use, including low risk perceptions compared with cigarettes and parental disapproval, respectively. In a nationally representative sample of adults, Greenberg et al[13] also focus on risk perceptions, finding lower support for a Federal Drug Admin-

istration (FDA) ban on menthol flavoring in cigarettes among menthol smokers, which may be related to factors other than perceived health risk. Few previous studies have examined the interest and use of electronic cigarettes among racial/ethnic minorities. Webb Hooper and Smiley[14] did not find an association between menthol cigarette smoking and e-cigarette use overall. However, menthol smokers reported less e-cigarette knowledge and were interested in trying these products to quit smoking.

Two articles in this issue focus on cancer disparity prevention among Hispanics living in the United States. Castro et al[15] compares lifetime cessation rates between White and Hispanic National Health Interview Survey respondents. Studies in this domain have produced mixed findings. Bivariate analyses in Castro et al[15] indicated lower odds of quitting among Hispanics; however, after accounting for sociodemographic factors and indicators of acculturation, Hispanics reported greater quit rates compared with Whites. In this study, White women were the least likely to report being a former smoker. The authors discuss the importance of including these factors in statistical models to avoid suppression of actual relationships between race/ethnicity and smoking status. Because Hispanic ethnicity includes all "races," testing the intersection between Hispanic ethnicity and "race" as defined by US categories might further clarify these associations. Fleming et al[16] describe the development of a group-based charla intervention to promote cervical cancer screening among Hispanic women in a farmworker community. Findings demonstrate the feasibility and acceptability of the approach and provide a signal toward efficacy.

Taken together, this collection of articles illustrates the importance of multi-directional education (ie, researchers, providers, communities, individuals) as we work to prevent tobacco-related cancer disparities. At the systems-level, prevention strategies include increasing awareness of and access to evidence-based and highly accessible interventions that apply knowledge of ethnocultural nuances, which may be key to change behavior and prevent disparities. Improving our understanding of individual-level factors within and across communities is essential to the development of such interventions. As highlighted by Alcaraz et al,[17] as the field continues to digitize interventions (eg, text-messaging and internet-based interventions), preferences for and access to these technologies must also be considered.

Addressing disparities in tobacco-related cancer risk factors across the lifespan can advance opportunities for prevention, health equity promotion, and reduce risk for other chronic conditions, such as cardiovascular disease.

References

1. NCHS. Murphy SL, Kochanek KD, Xu JQ, Curtin SC. *Final Data for 2015. National Vital Statistics Reports.* Vol II. Hyattsville, MD: Public Health Service; 2017.
2. Noone AM, Howlader N, Krapcho M, et al. SEER Cancer Statistics Review, 1975-2015. 2018; https://seer.cancer.gov/csr/1975_2015/, based on November 2017 SEER data submission, posted to the SEER web site, April 2018.
3. National Cancer Institute. Cancer disparities. 2018. Last accessed June 19, 2018 from https://www.cancer.gov/about-cancer/understanding/disparities.
4. Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.* Geneva: World Health Organization; 2008.
5. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. *Healthy People 2020. Phase I Report: Recommendations for the Framework and Format of Healthy People 2020.* 2008.
6. US Department of Health and Human Services The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. Atlanta (GA): Centers for Disease Control and Prevention (US); 2014.
7. American Cancer Society. *Cancer Facts & Figures for African Americans 2016-2018.* Atlanta, GA: American Cancer Society; 2016.
8. American Cancer Society. *Cancer Facts and Figures for African Americans 2007-2008.* Atlanta, GA: American Cancer Society. 2007.
9. Siegel R, Naishadham D, Jemal A. Cancer statistics for Hispanics/Latinos, 2012. *CA Cancer J Clin.* 2012;62(5):283-298. https://doi.org/10.3322/caac.21153 PMID:22987332
10. Lee S, O'Neill AH, Ihara ES, Chae DH. Change in self-reported health status among immigrants in the United States: associations with measures of acculturation. *PLoS One.* 2013;8(10):e76494. https://doi.org/10.1371/journal.pone.0076494 PMID:24098515
11. Bauer GR. Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. *Soc Sci Med.* 2014;110:10-17. https://doi.org/10.1016/j.socscimed.2014.03.022 PMID:24704889
12. Sheffer CE, Webb Hooper M, Ostroff J. Educational and clinical training considerations for addressing tobacco-related cancer health disparities. *Ethn Dis.* 2018;28(3):187-192.
13. Trapl E, Koopman Gonzalez SJ. Attitudes and risk perceptions toward smoking among adolescents who modify cigar products. *Ethn Dis..* 2018;28(3):135-144.
14. Webb Hooper M, Smiley SL. Comparison of e-cigarette use among menthol and

non-menthol smokers: findings from a community-based sample. *Ethn Dis.* 2018;28(3):153-160.
15. Castro Y, Bares CB, Castillo B, Kennedy A. Sociodemographics, but not acculturation proxies, account for differences in lifetime cessation between White and Hispanic smokers. *Ethn Dis.* 2018;28(3):145-152.
16. Fleming K, Simmons VN, Christy SM, et al. Educating Hispanic women about cervical cancer prevention: Feasibility of a promotora-led charla intervention in a farmworker community. *Ethn Dis.* 2018;28(3):169-176.
17. Alcaraz KI, Riehman K, Vereen R, Bontemps-Jones J, Westmaas JL. To text or not to text? technology-based cessation communication preferences among urban, socioeconomically disadvantaged smokers. *Ethn Dis.* 2018;28(3):161-168.