Objective 1:
Reduce Tobacco-Related Disparities

California has made great progress in reducing the overall rate of tobacco use, but alarming disparities based on demographic, socioeconomic, and geographic differences remain.[2] Among California adults in 2021–2022, the overall current tobacco use rate was 11.4%, but rates were considerably higher in certain subgroups, as shown below in Figure 2.

For decades, the tobacco industry has targeted historically marginalized communities using manipulative marketing tactics such as providing free or discounted products and using themes or models that reflect community values.[3–6] The industry's tactics also include masquerading as supporters of social justice, civil rights, and cultural issues with the goal of interfering with policy, selling more products, and profiting from the communities they target.[1,7] This has led to a situation in which many of California's priority populations not only suffer from higher rates of tobacco use, but also greater exposure to secondhand smoke at work and home, and higher rates of tobacco-related death and disease than the general population.[2,8,9] To reverse the damage that the tobacco industry has inflicted on many of California's communities, it is critical to identify tobacco-related disparities experienced by these communities and counter the industry's influence on them.

Key Themes

- The tobacco industry and its deadly products impact communities at different rates.
- Populations experiencing patterns of bias and exclusion tend to be the most impacted by tobacco.
- Health equity requires greater focus on tobacco prevention and cessation in these priority populations.

Recommended Strategies

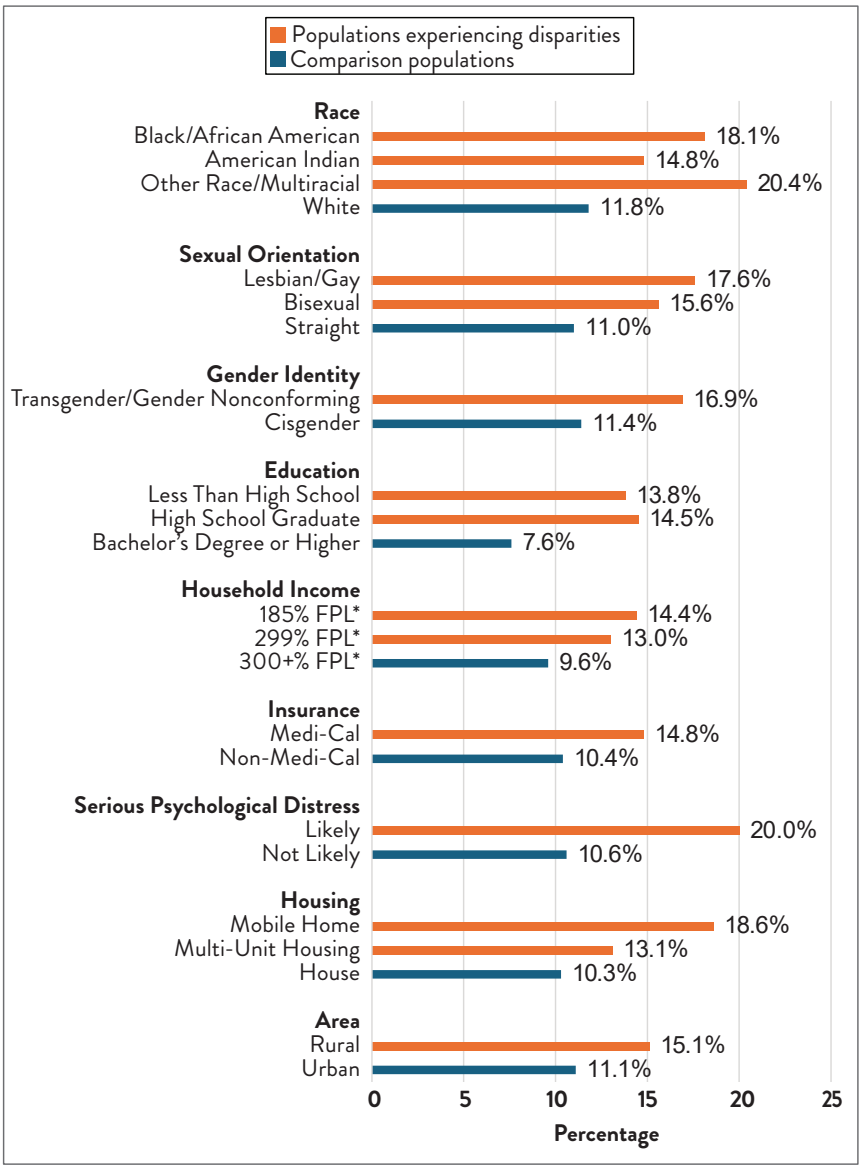
Policy

- Reduce the tobacco industry's ability to target communities with menthol and other product flavorings by:
  - Implementing and enforcing laws restricting the sale of flavored tobacco, including products marketed with cooling sensations and non-specific flavor concepts.
  - Closing policy loopholes that allow for the sale of certain flavored tobacco products, such as hookah and heated tobacco products.

Staff and volunteers of We Breathe and the California LGBTQ Health and Human Services Network at a 2024 Community Forum.
Source: We Breathe

    - Restricting online sales of flavored products by amending tobacco retailer license (TRL) laws to require that tobacco sales be conducted in person.
- Ensure that policy compliance efforts support social justice by:
    - Emphasizing education and social norm change in efforts aimed at community members, rather than fines and penalties.
    - Reserving enforcement actions for upstream violators, such as retailers who sell prohibited products or who sell to underage customers and advertisers who use illegal marketing tactics.
    - Avoiding purchase, use, and possession (PUP) laws that punish youth for violating tobacco-related age restrictions.
- Respect the sovereignty of Tribes in determining their own policy goals concerning the regulation of commercial tobacco.

Figure 2. Current tobacco use rates in selected populations, 2021–2022.



*FPL = federal poverty level

Source: California Tobacco Facts and Figures 2024, based on data from California Health Interview Survey, 2021 and 2022

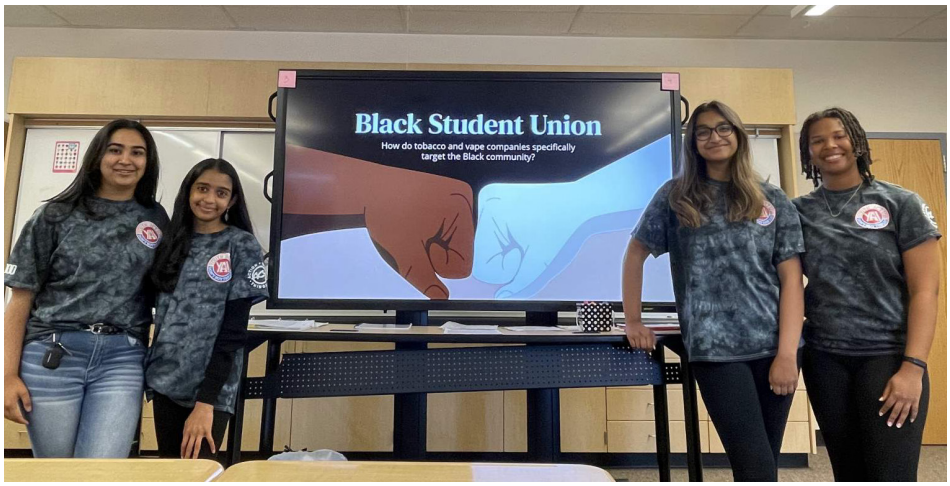
Education

- Increase awareness of the important differences between traditional/ceremonial tobacco use and commercial tobacco use.
- Keep policymakers and stakeholders informed about the latest tobacco prevention research, including surveillance data on the use of tobacco among priority populations and implications for public policy.

Research

- Conduct ongoing surveillance and rigorous evaluation to ensure that tobacco prevention programming is informed by accurate, up-to-date information about the populations it serves.
- Disaggregate surveillance and evaluation data to show subgroup differences, as sample sizes permit (e.g., report Asian Americans by specific Asian subgroups).

- Prioritize analyses of intersectionality among priority populations when conducting research, as individuals belonging to two or more marginalized groups may experience additional stressors that contribute to tobacco use.
- Prioritize research identifying and mitigating tobacco-related disparities by identifying and developing effective interventions for disproportionately impacted populations based on age, race/ethnicity, gender, sexual orientation, education, socioeconomic status, rurality, and other relevant characteristics.
- Conduct research addressing community factors that contribute to higher tobacco use rates and health disparities, such as minority stress, discrimination, industry targeting, and social norms.



Alameda County students and Black Student Union members engage in peer education on how the tobacco industry targets the Black community.
Source: Alameda County Office of Education

Partnership

- Involve advocacy organizations and other community groups, including those that may not have traditionally engaged in tobacco prevention work but that understand their communities' needs, at every step in the planning, implementation, and evaluation of programs intended to reduce tobacco-related disparities.

Funding

- Prioritize funding for programs and interventions designed to reduce disparities and promote health equity, that reach priority populations, and that emphasize culturally relevant activities for the communities they serve, recognizing how factors such as patterns of bias and exclusion contribute to tobacco-related health disparities.
- Fund applicants who show that they understand and can effectively serve the communities prioritized in requests for applications (RFAs).

References

[1] Centers for Disease Control and Prevention. Health disparities related to commercial tobacco and advancing health equity. May 15, 2024.
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[4] American Cancer Society Cancer Action Network. Tobacco industry targeting of the LGBT community.
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[8] Lee JG, Henriksen L, Rose SW, Moreland-Russell S, Ribisl KM. A systematic review of neighborhood disparities in point-of-sale tobacco marketing. *Am J Public Health*. 2015;105(9):e8–e18.
[9] Lee JG, Sun DL, Schleicher NM, Ribisl KM, Luke DA, Henriksen L. Inequalities in tobacco outlet density by race, ethnicity and socioeconomic status, 2012, USA: results from the ASPiRE Study. *J Epidemiol Community Health*. 2017;71(5):487–492.