



# **TOBACCO USE AMONG AFRICAN-AMERICANS IN MINNESOTA:**

A Survey and Conversations With African-American Communities

July 2009

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# Background and Project Overview

## Tobacco use threatens the health of Minnesotans.

As the leading cause of preventable death and disease in the United States,<sup>1</sup> tobacco use poses a serious threat to the health of Minnesotans. The U.S. Surgeon General has identified smoking as a cause for 10 types of cancer, four cardiovascular diseases, several respiratory diseases, reproductive complications and other effects, such as cataracts, low bone density and general diminished health status.<sup>2</sup> In Minnesota, more than 5,500 adult deaths can be attributed to smoking annually.<sup>3</sup> The financial toll only adds to the burden. In Minnesota alone, smoking was responsible for \$1.98 billion in excess medical care expenditures in 2002.<sup>4</sup>

Smoking harms people who do not smoke, as well: Exposure to secondhand smoke causes heart disease and lung cancer in adult nonsmokers.<sup>5</sup> Exposure to secondhand smoke increases children's risk for middle-ear infections, asthma, bronchitis and sudden infant death syndrome.<sup>6</sup>

## Tobacco use disproportionately affects African-Americans.

National research shows that the impact of smoking within the African-American community is even more devastating than in the population as a whole.<sup>7</sup> While African-Americans tend to start smoking later in life and smoke fewer cigarettes per day than whites,<sup>8</sup> these behaviors do not mitigate the harms caused by tobacco use.

- Historically, the years of potential life lost before the age of 65 has been higher in African-American smokers than white smokers.<sup>9</sup>
- African-Americans are more likely than whites to die from cancer. Lung cancer is the second most common cancer in both African-American men and women, and it kills more African-Americans than any other type of cancer. Across the U.S., more than 22,000 cases of lung cancer are expected to occur among African-Americans in 2009.<sup>10</sup>

- Not only is smoking responsible for almost 90 percent of all lung cancer cases, it is also a major cause of heart disease and stroke — the only conditions that kill more people in the African-American community than lung cancer.<sup>11</sup>
- The five-year survival rate for lung cancer is lower among African-Americans than among whites.<sup>12</sup>
- African-American men appear to bear the biggest burden in terms of tobacco-related morbidity and mortality. Between 2001 and 2005, the average number of new cases of lung and bronchial cancers in the U.S. was 36 percent higher in African-American men than in white men.<sup>13</sup> The average death rate from lung and bronchial cancer was 30 percent higher among African-American men than white men.<sup>14</sup>

## Menthol cigarettes are extremely addictive and cause the greatest harm.

There is growing evidence that menthol cigarettes play a major role in the smoking and quitting patterns of the African-American community. African-Americans are much more likely to smoke menthol cigarettes: Nationally, more than 75 percent of African-American smokers prefer menthol cigarettes, compared with only 23 percent of white smokers.<sup>15</sup>

The consequences of this phenomenon are potentially deadly. Menthol cigarettes may increase the risk of both lung and bronchial cancer more than regular cigarettes by promoting lung permeability and diffusibility of smoke particles.<sup>16</sup> Menthol cigarettes have also been shown to have higher carbon monoxide concentrations than regular cigarettes, and may be associated with a greater absorption of nicotine.<sup>17</sup> In fact, smokers of menthol cigarettes have higher levels of cotinine (the most common chemical produced by the body from nicotine) in their bloodstream than nonmenthol smokers.<sup>18</sup>

Menthol additives in cigarettes also appear to make it harder for smokers to quit. A 2009 study examined quitting rates among African-American and Latino smokers who attended a tobacco treatment clinic. Despite smoking fewer cigarettes per day, individuals who smoked menthol cigarettes were

much less likely to be able to quit smoking than those who smoked nonmenthol cigarettes. Among African-Americans, this effect was particularly dramatic: Menthol smokers were half as likely to be able to quit as nonmenthol smokers.<sup>19</sup>

### **Tobacco industry uses aggressive strategies to target African-American communities.**

The tobacco industry has been an active agent in promoting tobacco use among African-American communities. They engineered milder menthol levels in cigarettes to attract and addict young smokers by modifying the harshness of the first smoking experiences, and raised the menthol levels in cigarettes marketed to long-term users who were known to prefer a more pronounced menthol sensation. They then carefully marketed the various menthol cigarettes to these distinct target groups.<sup>20</sup>

In fact, tobacco companies strategically target African-American communities with a host of marketing and advertising initiatives. For decades, they have used artful strategies to embed a positive profile of tobacco and tobacco companies in African-American communities. They have provided financial support for African-American cultural, political and educational institutions. They have also supported social services and civil rights organizations to gain favor with the community and discourage tobacco control efforts. They have advertised heavily in African-American publications, not only reaching their intended audience with well-crafted campaigns glamorizing tobacco use in this community, but providing those publications a strong revenue stream that may be hard to replace.<sup>21</sup>

### **Minnesota's African-Americans are taking an active role in tobacco prevention and control.**

In an important effort to reverse the pattern of smoking in African-American communities, individuals and organizations in Minnesota formed the Minnesota African/African-American Tobacco Education Network (MAAATEN). MAAATEN is a coalition of African and African-American community leaders working to engage African and African-American communities throughout Minnesota to reduce the

harms of tobacco use. Formally convened in 2001, the group emphasizes health promotion and the reduction of health disparities in African-American and African communities.

MAAATEN received funding from Blue Cross and Blue Shield of Minnesota (Blue Cross) and ClearWay Minnesota<sup>SM</sup> to facilitate these crucial efforts. Since 2001 the group has worked industriously to build a community collaborative galvanized around the mission of promoting health and reducing the harms of tobacco use. Their key work involves educating community leaders, community-based organizations, and policy decision-makers about tobacco's toll on African-American and African communities in Minnesota.

As part of their work, MAAATEN partnered with Blue Cross, ClearWay Minnesota and the Minnesota Department of Health (MDH) to develop this in-depth Minnesota study on tobacco use among African-Americans.

### **Multi-agency partnerships guided the design of quantitative and qualitative research.**

The research reported here has two components, which were designed to be used together to fill gaps in the knowledge of cultural norms and patterns around tobacco use in the African-American community. The aim is to help provide a foundation of research for those working to develop effective, culturally competent interventions to reduce tobacco use among African-Americans in Minnesota.

In the first component, quantitative findings from the 2007 Minnesota Adult Tobacco Survey (MATS) were analyzed exclusively for U.S.-born African-American participants. The results shown in Section II, describe patterns of tobacco use — smoking in particular — and factors that influence tobacco use among African-American adults in Minnesota. The MATS initiative has been overseen by Blue Cross, ClearWay Minnesota and MDH since 1999, and has primarily focused on the general adult population. MAAATEN partnered with the MATS team for the 2007 survey to guide a new research design that, for the first time, allowed analysis to focus on African-Americans.

The second component was qualitative, community-based research conducted by Jennifer R. Warren, Ph.D., director

of Indigo Health Research & Consulting, Inc. The goal of this component is to gain insight into African-Americans' tobacco use that cannot be gleaned from statistics alone. Through focus groups and individual interviews, the perspectives of African-American community members and community leaders helped interpret the MATS findings and provide recommendations to help guide future tobacco control efforts in this community. The community-based research component was overseen by an advisory board of representatives from African-American service organizations, as described in Section III.

When used together, the quantitative survey data, the qualitative interpretation of these data by community members, and the insights of community leaders provide value for guiding tobacco prevention and control work with African-American adults in Minnesota.

### **The 2007 MATS study provides the most detailed look to date at smoking among African-American adults in Minnesota.**

The first of its kind, the 2007 MATS African-American study is distinguished by a tailored sampling design and a comprehensive assessment of tobacco use by U.S.-born African-Americans in Minnesota. The MATS initiative, described in Section II, was an existing research effort that was expanded in 2007 to survey more African-American participants than in previous years. In addition to questions about smoking behavior, MATS included many other questions related to the use of other tobacco products, attempts by smokers to quit, reactions to tobacco control policies, and exposure to secondhand smoke at home, at work and in other settings.

The study was unique in defining the population of interest as those individuals whose primary racial identification was African-American or black, and who were born in the United States. The research team did not see MATS as appropriate for use with African immigrants, whose values and cultural experiences would likely differ from U.S.-born African-Americans and affect their reported tobacco use.

### **Limitations**

Limiting the sample for analysis to only U.S.-born African-Americans ultimately reduced the final sample size and resulted in a significant margin of error around the final smoking prevalence estimate (plus or minus 12 percentage points). However, the study provides a new base of information that is highly culturally specific and addresses a broad range of tobacco-related issues, when compared with studies that have greater total numbers but a less well-defined population or capture only smoking prevalence. Moreover, the MATS findings were enhanced with a qualitative research component to provide data that to date have not been available.

### **Community-based research provides a broader context to the MATS African-American study.**

The community-based research project was developed to complement the MATS African-American study. It was guided by representatives from MAAATEN and other African-American organizations. First, African-American community members from the Twin Cities provided open-ended feedback in a series of focus groups on the main findings from the MATS study and discussed the role tobacco use plays in African-American communities in Minnesota. Second, individual interviews with African-American community leaders provided additional perspectives and recommendations for further progress on the African-American tobacco control movement in Minnesota.

### **Limitations**

While the findings add new insight into the use of tobacco by African-American adults in Minnesota that had previously not been documented, the results show that there is not always complete agreement among community members and community leaders on what constitutes the greatest influences on tobacco use. As with all qualitative research, the results from the community-based research project cannot be generalized to represent the views of all African-American communities in Minnesota, especially since there were no participants from outside the Twin Cities. It is, therefore, important to recognize that there are many voices within Minnesota's African-American communities, some of which may not be represented in this report.

# II

## Findings From African-Americans in the 2007 Minnesota Adult Tobacco Survey

### Study Methods

#### Study Background

The Minnesota Adult Tobacco Survey (MATS) is a comprehensive surveillance initiative designed to monitor progress toward meeting the goals of reducing tobacco use among Minnesotans. MATS is the most comprehensive source of information about smoking prevalence, behaviors, attitudes and beliefs in the adult Minnesota population. MATS provides valid scientific data for tracking the impact of comprehensive tobacco control efforts in Minnesota. MATS 2007 is the third survey in this surveillance initiative, building on the data collected in 1999 and 2003.

MATS 2007 was the first survey in the series to include a special focus on the African-American population. To this end, statistically valid research methods were used to increase the number of African-Americans invited to take the survey in 2007. The goal was to produce quantitative data that the community could ultimately use to plan tobacco prevention and control strategies.

#### Study Design

The research partners (Blue Cross, ClearWay Minnesota, MDH, MAAATEN) determined early on that the MATS African-American study should be limited to U.S.-born African-Americans. Other research has indicated that the cultural experiences and values of recent immigrants significantly affect their reported tobacco use. Combining data from both U.S.-born African-Americans and recently emigrated Africans would prevent the study from providing a clear picture of tobacco use in either population.

The research partners determined that the questions on the general population MATS survey would be culturally appropriate for the U.S.-born African-American population. Therefore, the same survey instrument was used to collect

data from both the MATS general statewide population and the African-American population. The survey included questions related to tobacco use behaviors, attempts by smokers to quit, tobacco control policies and exposure to secondhand smoke. Please refer to the *MATS 2007 Methodology Report* for more detail on the survey instrument and methods ([www.mnadulttobaccosurvey.com](http://www.mnadulttobaccosurvey.com)).

#### Study Participants

MATS 2007 identified potential respondents from the general population across the state using two methods. A random-digit dialing (RDD) sample was created by using standard research methods to randomly select telephone numbers with Minnesota area codes. The interviewer then randomly selected one adult within the household to answer the survey questions. A second sample was obtained by randomly selecting individual Blue Cross members from Blue Cross administrative records. Responses from both samples were then statistically adjusted and merged to create one data set from which valid statewide estimates could be produced.

For the MATS African-American study, the goal was to collect data from enough African-American respondents to produce an acceptable margin of error around the final smoking prevalence estimate. To this end, MATS 2007 increased the proportion of Minnesota phone numbers selected from geographical regions for which U.S. Census data reported higher concentrations of African-American households.



## Data Collection

MATS data were collected through telephone interviews between February and June 2007. Professional interviewers followed the same data collection protocol with all respondents. Questions to obtain the race and ethnicity of respondents were asked at the end of the survey. The survey took about 17 minutes to complete. All interviews were completed in English. Data collection protocols were approved by the Institutional Review Board of the survey vendor, Westat, Inc.

MATS 2007 yielded a total of 12,580 interviews of adult Minnesotans: 7,532 from the RDD sample and 5,048 from the Blue Cross sample. Total response rates were 41 percent for the RDD sample and 48 percent for the Blue Cross sample. Response rates specifically for the African-American population could not be calculated, because the race of a potential respondent was unknown at the time the call was placed. Survey responses were weighted by age, gender and education to accurately reflect the state's population.

## Data Analysis

To be included in the analysis for the MATS African-American study, survey data from the RDD and Blue Cross samples had to meet several criteria. The respondents must have reported that their race was "black or African-American".<sup>22</sup> If the respondents gave more than one race, they had to report that black or African-American best represented their race. Finally, respondents had to report they were born in the United States. As stated earlier, African immigrants were not included in the analysis in order to focus on the African-American community in Minnesota. In all, 232 respondents were included in the final analysis. See Appendix 1 for demographic information on African-American survey respondents.

## Limitations

The RDD sample in MATS 2007 did not reach households that rely solely on cell phones and do not have land lines. Therefore, these households are likely underrepresented in the survey findings.

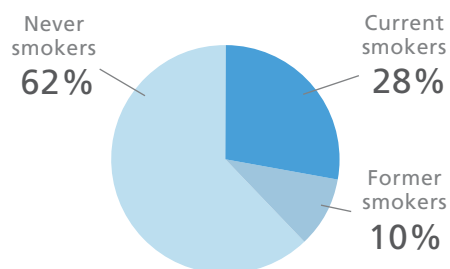
## Smoking Prevalence

### The prevalence of smoking among African-Americans in Minnesota is relatively high.

Based on the definition used by the Centers for Disease Control and Prevention, a current smoker is someone who reports smoking at least 100 cigarettes in his or her lifetime and now smokes every day or some days. A former smoker is someone who reports smoking at least 100 cigarettes in his or her lifetime but now does not smoke at all. A never smoker has not smoked at least 100 cigarettes in his or her lifetime. The CDC definition is based on reported smoking behavior and does not require the respondent to self-identify as a "smoker" in order to be counted as one.

Using the CDC's definition, the MATS African-American study found that 28 percent (plus or minus 12 percentage points) of U.S.-born African-American adults in Minnesota are current smokers, 10 percent are former smokers and 62 percent are never smokers (Figure 1). For the general Minnesota adult population, MATS 2007 found the prevalence of current smokers was 17 percent (plus or minus 1 percentage point).

**Figure 1** Twenty-eight percent of African-American adults in Minnesota smoke.



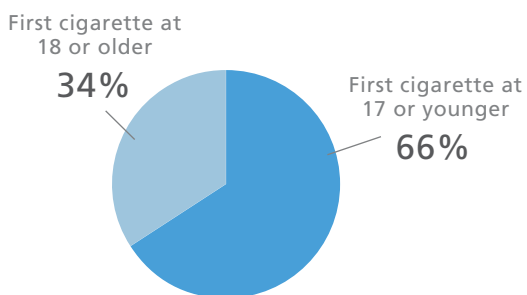
Appendix 2 describes smoking status among African-American smokers in MATS for several demographic characteristics. Appendix 3 provides the prevalence of current smoking found by other research with the African and African-American communities in Minnesota.

*Please refer to the comprehensive technical report "Creating a Healthier Minnesota: Progress in Reducing Tobacco Use" for additional findings from the general adult population in MATS 2007, including findings on quitting, secondhand smoke and other smoking-related issues ([www.mnadulttobaccosurvey.com](http://www.mnadulttobaccosurvey.com)).*

### Most African-American smokers tried their first cigarette before the age of 18.

The MATS African-American study data show that 66 percent of adult African-American current smokers tried their first cigarette, even if it was only one or two puffs, before the age of 18 (Figure 2).

**Figure 2** Two-thirds of adult African-American current smokers tried their first cigarette before age 18.

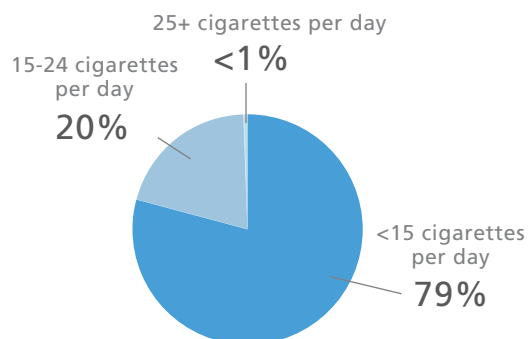


### Heavy smoking among African-Americans is rare.

Smoking intensity, as defined by the number of cigarettes that people smoke daily, measures smokers' direct exposure to cigarette toxins and their approximate level of addiction to cigarettes. The number of cigarettes per day was calculated as the number of days smoked in the past 30 days, multiplied by the number of cigarettes smoked on those days, divided by 30.

The study found 79 percent of African-American smokers in Minnesota smoke fewer than 15 cigarettes per day, while 20 percent smoke 15 to 24 cigarettes per day, and less than 1 percent smoke 25 or more cigarettes per day (Figure 3).

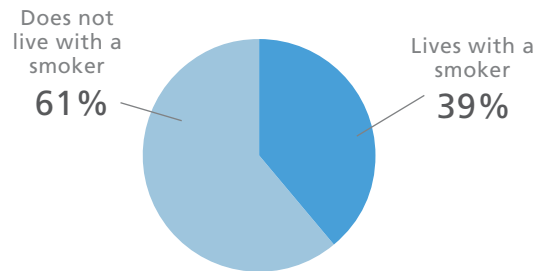
**Figure 3** Nearly 80 percent of African-American adult smokers smoke fewer than 15 cigarettes per day.



### Social environments around African-Americans support smoking.

Social environments — that is, the people around us in our daily lives at home, at work and in the community — have a major influence on an individual's behavior. The presence of smokers in the home, and having friends or family members who smoke, can support smoking behavior in a number of ways. It can increase opportunities to smoke, encourage the misperception that smoking is the social norm, model smoking as positive and acceptable, and increase the availability of cigarettes. Being around other smokers can make it harder for current smokers to quit. Moreover, breathing others' secondhand smoke is also a health hazard.

**Figure 5** Nearly 40 percent of African-American adults live with a smoker.



## Quitting Smoking

### Quitting smoking reduces the risk of death and disease.

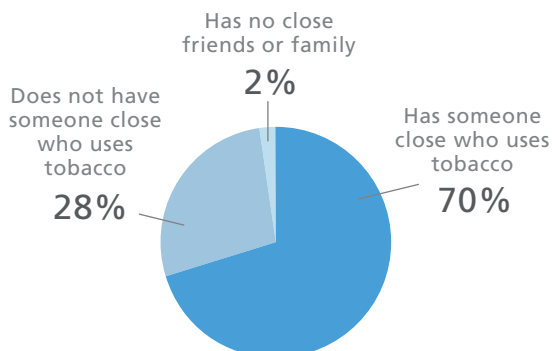
Quitting smoking has many immediate and long-term health benefits. While smokers benefit from quitting at any time, the earlier they quit, the more likely they are to realize substantial health benefits.<sup>23, 24</sup>

Yet, successfully quitting is a complex and often difficult process that usually involves multiple attempts. Smoking is addictive. Withdrawal symptoms — such as depression, weight gain, irritability, anxiety and difficulty concentrating — demonstrate the highly addictive nature of cigarettes.<sup>25</sup>

### Many African-Americans have friends or relatives who use tobacco.

Approximately 70 percent of adult African-Americans in Minnesota have someone close to them, such as parents, a spouse, children, close friends or relatives, who uses tobacco (Figure 4). Nearly 40 percent of African-Americans in Minnesota live with a smoker (Figure 5).

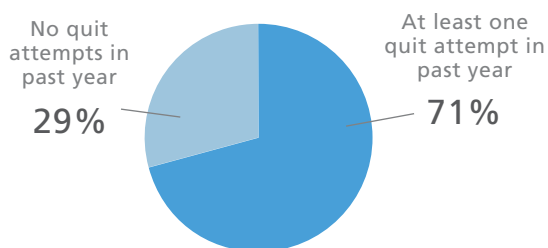
**Figure 4** More than two-thirds of African-American adults report that someone close to them uses tobacco.



### Most African-American smokers try to quit.

Most smokers in Minnesota’s African-American communities try to quit. More than two-thirds (71 percent) of African-Americans in Minnesota who had smoked in the past year stopped smoking for one day or longer in the 12 months before the survey because they were trying to quit smoking (Figure 6).

**Figure 6** More than 70 percent of African-American adults who smoked in the past year tried to quit.



### Assistance to quit smoking is widely available in Minnesota.

Studies show that only about three to seven percent of smokers succeed when they try to quit without any form of support.<sup>26, 27</sup> Evidence suggests that quitting success increases when recommended forms of assistance are used.<sup>28, 29</sup>

Every smoker in Minnesota can receive help with quitting, either through health care coverage or through ClearWay Minnesota’s QUITPLAN® Services, which include phone, online and in-person counseling options and free nicotine replacement therapy to smokers who also participate in behavioral counseling.

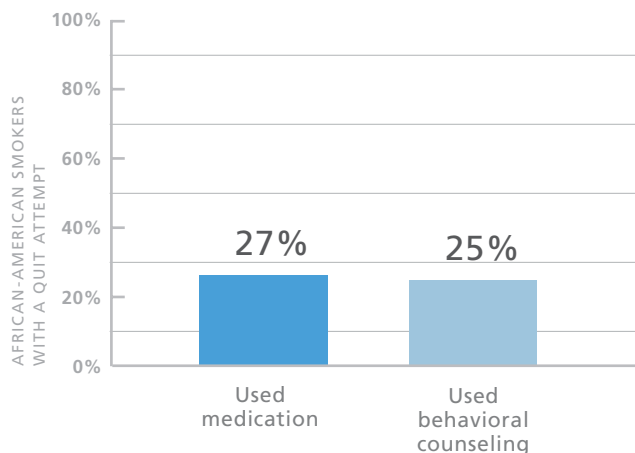
### More African-American smokers who try to quit could use assistance.

The MATS African-American study measures the level at which African-American smokers are making use of stop-smoking resources. Specifically, the study asked about use of the following kinds of assistance:

- Medications: use of at least one of the nicotine replacement therapy medications (nicotine gum, patch, nasal spray, inhaler or lozenge) or the non-NRT medications (Zyban/bupropion or Chantix/varenicline)
- Behavioral counseling: use of a stop-smoking clinic or class, a telephone quitline, a web-based counseling service or one-on-one counseling from a health professional

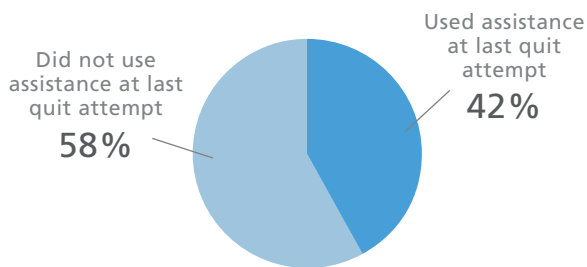
Only 27 percent of African-American current smokers with a quit attempt in the past 12 months used some kind of stop-smoking medication in their last quit attempt. A similar proportion (25 percent) used some type of behavioral counseling (Figure 7).

**Figure 7** About one-quarter of African-American adult smokers with a quit attempt in the past year used stop-smoking medication, and one-quarter used behavioral counseling.



In all, 42 percent of African-American current smokers with a quit attempt in the past 12 months used some form of stop-smoking assistance, either medication or counseling, or other assistance, such as print materials or websites. This means that more than half of current smokers who tried to quit in the past year did not use assistance (Figure 8).

**Figure 8** Less than one-half of African-American adult smokers with a quit attempt in the past year used any form of assistance.



**Most African-American smokers are interested in using available forms of assistance.**

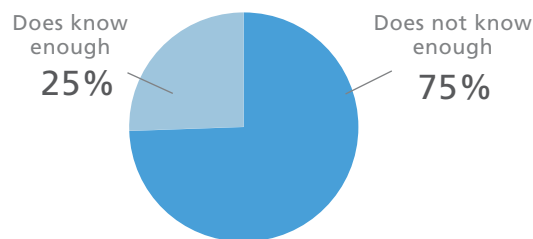
Among African-American current smokers, willingness to use some type of stop-smoking assistance is high. Seventy percent of current smokers say they would be willing to use some form of assistance if cost were not an issue.

Among the 70 percent of African-American smokers who indicated they would be willing to use a program, product or medication, the strongest interest was for using nicotine-replacement medications (87 percent), attending a quit-smoking class (74 percent) and using a telephone helpline (62 percent). There was the least amount of interest in web-based resources (29 percent).

**Despite their interest, African-American smokers face barriers to using assistance to quit.**

Two-thirds (67 percent) of African-Americans reported knowing that free help is available in Minnesota for smokers who want to quit. However, three-quarters (75 percent) of smokers with a quit attempt in the past 12 months report that they do not know enough about quit-smoking medications to use them properly (Figure 9).

**Figure 9** Three-quarters of African-American adult smokers with a quit attempt in the past year report not knowing enough about stop-smoking medications to use them properly.

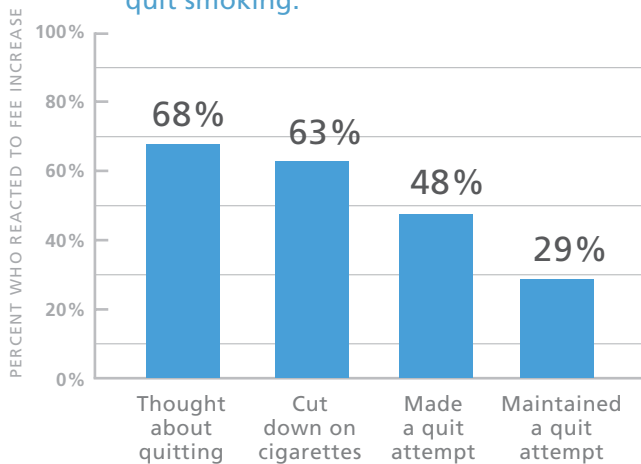


### Raising the price of cigarettes prompts African-American smokers to think about quitting.

Higher costs per pack of cigarettes keep youth from starting to smoke and encourage adults to quit smoking. Policies that raise the cost of cigarettes reduce the demand for cigarettes and ultimately shift social norms by discouraging smoking.

In 2005 Minnesota increased the total taxes and fees on a pack of cigarettes by 75 cents, to \$1.48. African-American current smokers, and former smokers who quit within two years after the fee increase, reported that this price increase helped them to think about quitting (68 percent), to cut down on cigarettes (63 percent), to make a quit attempt (48 percent), or to maintain a quit attempt (29 percent) (Figure 10).

**Figure 10** African-American current and former adult smokers report that the 2005 fee increase prompted them to reduce or quit smoking.

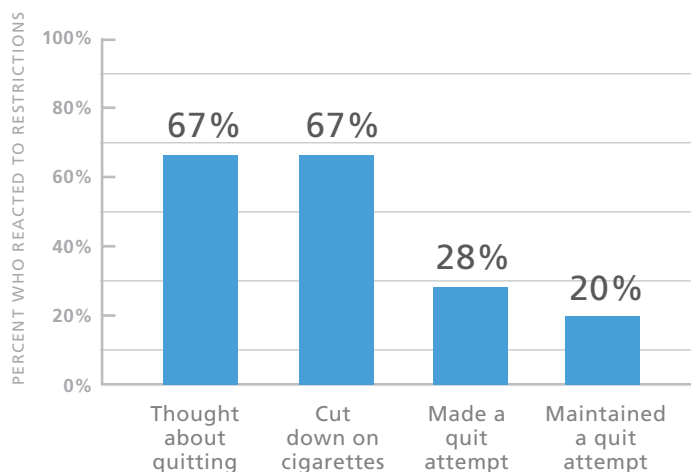


### Restrictions on smoking prompt African-Americans to think about quitting.

State and local smoke-free policies help create an environment in which tobacco use is less common and acceptable. While a primary goal of a smoke-free policy is protecting nonsmokers from secondhand smoke, the MATS African-American study results suggest that such a policy also encourages many smokers to try to quit.

African-American current smokers and former smokers who quit in the previous five years reported that policies restricting smoking helped them to think about quitting (67 percent), to cut down on smoking (67 percent), to make a quit attempt (28 percent), or to maintain a quit attempt (20 percent) (Figure 11).

**Figure 11** African-American current and former adult smokers report that smoking restrictions prompted them to reduce or quit smoking.



NOTE: MATS DATA WERE COLLECTED PRIOR TO PASSAGE OF THE 2007 FREEDOM TO BREATHE ACT.

## Secondhand Smoke Exposure

### Secondhand smoke causes death and disease.

Secondhand smoke is a complex mixture of chemicals in the smoke from a lit tobacco product (cigarette, cigar or pipe) and smoke exhaled by a smoker. Secondhand smoke contains more than 4,000 chemicals. Of these, more than 50 are known to cause cancer.<sup>30</sup>

In 2005, at least 581 adult and infant deaths in Minnesota were caused by exposure to secondhand smoke — deaths that could have been prevented if exposure to secondhand smoke had been eliminated.<sup>31</sup> In 2003 more than 66,000 Minnesotans suffered from diseases caused by secondhand smoke.<sup>32</sup> For infants and children, exposure to secondhand smoke can cause low birth weight, sudden infant death syndrome, lower respiratory illness, ear infections and asthma. For adults, exposure to secondhand smoke can cause lung cancer and coronary heart disease.<sup>33</sup> In Minnesota, \$215.7 million is spent each year to treat the health conditions caused by exposure to secondhand smoke.<sup>34</sup>

### MATS data were collected prior to passage of the statewide Freedom to Breathe Act.

MATS 2007 data were collected before the statewide law that ensures smoke-free air in restaurants and bars was implemented in October 2007. However, at the time data were collected, a number of communities, including St. Paul and Minneapolis, already had local ordinances in effect that prohibited smoking in public places, including bars and restaurants.

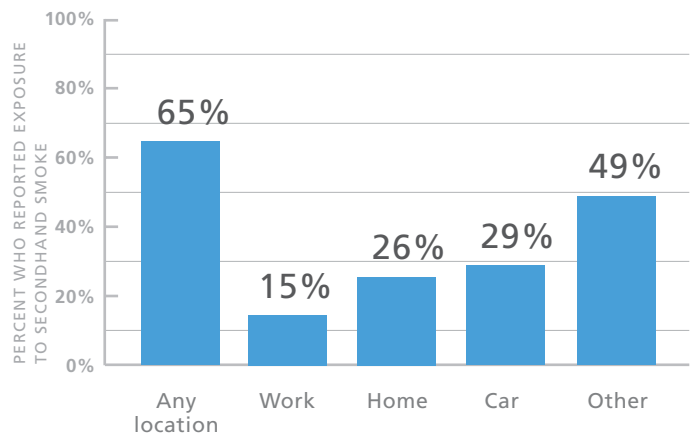
In fact, 82 percent of African-Americans participating in MATS in 2007 reported that there was a ban on smoking in bars and restaurants in their area. It is important to note, however, that Freedom to Breathe does not protect against exposure to secondhand smoke in homes, cars or outdoor workplaces.

### Most African-Americans in Minnesota breathe secondhand smoke regularly.

To measure exposure to secondhand smoke, MATS asked respondents if anyone had smoked near them in several different locations in the past seven days. Nearly two-thirds (65 percent) of African-Americans reported exposure to secondhand smoke in at least one location in the prior week (Figure 12).

African-Americans reported exposure to secondhand smoke in the past seven days in multiple locations, including at work for those who work indoors (15 percent), in their home (26 percent), in a car (29 percent) or at some other location (49 percent).

**Figure 12** Nearly two-thirds of African-American adults reported exposure to secondhand smoke in the past seven days.



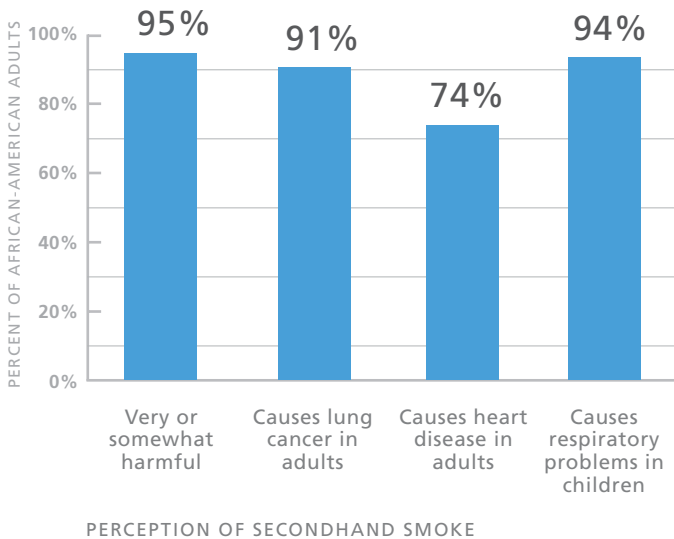
NOTE: MATS DATA WERE COLLECTED PRIOR TO PASSAGE OF THE 2007 FREEDOM TO BREATHE ACT.

**African-Americans in Minnesota know the dangers of secondhand smoke.**

Public perceptions of secondhand smoke’s harmfulness vary and may have an effect on Minnesotans’ interest in and support for clean indoor air ordinances. Tobacco control organizations in Minnesota conduct extensive community outreach efforts and implement media campaigns to raise Minnesotans’ awareness about the harm of secondhand smoke.

Nearly all African-Americans in Minnesota report being aware that secondhand smoke is harmful; 95 percent of respondents say that secondhand smoke is very or somewhat harmful to health. Most also recognize the specific diseases caused by secondhand smoke exposure (Figure 13).

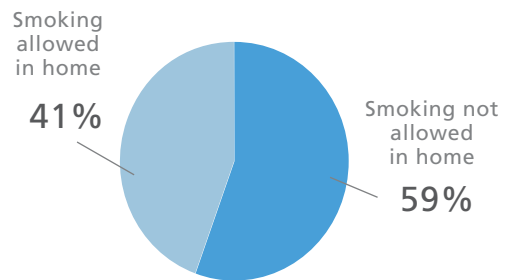
**Figure 13** Almost all African-American adults believe that secondhand smoke causes disease.



**Still, smoking is allowed in many African-American homes.**

Nearly 60 percent of African-Americans say that smoking is not allowed anywhere in their homes. However, this means that more than 40 percent of African-Americans in Minnesota still live in homes where smoking is allowed, potentially exposing them or their children to the dangers of secondhand smoke (Figure 14).

**Figure 14** More than half of African-American adults live in homes where smoking is not allowed.





# III

## Findings From Community-Based Focus Groups and Interviews

### Study Methods

#### A community-based research approach guided the qualitative study.

To complement the MATS African-American study, a community-based research approach was chosen to engage the communities directly affected by tobacco use. Jennifer R. Warren, Ph.D., an experienced community-based researcher and member of the African-American community, conducted this facet of the research.

The goal of the qualitative research component was to embed findings from the MATS African-American study in the realities and lives of the populations that experience this health issue most intimately. The intent was to capture unique perspectives of community members and community leaders on the subject of tobacco use among African-Americans in Minnesota.

#### An advisory board of African-American community leaders helped design the research project.

An advisory board of African-American community leaders in the Twin Cities was convened. Founding advisory board members included representatives of MAAATEN, NorthPoint Health & Wellness Center in Minneapolis, and the Minneapolis Urban League. These advisory board members generously donated their time to guide the development of the community-based research protocols and to review and interpret the community-based research findings. In addition, a senior research analyst and a project manager from Blue Cross participated on the team.

Warren facilitated monthly advisory board meetings from June 2008 through February 2009. During the advisory board meetings, everyone had equal participation and ability to voice their thoughts, concerns and suggestions. The study was designed to allow Warren to have the final voice in the research protocol.

The advisory board worked together to articulate these core research questions:

1. Without making comparisons to other communities, what are African-American community members' reactions to the MATS African-American data?
2. What data are most compelling and informative to community members? Why?
3. When community members think of tobacco use in their communities, what comes to mind? What role does tobacco play in their communities?
4. What are the community's strengths in relation to tobacco control and organizing around the issue?
5. Given the MATS results for African-Americans and the community's capacity, now what? What needs to be done on the community level to organize around smoking as an issue in African-American communities? What are other capacity-building and infrastructure needs?
6. What might prevent African-Americans from quitting smoking?
7. Are community members aware of programs in their area to help them quit smoking? If so, what are community members' perceptions of the smoking cessation programs and resources available?
8. What policy and environmental changes do community members believe influence smoking cessation?

### Study Design

The community-based research engaged a diverse cross-section of African-American community members, as well as leaders within the Twin Cities African-American communities.

Warren drew upon methods key to community-based research, such as the development of an advisory board consisting of community members. She used systematic,

open-ended, qualitative data collection strategies that allow the community to speak in their own words.

The final design for the community-based research project was to conduct focus groups with lay African-American community members and individual interviews with African-American community leaders. Community members could speak to the everyday experiences of African-Americans regarding tobacco use and whether the results of the MATS African-American study seemed authentic to them. On the other hand, community leaders could provide a more overarching perspective on tobacco use and make recommendations for how to address these issues, such as through public policy.

With the guidance of the advisory board, interview questions were developed for the community member focus groups and the community leader interviews. A professional recruiter was engaged to ensure a diverse group of community members and community leaders participated. A survey was developed to capture all participants' basic demographic information and smoking status. The survey also asked participants to rank the importance of other issues faced by the community not related to tobacco use.

## Focus Groups With Community Members

Interviewers asked community members in the focus groups to provide candid reactions to some of the key findings from the MATS African-American study. The advisory panel and qualitative research staff had pre-selected five tables of results on which they believed community members' reaction would be most informative. The tables included findings related to smoking prevalence, use of assistance to quit smoking, possible effects of cigarette price increases, and prevalence of exposure to secondhand smoke. In addition, community members were asked to respond to a number of other questions, such as how acceptable they think smoking is in African-American communities, what they think would work to reduce smoking in their communities, and what role they think tobacco companies play in African-American communities.

## Interviews With Community Leaders

Community leaders were not asked to respond to the MATS African-American study findings, but instead were asked to respond to broader questions. Questions included: what prevents African-Americans from quitting smoking, what resources are needed to help African-Americans quit, and what information do policy-makers and others working to reduce smoking among African-Americans need to understand in order to be successful.

## Study Participants

In total, 30 African-Americans from across the Twin Cities area participated in five focus groups. Relatively equal numbers of males and females participated in the groups. Members reflected diversity in age, marital status, education and socioeconomic status. Eighteen focus group participants (60 percent) were current smokers, eight (27 percent) were former smokers and four (13 percent) had never smoked.

A total of 15 individual interviews were conducted with African-American men and women who are considered "key informants" due to their roles as community leaders (e.g., clergy, local media owners, educators, community organizers, leaders of community-based programs). Community leaders worked in the same cities as the focus group participants. Two-thirds (10) of the community leaders were male. Four community leaders (27 percent) were current smokers, three (20 percent) were former smokers, and eight (53 percent) had never smoked.

For further information about the demographic and smoking characteristics of all community members and community leaders participating in the research, as well as their ranking of other issues faced by African-American communities, see Appendix 4.

## Data Collection

Focus groups with community members occurred across the Twin Cities area during September and October of 2008 in five carefully selected locations in St. Paul, Minneapolis and Brooklyn Center. The discussions, 90 to 120 minutes in length each, were facilitated by Warren and were audio-recorded. Participants were each compensated with a \$25 gift card, and food and beverages were provided at the focus group sessions.

Individual interviews with community leaders took place in private locations convenient to the community leaders, typically their worksites. The interviews were between 15 and 60 minutes in length, were conducted by African-American researchers and were audio-recorded. Community leaders were each compensated with a \$25 gift card.

Participants in both the focus groups and the individual interviews were assured that their comments would be kept confidential. Protocols for the community-based research project were approved by the Institutional Review Board of the Minnesota Department of Health.

## Data Analysis

**Phase One:** A professional, external analyst compiled the data from the focus groups and individual interviews. The analyst listened to the audiotapes from all focus groups and individual interviews to record key concepts and transcribe representative comments. (The quotes included in this report are adapted from these transcriptions.)

Warren performed data quality checks by listening to audio-files and reviewing the summary reports to ensure the analyst was accurate in her report. Warren organized the qualitative data from phase one into a first-level summary report disseminated to the advisory board.

**Phase Two:** The advisory board met to review the summary report. Warren used the feedback to interpret findings and note limitations. She used the project research questions

to organize and interpret data. After reviewing those data thoroughly, she identified themes for all interview questions with representative quotes.

**Phase Three:** Phase three involved a review of findings by select community members who had not participated in either the focus groups or community leader interviews. This step was designed to help assess the trustworthiness of the data. An informal group discussion involving four community members was held, at which time additional feedback regarding the findings was generated.

## Considerations

It is important to note that some community members in the focus groups expressed a fair amount of skepticism with the methods of the MATS African-American study. In particular, some reported concern with the accuracy of a telephone survey sponsored by a health plan. Others felt that the study's sample size affected the study's reliability. In phase three of the analysis, some community members cautioned against the use of these findings to perpetuate stereotypes of African-American smokers. For this reason, both the quantitative and qualitative components should be considered together to provide a more balanced perspective on tobacco use among African-Americans in Minnesota.

## Reactions to Key MATS African-American Findings

This section of the report shares the reactions of only the focus group participants to five key charts from the MATS 2007 survey. These charts included:

- The prevalence of cigarette smoking among African-American adults in Minnesota (Figure 1, page 5)
- Issues related to quitting, including use of any form of quit assistance such as medication or counseling (see Figure 8, page 9) and level of knowledge to properly use stop-smoking medications (Figure 9, page 9)
- Influence of the 2005 price increase on quitting among African-American current and former smokers (Figure 10, page 10)
- Exposure to secondhand smoke in any location in the past seven days among African-Americans in Minnesota (Figure 12, page 11)

These charts were selected because they represent primary outcomes of interest, were likely to generate lively discussion and were recommended by the advisory board. Moreover, they were viewed as among the most relevant to the African-American community.

### Smoking may be an even larger problem than described in the MATS.

Community members in the focus groups reacted with skepticism to the finding that 28 percent of African-American adults in Minnesota are current smokers. (See Figure 1, page 5.) Most said they believe the actual smoking rate among African-Americans is much higher.

Among the comments:

*Everybody smokes.*

— Female focus group participant, Minneapolis

*The results should be flipped — 10 percent should be classified as never smokers, 28 percent as former smokers and 62 percent as current smokers.*

— Female focus group participant, Minneapolis

*It's a lie. Everyone I know smokes.*

— Male focus group participant, Minneapolis

Many participants questioned whether the survey under-represented those who smoke occasionally and do not consider themselves to be smokers.<sup>35</sup>

*If you only smoke a few cigarettes a week, you might not consider yourself a smoker.*

— Female focus group participant, St. Paul

Community members also questioned the effect that the geography, education level, age and socioeconomic status of the MATS respondents might have had on the MATS results.

*If this survey had been conducted in North Minneapolis, it would have found more smokers.*

— Male focus group participant, Minneapolis

*I want to know more about how they came up with these statistics and I would like to know who these smokers are — their ages, education and socioeconomic status.*

— Male focus group participant, St. Paul

Not all community members disagreed with the findings. Some felt that the smoking rate reflects progress in tobacco control.

*Maybe this shows that education is working and people are taking the health consequences of smoking seriously.*

— Male focus group participant, Minneapolis

## Messages about stop-smoking assistance may not be reaching all African-Americans.

Community members in the focus groups had varied reactions to the finding that 42 percent of African-American smokers in Minnesota who had tried to quit in the past year had used a stop-smoking aid with their last quit attempt. (See Figure 8, page 9.) Some expected to see higher figures, others anticipated lower rates of using stop-smoking assistance, and still others felt the numbers are accurate.

*The number of people not using assistance does not surprise me.*

— Female focus group participant, Brooklyn Park

Many community members said that African-American communities lack awareness of the stop-smoking options available to all Minnesotans.

*Smokers might not know about the wide variety of anti-smoking aids available beyond patches or gum.*

— Male focus group participant, Minneapolis

*Lack of exposure to advertisements or public health announcements might affect whether people use anti-smoking aids.*

— Male focus group participant, Minneapolis

Community members in the focus groups generally agreed with the finding that many (75 percent) of African-American smokers do not know enough about stop-smoking medications to use them properly. (See Figure 9, page 9.)

*Ignorance of anti-smoking medications may stem from the aversion of “trading one drug for another” — people aren’t interested in anti-smoking medications because they aren’t addressing the root cause of addiction.*

— Male focus group participant, St. Paul

Some community members also felt that, ultimately, the individual must take the initiative to learn to use stop-smoking aids.

*People share medications without reading instructions.*

— Male focus group participant, Minneapolis

*The doctor may not always give you all the information you need to know, but that’s where you need to come in as an individual to seek information and get what you need.*

— Male focus group participant, Brooklyn Park

## The MATS may overstate the effectiveness of raising tobacco prices to encourage quitting.

Community members in the focus groups had varied reactions to the finding that 68 percent of African-American smokers in Minnesota thought about quitting as a result of the 2005 price increase. (See Figure 10, page 10.) Participants agreed that while a price increase may encourage the majority of smokers to think about quitting, such thought is not likely to translate into action. Many felt that the power of addiction has a stronger pull on smokers than any price increase could.

*If cigarettes go up to \$10 a pack, I’m going to pay it.*

— Male focus group participant, Minneapolis

*Everybody I know said they were going to quit when the price increased, but they didn’t.*

— Male focus group participant, Minneapolis

*Each and every time cigarette prices increased, I said to myself, “I’m not buying a \$4 pack. I most certainly am not buying a \$5 pack.” And yet I’m still buying them. As the price goes up, the addiction goes up.*

— Male focus group participant, Brooklyn Park

*It's just like any addiction. If cigarettes went up to \$20 a pack, people would find \$20 and buy a pack.*

— Female focus group participant, Minneapolis

Community members noted a price increase may be more likely to influence changes in smoking behavior, such as switching brands, buying packs on sale or even smoking cigarette butts.

*I used to smoke Camels, but I stopped buying them because they were so high in price. Now I smoke a cheaper brand. It's the same tobacco.*

— Male focus group participant, Minneapolis

*People will save the cigarette butts and try to re-light them.*

— Female focus group participant, Minneapolis

### **African-Americans see secondhand smoke as a serious concern.**

In response to the finding that 65 percent of African-Americans reported being exposed to secondhand smoke in the past seven days (see Figure 12, page 11), many community members thought this figure is conservative.

*The percentage exposed to secondhand smoke seems too low. It should probably be higher to truly represent the African-American community.*

— Male focus group participant, St. Paul

*I'm surprised that the number for those exposed to secondhand smoke wasn't higher — it seems very pervasive.*

— Female focus group participant, Brooklyn Park

Community members in the focus groups consistently stated that secondhand smoke is everywhere in their communities.

*Even if you don't smoke yourself, you're more prone to be exposed to secondhand smoke because of your peers. All of my guys smoke — all my friends except me.*

— Male focus group participant, Brooklyn Park

*Note: Focus groups with community members were conducted after passage of the statewide Freedom to Breathe Act, which prohibits smoking in indoor public places, including bars and restaurants. It is important to note, however, that Freedom to Breathe does not address smoking in homes, cars or outdoor workplaces.*

## **Additional Insights on Tobacco Use Among Minnesota's African-Americans**

This section reports the themes that emerged in both the focus groups with community members and the interviews with African-American community leaders related to the harm caused by smoking and the broader influences on tobacco use in Minnesota's African-American communities.

### **Many believe smoking causes great harm to African-Americans.**

Among the community leaders interviewed for this study, tobacco use represents an overwhelming negative burden on African-American communities, particularly in terms of health and financial consequences.

*I've never seen a chemical that has devastated a community like tobacco has.*

— Male community leader, Minneapolis

*A pack of cigarettes costs \$5 or \$6 — we're talking about a lot of money that is being taken out of the African-American community.*

— Male community leader, St. Paul

*Smoking leads to a path where, inevitably, somebody suffers a loss.*

— Male community leader, Brooklyn Park

### **African-Americans still seem to accept smoking.**

Several community leaders pointed out that acceptance of smoking is relative, especially in the face of other pressing concerns faced by the community.

*A lot of people say, "I'm not drinking, I'm not using any other drug — I'm just smoking a cigarette."*

— Female community leader, Brooklyn Park

*I think smoking is more acceptable in the African-American community than in other communities. Even those who don't smoke don't voice an objection to it.*

— Female focus group participant, Minneapolis

Some community members said that the connection between smoking and its harms is still not firmly entrenched in the community.

*As African-Americans, we are such a strong people. We're so resilient in so many ways. We really don't believe that if we smoke we're going to get sick.*

— Female focus group participant, Minneapolis

### **African-Americans may smoke to deal with stress of their community's experience.**

Community members and community leaders suggested that smoking might serve as a coping mechanism and stress reliever for the major life stressors that African-Americans face.

*We have so much to deal with in our lives that stopping smoking is not a top priority.*

— Male focus group participant, Minneapolis

*Cigarettes are cheaper than therapy. Five dollars for a pack of cigarettes is a better price to pay for satisfaction when you don't have money for a therapist.*

— Male community leader, Minneapolis

*Smoking provides a way for people to self-medicate and to cope in ways that don't force them to deal with their issues directly.*

— Female community leader, Minneapolis

*Smoking may be an outlet for all of the pain stemming from African-Americans' history of oppression.*

— Female community leader, Minneapolis

### **Smoking may not be about race.**

Some, however, described tobacco use as an individual-level behavior with no direct connection to race.

*Quitting smoking doesn't have anything to do with race. It's an individual struggle.*

— Male focus group participant, Brooklyn Park

*The thing that keeps African-Americans from quitting smoking is the same thing that keeps everyone else from quitting: It is addictive and it is habitforming.*

— Male community leader, St. Paul

Community leaders and community members also emphasized a notable connection between smoking and lower socioeconomic status.

*Smoking is more of a class issue than a race issue. It just so happens that many African-Americans are in the lower class.*

— Male focus group participant, Minneapolis

*When you see people smoking, you can almost pigeonhole them to be of a certain financial ilk. Professionals and upwardly mobile people in the black community do not smoke.*

— Male community leader, St. Paul

### **Smoking appears to be normal in African-American communities.**

Community members and community leaders agreed that smoking is a near-constant presence for many African-Americans, increasing the community's acceptance of smoking.

*We tend to feel like it's OK to smoke. It doesn't matter who is around you. We don't worry about it.*

— Male focus group participant, St. Paul

*Growing up in the African-American community, smoking was something you just picked up because other people were doing it.*

— Female focus group participant, St. Paul

*Smoking is passed on from generation to generation. My mom smoked; my dad smoked.*

— Male focus group participant, St. Paul

*Smoking is way too acceptable. People don't see the correlation between smoking and poor health.*

— Female community leader, Minneapolis

Smoking was described as a social tool, providing opportunities for individuals to develop a sense of camaraderie and connection.

*Having a cigarette with a person gives you some time with them, some intimacy, some privacy.*

— Male focus group participant, St. Paul

Several individuals noted that while the social nature of smoking may encourage people to start smoking, ultimately the addictive nature of tobacco is what keeps a person smoking.

*Smoking plays a social role at first, but then addiction takes hold.*

— Female focus group participant, Minneapolis

### **Attitudes toward tobacco may be changing.**

Some community members and leaders said that they see signs of changing attitudes toward tobacco in their communities.

*In the last 15 years, I've noticed a definite change in the number of people who accept smoking.*

— Male focus group participant, Brooklyn Park

*More smokers feel like they stand out like a sore thumb these days.*

— Male focus group participant, St. Paul

*Community-wise, people are starting to get the message that smoking isn't good for you and it can cause harm.*

— Female community leader, St. Paul



Some community leaders said they see smoking as a social inhibitor, rather than a social tool. Several described a stigma attached to smoking.

*People start to think there's something wrong with you because you smoke.*

— Male community leader, Minneapolis

*Smoking plays a stigmatizing role. Those who smoke are often labeled as belonging to the lower class.*

— Male community leader, St. Paul

### **African Americans report seeing tobacco everywhere.**

The ready availability of tobacco products in African-American communities was said to contribute to the perception that smoking is a cultural norm.

*Cigarettes are everywhere. They are littered and smoked everywhere — on the street corners, in parks, in restaurants and on the inside and outside of buildings.*

— Female community leader, Minneapolis

Community members participating in the focus groups described ways in which low-cost tobacco products are promoted and available in African-American communities, such as the prominent advertisement of low-cost cigarette-shaped cigars and the illegal practice of selling single cigarettes.

*There are still stores that will sell you a single cigarette.*

— Female focus group participant, Minneapolis

*People will smoke cigars instead of cigarettes.*

— Male focus group participant, Minneapolis

### **Tobacco companies appear as a constant, aggressive presence.**

Community leaders, in particular, said that tobacco advertising is ever-present in African-American communities.

*Advertising for cigarettes is everywhere and what we see is what we know. If we don't see counter-attacks of these smoking advertisements, we won't be thinking about the detriments of smoking. We'll only be thinking of the glamorous aspect of smoking as seen in ads.*

— Male community leader, St. Paul

Many said that tobacco companies specifically target African-American communities.

*Tobacco companies very intentionally market to the black people — they know what they're doing.*

— Male community leader, Minneapolis

*Tobacco companies target brands of cigarettes to African-Americans that are particularly toxic and addictive.*

— Male community leader, Brooklyn Park

Others said that for tobacco companies, it is a simple matter of supply and demand.

*Tobacco companies target everybody, but we're exposed to it more because our people are so oppressed.*

— Male community leader, Minneapolis

*Folks want cigarettes and the tobacco companies supply.*

— Male focus group participant, Minneapolis

*As long as there is a demand for tobacco, tobacco companies will continue to provide a steady supply of cigarettes.*

— Male community leader, St. Paul

### **African-Americans who wish to quit may not be using stop-smoking aids.**

Lack of awareness and skepticism about stop-smoking aids were offered as explanations why African-American communities have not utilized stop-smoking aids to a greater degree.

*They might know about medications, but not enough about how to use them.*

— Female focus group participant, Minneapolis

For some, the lack of access to — or even knowledge of — resources was said to be a barrier.

*Current resources are not sufficient to help African-Americans quit smoking.*

— Female community leader, Minneapolis

*I'm not aware of any resources.*

— Male community leader, St. Paul

Some said the reluctance to use stop-smoking aids stems from a lack of motivation to quit.

*Smokers don't want to admit they have a problem, so they don't want to ask for help.*

— Male focus group participant, Brooklyn Park

*If you learn how to smoke, you can learn about the medication to quit.*

— Female focus group participant, Brooklyn Park

Barriers to health insurance and affordable health care were also said to limit the use of stop-smoking aids by African-Americans.

*It's a struggle to get stop-smoking aids and medication paid for by your insurance.*

— Male focus group participant, Brooklyn Park

### **Willpower is still seen by some as the way to overcome addiction.**

Cultural beliefs in the value of self-determination and willpower also were said to influence the decision not to use stop-smoking aids.

*A lot of people I know would rather quit smoking on their own because they don't want any type of assistance.*

— Female focus group participant, Brooklyn Park

*It's a mind thing — we don't need Nicorette. When we want to quit, we'll just quit.*

— Male focus group participant, Minneapolis

For some smokers, belief in God was said to be a powerful source of strength in helping them quit, and the faith community a potentially powerful support network.

*Smokers rely on divine intervention to quit.*

— Female focus group participant, Minneapolis

### **The dangers of secondhand smoke may not be well understood.**

Community members revealed some misperceptions about secondhand smoke. In contrast to the MATS findings, some community members did not believe secondhand smoke is harmful.

*We don't know that secondhand smoke kills — it's based on a rumor.*

— Male focus group participant, Brooklyn Park

*People don't seem to make the connection that they're hurting other people besides themselves when they smoke.*

— Female community leader, Minneapolis

## Recommendations for Creating Culturally Competent Interventions

This section explores the conclusions and recommendations that emerged from the interviews with African-American community leaders.

### Counter the belief that “smoking isn’t that bad” with information that “tells it like it is.”

Participants in focus groups and interviews alike encouraged a direct, even graphic, approach to anti-smoking campaigns that focuses on the harms of tobacco and secondhand smoke. Such an approach, participants felt, is most likely to capture the attention of African-American smokers and compete with the constant presence of tobacco advertising.

*We need a different approach to advertising — something that is more startling with visual images of what is in a cigarette, like the poison and formaldehyde.*

— Male community leader, Minneapolis

### Create interventions that build on the strengths of African-American communities.

*Those who design anti-smoking programs for African-Americans need to understand and highlight the unique reasons why black people smoke, and they need to highlight the pride of the African-American community.*

— Male community leader, St. Paul

*African-Americans use cigarettes for different reasons than European-Americans do. And African-Americans have historic values and family norms that European-Americans do not. Those factors should be capitalized on because they are great strengths of the African-American community.*

— Male community leader, St. Paul

*African-Americans have a history of oppression in this country. Thus, anti-smoking campaigns that carry an oppressive message like “You’re doing something wrong” or “You can’t do this anymore” may not be effective. For anti-smoking messages to be effective in the African-American community, they need to be encouraging and uplifting.*

— Female community leader, Minneapolis

For several individuals, African-American history offers a powerful lens through which to view tobacco prevention efforts.

*Tobacco was used in the slave trades. If more African-Americans knew that fact — and felt that they were somehow contributing to the history of their enslavement — they might do something more to quit smoking.*

— Female community leader, Minneapolis

### Ground messages in an understanding of why African-Americans smoke.

To be successful, community leaders said that tobacco control programs must understand the reasons why African-Americans smoke and focus on providing smokers healthier alternatives.

*What do you do when you put the cigarette down? You need something to replace that cigarette.*

— Male community leader, Minneapolis

*We need to educate people on creative alternatives to smoking that will provide the same stress-relieving effect: playing basketball, going to the gym, taking a walk.*

— Male community leader, Minneapolis

## Use media to promote messages that resonate with African-Americans.

When asked how to reduce smoking in African-American communities, community leaders stressed the importance of tailored media messages.

*We need Afrocentric anti-smoking commercials with actors who look and talk like many African-Americans. This is especially important to youth, who will tune out messages that aren't directly relevant to them.*

— Male community leader, St. Paul

Several suggested that media messages showcase prominent African-Americans, such as hip hop artists, athletes and community leaders.

*I wonder what would happen if all the rap artists started talking about how stupid smoking is.*

— Male community leader, Minneapolis

Isolated media messages, however, were not seen as being enough. A multimedia approach was recommended to get tobacco control messages across most effectively.

*If billboards, commercials, magazine articles, classes and public health campaigns start to push the anti-smoking message, pretty soon it will be in the top two or three things I'm talking about.*

— Male community leader, St. Paul

## Involve the entire community in the fight against tobacco use.

Many of the community leaders interviewed believed that the solution to the problem of tobacco use must come from within the African-American communities themselves.

*As African-Americans, we need to take responsibility for educating our children and ourselves on the harmful effects that tobacco has on our community.*

— Female community leader, Brooklyn Park

*We need to fess up and face up. We can't live in denial that smoking isn't affecting us as a community.*

— Female community leader, Minneapolis

Several interviewees noted that it will take a major community-wide effort in order to have a substantial impact on African-American smoking rates.

*We need to flood our community with education.*

— Female community leader, Minneapolis

## Use successful quitters as the messengers.

Many interviewees expressed the importance of positive role models — African-Americans who have themselves successfully quit smoking — as a trusted source of information. These individuals, who “talk the talk and walk the walk,” can have the greatest sway with smokers who want to quit.

*Advice will be most effective when it is framed by us, for us.*

— Male community leader, Minneapolis

*We need people who are former smokers to talk about their struggles and how they made it through.*

— Male community leader, Minneapolis

### **Engage social networks to support stop-smoking efforts.**

Community leaders said they believe that the strong social networks of friends, families and faith institutions present in African-American communities provide a powerful asset to leverage in encouraging smokers to quit. They suggested that tobacco cessation models that utilize peer education and mentorship may offer a promising strategy for use within African-American communities.

*Generally, people don't start smoking by themselves. They start doing it in a social network. In this way, people may be more likely to quit if they are surrounded by a social network — a group of people who will meet regularly, not just to talk about smoking, but to talk about all the other issues related to smoking.*

— Male community leader, Brooklyn Park

### **Advocate for tobacco control policies.**

Community leaders' recommendations centered largely on community-based mobilization and education strategies for tobacco control in African-American communities.

*Wherever anybody has ever smoked, that's where our efforts need to be.*

— Female community leader, Minneapolis

Others expressed confidence in the role that price increases and environmental policy approaches (e.g., indoor smoking bans) have played in reducing exposure to secondhand smoke and encouraging smokers to quit.

*I agree with the smoking ban in Minnesota. I think it should be everywhere.*

— Male community leader, Minneapolis

The most commonly suggested approach to tobacco control was the total ban of all tobacco sales.

*Tobacco should simply be taken off the market.*

— Male community leader, St. Paul

# IV Summary

## Building on the Research

**This study is a unique combination of quantitative and qualitative methods that provides useful information for tobacco control advocates.**

Taken as a whole, this groundbreaking two-part study of tobacco use in Minnesota's African-American communities illuminates the issues inherent in reducing tobacco use in these communities. While the results of the MATS African-American study and the impressions of the focus group participants and community leaders showed some divergence of opinion, in combination they reveal the scope of the issue and the depth of understanding within the African-American communities about the need to reduce tobacco use.

Above all, the findings can be used to build upon interventions that are known to reduce tobacco use: public policy, the availability of stop-smoking aids, and changing social norms to make tobacco use less acceptable and less accessible.

**It is crucial to consider the diversity of opinions present within African-American communities.**

While numerous organizations in Minnesota have been working diligently to reduce tobacco use in African-American communities, the research highlights a need for a better targeted and more focused effort to truly achieve notable gains. Yet, the challenge — and opportunity — facing tobacco control advocates is to use these findings to develop and deliver interventions in a way that is culturally appropriate and relevant to African-American communities.



# Acknowledgements

## Collaborating Organizations

**Blue Cross and Blue Shield of Minnesota** (Blue Cross) is the largest health plan based in Minnesota, covering 2.8 million members in Minnesota and nationally through its health plans or plans administered by its affiliated companies. Prevention Minnesota is Blue Cross' long-term commitment to tackle preventable heart disease and cancers throughout Minnesota by addressing their root causes: tobacco use, exposure to secondhand smoke, physical inactivity and unhealthy eating. Prevention Minnesota is funded by Blue Cross' settlement proceeds from its landmark lawsuit with the tobacco industry, in which Blue Cross was a co-plaintiff with the State of Minnesota. Blue Cross and Blue Shield of Minnesota, a nonprofit corporation, is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross provides stop-smoking programs for its members, funds efforts to advocate for policy changes that help reduce tobacco use and secondhand smoke exposure, works with high priority populations to raise awareness of the harm of tobacco use, and promotes workplace health improvement.

For more information, go to [www.bluecrossmn.com/preventionminnesota](http://www.bluecrossmn.com/preventionminnesota).

**ClearWay Minnesota<sup>SM</sup>** is a nonprofit organization that strives to enhance life for all Minnesotans by reducing tobacco use and exposure to secondhand smoke through research, action and collaboration. ClearWay Minnesota serves Minnesota through its grant-making program, QUITPLAN<sup>®</sup> Services to help people quit smoking, and statewide outreach activities. QUITPLAN Services has helped more than 14,800 adult Minnesotans successfully quit smoking. ClearWay Minnesota designs and develops innovative statewide multimedia campaigns to inform the public of QUITPLAN Services and raise the awareness of the harm of secondhand smoke exposure. ClearWay Minnesota also works to build capacity and engage priority populations in reducing the harm that tobacco causes their communities. ClearWay Minnesota was created in 1998 when the state received \$6.1 billion from its settlement

with the tobacco industry and 3 percent, or \$202 million, was dedicated by the Ramsey County District Court to establish the independent nonprofit organization.

For more information, go to [www.clearwaymn.org](http://www.clearwaymn.org).

**The Minnesota African/African-American Tobacco Education Network** (MAAATEN) is a coalition of African and African-American community leaders working to engage African and African-American communities throughout Minnesota to reduce the harms of tobacco use. Formally convened in 2001, the group emphasizes both health promotion and the reduction of health disparities in African-American and African immigrant communities throughout the state. MAAATEN has received funding from Blue Cross and ClearWay Minnesota to facilitate these crucial efforts. The group has worked industriously since its inception to build a community collaborative galvanized around the mission of promoting health and reducing the harms of tobacco use. Their key work involves educating community leaders, community-based organizations and policy decision-makers about tobacco's toll on African-American and African communities in Minnesota.

**The Minnesota Department of Health** (MDH) launched the first state-funded tobacco control program in the nation in 1985 with a portion of the proceeds from a cigarette tax. Since then, MDH has undertaken a number of tobacco control initiatives, including participating as one of 17 American Stop-Smoking Intervention Study demonstration states, a national-level comprehensive tobacco control program sponsored by the National Cancer Institute. Funds from an endowment from the state's 1998 settlement with the tobacco industry were available to the department from 2000 through 2003 and were used to launch a comprehensive youth prevention initiative during that period. Currently, MDH works to reduce smoking through grants to reduce youth exposure to pro-tobacco influences, to create tobacco-free environments and to reduce tobacco related health disparities.

For more information, go to [www.health.state.mn.us](http://www.health.state.mn.us).

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Daphne Cornelia Rich

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MAAATEN policy and research committees  
Natalie Johnson Lee

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Laurie Alexander

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Stacia Noble  
Diane Perney  
Vivek Rau  
Patricia Stouffer  
Susan Swain, M.A.  
Kristie Taylor, Ph.D.

### For further information

Rebecca Fee  
Blue Cross and Blue Shield of Minnesota  
(651) 662-7104

Natalie Johnson Lee  
Minnesota African/African-American Tobacco Education  
Network  
(651) 642-0811



# VI Appendices

## Appendix 1

### Demographics of the African-American sample in MATS 2007

	Percent
<b>Gender</b>	
Male	59%
Female	41%
	100%
<b>Age group</b>	
18 to 24	17%
25 to 34	33%
35 to 44	16%
45 to 54	14%
55 to 64	16%
65+	4%
	100%
<b>Marital status</b>	
Married	27%
Not married	73%
	100%
<b>Education</b>	
Less than high school	20%
High school	38%
Some college	33%
College	10%
	101%*
<b>Income</b>	
\$0 to \$35,000	55%
\$35,001 to \$50,000	10%
\$50,001 to \$75,000	10%
\$75,001 or more	25%
	100%
<b>County of residence</b>	
Nonmetro	8%
Metro	92%
	100%

\*Total does not equal 100% due to rounding

## Appendix 2

### Smoking status by demographic characteristics for the African-American sample in MATS 2007

	Current smoker	Nonsmoker	Total
<b>Gender</b>			
Male	26%	74%	100%
Female	30%	70%	100%
<b>Age group</b>			
18 to 24	12%	88%	100%
25 to 34	25%	75%	100%
35 to 44	33%	67%	100%
45 to 54	50%	50%	100%
55 to 64	33%	67%	100%
65+	0%	100%	100%
<b>Marital status group</b>			
Married	11%	89%	100%
Not married	34%	66%	100%
<b>Education group</b>			
Less than high school	26%	74%	100%
High school	38%	62%	100%
Some college	21%	79%	100%
College	16%	84%	100%
<b>Income group</b>			
\$0 to \$35,000	44%	56%	100%
\$35,001 to \$50,000	17%	83%	100%
\$50,001 to \$75,000	17%	83%	100%
\$75,001+	5%	95%	100%

This table presents the proportion of current smokers and nonsmokers among various demographic subgroups of the African-American sample analyzed for the MATS African-American study. Due to small cell sizes, the categories of "former smoker" and "never smoker" were combined into one category called "nonsmoker." Also due to small cell sizes, the percent of current smokers and nonsmokers among African-Americans living outside of metropolitan counties is not presented.

## Appendix 3

### Recent surveys of smoking among African-American adults in Minnesota

The surveys below use the same definition of current smoker:

- Has smoked 100 cigarettes in lifetime, and
- Now smokes every day or some days

#### Minnesota Adult Tobacco Survey (MATS) — 2007

**Study sponsors:** Blue Cross and Blue Shield of Minnesota, ClearWay Minnesota<sup>SM</sup> and Minnesota Department of Health

**Population:** U.S.-born African-American (primary self-reported racial affiliation of “black or African-American”) Minnesota residents, ages 18+

**Sample size:** 232

**Current smoking estimate:** 28.1% (plus or minus 11.9)

#### Behavioral Risk Factor Surveillance System (BRFSS) — 2005–2007

**Study sponsors:** Minnesota Department of Health and U.S. Centers for Disease Control and Prevention

**Population:** African-American (self-reported racial identification of “black or African-American,” including non-U.S.-born) Minnesota residents, ages 18+

**Sample size:** 291

**Current smoking estimate:** 26.1% (plus or minus 6.9)

**Published source:** None; unpublished calculations using three years of BRFSS data

#### Survey of the Health of All the Population, and the Environment (SHAPE) — 2006

**Study sponsor:** Hennepin County Human Services and Public Health Department

**Population:** U.S.-born African-American (self-reported racial identification of “black or African-American”), Hennepin County residents, ages 18+

**Sample size:** 651

**Current smoking estimate:** 31.8% (plus or minus 5.6)

**Published source:** SHAPE 2006: Adult Data Book, July 2008 (<http://www.co.hennepin.mn.us/SHAPE>)

## Appendix 4

### Focus group participant and community leader demographics

	Focus Groups (N=30) n (%)	Community Leaders (N=15) n (%)
<b>Gender</b>		
Male	16 (53%)	10 (67%)
Female	14 (47%)	5 (33%)
	30 (100%)	15 (100%)
<b>Age group</b>		
18 to 24	2 (7%)	1 (7%)
25 to 64	25 (83%)	13 (87%)
65+	3 (10%)	1 (7%)
	30 (100%)	15 (101%)*
<b>Education group</b>		
Less than high school	6 (20%)	5 (33%)
High school or more	24 (80%)	10 (67%)
	30 (100%)	15 (100%)
<b>Income group</b>		
\$0 to \$35,000	10 (33%)	0
\$35,001 to \$50,000	12 (40%)	2 (13%)
\$50,001 or higher	8 (27%)	13 (87%)
	30 (100%)	15 (100%)
<b>Do you smoke cigarettes?</b>		
Current smoker	18 (60%)	4 (27%)
Former smoker	8 (27%)	3 (20%)
Never smoker	4 (13%)	8 (53%)
	30 (100%)	15 (100%)
<b>Does someone in your household smoke?</b>		
No	15 (50%)	13 (87%)
Yes	15 (50%)	2 (13%)
	30 (100%)	15 (100%)

\*Total does not equal 100% due to rounding

### Perceptions of other issues faced by African-Americans in Minnesota

Percent of community leaders and focus group participants (N=45) who reported that an issue was "most important"

Affordable housing	87%
Education	84%
Access to good health care	82%
Crime and safety	78%
Employment	78%
Availability of health insurance	76%
Discrimination	62%
Teen pregnancy	62%
Access to healthy food	56%
Breathing in smoke from others' cigarettes	42%
Preserving cultural traditions	40%

# VII

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