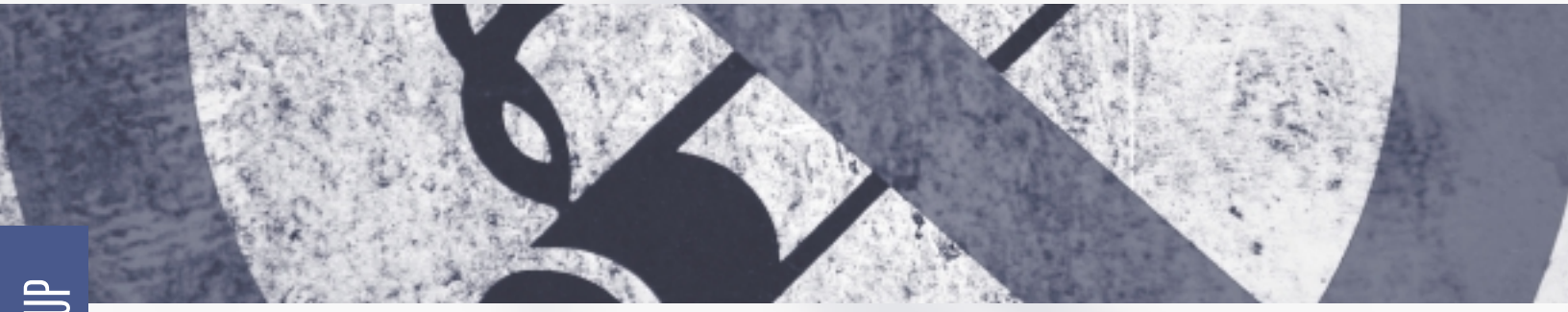

FOCUS GROUP

# Smoking Habits and Prevention Strategies in Low Socio-economic Status Populations

Prevention Research Center
Making a Difference in Appalachia

NATIONAL NETWORK *on* Tobacco Prevention *and* Poverty

# Smoking Habits and Prevention Strategies in Low Socio-economic Status Populations

Robert H. Anderson
DEPUTY DIRECTOR, WEST VIRGINIA UNIVERSITY, PREVENTION RESEARCH CENTER

Debra S. Oto-Kent
HEALTH EDUCATION COUNCIL (HEC)

Janet Porter
NATIONAL NETWORK ON TOBACCO PREVENTION AND POVERTY/HEC

Kerry Brown
NATIONAL NETWORK ON TOBACCO PREVENTION AND POVERTY/HEC

Liane Quirk
NATIONAL NETWORK ON TOBACCO PREVENTION AND POVERTY/HEC

Sallie Beth Johnson
WEST VIRGINIA UNIVERSITY, PREVENTION RESEARCH CENTER

## INTRODUCTION

*In 2000, the Health Education Council entered into a five year, cooperative agreement with the Centers for Disease Control and Prevention (CDC), Office of Smoking and Health, to develop a national network to reduce the burden of tobacco use among low socioeconomic (low SES) populations. This network, consisting of national organizations serving poor populations, came to be called the National Network On Tobacco Prevention and Poverty (NNTPP). NNTPP's mission is to identify resources and advocate for the elimination of tobacco use among populations of low socioeconomic status. In 2002, the Prevention Research Center of West Virginia University and the National Association of Community Health Centers (both NNTPP Stakeholder organizations) collaborated with NNTPP staff to convene a number of focus groups to collect additional data to gain a better understanding of low SES populations. Focus groups were conducted through West Virginia University Prevention Research Center in partnership with the National Network on Tobacco Prevention and Poverty. The objectives of the focus groups were to review the social and cultural nuances that support/encourage smoking in low socio-economic status (SES) populations, identify communication channels most effective in reaching this population with tobacco cessation/prevention messages, and to tailor prevention messages to reach low SES adults.*



## THE RELATIONSHIP BETWEEN SMOKING AND SOCIOECONOMIC STATUS

Tobacco use remains the leading preventable cause of death in the United States. Tobacco causes more than 440,000 deaths each year (one out of every five deaths), resulting in 5.6 million years of potential life lost.

Tobacco use poses a greater burden on minority, low income, and low literacy populations. Characteristics that describe low socio-economic status populations include low-income, individuals with less than 12 years of education, the medically under-served, the unemployed, and the working poor. Although there are many factors contributing to predicted tobacco use, socioeconomic status is the single greatest predictor. Americans below the poverty line are 40% more likely to smoke than those at or above the poverty line. Populations with high smoking prevalence include Native Americans, prisoners, gays and lesbians, blue collar workers and the mentally ill.

Americans living in poverty and other low SES populations suffer disproportionately from tobacco related morbidity and mortality. This may be due to the fact that low SES communities are less likely to have members with access to and/or who participate in cessation programs or receive cessation advice. In addition, little research and funding are available to support resources for smoking cessation and prevention strategies that effectively target low SES populations and many tobacco education materials and programs are not culturally or linguistically appropriate for low SES populations. Lastly, individuals from low SES populations often live in communities where tobacco advertising and financial support for tobacco are prominent. Hence, these communities are more likely to be influenced by tobacco company marketing and more likely to purchase tobacco products. They also lack the resources to replace the support/sponsorship tobacco companies provide in their communities.

> *Americans below the poverty line are 40% more likely to smoke than those at or above the poverty line.*

## BACKGROUND

In order to better understand attitudes and behaviors associated with tobacco use among low SES populations, the Health Education Council's NNTPP conducted focus groups in collaboration with the West Virginia University Prevention Research Center and the National Association of Community Health Centers. The objectives of the focus group were to review the social and cultural nuances that support/encourage smoking in low socioeconomic (SES) populations, identify communication channels most effective in reaching this population with tobacco cessation/prevention messages, and to tailor prevention messages to reach low SES adults.

The focus groups were conducted between May and June of 2002 at four different health centers in the United States. All were members of the National Association of Community Health Centers. Focus group sites were chosen based on states with the highest tobacco use rates, including Arkansas, Nevada, New Mexico, and West Virginia. The facilities are listed below:

1. Jefferson Comprehensive Care System in Pine Bluff, Arkansas (small city)
2. Health Access Washoe County in Reno, Nevada (urban)



3. Hope Medical Center in Estancia, New Mexico (rural)
4. Preston-Taylor Community Health Center in Grafton, West Virginia (rural)

A discussion guide and questionnaire were developed and underwent approval by the Institutional Review Board at West Virginia University and by the NNTPP stakeholder organizations. A pilot focus group was convened at the Union Gospel Mission in Sacramento, California with eight male smokers. Questions were revised as needed.

Two focus groups were convened at each site, with 6-10 participants in each group. Informed consent was reviewed with each participant and a cash incentive of $50 was offered for each individual's participation. Each session lasted approximately an hour and a half to two hours in length. All sessions were taped and later transcribed. With the exception of the focus groups conducted in Reno, which were separated by gender, the other three site's focus groups were mixed.

All participants in the focus group were between the ages of 25 to 34 years of age, were of low socio-economic status, and identified themselves as current smokers. Although not a requirement for participation, many of the focus group attendees were also patients at the health centers. Four main topics were explored during the focus groups: 1) Current smoking behavior and attitudes (likes and dislikes); 2) Brands and cost; 3) Smoking and health; and 4) Smoking cessation.

> *They also indicated that cigarettes were a companion to the use of alcohol and caffeine ...*

## FOCUS GROUP FINDINGS

### Current Smoking Behavior and Attitudes

The responses we received from the participants were fairly consistent among all of the focus groups. Across the board, the most common answers revealed that cigarettes helped them reduce stress and served as a tool to avoid boredom. They also indicated that cigarettes were a companion to the use of alcohol and caffeine and that they enjoyed cigarettes the most after a great meal and after sex. They also indicated that cigarettes helped them control their weight, but most importantly, cigarettes served as a loyal "friend" and smoking provided a private time (this is a theme often seen in cigarette advertisements) when they could relax and reflect. One significant reason for using cigarettes was simply because it was legal to do so (licit vs. illicit drugs).

One participant explained: "... I'm a recovering addict, so I've let go of anything else—my alcohol and my drugs and it's like this is the last crutch I have and it's like if you take this away from me it's really began to impede on my masculinity ..."

On the other hand, there were concerns and dislikes cited from participants around smoking. Many indicated that they did not like the smell or the smoke. Some cited price as a dislike, in addition to the short-



term effects of tobacco use (smelly clothes, having to smoke outside in some locations, etc.), and the majority viewed cigarette smoking as a behavior that they feel makes them a poor role model for children. They also cited cigarette smoking as having an impact on whether or not they make a positive impression on others.

With regard to secondhand smoke, most are aware that it is a health hazard. As one participant stated: "I don't smoke in my house, I don't smoke in my car. I don't smoke around my kids. I know it's nasty and it's dirty and it's bad for everybody else ..." Surprisingly, many believed that secondhand smoke is more harmful than smoking: "There's been a percentage, that people die more—there's been more people that die of secondhand smoke than there are people that smoke." This arose in every state—often without this question coming up. Few participants could explain where they had heard this.

## Brands and Cost

With regard to brand and cost, many participants cited Marlboro, Camel, and Newport as popular brands or as brands they smoked the most. Some participants indicated that they will smoke "anything." Others opted for generic brands when they couldn't afford the premium brands and almost all participants can quote the exact price they pay for their cigarettes. In addition, in-store promotions (such as buy two, get one free) served as a huge incentive to purchase cigarettes among this population. Many participants had strong opinions about their particular brand of cigarettes and a great loyalty to the brands they smoke. Some reported that generic brands hurt their lungs. Some participants claimed that they would be motivated to quit smoking if prices in cigarettes were raised "too high" but the majority indicated that an increase in price would only force them to just buy generic brands ("buy down") or resort to other means such as "rolling their own" cigarettes.

## Smoking and Health

All of the participants in each of the focus groups indicated an awareness about the health hazards of tobacco use. All participants were able to cite at least one health risk related to smoking and responses ranged from coughing, shortness of breath, and impaired athletic performance to asthma and emphysema. Many of the participants also had relatives who suffered from a smoking-related illness. Although some recognized the health hazards related to smoking, other participants did not relate smoking mortality or morbidity to themselves: "It probably is having an effect; I just don't know it. It's not bothering me mentally or physically or nothing and that's why I probably do it. I'm sure it is, but I just don't think about it." Although many indicated that they had watched a loved one die of smoking related illness, they did not see a connection between their own smoking behavior and their own health risks.

## Cessation

All participants had tried to quit smoking at least once in their lives, but they had all been unsuccessful at achieving long term cessation. Common reasons cited for relapse included stress, environmental cues (alcohol, coffee, smoking environments), and influence of peers, relatives, and spouses/partners. Most were surrounded by friends and family members who also smoked, making quitting much more difficult. "Cold turkey" was the most common method cited by participants when trying to quit. In addition, some participants reported problems and/or side effects with pharmaceutical use in quitting.

One of the most consistent findings from each focus group was the revelation that few were asked about



smoking by their providers: "If my doctor had told me to stop smokin', I probably would have by now. . . they don't say nothin', so I don't think about it." Furthermore, some participants claimed that when they asked for help in quitting, little or no advice was provided by their doctors. With regard to smoking during pregnancy, some of the female participants of the focus group indicated that they were able to quit smoking successfully during pregnancy, but resumed immediately or a few months later post delivery. In addition, many were reluctant to tell their doctor about their smoking behavior for fear of being scolded or "talked down to."

Others made a distinction between quitting and being forced to stop smoking when going into a rehabilitation program, boot camp, or correctional facility where smoking was not permitted. They viewed this period as one where they simply stopped smoking temporarily but didn't view it as quitting or as an opportunity towards long term cessation. Most participants claimed they wanted to quit smoking, but had very little confidence in being able to do so successfully. One participant even reported nicotine as being more difficult to quit than other, illicit drugs: "I used to do a lot of different drugs and I did a lot of hard drugs. I did coke, crank, uppers and downers. Any illegal pharmaceutical I did . . . and I had a heroin addiction one time and I had to go in rehab for three months to get over that, and then I did the opposite end of the spectrum and I had stimulants, cocaine, and crank, methamphetamines, and that was easier for me to kick than smoking."

## SUMMARY

There were several findings worthy of note during the focus group sessions:

- Smoking meets a "need" for each participant that can not be replaced with anything else.
- Smoking is considered the norm among participants interviewed. Because they are surrounded by family and friends who smoke, they assume that the smoking prevalence is much higher than it really is. The social milieu of most participants included tobacco use.
- Although many participants had tried to quit smoking, they relapsed largely due to stress, environmental triggers, and the influence of other smokers around them (friends, family, spouse/partner).
- Most participants would like to quit, but have low self-efficacy and a belief that they are powerless to overcome their addiction.
- Participants do not see providers as being instrumental in helping them quit. For the most part, providers treating this population, do not ask about smoking cessation and when participants ask their providers, little or no information and support is provided around smoking cessation resources.
- The majority of participants felt strongly that a strong desire or "will power" was key to successful quitting.
- Most participants saw secondhand smoke as more dangerous than smoking. Efforts of smokers to not expose their children and other non-smokers were not necessarily effective. For example, participants may smoke in the home, but in another room as opposed to going outside.
- In response to potential increases in cigarette prices, some participants claimed they would quit but many others said they would not. Others would choose to switch to generic brands or reduce consumption. And some participants claimed they would resort to "rolling" their own cigarettes.

## LIMITATIONS

This qualitative research was conducted with a small non-random sample hence, these findings can not



be generalized for all low SES populations. However, these findings do correlate with findings from the 2002 National Health Interview Survey (NHIS) sample adult core questionnaire. Findings from that report concluded that there is a continued need for targeted interventions that can better reach persons of low socioeconomic status. The NHIS report concluded with several recommendations including offering comprehensive smoking cessation assistance through Medicaid and Medicare; offering smoking cessation advice and counseling through clinics that care for the uninsured; increasing support for smoking cessation at work places, particularly for low-income and blue-collar workers; implementing telephone quitlines in all states; and employing more media-based cessation campaigns.

## RECOMMENDATIONS

As findings from these focus groups indicate, there remains a need to reduce the burden of tobacco use among low SES populations and continued efforts are needed to assist this populations with quitting. Recommendations for working with low SES smokers around tobacco prevention and cessation include:

1. Offering support to post-partum women. An estimated 95% of women who quit smoking during pregnancy return to smoking ultimately after delivery. In addition, counseling for smoking cessation needs to be accessible, sensitive, and conducted in a comfortable environment. Smoking and pregnancy is a special concern for low SES populations. One indicator of low SES is educational attainment. The 2001 Surgeon General's Report, Women and Smoking, found that whereas 2.2% of mothers with a college degree smoked during pregnancy, 25.5% of mothers with 9 to 11 years of education did so. West Virginia has the highest smoking and pregnancy rate (26.3%), with Washington, DC having the lowest rate (2.2%). However, the national goal of a 1% smoking and pregnancy rate has not been seen anywhere. Furthermore, since some women shield their smoking from their physicians we are certain the actual rates are higher than what is reported.
2. Continue with efforts to educate healthcare providers. Those providers working with low SES populations are not being reached or are not implementing interventions to assist their patients with quitting smoking.
3. Implement campaigns to reduce secondhand smoke exposure. Providers, health educators, counselors, and others working with low SES smokers should explain appropriate methods for eliminating exposure to secondhand smoke.
4. Partner with correctional facilities, the military, rehabilitation programs, and others to establish policies and tobacco cessation programs. Many participants indicated that policies do have an impact on their smoking behavior. In addition, by providing more cessation opportunities through non-traditional partners, situations in which people must quit temporarily can become opportunities for long term cessation.
5. Encourage state and local governments to fund tobacco prevention and cessation programs that specifically target low SES populations. Programs and resources must be tailored to low SES communities in order to see a reduction in consumption among this population. Unfortunately, many states, in light of budget deficits, are cutting tobacco programs that mostly benefit the poor.

## ACKNOWLEDGMENTS

National Association of Community Health Centers

West Virginia University, Prevention Research Center

West Virginia – Bureau for Public Health

Texas Department of Health, Office of Tobacco Prevention and Control

The Salvation Army - Central Territorial Headquarters

National Council on Alcoholism and Drug Dependence- South Bay

National Community Build, Inc.

National Commission on Correctional Health Care

Association of Gospel Rescue Missions

American Heart Association

## REFERENCES

U.S. Department of Health and Human Services. Reducing Tobacco Use: a report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2000

Centers for Disease Control and Prevention (CDC). Cigarette Smoking Among Adults – United States, 2002. Morbidity and Mortality Weekly Report, May 28, 2004. Vol.53, No. 20,

U.S. Department of Health and Human Services. Women and Smoking: a report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2001

## FOR MORE INFORMATION

***Janet Porter***

*NATIONAL NETWORK ON TOBACCO PREVENTION AND POVERTY*
*HEALTH EDUCATION COUNCIL*

*3950 Industrial Blvd., Suite 600*
*West Sacramento, CA 95691*

*(916) 556-3344 phone ❙ (916) 446-0427 fax*

*(888) 442-2836 toll free*

*www.**nntpp**.org*

***Robert H. Anderson***

*WEST VIRGINIA UNIVERSITY, PREVENTION RESEARCH CENTER*

*3820 HSC South*
*P.O. Box 9190*
*Morgantown, WV 26506*

*(304) 293-1828 phone ❙ (304) 293-8624 fax*

Prevention Research Center
Making a Difference in Appalachia

NATIONAL NETWORK *on* Tobacco Prevention *and* Poverty

Health Education Council

This project is supported by Cooperative Agreement Number #919140 from the Centers for Disease Control and Prevention (CDC), Office of Smoking and Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.