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

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)
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.

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 workplaces, 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 postpartum 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.
REFERENCES


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 I (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 I (304) 293-8624 fax

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