Maryland Department of Health & Mental Hygiene
Cigarette Restitution Fund Program
Tobacco Use Prevention and Cessation Program

Exploring Cultural, Psychosocial, and Environmental Factors Influencing Tobacco Use among Asian Americans, Hispanics, African Americans and American Indians in Maryland

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Health and Mental Hygiene

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STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street. Baltimore, Maryland 21201
Martin O'Malley, Governor. John M. Colmers, Secretary

Dear Fellow Marylander:

I am pleased to present this publication that is part of the on-going series of reports monitoring Maryland's progress in reducing the use of tobacco products. This document presents qualitative information on the use of tobacco products among minority adult populations. The information provided is based on a series of focus groups aimed at exploring cultural, psychosocial, and environmental factors influencing tobacco use among Asian Americans, Hispanics, African Americans and American Indians in Maryland.

The mixture or combination of research methodologies (quantitative data from the Maryland Adult Tobacco Survey, and the focus group data) provides complementary strengths and non-overlapping weaknesses to the Maryland tobacco strategy. For example, estimates produced from the Maryland Adult Tobacco Survey (e.g., Asians) may be too general for direct applications to specific local situations, and the categories used may not reflect local constituency's understanding. Qualitative research is useful for describing complex phenomena, and is especially responsive to local situations and stakeholder needs. Narrative can be used to add meaning to the numbers from the Maryland Adult Tobacco Survey, and insights and understanding can be added. Since the Maryland Adult Tobacco Survey has already been conducted, a sequential mixed methods design approach was performed.

This is another publication that contributes to our successes. Since 2000, Maryland has made very substantial progress in reducing smoking and tobacco use among racial and ethnic minority adult populations. The 2000-2006 Maryland Tobacco Studies Report informed a 24% decline in current cigarette smoking among African-American/Black adults; a 46% decline in current cigarette smoking among Hispanic/Latino adults; and a 15% decline in current cigarette smoking among White adults. This progress must continue, particularly with respect to those with lower educational attainment and income status. An adult with less than a high school education is more than four times more likely to be a smoker than a college graduate (26.0% vs. 6.1%). An adult earning less than $50,000 annually is almost twice as likely to smoke as is an adult earning more than that amount (20.0% vs. 10.4%).

While certainly applauding successes, it also must be recognized that a great deal more work must be done to preserve the positive changes achieved to-date, and to build on those for even greater successes in the future. We encourage using this document to identify and address determinants influencing a relatively higher tobacco use among certain adult minority populations and adults of low socio-economic status. In Maryland, we are committed to continue using a strategic approach allowing the revision and adjustment of our plans. We are confident that the data presented will significantly contribute to achieving our ultimate goals of reducing disparities in tobacco morbidity and mortality as well as eliminating disparities in tobacco behaviors.

There is no question that Maryland must strive for even greater future success. Smoking still causes disease and cancers in Maryland residents that result in an estimated $2 billion in medical care annually ($7.40 per pack sold). Government sponsored health care programs end up paying for at least 60% of these costs, adding $590 to the tax bill of the average Maryland household each year. And finally, we cannot forget the almost 150,000 Maryland residents who currently live with one or more cancers or other diseases caused by their smoking, or the estimated 6,800 who die prematurely each year as a result of their smoking.

Quitting can greatly improve the odds of avoiding a smoking-attributable disease or cancer, and the sooner one quits, the better the odds. Quitting is often not easy, but help is available with free smoking cessation counseling through local health departments and the Statewide 1-800-QUITNOW telephone cessation counseling service. Many of these programs can also assist with nicotine replacement therapy (i.e., nicotine patches and gum). As always, if you want additional information about Maryland's efforts to reduce the use of tobacco, please feel free to call your local health department about activities in your community, or the Center for Health Promotion, Education and Tobacco Prevention (410-767-1362) for information on Statewide initiatives.

Sincerely,

Carlessia A. Hussein, Dr.P.H.
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Office of the Secretary
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Executive Summary

The State of Maryland's Department of Health and Mental Hygiene (DHMH) has commissioned the development and implementation of the qualitative study "Exploring cultural, psychosocial, and environmental factors influencing tobacco use among Asian Americans, Hispanics, African Americans and American Indians in Maryland." This report is intended to serve as a tool for identifying and addressing determinants influencing a relatively higher tobacco use among certain adult minority populations and adults of low socio-economic status. For all four racial/ethnic minority groups, we recruited both smokers and ex-smokers to delve deeper than the quantitative phase can regarding issues that can help with future successful cessation and relapse prevention/management. We explored past successes of successful quitters, and the experience of quit attempts of current smokers, by using separate focus groups of successful quitters and current smokers.

A preliminary study including a literature review and an analysis of the *2006 Report on Disparities in Tobacco Use Behaviors by Adult Minority Populations in Maryland* enlightened the formulation of specific research questions for each racial/ethnic minority group sub-component. In addition, a brief standard set of questions was used that are common to all racial/ethnic groups so that comparisons can be made. A research study protocol was drafted by University of Maryland faculty and project staff, and reviewed and approved by University of Maryland and the Maryland Department of Health and Mental Hygiene Institutional Review Boards. The use of this methodology was crucial for collecting data aimed at improving our understanding of racial/ethnic smoking patterns and identifying strategic tobacco control opportunities.

Findings from this report together with the *2008 Report on Disparities in Tobacco Use Behaviors by Adult Minority Populations in Maryland* and the *2008 Maryland Tobacco Use Prevention and Cessation Logic Models* are important sources for developing effective decision-oriented evaluations. Planners, implementers, and evaluators working at both the local and the state levels can use this report to monitor progress in achieving short-term, intermediate, and long-term outcomes that will allow us to achieve our four program goals:

Goal #1 – Prevent Initiation of Tobacco Use.
This goal is to reduce initiation of smoking and tobacco use in Maryland among youth and adults.

Goal #2 – Reduce Disparities in Tobacco Use.
This goal is to reduce relatively higher tobacco use among certain youth and adult minority populations and adults of low socio-economic status.

Goal #3 – Reduce Exposure to Secondhand Smoke.
This goal is to reduce adult exposure to secondhand smoke in the workplace as well as to reduce under-age youth exposure to secondhand smoke.

Goal #4 – Increase Smoking Cessation.
This goal is to increase the number and proportion of adults who want to quit smoking, are trying to quit smoking, and who succeed in quitting smoking and use of other tobacco products.

It is important to emphasize that results from this study should be reviewed from a qualitative approach. The information presented cannot be generalized to all Maryland constituents as they are valid from the perception of the participants, and therefore is limited to the participants' opinions, knowledge, sources of information and specific socio-economic environments. This document consists of four chapters:

1. Understanding Latino Barriers to Access Available Smoking Cessation Services and the Use of Community Resources to Promote Smoking Cessation Services.

2. Understanding the Underlying and Proximate Determinants of American Indians' High Smoking Rates in Maryland.

3. Exploring Cultural, Psychosocial, and Environmental Factors Influencing Tobacco Use among Asian Americans in Maryland

4. Understanding cultural attitudes and environmental factors for tobacco use among African Americans in Maryland to inform smoking cessation programs

The following section highlights the findings on each of the four chapters.

CHAPTER I

Understanding Latino Barriers to Access Available Smoking Cessation Services and the Use of Community Resources to Promote Smoking Cessation Services

Preliminary data from the "2008 Maryland Minority Adult Report" indicates that the Latino population in Maryland is more knowledgeable than other ethnic/racial groups that smoking is physically addictive, that there are dangers to smoking while pregnant, that second hand smoking causes lung cancer and heart disease in adults and respiratory problems in children. However, the same data shows that Latinos use the different sources to obtain quit-smoking information less than all of the other ethnic/racial groups with the exception of radio.

Disparities in accessing smoking cessation information may impact dramatically the number of Latino residents at risk of developing diseases such as lung cancer and dying from these diseases over the coming decades. It is important to highlight that among all minority group in Maryland, the top reasons that influence former and current smokers to change their intention to quit are physical fitness, health problems and to be an example (e.g., serving as a role model). However, Latinos are less likely than other racial/ethnic groups to cite these reasons as reasons for changing their intentions to quit, with the exception of being an example. One possible explanation for this ethnic difference is that "being an example for others" is consistent with the strong family and social ties of the Latino culture. These Latino cultural values can be capitalized to reach out to the community for smoking prevention and cessation programs. Nevertheless, there is a need for in depth information that will complement available quantitative data that can help with future successful cessation and relapse prevention and management programs. In order to address these problems, this document developed and implemented a qualitative research consisting on 5 focus groups to:

- Informing the barriers and difficulties Latinos face in trying to quit and what they think will help them.
- Understanding the underlying characteristics that make some smoking cessation services more/less appealing to the Latino community.
- Understanding the configuration of Latino social networks and sources of information and how they can be used to promote available smoking cessation services as well as to disseminate smoking prevention and cessation messages.

Methodology

Five focus groups with Latinos females and males between the ages of 18 to 65 years old were conducted. A total of fifty-five respondents participated in all five focus groups. Participants who were current smokers but planned on quitting smoking were included in the smokers group (16 males, 18 females), while those who had already quit smoking at least six months ago were included in the non-smokers groups (12 males, 9males). Focus groups were

conducted in Montgomery County (Silver Spring/Wheaton) and in Prince George, MD (Langley Park/Bladensburg). Focus group participants were recruited from community locations such as community health clinics, Latino events, among others. All participants were provided with informed consent documents in English and Spanish. Focus groups themselves were held at accessible locations by bus or metro for the participants. Groups were facilitated by an experienced moderator, with two additional persons taking notes as back up to an audio-taping of each session. Each focus group lasted for around 2 hours. Audiotapes were transcribed verbatim and then coded and analyzed using qualitative software. Senior researchers developed the coding schemes, trained and supervised the coding (conducted by graduate or undergraduate assistants), and wrote the reports. Groups were conducted in community settings with the assistance of a community-based organization.

The following are the characteristics of each focus group:

- One focus group with males and females who smoke an average of 1-5 cigarettes a day in the past 30 days.
- One focus group with males who smoke 6 cigarettes or more in the past 30 days.
- One focus group with females who smoke 6 cigarettes or more in the past 30 days.
- One focus group with males who report having quit smoking and having no use of tobacco (not even a puff) during the past 6 months.
- One focus group with females who report having quit smoking and having no use of tobacco (not even a puff) during the past 6 months.

Research Findings

- The overwhelming majority of participants agreed that it was for personal health reasons that they quit smoking. Such as “When I go up the stairs, I get out of breath. I sometimes have to sit down”, “it makes me dizzy and gives me a stomach ache”, and “it makes my lungs hurt when I smoke too much”. Additional predominant reasons were: for their families and to set a good example for their children. Health as the primary personal reason to quit smoking was consistent across groups, smokers and ex-smokers, as well as men and women. For men smokers, the second most mentioned reason was cost, for women smokers it was family.

- The most challenging barrier for participants to quitting smoking were that participants became tempted to smoke again when they would see/smell other smoking, either socially or at work. In their words, “Seeing others smoke awakes my desire to smoke”, “I see a movie with everyone smoking, and I want to”, and “Others that offer you cigarettes”. The second most cited was because they felt anxious, depressed or stressed and they felt them needed the cigarettes

to relax them. For example, “I have anxiety and depression and it calms me” and “you get depressed and lonely at night so you smoke”. For men smokers and ex-smokers, the most common barrier mentioned was seeing/smelling others smoke, while for women smokers and mixed gender smokers, the most commonly mentioned barrier was the relaxing sensation they felt from smoking that relieved them of their anxiety, depression or stress. For women ex-smokers, the most common barrier was that they had a spouse that smoked.

- The three most common methods for participants to quit smoking mentioned were will power; using another oral alternative/keeping mouth busy; and finding another activity, whether recreational or educational. For men smokers and mixed gender smokers, the most common method used was to use another oral alternative/keep mouth busy, while for men and women ex-smokers the majority used will power.

- The overwhelming majority of participants indicated that social factors/friends were very influential in perpetuating the cycle of smoking. A trend in responses was that participants were tempted to smoke at social gathers, either to be accepted or part of the group, or to impress the opposite sex. Most participants in all groups tended to agree that the use of alcohol was highly associated with smoking.

- The majority of participants were unaware of smoking cessation services available to Hispanics in Maryland. Very few respondents had heard of the 1-800-quit-now service, but for those who had, nobody had called it. Nobody have specific reasons for not having called, except one respondent said because it seemed like it was in English.

- Participants generally agreed that health promoters were the best method for smoking cessation among Hispanics.

CHAPTER II

Understanding the Underlying and Proximate Determinants of American Indians' High Smoking Rates in Maryland

It's well known that American Indians in the United States have the highest rates of tobacco use compared to other ethnic and racial groups. This national-level disparity is also evident in the state of Maryland. Data from the "2008 Maryland Minority Adult Report" indicates that American Indians consistently reported the highest rates of current tobacco use (23.6%) and exposure to second hand smoke in the car (29.6%) and in the workplace (29.6%). In addition, American Indian smokers smoke an average of almost a pack of cigarettes a day (19.9 cigarettes), more than any other racial/ethnic group.

American Indians are a small minority in Maryland, and little is known about why their smoking rates are so high or what can be done to address this problem. To develop effective smoking cessation programs that are responsive to the needs of the target population, it is essential to understand smokers' own perspectives on tobacco use and the quitting process. This document describes a qualitative study developed to inform the design and delivery of smoking cessation and health promotion programs for American Indians in Maryland. The study sought to illuminate the social and cultural contexts of tobacco use, identify barriers to quitting, and explore perceptions on various smoking cessation techniques and intervention approaches.

Methodology

Four focus groups were conducted with a total of thirty-five American Indian participants in late 2008. Participants included seventeen males and eighteen females between the ages of 18 and 65. Twenty-one of the participants planned on making a quit attempt in the next 6 months, five were unsure if they would, four were not planning to quit, and five were former smokers who had already quit. Participants hailed from urban areas (Baltimore and the surrounding Metro area). Focus group participants were recruited via outreach by a local community-based American Indian service provider (the LifeLines Community Native American Program). All participants provided informed consent, with documents in English.

Groups were facilitated by an experienced moderator. The moderator utilized a semi-structured question guide developed in collaboration with the community-based service provider and senior study personnel. Each topical area was augmented with contextual probes to further illuminate participants' perspectives on key issues. Special techniques were used to facilitate discussion, primarily a card sort exercise in which participants ranked twelve different smoking cessation strategies and service delivery venues, with each participant's marginal selections (best and worst) discussed and debated in the group setting. Each focus group lasted for approximately 2 hours. Each session was audio-recorded, transcribed, and analyzed qualitatively using an iterative coding strategy to identify emergent themes in the narratives.

Research Findings

Social and Cultural Aspects of Tobacco Use

- A minority of participants had personal experiences using tobacco ceremonially, but only two reported currently using tobacco in a ceremonial way on a regular basis. The history of tobacco use in American Indian cultures was perceived differently by different participants. For example, one individual stated bluntly that the history of ceremonial tobacco use among American Indians *"means that I can smoke cigarettes."* However, another participant noted that she quit smoking (and other unhealthy behaviors) when she re-committed herself to her cultural traditions, perceiving cigarette use as incompatible with using tobacco in a religious, ceremonial way.

- Some participants linked the high rates of cigarette use among American Indians in Maryland as a natural consequence of a history of tobacco farming as a subsistence strategy among some tribes whose members migrated to the area.

Reasons to Quit and Barriers

- The most frequently mentioned reasons to quit were individual health, the cost of cigarettes, bad smell/taste, setting a better example for children and youth, and the harmful effects of second-hand smoke on family members. Many participants noted that they knew friends or family members who had died from smoking-related illness or were living with severe health repercussions from smoking.

- Cigarettes were viewed as a complex addiction. Participants also reported stress relieving functions of smoking, noting life stressors arising from low socioeconomic status and opportunities. The ubiquity of cigarette use in urban environments in general and among participants' social networks specifically (friends and family) was viewed as a major barrier to successful smoking cessation.

- Cultural values of self-reliance may adversely impact willingness to utilize available health and preventive services.

Perspectives on Cessation Strategies

- The importance of willpower and individual responsibility for making the decision to quit were recurrent themes in the focus groups, sometimes to the extreme that interventions or cessation programs were viewed as ineffective. The following quote reflects the general sentiment that successful smoking cessation starts and ends with the individual and their own capacity for

changing behavior: *"You can't motivate somebody [to quit smoking] unless they want it. It's impossible."*

- Participants were most receptive to strategies and interventions that emphasized empowerment for behavior change and utilized targeted messaging with culturally-relevant concepts and symbols.

- "Encouragement from Family and Friends" was mentioned frequently by participants as a potentially important ingredient for successful smoking cessation. As one participant noted: *"I think the opinions of people close to me, about my health, are more valuable to me than those of a physician or dentist."* Ironically, widespread use of cigarettes among social network members was also seen as one of the most persistent impediments to smoking cessation.

- Mainstream medical approaches (e.g., medications and nicotine replacement therapy) and delivery agents (e.g., healthcare professionals) were generally viewed as playing an important role in smoking intervention, although perceptions of their usefulness varied. In every focus group, participants described adverse reactions and side-effects with nicotine replacement therapy; however, participants also reported incorrect use of these products (for example, chewing the gum incorrectly, continuing to smoke with the patch, or sleeping with daytime-only patches).

Recommendations

- The focus on willpower and individual agency among focus group participants suggests that it may be useful to more explicitly position interventions (e.g., advertisements, informational resources, behavioral support programs, medications, etc.) as mechanisms to motivate, empower, and support individuals in their decisions to quit smoking.

- Community-level, social network, and/or family-based interventions that aim to change smoking behaviors and foster social support to prevent relapse to cigarette use may be worthy of consideration.

- Culturally-specific messages and symbols could enhance the impact of advertising, informational resources among American Indian target audiences.

- Some American Indians in urban areas may experience disintegration of cultural belonging. Interventions targeting American Indians should explicitly confront the misconception of recreational cigarette use as a legitimate extension of the cultural use of tobacco for ceremonial purposes, providing alternative opportunities for cultural learning and expression whenever possible.

- Explicit messages about the adverse health effects of smoking relying on compelling visual images may have added resonance.

- Programs using nicotine replacement therapy or medications may want to consider providing additional education about the proper use of these products and the importance of using them as directed.

- Some participants noted that they were able to limit their cigarette use by not smoking indoors. A campaign urging smokers to avoid smoking indoors may be a public health strategy that could reduce harms to the individual smoker who is not ready to quit (by presumably reducing consumption quantity) as well as others in the household by reducing the effects of second-hand smoke.

CHAPTER III

Exploring Cultural, Psychosocial, and Environmental Factors Influencing Tobacco Use among Asian Americans in Maryland

Although Asian Americans are a very diverse group of people originating from many different countries and they have separate and distinct social and cultural backgrounds that may influence smoking, there has been no data collected that thoroughly examined smoking behaviors of various subgroups of Asian Americans in Maryland. Furthermore, existing survey data collected in aggregated Asian Americans in Maryland has been too general, too broad, and lacking in depth of information. In order to address this problem, this document developed and implemented a qualitative study including four focus groups to:

- Explore the knowledge, attitudes and practices of Asian-American former smokers for quitting smoking. Which techniques and approaches were most used for quitting smoking? Which techniques have not been helpful?

- Identify the barriers and difficulties Asian Americans who are current smokers face in trying to quit, and explore their perception on which techniques they believe will be the most effective.

- Understand the roles culture and society on both smoking and smoking cessation within the Asian -American community and explore how they can promote available smoking cessation services and smoking prevention and cessation messages.

Methodology

We conducted four focus groups in four major Asian American communities (Asian Indian, Chinese, Korean, and Vietnamese) in August 2008 within the state of Maryland. The Asian Indian, Chinese, Korean, and Vietnamese communities were selected because they are the four larger Asian American groups in Maryland and smoking rates of originating countries are very high (56%-67% in men). The Asian Indian focus group was held in a community center located in Rockville, MD, both Chinese and Korean focus groups were conducted on University of Maryland campus, and the Vietnamese focus group was conducted in a community center located in Wheaton, MD. A total of forty-three respondents participated in all four focus groups (11 Asian Indians, 12 Chinese, 12 Koreans and 10 Vietnamese). Open-ended questions were used to collect qualitative data on cultural, psychosocial, and environmental factors that influence tobacco use. Additionally, recommendations for the development of community-specific smoking cessation programs were discussed. All participants were provided with informed consent documents in English and in Vietnamese, Chinese, Hindi or Korean. We used MAX QDA to code emergent themes and analyze data. The emergent themes were organized by major categories that were identified during the analysis. Groups were facilitated by an experienced moderator, with two additional persons taking notes as back up

to an audio-taping of each session. Each focus group lasted for around 2 hours. Audiotapes were transcribed verbatim and then coded and analyzed using qualitative software. Senior researchers developed the coding schemes, trained and supervised the coding (conducted by graduate or undergraduate assistants), and wrote the reports. Community-based organizations provided assistance in recruiting participants.

The following are the characteristics of each focus group:

- Out of 43 participants, 31 (72%) of them were current smokers and 12 (28%) were past smokers.

Research Findings

- Many themes were common to all of the four Asian American groups. Social and cultural influences played a major role in the smoking behaviors of the participants as a majority of the participants cited social smoking as a key component of their culture. Peer groups and co-workers were the major social networks that influenced their smoking behaviors.

- Immigration to the United States influenced many of the participants' smoking behaviors. For some of the participants, immigration increased their smoking rate, while it decreased their smoking rate for others.

- Generally, gender had a significant impact on smoking perceptions as male and female smokers were often treated differently. Generally, female smoking was identified as a stigma, while male smoking was perceived as "masculine" and "macho". Most participants were aware of the negative health consequences of smoking, but this was not necessarily a motivation to quit.

- Many of the past smokers quit without seeking any external help, rather they relied on self-control and willpower. Some individuals found that social support was crucial to their quitting.

- Some of the barriers to quitting included: physical addiction, and the enjoyable effects of smoking such as increased relaxation and concentration. Participants did not utilize smoking cessation programs. Few of the participants were aware of the 1-800-Quit-Now program, but none of them had used it as a smoking cessation aid.

- Some trends also emerged that were specific only to certain groups. The Vietnamese American group identified certain experiences, such as being a war refugee and being held in concentration camps, as influences on their smoking behavior. Both of these experiences were very stressful and encouraged their smoking. The Asian Indian American group identified the popularity of bidis in their community, which is a unique tobacco product that most other groups did

not mention. The Chinese American group stressed on the fact that smoking was integrated into many cultural traditions such as celebrations like weddings, Chinese New Year, and other social gatherings; additionally, there is the tendency to give cigarettes as gifts. The Korean American group identified men joining the Korean army (26-month military services is mandatory for all Korean men), as a main site of smoking initiation because of pressure from superiors and the perception that smoking was manly.

Recommendations

- Smoking cessation programs need to focus on increasing their visibility. Smoking cessation programs should utilize community specific communication channels to effectively reach their audience including community based organizations: faith based organizations; community specific medias such as newspapers, radio, and television stations; grocery stores; and restaurants.

- Both educational materials and programs should be linguistically appropriate and culturally sensitive. Healthcare professionals and former smokers can be used as credible and trust-worthy educators in smoking cessation educational programs.

CHAPTER IV

Understanding cultural attitudes and environmental factors for tobacco use among African Americans in Maryland to inform smoking cessation programs

Although African Americans tend to smoke fewer cigarettes per day and have a later onset of smoking initiation when compared to other racial/ethnic groups, they suffer disproportionately higher rates of lung cancer and other tobacco-related disease. In order to address this problem, this document developed and implemented a qualitative study including four focus groups aimed at:

- Understanding the cultural attitudes and environmental factors influencing tobacco use among African Americans in diverse (urban, suburban and rural) regions of Maryland.

Methodology

Ten focus groups were conducted in 4 regions of Maryland: two (one group of smokers and one of ex-smokers) in Region 1-Baltimore City; Six (three groups of smokers and three groups of ex-smokers) in Region 2-Suburban Maryland (Prince George's county); and two (one group of smokers and one of ex-smokers) in Region 6-Lower Eastern Shore (one group of ex-smokers in University of Maryland Eastern Shore and one group of smokers in Somerset county). The study entailed asking open-ended questions about smoking initiation, smoking behaviors specific to the community as well as cultural attitudes toward smoking and the resulting barriers to accessing cessation programs; all of which will lead to recommendations for the development of community-specific smoking cessation programs. The core questions examined participants' views in the broad domains of (a) the cultural and social contexts of tobacco use; (b) experiences with and attitudes towards quitting; and (c) perceptions of specific intervention approaches, delivery agents, and venues. Groups were facilitated by an experienced moderator, with two additional persons taking notes during each session as back up to an audio-taping of each session. Each focus group lasted for about 2 hours. All participants were provided with informed consent documents in English. Audiotapes were transcribed verbatim and then coded for dominant themes and analyzed using qualitative software. Senior researchers developed the coding schemes, trained and supervised the coding (conducted by graduate or undergraduate assistants), and wrote the reports. Groups were conducted in community settings with the assistance of a community-based organization. The following are the characteristics of each focus group:

- Out of 67 participants, 43 (64%) of them were men, 43 (66%) of them were age 30 or less and the ages ranged from 18 to 70.
- The mean quit attempts were 5.1, with 1.6 for current smokers and 9.9 for ex-smokers. The median of daily cigarette use of the currently smoking participants was 6.5, and 79.4% of them were planning to quit in next 6 months.

Research Findings

- Most participants in all groups felt that smoking was harmful, pointing to shortness of breath, headaches, cancer, and other health effects as well as the cost of cigarettes. Several referred to it as a "nasty" or "bad" habit. There were some, however, who believed that smoking was not a harmful habit overall but could be harmful for certain categories of people, notably children, pregnant women, older people, and people with health problems. Some felt that smoking was not harmful.

- Smokers and ex-smokers agreed that smoking was trendy, though ex-smokers tended to think it was not as trendy as it used to be. Many smokers and ex-smokers said they had begun smoking because everyone else around them did. Most had been introduced to smoking by a friend or family member. When asked "who smokes or uses tobacco in your community" many smokers said "everybody" or "almost everybody" and there was general agreement that smoking was not confined to any particular groups or categories.

- When asked why mentholated cigarettes seemed to be so popular with African Americans, the most frequent responses among both smokers and ex-smokers related to the taste and sensation of the inhaled smoke. Some suggested advertising or imitation of others as motivating factors. In a three groups the belief that menthol cigarettes are stronger or higher in nicotine was voiced. Some attributed it to the way in which mentholated cigarettes were marketed.

- In all of the smoker groups, participants said they had thought about quitting smoking, some of them think about quitting "a lot" or "all the time." The most frequent reasons given were: their own health, the cost of cigarettes, and concern for others, particularly their children. Many smokers said their spouse/partner had tried to get them to stop smoking. Children and grandchildren were also mentioned. Some mentioned that health insurance and life insurance are more expensive for smokers. Ex-smokers gave similar reasons but were more apt to mention the smell of tobacco that clings to a smoker's clothes or makes their breath smell bad. About 2/3 of the smokers had tried to quit smoking at least once, over half reported trying to quit more than once.

- The most common reasons given by smokers and ex-smokers for resuming smoking after failed quit attempts in the past were: a craving for nicotine, missing cigarettes in general or at certain times (when drinking, after a meal, with morning coffee), stress or "aggravation, and being around family or friends who smoked. In all smokers' groups there were individuals who expressed serious doubts about their ability to stop smoking, even when they were motivated to do it.

- Many ex-smokers mentioned avoiding triggers as their primary smoking cessation tool used in successful quitting. The primary triggers mentioned were

exposure avoidance strategies such as, not socializing with people who smoked, not drinking alcohol, not going to bars, or avoiding stressful situations.

- Few smokers or ex-smokers were aware of any specific community programs that offered help with smoking cessation and none had used such a program. Most had not heard of the Maryland Quit Line. A theme that was mentioned all of the groups involved not using nicotine replacement therapy (NRT) when it had been offered or not participating in smoking cessation programs even when they were available.

Recommendations

- Emphasize negative health effects of smoking, including health examinations that can reveal harmful effects of smoking on participants and demonstrate health improvements subsequent to smoking cessation.

- Increase smokers' awareness that smoking can make them less attractive because it smells bad and makes them smell bad.

- Provide more information about resources to aid in smoking cessation.

- Strengthen smokers' sense of self-efficacy and confidence in their ability to quit smoking.

- Offer financial incentives for participating in programs and for smoking cessation.

- Locate smoking cessation programs in areas where community members naturally aggregate: churches, schools, workplaces, and apartment complexes.

- Use a variety of people to educate people about smoking cessation: doctors, nurses, and are appropriate, but it is also very important to include ex-smokers, celebrities who have stopped smoking, young role models respected in the community and local firefighters, police, or community leaders who can command the respect of people in the community.

- Consider developing a 12-step-based peer-support smoking cessation program that provides mentors (sponsors) and holds a variety of regular drop-in meetings similar to those of 12-step programs.

- Experiment with innovative ways of marketing smoking cessation models, including but not limited to: outreach outside of stores where cigarettes are sold, word of mouth, fliers, radio or television ads, ads on MySpace, sponsorship of broadcast sports events or teams, and focus groups , and printed t-shirts.