

ENVIRONMENTAL FACTORS AFFECTING THE INITIATION AND CESSATION
OF TOBACCO USE AMONG AFRICAN AMERICAN MEN AGES 18 TO 40: A
REVIEW OF THE LITERATURE

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CHAPTER I

THE PROBLEM

Introduction

Identifying and eliminating health disparities has increased in importance over the last decade among health education and health promotion programs nationwide. Historically, public health initiatives addressing the general population were not always effective in reaching specific racial and ethnic populations. African Americans, particularly African American men, have experienced health disparities that are disproportionate to the general population, yet received little attention in terms of public health initiatives over the years. Famed civil rights leader, Martin Luther King, Jr., stated “of all the forms of inequality, injustice in health care is the most shocking and inhumane” (Good Reads, 2009). Nothing is more poignant than these words as they apply to the national public health system’s disregard for the needs of minority populations until recent years. The need to implement population-specific programs should be a priority among national, state and local public health agencies and every health education professional.

Identifying and eliminating tobacco-related health disparities is at the forefront of national tobacco control programs. In 2002, Indiana took the lead in addressing health disparities when it developed its first strategic plans targeting such health inequities. Using qualitative and quantitative data, the strategic plan identified populations with tobacco-related health disparities using qualitative and quantitative data as well as aggressive marketing tactics by the tobacco industry to target racial and ethnic minorities.

In Indiana's strategic plan for identifying and eliminating tobacco-related health disparities, there is significant emphasis on the impact that tobacco use has had among African American men ages 18-40. This specific population group has been negatively impacted by the effects of tobacco industry targeting, and the disproportionately high tobacco-related morbidity and mortality, indicates a public health emergency. But because tobacco products are legal and have been available for centuries, public perception and/or acceptance of tobacco use has masked the atrocities that have occurred due to its consumption. Also, the plight of African American men goes beyond the realm of health disparities into areas of social, economic and educational inequities. These inequities may even contribute to the overall health of African American men and the reasons for their tobacco use and other unhealthy behaviors.

Environmental, social and even historical implications lie within the context of how tobacco use impacts African American men. Until public health professionals makes a concerted effort to change the current trend of tobacco use among African American men, the health impacts will continue to contribute to the plight of African American men and their families.

Statement of the Problem

The problem of the study was to investigate the environmental influences on tobacco use initiation and cessation among African American men ages 18-40.

Purpose of the Study

In developing tobacco control programs it is imperative to the success of any program to identify the potential barriers that affect the participation of special populations. The purpose of this paper was to identify environmental influences that impact African American men in their behaviors related to tobacco use and cessation efforts, and to identify the barriers faced by tobacco control advocates as well as public health professionals when developing health education programs for this population. Along with identifying the barriers, some recommendations will be provided to assist in overcoming these barriers and for tobacco control advocates and public health professionals to become more culturally competent in reaching African American men within the ages of 18-40.

Knowledge of these environmental influences and recommendations for improving population-specific tobacco control programs will be useful in enhancing the effectiveness of tobacco prevention and cessation programs for African American men and most importantly will reduce the tobacco-related disparities experienced by this population.

Significance of the Study

The Centers for Disease Control and Prevention/Office on Smoking and Health (CDC/OSH) has made it a priority for states to develop a strategic plan to identify and eliminate tobacco-related health disparities. Although CDC/OSH has developed state-

level requirements and national networks focused on eliminating disparities, effective tobacco use prevention and cessation programs reaching African American men has been limited or completely absent. Research studies on cessation initiatives in the African American community have had limited response in the number of participants, particularly among African American men. It is not uncommon for many minority populations to have trepidations when participating in research and trial studies due to mistrust of the researchers, and of the public health system itself.

The fact that African American men suffer disproportionately from lung cancer compared with other racial groups is an important reason why more information needs to be obtained on the impact tobacco use has on African American men compared to other populations to assist in eliminating this disparity. Tobacco control advocates must be empathetic of the social, cultural and historical factors that lead to the tobacco use behaviors of African American men. Identifying environmental influences on the initiation and cessation of tobacco use among African American men can provide information to develop effective tobacco prevention and intervention programs be established for this population. Efforts in cessation programs specifically tailored to the African American community have had challenges as well, and more knowledge on the environmental influences to encourage cessation will increase successful quit attempts among African American men. Finally, little is known about the factors that contribute to tobacco use behaviors among African American men despite the fact that they suffer from more health disparities than other racial populations in the U.S.

Delimitations

The study was delimited by the following:

1. Literature reviewed was retrieved from databases covering the period from 2002 to 2008.
2. Data on tobacco use among the African American population were collected during a seven-year period from 2002 through January, 2009.
3. The databases were accessed utilizing the MultiSearch tool available through the Ball State University library services.
4. Literature on the need to address tobacco use among African American men included Smokefree Indiana's focus group research study relevant to the factors that contribute to the initiation and cessation of tobacco use.
5. Smokefree Indiana's focus group research study on African American men and tobacco use was conducted over a six-month period in 2007
6. Smokefree Indiana's focus group research study on African American men and tobacco use utilized samples that included up to ten African American men ages 18 to 35 years old.
7. Smokefree Indiana's focus group research study on African American men and tobacco use was facilitated by a peer from the sample population and was directed by a facilitator's guide of questions provided for open discussion. Two separate focus group discussions were conducted, with verbal transcripts and video recordings collected as data.

8. Data collected using video and transcript recordings of the focus groups were analyzed and common themes and ideas shared by the focus group participants were extracted from the information.

Limitations

This study was limited by the following factors:

1. The researcher found that quantitative research specifically on African American men and tobacco use was limited.
2. Much of the data found in the research included studies on African Americans in general and the researcher extrapolated information within the studies that pertained to African American men.
3. The focus group research study conducted by Smokefree Indiana addressed tobacco use among African American men ages 18 to 35, and the limited attention to the process used for the data analysis can affect the significance of the study.

Assumptions

The basic assumptions of the study were as follows:

1. The literature reviewed was conducted in a systematic and unbiased manner by the author.
2. A concerted effort was made to fairly describe the findings of the research as representative of the total articles available on the topic.
3. Qualitative research was selected over quantitative research in pursuit of more descriptive information would have been constrained by quantitative data collection processes.

Research Question

What are the environmental influences on the initiation and cessation of tobacco use among African American men ages 18 to 40 years old?

Definition of Terms

For consistency of interpretation the following terms are defined:

1. African American – a person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black, African Am., or Negro," or provide written entries such as African American, Afro American, Kenyan, Nigerian, or Haitian. In regard to this research topic, this would include Black racial groups of non-Hispanic origin (U.S. Census Bureau, 2000).
2. Environmental Influences – factors that contribute to a certain behavior that are external in nature. This includes familial, social, economic or historical influences.
3. Health disparities – A particular type of difference in health (or in the determinants of health that could be shaped by policies) in which disadvantaged social groups systematically experience worse health or more health risks than do more advantaged social groups. Disadvantaged social groups include racial/ethnic minorities, low-income people, women, or others who have persistently experienced discrimination (Braveman, 2009).
4. Tobacco control – A comprehensive approach to tobacco use prevention and cessation that includes implementing tobacco-free policies to protect individuals from secondhand smoke exposure, providing education to prevent

tobacco use among youth, reducing tobacco use among adults and eliminating tobacco-related disparities.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The problem of the study was to investigate the environmental influences on tobacco use initiation and cessation among African American men ages 18-40. The literature review for this chapter is presented under the following topics: (a) literature review methodology, (b) cigarette smoking prevalence in the U.S., (c) the health impact of cigarette smoking in the U.S. and among African American men compared to other racial or ethnic groups, (d) ingredients in cigarettes and consumption by African American men, (e) environmental influences on the initiation of cigarette smoking, (f) environmental influences on the cessation of cigarette smoking, (g) summary.

Literature review methodology

The methodology of the literature review involved the location of information from several sources such as peer-reviewed journals, public health publications related to the topic, and government or non-profit public health agencies. Several sets of data focusing on African Americans and tobacco use were gathered in 2002 by the researcher during the development of the Smokefree Indiana's strategic plan for the identification and elimination of tobacco-related disparities. Other procedures for conducting the literature review involved the identification of literature utilizing the databases available through the Ball State University libraries.

Access through the MultiSearch database webpage

<http://www.bsu.edu/libraries/databases/> assisted the researcher in searching all available databases on the research topic. MultiSearch is a relatively new service provided by Ball State University that attempts to streamline the literature search process for its users. It allows you to search a wide variety of databases simultaneously or conduct a search using a particular database. When using the MultiSearch tool by subject area, results are presented together and a clustering feature allows you to narrow in on specific subjects and terms as you view the search. Databases are categorized under each section in order to provide a more efficient search within the university libraries. The researcher chose this research tool because of its simplicity and efficiency of searching all the databases available in the university libraries.

Users of the MultiSearch search option can conduct the search by selecting the following categories:

- Words found anywhere in the document
- Author
- Title
- Subject
- Keywords
- Full text
- Abstract
- ISBN
- ISSN

The researcher selected the options “words found anywhere in the document”, “title”, “subject”, and “keywords” while conducting the research using the MultiSearch tool. The categories provided significant results concerning the topic being investigated. The following subjects are listed under the basic MultiSearch option:

- Art and Architecture
- Business
- Education
- History
- Humanities
- Law
- Music
- News
- English and Linguistics
- General
- Health
- Philosophy & Religion
- Psychology
- Science
- Social Science
- Technology

The researcher began the search utilizing all subject areas before narrowing down the search to the following subject areas: (a) Health, (b) Education, (c) General, (d) Psychology, (e) Social Sciences, and (f) Science. The researcher found that these subject areas resulted in more extensive results related to tobacco use compared to the other subject headings or selecting the subject area of health alone. Nine databases accessed during the search included: (a) CINAHL, (b) CQ Researcher, (c) ERIC, (d) Gale Virtual Reference, (e) GreenFile, (f) MEDLINE, (g) ProQuest, (h) Web of Science, and (i) Worldcat.org. The researcher compiled all the databases that were accessed through MultiSearch and created a database matrix that lists all eight databases in alphabetical order detailing the name of the database, subject heading, and type of materials in the database (see Figure 1).

The researcher used the thesaurus of the MultiSearch tool to determine what key words to use when conducting the database search. The following terms were found to be the most helpful during the search:

- Adolescent
- Cessation

- African American
- Black
- Environmental influences
- Ethnic
- Family influence
- Genetic
- Influence
- Initiation
- Mentholated cigarettes
- Men
- Peers
- Predictors
- Delinquent behavior
- Environmental factors
- Quitting
- Racial
- Youth
- Smokers
- Smoking
- Tobacco
- Tobacco control
- Tobacco industry targeting
- Young adult

The following parameters were followed in identifying related literature once the research tool was identified and the key words were selected. The first parameter of the study was to include literature that focused on cigarette smoking prevalence in the United States. Statistics from other nations would only be stated in comparison with studies conducted in the United States. The second parameter was to include literature published only in the United States. The third and final parameter of the study was to search for articles published from 1995 to 2009.

Figure 1. Database Matrix

Database	Subject Heading	Database Time Period Covered	Type of Materials Indexed
CINAHL	Nursing and Allied Health	1981 to present	Journals
CQ Researcher	Health, Education	1991 to present	Online editorial reports
ERIC	Education	1966 to present	Journals
Gale Virtual Reference	General	Current	Encyclopedias and specialized reference sources
GreenFile	Environmental, Biosciences	1970s to present	Publications
MEDLINE	Medical, Nursing, Dentistry, Pre-clinical Sciences	Current	Journals, publications
ProQuest Nursing and Allied Health Source	Health & Nursing	1894 to present	Journals
Web of Science	Sciences, Social Sciences, And Arts And Humanities	Current	Journals, international conference reports
WorldCat	General	Current	Books and other materials in libraries worldwide

Cigarette smoking prevalence in the U.S.

Tobacco use in the form of cigarette smoking is one of the most prevalent unhealthy lifestyle behaviors in the United States. According to the Centers for Disease Control and Prevention's Office on Smoking and Health, more than 45 million adults in the U.S. smoke. Cigarette smoking is more common among men than women, with men at 23.9% and women at 18.0%. Prevalence rates by age include 23.9% for ages 18-24, 23.5% for ages 25-44, 21.8% for ages 45-64, and 10.2% for ages 65 and older. Individual states have been identified as having either higher prevalence of cigarette smoking or the lower prevalence compared to other states. State-specific estimates have identified Kentucky, West Virginia, Oklahoma and Mississippi as having the highest prevalence of smoking with rates of 29.1%, 27.9% and 27.9% respectively. States with the lowest estimates included Utah at 10.4%, California at 18.5%, Massachusetts at 18.5%, and Montana at 18.5%. States with the highest prevalence of smoking among men included Kentucky at 29.1%, Mississippi at 27.9% and Oklahoma at 27.9%. The lowest estimates of smoking among men were in Utah, California, Massachusetts and Montana at 10.4%, 18.5%, 18.5% and 18.5% respectively. Estimates for cigarette smoking among women identified Kentucky at 28.1%, West Virginia at 26% and Alaska at 22.9% as having the highest prevalence. Utah at 9.2% and California at 11.4% are the lowest in smoking prevalence among women (Centers for Disease Control and Prevention, 2007).

It is illegal for a person under the age of 18 to purchase tobacco products, yet cigarette smoking is prevalent among youth. Over 3 million, or 20%, of high school students have used tobacco products in the last 30 days. More than 3,000 youth under the age of 18 experiment with tobacco for the first time with more than 1,000 youth under the

age of 18 becoming regular daily smokers, according to the Campaign for Tobacco-Free Kids (2009a).

Smoking prevalence among specific populations such as ethnic/racial populations, low-educated, or low-income populations vary greatly. Estimates among ethnic and racial populations find that cigarette smoking prevalence is highest among American Indians/Alaska Natives at 32.4%. African Americans follow with a prevalence of 23%, Whites at 21.9%, Hispanics at 15.2% and Asians (excluding Native Hawaiians and other Pacific Islanders) at 10.4%, (Centers for Disease Control and Prevention, 2007).

Smoking prevalence according to education level is highest for adults with a General Education Development (GED) diploma at 45%, and for adults with 9-11 years of education at 35.4%. Adults with the lowest prevalence according to education level are adults with an undergraduate college degree or a graduate college degree, with estimates 9.6% and 6.6% respectively. In relation to income levels and smoking prevalence, adults living below poverty level have a higher prevalence of smoking at 30.6% compared to adults living at or above the poverty level at 20.4% (Centers for Disease Control and Prevention, 2007).

Progress has been made on reducing tobacco use prevalence nationwide. The U.S. Department of Health and Human Services (2008) found that adults age 18 and over reduced cigarette smoking from 24% in 1998 to 21% in 2006. The decrease was consistent during the same time period for all racial and ethnic groups where data were available for the age-adjusted proportion of adults who smoked cigarettes. American Indians/Alaska Native smokers decreased from 35% to 27%; non-Hispanic Blacks from 25% to 22%; non-Hispanic Whites from 25% to 23%; Hispanics from 19% to 15%; and

Asians from 13% to 11%.

Despite the rate of decrease in adult cigarette smoking, this improvement is not sufficient to meet the Healthy People 2010 objective of 12% (U.S. Department of Health and Human Services, 2008). The rates of improvements are also not sufficient to meet the objectives for cigar smoking, use of smokeless tobacco, and attempts at smoking cessation.

The health impact of cigarette smoking in the U.S. and on African-American men

Cigarette smoking is the number one most preventable cause of morbidity and mortality, causing 5 million deaths worldwide each year (World Health Organization, 2008) with an estimated 440,000 deaths per year attributed to smoking in the U.S. alone (U.S. Department of Health and Human Services, 1998). About 8.6 million people in the United States have at least one serious illness caused by smoking (Centers for Disease Control and Prevention, 2002). According to the Campaign for Tobacco-Free Kids (2009a), smoking kills more people than car accidents, alcohol, AIDS, illegal drugs, murders, and suicides combined.

The 28th Surgeon General's report (U.S. Department of Health and Human Services, 2004) revealed for the first time that smoking causes diseases in nearly every organ in the body, and linked tobacco use to diseases such as pneumonia, periodontitis, and cancers of the cervix, kidney, pancreas and stomach. Tobacco use is a major contributor to heart disease, where people under 40 are five times more likely to suffer from a nonfatal heart attack if they smoke. In a recent study, tobacco use was responsible for two thirds of heart attacks in men and for over half in women, between ages 35 and 39 (Mähönen, McElduff, Dobson, Kuulasmaa, & Evans, 2004). Tobacco use is also a

major contributor to stroke. Young women who smoke cigarettes are at a heightened risk of ischemic stroke which increases with the number of cigarettes smoked per day (Bhat et al, 2008). Young women who smoke have more than double the risk of ischemic stroke compared to nonsmoking women, with those smoking the most among them having nine times the risk. A similar finding was made for men who smoke and their increased risk for hemorrhagic stroke. Kurth and colleagues (2003) found that the risk of hemorrhagic stroke in men increases proportionately with the number of cigarettes smoked. Interestingly, both studies found no difference in risk for ischemic or hemorrhagic stroke when comparing former smokers to those who have never smoked, indicating the reduced health risk of quitting smoking.

The impact of cigarette smoking as it relates to cancer-related deaths is the most dramatic. Smoking is responsible for 87% of all lung cancer in the U.S. (Okuyemi, Ebersole-Robinson, Nazir, & Ahluwalia, 2004). Deaths due to lung cancer are higher than all cancer-related deaths, including breast and prostate cancer combined (American Cancer Society, 2009). Smoking is not only responsible for the preponderance of lung cancer incidence, but in recent years has even been linked to other forms of cancer. In addition to links between tobacco use and cancers of the cervix, kidney, pancreas and stomach (U.S. Department of Health and Human Services, 2004), a recent study found that cigarette smoking accounted for up to 50% of all cases of bladder cancer (Strope & Monte, 2008).

Out of the over 440,000 Americans that die each year from tobacco-related illnesses, an estimated 45,000 of them are African Americans. African Americans suffer disproportionately from tobacco-related illnesses such as lung cancer compared to

Caucasians. Lung cancer kills more African American men than any other cancers. African Americans have a higher incidence and death rate due to lung cancer than any other racial or ethnic group (U.S. Department of Health and Human Services, 1998). Between 1997 and 2001, the U.S. death rate from lung and bronchus cancers was 36% higher in African-American men than Caucasian men. In Indiana, the lung cancer death rate for African American men, during 2000-2003, was 111 per 100,000 according to the American Cancer Society. In contrast, the lung cancer death rate for Caucasian men was 105.7 per 100,000 for the same time period (Brooks, Palmer, Strom, & Rosenberg, 2003). One study found that African American men have the highest incidence of cancer in the U.S., with the excessive cancer prevalence linked to smoking. Cancer death rates among African American males would decline by two thirds if their consumption of cigarettes were eliminated (Liestikow, 2004).

The results are interesting when analyzing cigarette smoking behaviors and impact among African American men compared to the smoking behaviors of other racial/ethnic groups. When compared to Caucasians in the U.S., African Americans smoke fewer cigarettes but inhale more deeply. There are also dramatic differences in smoking patterns between African Americans and Caucasians in regards to tobacco product of choice, with mentholated cigarettes preferred by African American men by approximately 80% compared to about 20% of Caucasians. Because a majority of African American smokers consume mentholated cigarettes and because African Americans suffer from more tobacco-related health conditions than do Caucasians, researchers have investigated factors that may contribute to African Americans' preference for the tobacco product. Studies have also been conducted in an attempt to

identify connections between mentholated cigarettes and an increase in lung cancer among African American men.

Cigarette smoking impacts racial/ethnic groups quite differently across the globe. Over one billion people smoke cigarettes worldwide, but the smoking patterns and consequences related to cigarette consumption are strikingly different between cultural populations (Peto, Lopez, Boreham, Thun, & Heath, 1992). According to an international case-control study on smoking and lung cancer risk in American and Japanese men, the rates of lung cancer in American men greatly exceed those in Japanese men despite a higher prevalence of smoking in Japanese men (Stellman et al, 2001). Possible explanations for the substantially higher risk of lung cancer in the United States include the earlier initiation of smoking by American men and the more toxic cigarette formulation of American-made cigarettes compared with Japanese-made cigarettes.

The research findings on the impact of cigarette smoking among racial/ethnic populations have suggested the possibility that genetic susceptibility and lifestyle factors have an effect on the health impact of cigarette consumption. In addressing tobacco-related health disparities among African American men, smoking behavior and the cigarette product preference may be just the beginning in the identification of contributing factors.

Ingredients in cigarettes and consumption by African American men

There are over 500 ingredients in a cigarette that can be identified as naturally occurring components in tobacco, or flavorings and chemicals added during the manufacturing process. Once ignited, cigarettes produce smoke containing over 4,000 chemicals, including 200 known cancer-causing agents. Chemicals such as ammonia and

acetaldehyde are just a few ingredients that have been found in cigarettes and are added to increase the addictive nature of the nicotine drug. Ammonia is used to enhance the absorption of nicotine creating high levels of “free nicotine” that can be absorbed more quickly than “bound” nicotine in the body (Willems, Rambali, Vleeming, Opperhuizen, & van Amsterdam, 2005). Acetaldehyde is an additive that supposedly works synergistically with nicotine to increase the addiction. Both ingredients are toxic chemicals that are detrimental when consumed. Ammonia causes irritations to the skin, eyes and throat and can cause lung damage (U.S. Department of Health and Human Services, Agency for Toxic Substances and Disease Registry, 2004). Acetaldehyde is a by-product of alcohol metabolism that is considered more toxic than alcohol itself (Fowkes, 1996).

Flavorings and sweeteners are commonly added to tobacco products to mask the taste of tobacco smoke, making cigarettes more appetizing to children and other first-time users. Additives such as cocoa are added not only to improve the flavor of the cigarette, to also mask the harsh taste of the tobacco and act as a bronchodilator. This permits deeper inhalation of the cigarette which can directly affect the smoking patterns of the cigarette smoker. So although additives such as cocoa might seem like harmless ingredients in a cigarette, they serve as both a disguise and as an enhancer to tobacco addiction (Campaign for Tobacco-Free Kids, 2009b).

The most distinct and marketed additive in tobacco products is menthol. The chemical menthol is a naturally occurring compound with topical cooling and anesthetic properties used in a wide range of products such as mints, gum and cough drops. It first appeared in menthol cigarettes in the 1920s but was not in widespread use until the 1950s

(Brooks, Palmer, Strom, & Rosenberg, 2003). Mentholated cigarettes now account for up to 30% of all cigarettes sold in the United States (Federal Trade Commission, 2003).

For many years, mentholated cigarettes were the only tobacco products identified by the inclusion of flavor additive and constituted more than a quarter of the overall tobacco industry market. An investigation of tobacco industry documents was made to identify the historical background in the marketing of mentholated tobacco products. Wayne and Connelly (2004) conducted a review of internal tobacco industry documents to identify pharmacological research and marketing tactics supporting mentholated cigarettes and its use. They found that mentholated cigarettes were introduced in 1926 as a specialty product offering an alternative to the harshness of regular, non-mentholated cigarettes. When filtered menthol cigarettes were introduced in the mid-1950s and reduction in tar levels among all cigarette brands occurred across all industries between 1957 and 1962, this elevated menthol cigarettes into a significantly marketable product. Tobacco industry documents suggested that menthol plays an important role in the style, packaging, and marketing of cigarette brands. The consumption of menthol cigarettes may have been a result of consumer response and successful marketing that did not include an investigation of the physical factors contributing to menthol's role in the product.

Public health researchers have considered the use of mentholated brands as a possible explanation of the increase of health disparities, particularly between racial/ethnic groups, and have explored the effects of menthol on smoking behavior and consumption patterns. Research has investigated the suggestion that race, gender and menthol cigarette use influence tobacco-smoke exposure and smoking-related disease

risk. An analysis of cigarette consumption according to cigarette type revealed there were no differences in the number of cigarettes consumed each day between nonmenthol and menthol smokers (Mustonen, Spencer, Hoskinson, Sachs, & Garvey, 2004).

An observational study on the effects of menthol versus nonmenthol cigarettes and the effects on smoking behavior found that the baseline heart rates of subjects who preferred menthol cigarettes were higher than subjects who preferred nonmenthol cigarettes (McCarthy, Caskey, Jarvik, Gross, Rosenblatt, & Carpenter, 1995). The study also found that participants inhaled almost 40% more smoke from nonmenthol cigarettes than from menthol cigarettes, but there was no difference in blood pressure or carbon monoxide level between menthol and nonmenthol smokers. One key finding from the study was the significant decrease in smoke exposure among menthol smokers with no apparent decrease of nicotine exposure.

Disparities exist with lung cancer prevalence among African American men compared to the other populations. A study by Brooks, Palmer, Strom and Rosenberg (2003) revealed that lung cancer incidence is 50% higher among African American men than among white men. Although African American men are more likely to smoke, it does not appear that the excess occurrence of lung cancer can be fully explained by a higher prevalence of smoking. The researchers hypothesized that smoking menthol cigarettes might increase lung cancer risk more than smoking non-menthol cigarettes and might at least partly explain the observed disparities in lung cancer incidence. Two factors were proposed to explain how menthol cigarettes could elevate lung cancer risk. First, menthol's combustible products directly exert a carcinogenic effect on lung tissue. Second, menthol's cooling and anesthetic properties might permit larger puffs, deeper

inhalation, or longer retention in the lungs, which would all result in increased exposure to the carcinogenic components of tobacco smoke. This proposed explanation was not supported by the previously cited observational study conducted by McCarthy et al. (1995) and was inconclusive in this study as well. Despite the logic in the two factors proposed by Brooks and colleagues (2003), the researchers found no evidence in the study to support the hypothesis that smoking menthol cigarettes poses a greater risk of lung cancer than smoking non-mentholated cigarettes.

African American men are the major consumers of mentholated cigarettes in the U.S., and the effect of their consumption is significant. High proportions of African Americans prefer menthol cigarettes and despite smoking fewer cigarettes per day than Caucasians, tend to have higher cotinine levels. Cotinine is a byproduct of nicotine and higher cotinine levels have been found in menthol cigarette smokers compared to nonmenthol smokers (Ahijevych & Parsley, 1999).

According to Mustonen and colleagues (2004), the impact of tobacco smoke on the development of lung cancer depends on biological factors (such as race and gender), behavioral factors and exposures to harmful substances. Race and gender differences in smoking behaviors, which includes length of cigarette smoked, depth of inhalation, and cigarette preference, may provide some explanation for the morbidity and mortality differences among these subgroups. Within this study, several hypotheses were offered to explain race differences in cigarettes per day and cotinine levels including the hypotheses that race differences are due to consumption reporting errors and another hypothesis that race differences are due to differences in millimeters of cigarettes consumed. However, the hypothesis that race differences in consumption and cotinine

ratios are due to a higher proportion of African American smokers who smoke menthol cigarettes is gaining support.

Researchers have ultimately been baffled by the findings of their studies in identifying an association between menthol cigarettes and increased lung cancer incidence among African American men. Other studies have come to similar conclusions as those of Brooks and colleagues (2003). Kabat and Hebert's (1991) study on mentholated cigarettes and lung cancer risk found no increased risk associated with smoking menthol cigarettes for men or women. In interpreting the results of these studies it is important to consider factors that might have obscured the association between smoking menthol cigarettes and lung cancer, such as inaccurate information provided by patients during self-reporting. There were also no observations in Brooks and colleagues (2003) and Kabat and Hebert's (1991) studies of the patients using menthol cigarettes to conclude whether they actually inhaled deeper, took larger puffs and retained cigarette smoke longer in their lungs than non-menthol smokers. The previously mentioned study by McCarthy and colleagues (1995) did use observation to study the effects of smoking behavior for menthol and nonmenthol cigarette smokers and found an indisputable effect of menthol cigarette in relation to puff frequency and volume, but did not identify race as significant in the physiological measures.

If these studies have concluded that there is no increased risk of lung cancer associated with smoking mentholated cigarettes, more investigation needs to be conducted on other behavioral risk factors that contribute to the increase of lung cancer incidence among consumers of menthol cigarettes, specifically African American men.

Environmental influences on the initiation of cigarette smoking

The initiation of cigarette smoking can be attributed to many factors. Research has been conducted on environmental influences such as perceived peer acceptance of smoking, exposure to environmental tobacco smoke (ETS), socioeconomic status, and tobacco industry marketing. Most studies found that smoking initiation usually occurs in adolescence, when youths are apathetic to or incompetent at making sound decisions and unaware of the addictive nature of smoking (Raptou, Mattas, & Katrakilidis, 2009). One investigation included a secondary analysis of the Indiana Youth Tobacco Surveys (IYTS) from 2000 and 2004, intended to identify factors influencing the openness of future smoking among non-smoking adolescents in public middle schools and high schools in Indiana (Seo, Torabi, & Weaver, 2008). The researchers found that in 2000, 74% of the students were not open to future smoking, and in 2004 the percentage increased to 77%. The researchers believed that between 2000 and 2004, a decrease on pro-tobacco messaging as well as a decrease in exposure to ETS were contributors to the higher percentage of students not open to smoking cigarettes in the 2004 IYTS. Although the study determined that gender, race/ethnicity, education level, and exposure to anti-tobacco messaging were not significant predictors of the openness to future smoking among adolescent non-smokers, exposure to ETS in the home or car from a parent or guardian who smoked was considered a factor and higher exposure to ETS results in an increased openness to future smoking.

Investigations on the environmental influences of cigarette smoking within the U.S. and other countries have resulted in various findings. A clinical review on the societal and community influences on cigarette smoking found a strong correlation

between social ties and socioeconomic status (Cummings, Fong, & Borland, 2009). The review found that the social environment influences smoking behavior, and if an individual's social ties were among non-smokers, that individual is less likely to smoke than an individual in a social network of smokers. Socioeconomic status was also found to be a strong predictor of smoking, and economically disadvantaged populations can be identified by cigarette smoking prevalence (Jarvis, 1994).

Smoking prevalence inequalities have been pervasive among communities in both the United States and the United Kingdom and have continued to widen. This is due mainly to the difference in cessation rates among the affluent compared to individuals living in poverty. Cessation efforts changed very little among the poor in the United Kingdom between 1973 and 1993 (Jarvis, 1994). Cummings and colleagues (2009) proposed that U.S. consumption of cigarettes since the 1960s has declined due to the increase in public awareness of the dangers of tobacco use, the change of social norms related to cigarette smoking and an increase in government regulations on the sale and advertising of tobacco products. The review also determined that the most significant change occurring over the past two decades was the attitudes, perceptions, and policies related to cigarette smoking in enclosed public places.

Several countries have implemented comprehensive smoke-free policies in all public places and workplaces, with other countries following suit. This limitation for individuals who smoke has contributed to the social norm deeming smoking cigarettes as unacceptable. A study was conducted to identify psychosocial characteristics that differentiate smoking patterns and found that individuals with a stronger attachment to religion are less likely to smoke (Raptou, Mattas, & Katrakilidis, 2009). The probability

for smoking participation increases by 18.17% for individuals with weak family bonds and less supportive or unsound family environment.

It is apparent that tobacco industry marketing is a major factor in the initiation of cigarette smoking. Compared to other corporations in the U.S. business sector, the tobacco industry has been at the forefront of strategic marketing. Successful marketing campaigns are vital to the tobacco industry in order to replace the 1200 current smokers who die each day from the tobacco addiction (Campaign for Tobacco-Free Kids, 2009a). The tobacco industry spends over \$13 billion annually on marketing its products nationwide, which is an estimated \$36 million a day spent on advertising. Several studies have found that youth are three times more receptive to tobacco advertising than are adults and are more influenced by cigarette marketing than by peer pressure. A third of experimentation with cigarette smoking by underage youth can be attributed to tobacco industry advertising and promotion. The number of cigarette packs consumed by youth is an estimated 800 million, bringing in an estimated 2 billion dollars in profit to the tobacco industry (Campaign for Tobacco-Free Kids, 2009a).

As part of a 1998 multi-state settlement with the tobacco industry called the Master Settlement Agreement, the U.S. tobacco companies released marketing research papers and memos related to product placement and promotion. These documents were compiled and posted online and are available to the public by going to www.tobaccodocuments.org as part of the Master Settlement Agreement. Utilizing the collection of the industry documents, tobacco control researchers identified unethical or illegal tactics used to lure certain populations to smoke. Since 90% of all smokers start before the age of 18, the tobacco industry documents exposed schemes targeting youth,

including the placement and promotion of tobacco products at strategic locations that have been proven to lure smokers as young as 13. Youth has always been the priority population for the tobacco companies, but other populations have been an interest and were sometimes described in tobacco industry documents by degrading references. R.J. Reynolds' Project S.C.U.M. - Sub Culture Urban Marketing - was a strategy to increase the marketing of Camel cigarettes to “sub-cultures” in the San Francisco area, specifically to gay and homeless people. Within the documents, handwritten notes identified that these communities were chosen because of the subcultures’ higher incidence of smoking as well as high drug use (Landman, 1995).

The examples of the tobacco industry’s attempt to lure potential consumers demonstrate how the tobacco industry’s targeting through marketing and product placement is incomparable to marketing products such as a pair of shoes or a type of gum. Even after the Master Settlement Agreement exposed the tobacco industry’s tactics, efforts are still being made to lure youth, including young African American men, to use tobacco products. But these attempts are being met with retribution from tobacco control advocates. In 2004, R.J. Reynolds launched a campaign specifically targeting urban youth and young African-American men. The Kool Mixx campaign included free giveaways of mentholated cigarettes, free CD-ROMs with interactive games, DJ contests and concerts in large, urban areas such as Chicago and Detroit. Despite R.J. Reynolds’ unique and creative attempt to launch the Kool Mixx campaign and attract young urban smokers, a lawsuit filed by the Attorneys General of New York, Illinois and Maryland claimed that the Master Settlement Agreement had been violated by the tobacco company. The Kool Mixx campaign was removed and also resulted in a \$1.46 million

settlement to the states for youth prevention in the African-American community.

Environmental factors related to the initiation of cigarette smoking by African Americans, in particular African American men, are still being investigated. African Americans begin smoking later than Caucasians, but a limitation in available data hinders conclusive identification of environmental factors that contribute to the late initiation of cigarette smoking among African American men. According to this researcher's literature review, there are only two studies that examine the determinants of late initiation of cigarette smoking among African American men. One study used prospective data collected from early adolescence into young adulthood (Violette, Metzger, Stouthamer-Loeber, & White, 2007). This study observed risk factors for late-onset cigarette smoking among African American males. Information was derived from a longitudinal study of 281 African American young men followed from ages 13 to 25. Comparisons were made between individuals who never smoked and those who began smoking at age 16 as well as those who began smoking at age 17 or older. Predictive factors for smoking were used to differentiate young men who had already begun smoking from those who had not, with measurements beginning at age 16. In this study, the researchers utilized several factors such as family socioeconomic status and welfare, sports participation, marijuana use, religiosity, and peer and parental influence. The researchers also examined changes in the life status that occurred in late adolescence, such as leaving home, gang membership, incarceration, and obtaining a driver's license.

The study by Violette and colleagues (2007) found that among those who never smoked by age 16, truancy was the only adolescent risk factor that could predict who would later become a smoker and who would remain a non-smoker into emerging

adulthood. Truancy was also related to both late-onset and early-onset smoking. The researchers believed that since truant youth have more freedom from social control than those in school, more opportunities are available for these youth to smoke.

Environmental influences on cessation of cigarette smoking

Although cigarette smoking is an addiction that is difficult to break, it is not impossible. In 2006, approximately 19 million people quit smoking cigarettes for at least one day (Centers for Disease Control and Prevention, 2007). Among adults that smoke cigarettes, 70% want to quit completely (Centers for Disease Control and Prevention, 2002) and more than 40% of adult smokers quit each year (Centers for Disease Control, Office on Smoking and Health, 2007).

The most important environmental factor influencing tobacco cessation is interventions that are both comprehensive in approach and impact smokers repeatedly. The clinical review by Cummings and colleagues (2009) found that tobacco control interventions such as higher taxes on tobacco products, restrictions on advertising tobacco products and comprehensive smoke-free policies are most effective in reaching large numbers of smokers and reducing smoking prevalence. The review also found that despite the efficacy of stop-smoking treatments, little evidence has been found that these treatments dramatically influence the population at large. This may be due to the small number of smokers that actually utilize these treatments when attempting to quit. Therefore, it is suggested that reaching a larger number of smokers with a wide range of tobacco control interventions would increase the impact of smoking cessation efforts nationwide.

A significant influence on smoking cessation is consumer education. The

majority of cigarette smokers are aware that tobacco use poses a health risk, but the level of knowledge of these risks varies. The World Health Organization (2008) considers public education on the health effects of smoking as a primary goal of tobacco control policy. Government efforts to warn the public on the dangers of cigarette smoking include information on the health risks of cigarette smoking displayed prominently on tobacco products and advertisements, anti-smoking campaigns using mass media sponsorship, and providing reports that present information on the health risks of tobacco use such as cigarette smoking.

Research has found that warning labels, depending on their size and message, are a significant means of providing education to consumers of cigarettes. Labels using only text with vague messages were not as likely to attract a smoker's attention and support message recall as compared to large warnings with graphic photos (Thrasher, Hammond, Fong, & Arillo-Santillan, 2007). A study on the effectiveness of cigarette warning labels compared reports of adult smokers in the United States, Canada, the United Kingdom and Australia (Hammond, Fong, McNeill, Borland, & Cummings, 2006). It was found that two thirds of cigarette smokers consider cigarettes packages as a source of information for health risks. An association was found between the strength of the warning labels and the likelihood that the warnings would be cited as a source of health information. In summary, the larger and more graphic warnings on cigarette packages were found to be effective means of providing health information.

Anti-tobacco campaigns using mass media have been effective in initiating cessation efforts when funded adequately (Fichtenberg & Glantz, 2000). When the first nationwide campaign to educate the public about the health effects of tobacco use

occurred between the years of 1967 and 1970, cigarette consumption decreased at a faster rate than the period immediately before or after the campaign ran (Cummings, Fong, & Borland, 2009). These studies have confirmed that appropriately funded mass media campaigns that educate the public on the risks of smoking do lead to a decrease in cigarette consumption.

African American men smoke fewer cigarettes per day and begin smoking later in life than Caucasians and studies have found that African Americans are more likely to attempt to quit smoking than Caucasians in any given year. Yet the success rate for African Americans is 34% lower than it is for Caucasians (Pletcher, Hulley, Houston, Kiefe, Benowitz, & Sidney, 2006). Tobacco cessation intervention and treatment programs available in the health care system have not bridged the gap in providing effective services in the African American community. Research focused on ethnic and racial disparities in tobacco cessation found that compared to Caucasian smokers, African American smokers that were treated by a healthcare professional were less likely to have been asked about tobacco use, less likely to have been advised to quit and less likely to have used tobacco cessation aids during the past year in a quit attempt (Cokkinides, Halpern, Barbeau, Ward, & Thun, 2008). The differences in the use of smoking cessation among races/ethnicities remained significant even after controlling for various other factors such as health insurance or socioeconomic status.

There have been several studies that suggest that successful attempts at quitting smoking are more difficult for African Americans that consume mentholated cigarettes compared to nonmentholated cigarette smokers. A study on cessation experiences among African American menthol and nonmenthol smokers found that menthol smokers had a

higher number of recent quit attempts compared to the nonmenthol smokers, yet had shorter periods of abstinence compared to nonmenthol smokers (Okuyemi, Ebersole-Robinson, Nazir, & Ahluwalia, 2004). The researchers suggested that compared to nonmenthol smokers, menthol smokers preferred cigarettes with longer length rods with higher tar and nicotine content. Because nicotine is the addictive drug in a cigarette, it is logical to expect a greater level of addiction when consuming a product with a higher content of the chemical. A randomized controlled trial for smoking cessation also found that menthol cigarette smokers considered cigarette taste and satisfaction more favorably than nonmenthol cigarette smokers, thus providing a rationale for preferring menthol cigarettes over nonmenthol cigarettes (Ahluwalia, Harris, Catley, Okuyemi, & Mayo, 2002). It is possible that greater preference for menthol cigarettes due to taste and satisfaction makes menthol smokers less willing to abstain from smoking.

The findings on smoking prevalence, mentholated cigarettes, tobacco industry targeting and cessation efforts have led to an investigative study of the environmental influences on product choice and factors that affect tobacco initiation and cessation efforts among African American men ages 18-35, which is the focus of the third chapter of this paper. Qualitative studies such as Smokefree Indiana's research study report (2007) have identified key findings and common themes related to the smoking behavior of African American men and found that there is relationship between lifestyle behaviors, environmental influences and targeted tobacco advertising that lead to later initiation of tobacco use as well as efforts to quit.

Summary

The studies cited in this literature review were substantial in developing this researcher's interest in the topic of African American men and tobacco use. Multiple studies have been conducted to identify determinants of high lung cancer rates among African American men, the preference for mentholated cigarettes by this population group and the limited success in cessation attempts. Quantitative research studies have not been able to determine a rationale for the high incidence of lung cancer and many findings have disputed the hypothesis that smoking mentholated cigarettes increases lung cancer incidence. More research needs to be conducted in this area order to improve our understanding of cultural, environmental and social factors that affect the initiation and cessation behaviors of tobacco use among African American men. This information can be helpful in determining the direction for public health initiatives that are focused on eliminating tobacco-related health disparities that impact this population.

CHAPTER III

SMOKEFREE INDIANA FOCUS GROUP STUDY

Introduction

The problem of the study was to investigate the environmental influences on tobacco use initiation and cessation among African American men ages 18-40. The previous chapter provided information on cigarette smoking prevalence in the U.S. and environmental factors that influence the initiation and cessation of cigarette smoking. Additional information was shared on the impact of cigarette smoking, cigarette brand preference and cessation attempts among African American men. Literature reviews conducted prior to 2007 provided major points regarding cigarette smoking among African American men, but more information was needed in regards to environmental factors related to initiation and cessation. This led to the researcher's involvement with Smokefree Indiana's study on African American men ages 18-35 conducted in 2007. The study utilized qualitative ethnographic methodology, generating data derived from semi-structured survey items administered by a peer facilitator to focus group subjects. The research methodology, findings, and discussion will be presented under the following topics: (a) focus group study rationale, (b) methodology, (c) instruments and materials, (e) procedure, (f) data analysis, (g) key findings, and (h) summary.

Focus Group Study Rationale

Smokefree Indiana was established in the mid-1990s as a tobacco control advocacy organization for the state. The organization conducted statewide tobacco control programs with the support of funding from the Centers for Disease Control and Prevention's Office on Smoking and Health, and had a strong initiative focused on identifying and eliminating tobacco-related health disparities. Due to the limited information available regarding the late onset of cigarette smoking among African American males, Smokefree Indiana and other collaborative partners initiated a project to gather qualitative data on the cigarette smoking behavior of African American men. Organizations that collaborated in this effort included the Indiana Tobacco and Prevention Agency, the Indiana State Department of Health, the Martin Luther King Jr. Center of Indianapolis, the Marion County Health Department, the Marion County Minority Health Coalition and the St. Florian Center. Smithmark Marcom was hired to assist in the recruitment of participants and to facilitate focus group sessions with African American men ages 18-35 years in order to gain valuable insight into the attitudes, opinions, behaviors, and beliefs concerning tobacco usage. Smithmark Marcom had a history of working with African American men with research studies and was able to provide a peer facilitator to conduct the focus groups.

The major objectives of the study were: (a) to provide insight into tobacco use and cessation among African American males ages 18-35 years, (b) to better understand factors affecting first experiences with cigarette smoking and reasons for experimentation, brand preference and tobacco usage; (c) to identify key motivators and resources for quitting, including tobacco cessation aids used successfully by ex-smokers;

(d) to identify attitudinal, physical, and behavioral barriers that have prevented current smokers from quitting successfully; and (e) to identify the media formats that are effective in reaching study participants.

Methodology

Subjects

Assembling subjects for the study involved both criterion and purposive sampling. Participants had to meet the requirements of being African American, a current or former smoker, between the ages of 18 and 35 years, and a resident in the Indianapolis area. Urban African-American men between the ages of 18 and 35 begin smoking at a later age, are less successful at quitting and are more likely to choose mentholated cigarettes. Therefore, the researcher proposed the recruitment of participants within the specific age range from the Indianapolis metropolitan area who were current or former smokers. Focus group participants were recruited in excess of the maximum number required with the expectation that a percentage of interested applicants would not show at the actual focus group meeting. Recruitment of participants included promoting the focus groups to potential applicants through the partner organizations and using the existing database at the Herron Institute for Research. Smokefree Indiana also received assistance from Herron Institute for Research in conducting screening activities, utilizing a tool that assesses age, race, residency, smoking status and smoking history in order to assure that the interested applicants fit the criteria to participate in the focus group study. The screener used during the recruitment process contains the assessment questions and can be found in Appendix A. A small stipend was offered to all applicants who attended and completed the focus group activity in order to increase the response of applicants.

The study consisted of two separate focus groups. A total of 23 current and former smokers were recruited, with the expectation that 11 would participate in one group and the remaining 12 in another. Of those 23 individuals, 13 showed up and participated in both sessions. The first focus group was comprised of 7 African American men who were either current smokers or former smokers whose tobacco use history ranged from 1 ½ to 11 years. Consumption for current smokers and past consumption for former smokers ranged from ½ pack to ¾ pack per day. Descriptions of each focus group can be found in Appendix B.

The second focus group included six (6) African American men ages 18 -35 and who also reside in the Indianapolis area. Like the first group, these participants included both current and former smokers. Consumption for the current and past consumption for former smokers ranged from ½ to 1 ½ packs per day and years of tobacco use ranged from 2 ½ to 14 years. The participants in this group preferred menthol cigarettes, but no specific brand. Similar to the first focus group, there was one individual who only smoked “Black & Mild” tobacco products.

Instruments and Materials

Smokefree Indiana and its collaborative partners developed a facilitator’s guide to gather qualitative data on the cigarette smoking behavior of African American males. A peer facilitator was hired to conduct the focus group activities and implement the facilitator’s discussion guide (see Appendix C). Topics such as stress, rites of passage, peer pressure, targeted marketing campaigns, brand preference and tobacco usage were discussed to identify common themes related to environmental influences. In regards to cessation, the focus groups shared key motivators and resources that included tobacco

cessation aids that were successful. Two focus groups were conducted and consisted of both current and former smokers.

Focus group survey questions in the facilitator's discussion guide were derived from a literature review of information related to African American men and tobacco use. Topics covered in the discussion guide include factors contributing to initiation, reasons for tobacco product used by participants, and reasons for considering quitting or having quit tobacco. The facilitator's discussion guide provided topics of focus that included probe questions and self-directed activities. The major areas of focus in the facilitator's discussion guide include the following:

- Provide introductions and Opening Remarks – included facilitator introductions and ice-breaker activities and an explanation of the focus group process
- Share objectives of the focus group study.
- Setting ground rules – requesting everyone's participation and responses to the focus group questions.
- Explore participants' tobacco consumption history and patterns – included identifying age of onset of tobacco use, motivations for starting, and frequency of use.
- Determine what and how much they know about the negative effects of tobacco, as well as the positive effects of quitting – included questions on chemical content in cigarettes, harmful effects of smoking and secondhand smoke.

- Discuss their concerns and sensitivities about tobacco use and quitting – included a self-directed activity listing any concerns about tobacco use and quitting (i.e. physical, social, economic impact of its use).
- Discuss the resources, processes, techniques, and outcomes of their attempts to quit (successfully) where applicable – included questions based on participants' knowledge of resources available for quitting smoking and individual efforts to quit. Experiences in coping, challenges, tools used to quit were discussed.
- Explore media and Smokefree Indiana Awareness – Advertisements meant to entice smokers were shared along with anti-smoking advertisements, and discussion followed to assess their impact on focus group participants. Questions were asked to see what impacts the participants most when using various marketing tools such as radio, billboard, or print advertising for pro and anti-tobacco messages. Tobacco industry targeting of African Americans was also discussed.

Examples of questions included in the facilitator's discussion guide related to these topics are below. The full text of questions posed of focus group participants is in Appendix C within the focus group discussion guide.

#1. Motivations for starting. Key influencers (people, situations, etc)

PROBE: Ok. They say Black people start smoking later than white people...do you think that this is true? Think about high school, were the black kids using tobacco/smoking? What about some other "urban legends" regarding tobacco, gender and ethnicity.

- #2 Discuss their perceptions about the health issues regarding smoking – both at their current age and later. Explore their beliefs about returning to a healthier state and reversing some of the damage that’s been caused by years of tobacco consumption, with the expectation to hear “gonna’ die of something”.
- #3 Talk about what you have gone through, the process, to stop using tobacco products.

PROBE: What was done, how long ago, how long it lasted, how did you cope, what did you use a substitute OR did you use a substitute (snuff or chew OR LIGHT cigarettes – you thinking that better), did it OR how did it change your social behavior patterns and what are some of the final outcomes?

An audio/video recording of the focus group discussions was used to collect the information. Release forms were signed by participants in the focus groups stating that the audio/video recordings will only be viewed by researchers connected to the study topic. The peer facilitator also took written notes during the focus group discussion to identify common statements and underlying themes. This served as supplementary information when the audio/video recordings were analyzed.

Focus Group Procedure

Two 90-minute focus group sessions were conducted at the Herron Research Facility in Indianapolis on April 26, 2007. Both groups were conducted during the evening. Each participant received \$50.00 for participating in one of the focus groups. None of the focus group participants objected to being audio taped, videotaped, or observed through the one-way mirror by members of the project team from Smokefree Indiana.

The process of recruiting participants, conducting the focus groups and collecting the data was time intensive. Participants that fit the inclusion criteria were usually found in Indianapolis areas where outreach programs and research activities have had limited success. Collaborating with multiple organizations that saw the need for this study on such a specific ethnic group ensured an acceptable number of participants for the focus group.

All aspects of the study were carried out in 2007. A timeline of the research study was as followed:

- February-March – Recruitment of participants for the two focus groups;
- April – Focus groups conducted;
- May – Transcripts of audio and video record composed, data interpreted;
- June – Findings and recommendations shared.

Data Analysis

The analysis was not limited by a previously developed structure but rather themes were allowed to emerge from the data. The audio and video recordings were reviewed and transcripts were developed to identify common themes related to the topics identified in the facilitator's discussion guide. Duplicate responses made by participants and references made repeatedly contributed to the development of the themes. Data were analyzed and organized according to these themes. The two focus groups conducted had fewer than ten participants in each session. Responses to certain themes were categorized as "most" for more than half of the participants with similar responses, and "some" for less than half of the participants with similar responses. Notes taken by the peer facilitator were also compared to the information provided in the transcripts to confirm

the major points identified during the focus group discussion. Names and contact information were held confidential and were not used for any other purpose than to contact participants for follow-up research when necessary.

Key Findings

In a qualitative, ethnographic research study such as the Smokefree Indiana Focus Group Study on African American men ages 18-35, key findings are identified by common themes and statements derived from the information provided by the research participants. The common themes which emerged were identified as the following: (a) behaviors related to brand preference and initiation, (b) knowledge about the negative effects of tobacco, (c) tobacco cessation attitudes, opinions, and behaviors, (d) awareness of smoking cessation aids, and (e) exposure to tobacco marketing and advertisements.

Behaviors related to brand preference and initiation

The participants provided significant details about their attitudes, opinions, and behaviors related to brand preference and initiation of smoking. The majority of participants preferred menthol cigarettes, and nearly half of them smoked *Newports*. Menthol cigarettes were perceived to enhance or “smooth out” the high from alcohol and/or marijuana.

The younger participants, ages 18-25, reported started smoking because their peers, sibling(s), and/or other family members smoke. Most of the participants reported that one or more of their parents or guardians smoke. The older participants, ages 26-35, indicated that they were influenced by marketing tactics such as free samples, offering coupons, and other marketing strategies which target African American males.

Subjects were aware of how much they smoke and none considered themselves to

be “chain smokers”. Participants gave various reasons for starting to smoke. Several of the men were encouraged to smoke their first cigarette by a school mate, friend, older sibling, or other family member relatively close in age. Most of the smokers and ex-smokers in the study had at least one parent or close adult relative who smoked around them. Occasionally, a smoker or ex-smoker said they started smoking because it was the “in thing” to do at the time. One focus group participant made the following statement:

“Just about everyone in my family smoked; everybody around me smoked everybody else was doing it.”

According to the discussion from the research participants, cigarette smoking began after the use of marijuana or alcohol. Several of the men reported starting to smoke cigarettes after 18 years of age, and one participant recalled having smoked his first cigarette at a pre-teen age. Tobacco industry marketing appears to have influenced the cigarette smoking behaviors of several of the focus group participants. There were comments about tobacco companies passing out free samples, offering coupons, and other marketing strategies which targeted African American males. One participant stated:

“I was trying to start off on Newports but they were like three something a pack. It was high. So, Kools and Marlboro always run specials. Buy one and get one free. That is when I started trying different brands”

But the tobacco industry’s marketing tactics seem to have had a greater influence on the older smokers and former smokers than on younger ones. The younger participants stated their reasons for starting were typically related more to peer pressure, image projections, or simple curiosity.

Knowledge about the negative effects of tobacco

Smokers in both groups expressed some degree of awareness about the health risks and negative consequences associated with tobacco use. They obtained their information from news articles, advertisements, and package labels. Although many participants had children, they primarily focused on their perceptions of the negative effects of smoking on their health, rather than the impact of their smoking on others.

Both groups named the same types of health problems and diseases that are either caused or exacerbated by smoking, such as heart disease, emphysema, asthma, shortness of breath on exertion, and lung cancer. Death due to a smoking-related condition surfaced as a minor concern in both groups. The men talked about others they knew who have died from smoking-related diseases. The toxicity of cigarettes was an understood component of smoking. Cigarettes were referred to as “cancer sticks”. Both groups of men were asked about the ingredients in cigarettes. Most participants believe cigarettes contain nicotine and chemicals of some kind. The words “pesticides” or “carcinogens” were not used specifically. Participants were aware that cautions regarding the negative effects of cigarettes were “on the label”. Also, they were knowledgeable of the “Truth” and “White Lies” campaigns.

Many participants indicated that they do not smoke around non-smokers or their families. They are not all doing this to avoid the effects of secondhand smoke on others. Several indicated they are avoiding hearing comments about their need to quit or complaints about the smell. One participant made the following statement:

“When my kids ask me why I smoke...I tell them I’m grown and when they grown they can do what they want to”

It appears clear that secondhand smoke is perceived by the focus group participants as more of a nuisance than a health hazard. Participants reported not smoking in restaurants because they want to smell their food. Someone in each group talked about not liking the smell of smoke in their homes, cars, on their clothing, or in their hair. Others admitted to brushing teeth prior to intimacy. A participant who works around children indicated the following:

“I spray Febreeze before the kids get on the bus”.

The cost of cigarettes surfaced as a concern by both groups of smokers. They shared the opinion that manufacturers must know they have priced the brand preferred by African Americans highest in the marketplace. Internet coupon promotions, or “hook-ups” as referred by a focus group participant, were mentioned as a significant cost controller for budget-minded smokers. One participant stated:

“You can even get them mailed to your house!”

Various types of social pressures were mentioned in both groups. The men talked about feeling embarrassed by smoking in particular situations, for example, smoking around non-smokers and family members who want them to quit. Participants stated that they seek out nonsmoking areas when they are in public. All of them have been encouraged or pressured to quit at some time or another by their girlfriends, spouses, “momma”, friends, relatives, and/or children.

Tobacco cessation attitudes, opinions, and behaviors

The participants shared a wide variety of reasons for wanting to quit. The former smokers in both focus groups shared their reasons for quitting, as well as their cessation experiences and methods and said they quit for personal reasons – children, health, other

life changes. Current smokers of both focus groups were unsure about quitting, if they were faced with a serious health condition. Nonchalant attitudes about the health risks were common among the current smokers when first addressed to both focus groups, with one participant saying that you have to “die from something”. But when the suggestion of chronic diseases such as serious breathing problems and lung cancer were mentioned in both groups, they appeared to be compelling motives to quit smoking for good. The men in both groups were forthright in admitting that smoking is an addiction.

The majority of current smokers believe they can quit if they make up their minds to do so. A few of them admitted some uncertainty about their ability to really be successful. The former smokers in both groups admitted to feeling vulnerable to relapsing. Although it had been months since they quit, they indicated that they were still fighting the addiction and looking for additional ways to cope. Several participants could readily name some specific benefits of quitting such as feeling better physically, increasing stamina, having a better lifestyle and social life, and saving more money to spend on other things.

It was clear from the discussions on barriers, quitting, and relapsing that there are primary factors that really influence their thoughts and behaviors. Other factors such as the effects of secondhand smoke, the negative smell, weight control, and stress management are important to their decision making process.

Awareness of smoking cessation aids

There were varying levels of awareness of all available tobacco cessation products. Participants knew that there were multiple sources of assistance available, but

had doubt as to the effectiveness of these products, especially nicotine replacement products. Some of them had tried various aids and had ended up smoking again.

Participants did not want any brochures or literature, nor did they want to purchase any products that would put a strain on their budgets. Most of them had heard of the nicotine patch and gum, but few had actually tried them. One participant stated:

“They don’t work....too expensive...wearin’ a patch and still smoking”.

It was clear that ex-smokers in both groups believe that the quitting has to directly benefit the smoker in order for a quit attempt to be made, and that will power is the best motivator in quitting.

Exposure to tobacco marketing and advertisements

Men in both groups listed basically the same media formats—television, radio, and billboards—that should be used to communicate tobacco cessation messages to them. When asked to recall ads designed to encourage people to quit or to not smoke at all, both groups of men mentioned the “Truth” and “White Lies” campaigns. They described these as effective ads for getting their attention and communicating the negative health effects of smoking, as well as its being a turn-off to nonsmokers.

Summary

Smokefree Indiana's Focus Group Study on African American men ages 28-35 and tobacco use provided information that complements the findings of other research related to initiation and cessation efforts. Special attention was given to the similarities between both focus groups' participants as well as nuances. Despite differences in age and tobacco consumption, there were many similarities among the participants in attitudes, opinions and behaviors. The younger participants, ages 18-25, reported started smoking because their peers, sibling(s), and/or other family members smoke. Most of the participants reported that one or more of their parents or guardians smoke. The older participants, ages 26-35, indicated that they were influenced by marketing tactics such as handing out free samples, offering coupons, and other marketing strategies which target African American males.

Subjects were aware of how much they smoke and none of them considered themselves to be "chain smokers". The majority of the men reported smoking menthol cigarettes, with *Newports* being the preferred brand. Menthol cigarettes were associated with alcohol and marijuana use. It was said that menthol cigarettes increase the high they get from these substances. Participants in these focus groups indicated that they want to quit smoking. These men were aware of the health risks associated with smoking and they recognized that there are benefits in quitting. Despite all of the public health evidence against smoking and all the media messages that discourage smoking, peer pressure continues to be a key reason given by young people today for starting smoking.

There are no other studies to which Smokefree Indiana can compare these findings. The focus groups with African American males were considered a pilot study.

The results of this focus group study cannot be generalized to all African American males in Indiana, 18-35 years of age, yet the results should be used as a guide for additional research. Recommendations derived from the Smokefree Indiana focus group study and the literature review of other research will be addressed in the next chapter.

CHAPTER IV

RESULTS, DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

Introduction

The problem of the study was to investigate the environmental influences on tobacco use initiation and cessation among African American men ages 18-40. This chapter includes the following sections: (a) results and discussion of literature review, (b) results and discussion of the Smokefree Indiana focus group study, (c) conclusions, (d) recommendations for further study, and (e) recommendations for implementations.

Results and discussion of literature review

Based upon the design of the study, a database search was conducted to identify literature related to the problem statement. The MultiSearch tool available through the Ball State University Library Services was utilized to expand the search to multiple databases simultaneously. As a result, 58 articles were identified during the literature search when using terms associated with the problem statement, with 35 of those articles having information pertinent to the issue of cigarette smoking among African American men ages 18-40. The Smokefree Indiana focus group study on African American men ages 18-35 was also reviewed and provided helpful information in regards to the problem statement.

Questions to be answered:

In studying the problem, the researcher examined the research to answer the following question:

What are the environmental influences for the initiation and cessation of tobacco use among African American men ages 18-40?

The literature review revealed the following pertinent findings relative to smoking among African American men:

In addressing the research question in the area of initiation of cigarette smoking, the majority of the articles in the literature review identified influences related to the general population and influences on initiation such as tobacco industry marketing, peer and familial influence. The population-specific data available from these studies focused on age, education and socioeconomic status, with limited findings specifically on race and gender. Principal findings were:

1. Smoking initiation usually occurs in adolescence, when youths are apathetic to or incompetent at making sound decisions and unaware of the addictive nature of smoking,
2. Exposure or limited exposure to environmental tobacco smoke (ETS) in the home or car from a parent or guardian who smoked was considered a factor in both smoking initiation and cessation, and higher exposure to ETS results in an increased openness to future smoking.
3. There is a strong correlation between social ties and socioeconomic status.
4. Youth are three times more receptive to tobacco advertising than are adults and are more influenced by cigarette marketing than by peer

pressure. A third of experimentation with cigarette smoking by underage youth can be attributed to tobacco industry advertising and promotion.

5. Among young African American men who never smoked by age 16, truancy was the only adolescent risk factor that could predict who would later become a smoker and who would remain a non-smoker into emerging adulthood.
6. Higher taxes on tobacco products, restrictions on advertising tobacco products and comprehensive smoke-free policies have are the most effective in reaching large numbers of smokers and reducing smoking prevalence.

Results and discussion of the Smokefree Indiana focus group study

The Smokefree Indiana focus group study resulted in qualitative data that identified factors for the onset of smoking among African American men, contributing factors for initiation of cigarette smoking, and influences on cessation (2007). From this study, the researcher identified the following findings:

1. Younger participants reported started smoking because their peers, sibling(s), and/or other family members smoke while older participants indicated that they were influenced by marketing tactics such as free samples and coupons.
2. Many participants began smoking cigarettes after the use of marijuana or alcohol.
3. Participants found personal decisions and health-related issues as influential factors for quitting smoking

4. Nonchalant attitudes about the health risks of cigarette smoking were common among the current smokers in the study, but when chronic diseases such as serious breathing problems and lung cancer were discussed, they appeared to be compelling motives for the participants to quit smoking for good.
5. Factors such as the effects of secondhand smoke, the negative smell, weight control, and stress management were found to be important to their decision making process.

Conclusions

The results of the study indicate the following concluding points:

1. Environmental factors influencing the initiation and cessation of cigarette smoking among African American men vary from the general population.
2. Tobacco industry targeting, familial history of smoking and prior marijuana use has a significant impact on the smoking patterns and cigarette brand of choice among African American men who smoke.
3. Efforts in cessation are more prevalent, yet less successful, among African American men ages 18-40 compared to the general population.
4. There is a gap in the health care system to provide adequate cessation resources to this population group.
5. Although lung cancer is more prevalent among African American men than any other racial group, research to identify underlying causes and successful interventions are limited.

Recommendations

Based upon the results of this study, the researcher recommends the following:

1. Additional research needs to be conducted on the initiation and late onset of cigarette smoking among African American men.
2. Additional research needs to be conducted on factors that influence smoking cessation among African American men.
3. More pilot studies are needed to identify successful cessation interventions for African American men.
4. Results of this study should be shared with tobacco control advocates, state and local public health professionals in order to improve tobacco control interventions for African American men.
5. Tobacco control specialists can apply counter marketing efforts to reduce the initiation of tobacco use among African American youth, in particular young men.
6. Healthcare professionals should implement strategies for successful cessation interventions for African American men that use tobacco.

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APPENDIX A

Smokefree Indiana Focus Group Study Screener

Qualitative Research Project
SmokeFree Indiana – April 2007
Focus Group Screener

Marion County (Indy)

Group A: 5:30PM 18 – 35 yrs AA Male Idea Center TBD

B _____

Group B: 7:30PM 18 – 35 yrs AA Male Idea Center TBD

Assignment Group (check one)

A _____

Respondent: _____ Phone: _____

Address: _____ Cell: _____

City: _____ State: _____ Zip: _____

Email: _____

Hello, my name is _____ from _____ a marketing research company in _____ and we are conducting a study on tobacco usage in Indianapolis, and we would like to include your opinions in a group discussion. Let me assure you that we are only interested in your opinion and this will not involve the sale of any goods or services.

1. First of all, are you a resident of (Marion County)?

YES
1

(CONTINUE TO 2)

NO
2 **TERMINATE**

2. Are you a current OR former smoker AND have you ever purchased cigarettes?

CURRENT
1

FORMER
2 (CONTINUE TO 3)

NO
2 **TERMINATE**

3. Did you begin smoking cigarettes before your 18th birthday?

YES
1

NO
2

4. When was the last time that you purchased cigarettes? (**READ LIST**):

YES
NO
Today 1 ACCEPT

2	Yesterday	1	ACCEPT
2	Less than one (1) week ago	1	ACCEPT
2	Greater than one (1) month ago	1	ACCEPT
2			

5. Are you or anyone in your immediate family employed by or a decision maker for: **(READ LIST)**

	<u>YES</u>	<u>NO</u>
If YES, TERMINATE	1	2
A Marketing Research Company	1	2
An Advertising or Public Relations Company	1	2
A State government agency	1	2
The Media, such as Radio, Television, Newspapers	1	2

6. When was the last time that you participated in a group discussion for the purpose of marketing research?

	<u>YES</u>	<u>NO</u>
LESS THAN SIX MONTHS AGO	1 TERMINATE	2
Continue		
GREATER THAN SIX MONTHS AGO	1 Continue	2
Continue		

The following questions are for demographic purposes only to group your responses with others like yourself.

7. Which of the following groups includes your age: **(READ LIST)** YES
NO

2	18-25	1
2	26-35	1
2	36-45	1 HOLD
2	46-55	1 TERMINATE
2	56-65	1 TERMINATE
2	66 or greater	1 TERMINATE
2	REFUSED	1 TERMINATE
2		

8. **(RECORD GENDER)**
- | | <u>YES</u> | <u>NO</u> |
|-------------------------|------------|-----------|
| Male | 1 | 2 |
| Female TERMINATE | 1 | 2 |

9. Which of the following categories best represents your ethnic background? (**READ LIST**)

African-American	1	ACCEPT
All Others.....	2	TERMINATE

10. Are you currently employed OR unemployed? (**RECORD AND CONTINUE**)

Employed.....	1	Unemployed.....	2
---------------	---	-----------------	---

11. Which of the following categories includes your household Income Range? (**READLIST**)

Less than \$15,999	1
\$16,000 to \$19,999	2
\$20,000 to \$24,999	3
\$25,000 to \$39,999.....	4
Greater than \$39,999.....	5

12. Which of the following categories includes your Education? (**READ LIST**)

Some high school	1
High school graduate	2
Some College	3
College Graduate	4

13. Which of the following best represents your marital status? (**READ LIST**)

Single....	1	Married....	2	Divorced....	3	Widower....	4
------------	---	-------------	---	--------------	---	-------------	---

14. Do you have children in your household OR that ride in a vehicle with you on a regular basis?

YES

NO

1

2

13. And finally, describe for me your first smoking experience including your age at that time and the location where it took place?

If extremely negative or non-descriptive, TERMINATE

The reason for my questions is that we will be conducting a marketing research group discussion on **(THURSDAY/APRIL 26TH)** at **(TIME)** at the **IDEA CENTER**, and we would like to invite you to participate. The topic of this group discussion will be smoking and tobacco usage. The session will last 1 ½ to 2 hours. As a token for your participation, you will receive a cash honorarium of \$20.00 and a \$20.00 Speedway Gas Card. Would you be willing to join us for this discussion?

We look forward to seeing you on **(APRIL 26TH)**. You will receive a letter of confirmation that will have detailed directions to the **(IDEA CENTER)**. We would like for you to arrive 10-15 minutes early so that you can join us for light refreshments. You will need to bring one piece of ID with you to the session.

Thank you for your interest.

APPENDIX B

Smokefree Indiana Focus Group Study Participant Demographics

Appendix B.

Smokefree Indiana Focus Group #1 – Participant Demographics

Participant Number	Current or Former Smoker	Begin Before 18th Birthday	Last Time Purchased	Age	Employment	Income	Education	Marital Status	Children (Y/N)	Describe your first smoking experience.
1	Current	Yes	Yesterday	18-25	Not Employed	\$16-19k	HSG	SNG	Yes	I was about 16 years old outside with a friend.
2	Former	No	Greater than one month	26-35	Employed	+\$39k	CG	SNG	No	I was 20 or 21 at college – Indiana State and everyone was trying it and so did I.
3	Former	No	Greater than one month	26-35	Employed	+\$39k	HSG	SNG	Yes	At work was 20 years old was pretty stressed out and got a cigarette from a coworker.
4	Current	Yes	Yesterday	18-25	Not Employed	-\$16k	HSG	SNG	Yes	I was 14 and in Michigan, probably in school.
5	Current	No	Yesterday	26-35	Employed	\$25-39k	SC	MAR	Yes	I was 18 years old and I was smoking weed and was told cigarette would boost my high. It was at my aunt's house.
6	Current	No	Yesterday	18-25	Employed	\$16-19k	SC	SNG	No	I was 18 years old and my friend gave it to me at a party.
7	Current	Yes	Today	18-25	Employed	\$25-39k	HSG	SNG	Yes	I was in Germany and 12 years ago me and my friends just decided to smoke a cigarette.

Appendix B.

Smokefree Indiana Focus Group #2 – Participant Demographics

Participant	Current or Former Smoker	Begin Before 18th Birthday	Last Time Purchased	Age	Employment	Income	Education	Marital Status	Children (Y/N)	Describe your first smoking experience.
1	Current	Yes	Less than one week	18-25	Not Employed	\$25-39k	HSG	SNG	No	I was around 17 years old. I was outside hanging out with friends.
2	Current	No	Yesterday	26-35	Employed	\$16-19k	HSG	SNG	No	I was at home. Nine years old and tried my first cigarette.
3	Current	No	Less than one week	26-35	Employed	\$16-19k	HSG	MAR	No	I was at Denny's with a group of friends. It was a Marlboro and I was 19 years old. I remember exactly.
4	Current	Yes	Today	26-35	Not Employed	\$20-24k	SC	SNG	No	I was 17 years old at home and I was really dizzy. That's all I remember.
5	Current	No	Yesterday	26-35	Not Employed	\$25-39k	SC	MAR	Yes	I was 19 years old and it was in my apartments.
6	Former	No	Greater than one month	18-25	Employed	+\$39k	SC	SNG	Yes	I was 18 years old at college.

APPENDIX C

Smokefree Indiana Focus Group Study Discussion Guide

Appendix C.

Smoke Free Indiana Discussion Guide
April 3, 2007

Introductions and Opening Remarks

- **Introductions**

1. Welcome Greeting and Moderator Info
2. Explain focus group process
3. Intro of Participants: **WHAT'S IN OR HAS BEEN IN YOUR POCKET – LAY IT ON THE TABLE – THAT IS WHAT TONIGHT IS ABOUT REGARDING SMOKING HABITS, PREFERENCES AND BEHAVIORS.** Name, Family Structure/Lifestyle. Type and amount of tobacco currently/formerly consumed in an average day

- **Objectives**

- **Ground Rules**

1. Your forum: Spit a Rhyme, tell a story, like an open mic BUT one person must speak at a time. Basically, just be you!
2. Everybody needs to participate
3. This is not ISTEP, so there is no right or wrong answer. We are different and need to respect different opinions. I am not trying to have a JERRY SPRINGER show up in here and Maury won't be asking you "are you the father". So, we don't need to trip if someone thinks different than someone else.

II AWARENESS AND OPINIONS ABOUT TOBACCO USE AND CESSATION

- **Explore their tobacco consumption history and patterns**
 1. Age onset. Number of years they used tobacco products
 2. Motivations for starting. Key influencers (people, situations, etc)
 - PROBE: Ok. They say we start smoking later than white people...do you think that this is true? Think about high school, were the black kids using tobacco/smoking? What about some other “urban legends” regarding tobacco, gender and ethnicity (for example... “smoking in front of momma ‘nem”)...even smoking and sophistication and sex appeal, mackin’, and sex
 3. Frequency of use. Types and Amounts Consumed (very specific). Any fluctuations or variations in amount consumed over the years. Occasions for using and NOT using tobacco products. (eg. stops/starts – kids being born, jobs, environments, stress)

- **Determine what and how much they know about the negative effects of tobacco, as well as the positive effects of quitting**
 1. Discuss the risks, hazards, and consequences associated with tobacco products. **IS TOBACCO TOXIC? WHAT ARE SOME OF THE INGREDIENTS IN CIGARETTES? WHAT IMPACT DOES OR DID THIS KNOWLEDGE HAVE ON YOUR DESIRE TO USE OR QUIT? Now: you know the negative effects, why do you/did you still choose to smoke?**
 2. Determine how they’ve become informed about the risks, hazards, etc.
 3. Discuss their perceptions about the health issues regarding smoking – both at their current age and later. Explore their beliefs about returning to a healthier state and reversing some of the damage that’s been caused by years of tobacco consumption (expect to hear “gonna’ die of something”)

- **Discuss their concerns and sensitivities about tobacco use and quitting**
 1. **SELF DIRECTED ACTIVITY (Moderator will step out of room to meet with client).** List on the sheet of paper in front of you any concerns that you might have regarding tobacco use (if necessary will provide examples of physical health, diseases, death, social stigma, pressure from family/friends, secondhand smoke, negative role modeling, etc.)
 2. Now, look at what you have written, is the focus of your concern more about YOU or others around you
 3. Now...put an asterisk symbol by the most important factors on your list.
WHICH OF THESE ARE COMPELLING REASONS TO QUIT?
 4. **INFLUENCERS:** Who do would you be most likely to **LISTEN & RESPOND TO AND CHANGE** for if they were speaking to you?
(healthcare professional, grandparent, child, employer, other relatives, friends, spouse/mate)

- **Discuss the resources, processes, techniques, and outcomes of their attempts to quit (successfully) where applicable.**
 1. What is available in Indianapolis to help you quit smoking if you have/want to quit. Which did you seriously consider or for some of you, used?
 2. Tell me about what you have gone through, the process, to stop using tobacco products.
 3. (Probe: What was done, how long ago, how long did it last, how did you cope, what did you use a substitute OR did you use a substitute (snuff or chew OR LIGHT cigarettes – you thinking that better), did it OR how did it change your social behavior patterns and what are some of the final outcomes?)
 4. One more push – What has the impact of “smoke-free environments” had on your usage of tobacco products? Did it change where you “hang-out”?

5. What are some of the more individual or personal barriers to quitting.
Basically...if you are still smoking, **CAN YOU QUIT? Or HOW BADLY DO YOU WANT TO QUIT?**

- **Explore Media and Smokefree Indiana Awareness**

1. Identify the ads they recall seeing that are designed to encourage folks to smoke (includes coupons, in-store, etc.). Then, those designed to **DETER** people from using tobacco products.
2. Does the tobacco industry advertise more in AA communities, other communities or about the same?
3. What in that ads were appealing and/or memorable – people, messages, setting, etc? Who did the ad target? Be very specific for me...what images attract you? Is it the fine, sexy hot looking chick/female?
4. Which advertising format works best for you (TV/radio/billboard/newsprint/direct mail)?
5. Which local stations or publications do you listen to/read regularly? Do you use the internet? Have email? Which sites do you regularly visit?
6. Smokefree Indiana stimulus: Get reaction to, determine awareness prior to today.