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Perceptions of Smoking Cessation Programs in Rural Appalachia

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Abstract

Objectives—To identify perspectives on smoking cessation programs in Appalachian Kentucky, a region with particularly high smoking rates and poor health outcomes.

Methods—Insufficient existing research led us to conduct 12 focus groups (smokers and nonsmokers) and 23 key informant interviews.

Results—Several findings previously not described in this high-risk population include (1) transition from pro-tobacco culture toward advocacy for tobacco cessation approaches, (2) region-specific challenges to program access, and (3) strong and diverse social influences on cessation.

Conclusions—To capitalize on changes from resistance to support for smoking cessation, leaders should incorporate culturally appropriate programs and characteristics identified here.

Keywords

smoking cessation; Appalachian region; program development

Cigarette smoking is responsible for more preventable deaths than any other behavior, with approximately 4.9 million lives lost each year due to smoking.¹ Smokers are at elevated risk for heart disease, diabetes, COPD, and many types of cancer. Lung cancer, the most common cause of cancer mortality, accounts for approximately one third of all cancer deaths, and smoking is a primary risk factor.²

Despite the near 50% reduction in smoking rates in the past 50 years, 44.5 million Americans continue to smoke.³ Kentucky ranks second among the 50 states and the District of Columbia for smoking prevalence and first for youth smoking and smoking-related mortality.⁴ Between 24 and 34% of adults residing in the 6 central Appalachian counties in which the current study was conducted smoke, compared to 21% of adults in the nation.⁵ Such high rates of smoking have contributed to elevated rates of morbidity and mortality among Appalachian Kentucky residents. For example, in the study area, deaths from lung cancer exceed the national rate by between 63 and 89%.⁵

Numerous factors contribute to high smoking rates in Appalachian Kentucky. Appalachian residents are more likely than their national counterparts to have lower socioeconomic status, a risk factor for smoking. In the United States overall, 29% of those living below the poverty level and 34% of those with less than a high school education smoke.⁶ In Appalachian Kentucky, 24% of residents live below the poverty level, and 37% have less than a high school diploma (compared to national rates of 12% and 20%, respectively).⁷ Additionally, long traditions of economic dependence on tobacco in resource-challenged economies traditionally have made communities more accepting of smoking.⁸ Even within metropolitan areas of Appalachia where farming is not the primary source of income, half of all primary care patients have had some personal relationship with tobacco production, sales, or use.⁹ Finally, smoking is heavily modeled by family and close social relations.¹⁰

Determinants of Smoking Cessation in Appalachia

Despite these factors contributing to high smoking rates in Appalachia, secular trends and characteristics of the region may promote smoking cessation. Agricultural dependence on tobacco is declining in Appalachian Kentucky; production decreased by 137,000,000 pounds from 1999 to 2000.¹¹ The number of Kentucky farms growing tobacco has also decreased from 59,000 in 1992 to 29,000 in 2002.¹² Decreased economic dependence on tobacco may reduce the taboo against antitobacco campaigns. Furthermore, the region is becoming more exposed to mainstream media via improved cable and Internet connections and the ubiquity of television.¹³ This exposure may inform and influence previously semi-isolated Appalachian residents about the dangers of tobacco use.

Additionally, interpersonal factors such as family's and friends' smoking behaviors and their perceptions of smoking affect cessation perceptions and attempts in Appalachian Kentucky.¹⁴ For example, although Appalachian residents may be aware of the long-term personal health effects of smoking, the desire to avoid harming those around them makes familial reasons to quit smoking more powerful than individual reasons.¹⁵ Friends and family who encourage quitting have been described as important motivators to smoking cessation in the region.^{15,16} Lack of access to parents' cigarettes also has a positive impact on preventing youth uptake of smoking in Appalachia.⁸ Physician recommendations to quit smoking have also been correlated with cessation attempts in Kentucky.¹⁷

Intervention Programs in Appalachia

High smoking rates and negative health sequelae have led some researchers to examine optimal smoking cessation programs in Appalachia. Community-based programs (eg, the 12-step Cooper/Clayton program¹⁸ and the Quit line¹⁹) have targeted individuals, families, or groups in Kentucky, as have contingency management cessation programs operating via the Internet and other media (telephone, mail).²⁰ Other cessation intervention efforts in the region have been implemented by various health care providers such as physicians²¹ and dentists.²² Policy measures such as tax policies and smoking bans may also promote smoking cessation in the region.²³

Although these approaches are promising, such public health-focused interventions may have limited efficacy unless local perspectives are incorporated into programmatic planning.²⁴ Given the lack of current insight from local residents, continued high smoking rates in the Appalachian region, and high rates of church attendance in the region,²⁵ we worked with local churches and others interested in fostering smoking cessation. The goal of the current research was to understand community members' perspectives on smoking cessation programs that could be implemented through collaboration with churches in Appalachian Kentucky. The question that guided the current research was "What characteristics of smoking cessation programs do rural Appalachian Kentucky residents consider appealing?" The information gathered through this study is useful for informing the development of cessation intervention programs in the Appalachian region and similar locales.

METHODS

Because there is little published research on community members' preferences for smoking cessation programs, we employed focus groups (FG) with both current and former smokers and key informant (KI) interviews (an in-depth and targeted method to gather data from those with specialized knowledge²⁶). The procedures, measures, and analyses were similar between the FG and KI interviews. All protocols were approved by the University of Kentucky's Institutional Review Board, and all participants signed informed consent forms prior to participating in this study.

Setting

In 1965, the US Congress enacted legislation that designated a large geographic expanse from New York to Mississippi as *Appalachia*. The Appalachian region now includes 13 states, 410 counties, and 23 million residents – approximately one out of 12 Americans. Nearly half (42%) of Appalachia's residents are rural, compared with 20% of the rest of the nation.²⁷ Appalachian Kentucky, comprising 54 of the 120 counties in Kentucky, is located in the center of the region. Along with numerous assets, residents of these counties maintain health status, health behavior, and socioeconomic indicators that place them at elevated risk compared with their national counterparts.²⁸ For example, between one fifth and one third of residents in the study counties smoke cigarettes.⁵

Participants

Purposive and snowball sampling guided recruitment efforts,²⁹ and theoretical saturation principles informed our sample size.³⁰ As is standard in most qualitative paradigms and purposive sampling protocols, the intention is not to obtain a representative sample, but rather an inclusive and salient sample of those with backgrounds and insights appropriate to answer the research questions.³¹ Twelve FG (6 with current smokers [n=36] and 5 with former smokers [n=27]) were required before reaching saturation. For several reasons, most FG participants were recruited through churches. Many, if not most, people in the region attend church.²⁵ We leveraged our previous partnerships with churches, facilitating access to diverse participants (for example, African Americans in a predominantly white region). Finally, because the data collected were intended to inform the development of a faith-based intervention, insights gleaned from church participants could enhance appropriate and relevant programming. However, because some congregations perceive smoking to be sinful and even claim not to have smokers as church members, we also sought other venues to recruit FG participants, including health and social services agencies, neighbors and friends of our community-based staff, and health department patients.

In addition to FGs, we also conducted KI interviews with 23 participants (9 who had never smoked, 7 current smokers, and 7 former smokers). KIs included staff from local health departments and health clinics, including technicians, nurses, and physicians; those who coordinate smoking cessation programs, including a federally qualified health clinic director who conducts a tobacco treatment program; current and former smokers from the local communities; and individuals who had made multiple quit attempts.

FG participants received a meal and an honorarium (\$25), whereas key informants received only an honorarium (\$25). Table 1 displays the demographic characteristics of both the FG participants and the KIs.

Measures and Procedures

Our discussion guides (Tables 2 and 3) were developed by project staff, which included both academic researchers and community members.

Two members of our community staff with extensive experience organizing and moderating FG and KI interviews conducted the sessions over 5 months. The community staff consisted of 2 primary moderators who conducted all of the sessions with additional experienced staff members assisting them in collecting paperwork, taking field notes, and writing memos. The following steps were taken to ensure consistency: one discussion guide was used, transcripts were reviewed immediately to detect deviation from or incompleteness of the discussion guide, and outside investigators periodically attended the sessions. Most sessions lasted 90–120 minutes. The moderator opened by describing the purpose of the FG or KI interview and then posed the open-ended questions from the appropriate discussion guide to the group or individual. Upon completion of the discussion, participants completed a socio-demographic form.

Analysis

The tape-recorded sessions were transcribed by local, trained transcriptionists and reviewed for accuracy by the community staff. The transcripts were then imported into NVivo (QSR, Melbourne, Australia) for coding, organization, and analysis. Coding began with one researcher engaging in line-by-line coding of the transcripts, affixing codes to each text segment. She then worked with another researcher to define and refine codes, developing a preliminary codebook that allowed standardization of the content analysis and served as a record for definitions and operationalization of codes. The codebook was refined 6 times.³²

In addition to the standardization of the codebook, several steps enhanced the rigor and transferability of the data collection and analysis. First, we employed member checks through summarizing what was said at the completion of each FG or KI interview and asking participants if the team was posing relevant questions and comprehending the group's messages.³³ Second, consistent with standard interrater reliability techniques, transcripts were co-coded by 2 researchers resulting in a final rate of 85%, generally considered strong evidence of reliability.³⁴ Following standard qualitative research practices, ideas and themes that came up in multiple KI and FG interviews are presented in the next section along with representative quotes from participants.

RESULTS

Perspectives on Quitting Smoking

Although many participants still smoked, nearly all described negative consequences of smoking such as threats to smokers' health and to those exposed to secondhand smoke. Current and former smokers reported that the benefits of smoking (alone time, the calming

effect of nicotine, appetite suppression, and relief of boredom) and physiological addiction made quitting difficult. Witnessing family members smoke encouraged smoking, whereas the health and desires of family promoted quitting. Coworkers and friends not only facilitated smoking by encouraging each other to take smoke breaks but also fostered cessation as smokers reported feeling like outcasts among their nonsmoking friends. Participants also reported that health care workers influence smoking behavior, by modeling smoking behavior or not advising smokers to quit (which encouraged continued smoking) or by engaging in efforts to help smokers quit (which fostered cessation).

Several current smokers indicated feeling increasingly marginalized with the implementation of smoking bans and some key community members' cessation. One current smoker noted that when the smoking ban was implemented in his county in 2006, it was among the first in Appalachian Kentucky, but it was supported by 70% of residents. The ban and its overwhelming support left smokers feeling like outsiders in a place where people once congregated around smoking. "No more—you see people huddle outside of the courthouse in the freezing cold, alone, because they aren't allowed to smoke. Nowadays, you're just sorry [locally term for "pathetic"] if you smoke. Before it was just normal." Participants indicated that such alienation and perceived humiliation have led prominent citizens to quit, only reinforcing the dramatic change in the desirability of smoking cessation.

Program characteristics -capitalization on personal motivation, accessibility, good leadership—Although participants highlighted several characteristics and components of programs likely to contribute to cessation, an individual's commitment to quitting was viewed as essential to success in quitting smoking. As one former smoker reported, "You have to be serious, really want to quit, and do whatever it takes to actually quit."

Participants stressed the need to capitalize on such motivation, primarily through enabling smokers to join a cessation class as soon as they develop the desire to quit, rather than being put on a waitlist. Such immediate access is important because, as one participant pointed out, "...a couple of days go by or a week goes by [after deciding to quit], and other things start to push into that person's life and the stressors come back, and as much as at that one moment they were ready to quit, and now they're not." One KI, a nurse practitioner who led cessation programs, reported that when she put people on a waitlist, up to 75% either could not be reached or declined to participate at a later date. A FG participant confirmed the problem of being waitlisted, noting that "me and my daughter wanted to quit once, but when we called the Health Department, they told me there was a big long list in front of us, and we never did call back."

A KI suggested letting people join a class at any point, noting that "for us what is nice about it is that we'll have someone who is here maybe for their eighth time with somebody who is here for their first time. And so that person who is here for the eighth time is a real encouragement and role model for the person who is here for the first time." Participants felt that programs had to be continuously restarted so that there was always one available when smokers wanted to quit. A current smoker indicated that "it can't be something you start and then quit. It has to be long term."

Because of the geographic isolation and high rates of poverty in Appalachia, participants felt that physical accessibility of a cessation program was also essential to programmatic success. Traveling long distances on challenging mountain roads was frequently mentioned as a barrier to participation, as was lack of access to reliable transportation. Thus, participants suggested implementing several programs at diverse or satellite locations within

the counties or region rather than holding one program in a centralized location. A current smoker reported that “it would have to be close, somewhere close to your home. I wouldn’t want to drive a county over.”

Cost was another factor associated with accessibility, according to participants. One KI, a volunteer health educator, indicated that “any costs associated with a program would be an important factor to keep in mind because for some people, maybe for a lot of people, that would be a hindrance.” Several participants indicated that a free program would be ideal, but many reported that keeping costs low would be sufficient, and still others emphasized the need for participants to contribute financially to cessation efforts. As one KI confirmed, “I believe that sometimes something becomes more valuable if you have to pay into it.... It would have been, ‘I paid that money,’ and so they would’ve had a little bit more of a connection or motivation to stay and participate because they had paid \$25.00 to participate.”

Participants reported that variable program scheduling would also enhance accessibility. Some participants reported working during the day and valued an evening program, whereas others thought weekends might be best. A few advocated early morning programs, indicating the need to address the urge to smoke upon waking. With the wide variation in program timing requests, a tobacco cessation coordinator at a local health department suggested, “I think it [program scheduling] needs to be versatile. If you could have 2 classes at a time, one daytime class and one nighttime class.... You got people on different shifts, working moms. You gotta take that into consideration.” Shift work, particularly in logging and coal mining operations, is a common phenomenon to Appalachian Kentucky and figures prominently into accessible programming.

In addition to capitalizing on motivation to quit and being accessible in a variety of ways, participants indicated that successful programs should have socially supportive leaders who are sensitive and well trained. Participants emphasized the necessity of greater sensitivity due to transitions from pro-tobacco culture to an antitobacco culture. Good leaders would avoid criticizing or insulting participants and, as a FG participant indicated, would “...make people aware and not like a second-class citizen, be more caring about the smokers.” Emphasizing the asset of social support, participants recommended providing buddy programs and having former smokers lead or participate in classes, sharing their experience with would-be quitters. A current smoker reported that “it’s very important that you have former smokers to talk to current smokers rather than people who have never smoked. I think that would give them more determination.”

Participants indicated that good leaders should have and enforce rules for program participation, although they also advocated leaders’ being flexible. A KI with experience leading cessation classes reported that if smoking cessation participants must miss a session, “...they can come into my office and do the video and all that if something has come up and get their patches, but they can’t have somebody pick them up whenever they want to.” Another KI suggested having smoking cessation participants sign contracts acknowledging the rules and consistently encouraging them to follow the rules.

Program components -transportation and childcare, social support networks, nicotine replacement and other incentives, education, advertisement—In addition to the aforementioned characteristics of good programs, participants also discussed programmatic components that were likely to contribute to success. A former nurse and program coordinator at a local health department noted that “a lot of people would signup if they had transportation.” Another KI, a US Public Health Service commissioned officer, highlighted the importance of transportation for young people in a youth cessation program

she ran, indicating that”[students are] more dependent on somebody else for transportation.... And where they had wanted to have a class in the middle of the day, maybe parents weren’t available to transport them....”

Childcare was mentioned less frequently than the issue of transportation but often enough to warrant consideration. Participants reported that many would-be quitters have children who would need to be cared for while their parents took part in a cessation class. One KI mentioned that parents often “...ask, ‘Is it okay if I bring my kids?’ and I tell them it’s okay because I understand how it is.... I understand that completely because I have a kid, and it’s hard to find someone to watch a kid to do anything. If you can’t take your child with you, you don’t go [out] for a lot of people.”

Participants described how cessation can be bolstered by social support efforts ranging from role modeling and encouragement of cessation by health care providers to individual-level support and support groups. Participants indicated that health care workers should model the behavior they want their patients to adopt. As one KI, the director of management at a local community mental health center, put it, “I think the most powerful statement that I’ve experienced is when I have seen nurses and doctors or employees of a hospital smoke outside.” Participants also reported that support groups would allow smokers to discuss the challenges they face as they quit, get advice from others regarding how they handled such challenges, and see others model successful quitting behavior. Some participants also suggested having one-on-one support that would allow them to call for assistance when they became stressed or experienced a craving because, as one participant mentioned, cravings are short-lived, and if one can be distracted from it, the craving might pass.

Nicotine replacement therapy (NRT) and other incentives were frequently discussed as means of increasing participation in cessation programs although one man, a former smoker, stated, “My reward was the promise of better health.” One KI reported that “some of these programs offer free nicotine substances, patches, which serves as the incentive. Just because they get the free medicines, this keeps them motivated.” Several participants agreed, however, that providing NRT is not enough; class participation is essential.

Two concerns were raised with using NRT as an incentive. Such therapies cannot be provided to people under age 18 because they have not been FDA approved for use with children. Because many participants prioritized focusing on youth, they felt it necessary to develop alternative incentives for youth-focused programs. Additionally, because some forms of NRT require a prescription, lay-led classes cannot distribute all forms of NRT. Leaders of such classes reported having to spend significant amounts of time addressing questions about obtaining a prescription for NRT.

Some participants advocated monetary incentives. The director of management at a local substance abuse treatment facility indicated that “...if at the end you completed a program they would compensate you like \$50 or something, and that was encouraging.” A former smoker confirmed the value of such incentives, noting that “...it did make me want to push because...there was a monetary incentive.” A program specialist at a local health department reported that without incentives, a program’s success rate would be very low and went on to point out that “...it is sad, but we see it every day. It is horrible to say, but they just won’t come if they don’t get something.”

Another program component participants strongly endorsed was education. Recommended messages included positive information about the benefits of quitting, neutral or strictly factual information about the consequences of smoking, and information regarding the negative aspects of smoking. As one KI put it, “I think just getting the education out there, in-your-face education about what smoking is doing to their bodies, what it’s doing to their

kids' bodies, whether they mean to or not." This education effort included increasing community members' awareness of local smoking cessation opportunities. Advertising suggestions included having those who had successfully quit promote the program, publishing notices in hospital newsletters, and advertising on local radio stations. Verbal advertisements were seen as being more effective than written ads although a FG participant recommended "...[putting]up fliers in the cigarette stores or beer stores."

Program types – community based, provider based, and policy based—In addition to suggesting appealing program characteristics and components, participants discussed types of programs that could work in the region. Discussion regarding community-based programs frequently revolved around the Cooper/Clayton method, a 12-week program created in Kentucky and employing trained facilitators to distribute NRT and provide education and social support.³⁵ Many participants perceived the program positively, describing it as being "...very thorough...and holistic in its approach."

Participants frequently emphasized the need to target youth with community-based programming. They focused on 3 key aspects of smoking behavior to target among youth: (1) prevention, (2) addiction avoidance (preventing youth who have tried cigarettes from converting their experimental behavior into addiction), and (3) cessation. Many participants differentiated between the time when they began smoking and when they became addicted, identifying a potential point of intervention.

Participants strongly recommended that provider-based programs leverage health care providers' status and expertise to encourage their patients to quit smoking. Several participants felt that health care providers have a duty to encourage patients to quit smoking, even if the patient expressed no interest in doing so. One KI demanded that health care facility administrators "...[teach] anyone working in the health area that it's their responsibility to make people aware of the dangers."

Although some current smokers indicated resentment of infringements on their right to smoke, most participants supported development and enforcement of policy-based measures to reduce smoking, including bans in public places and increased taxes on cigarettes. One KI, a former smoker, noted that "you used to be able to smoke anywhere you wanted to at any time, and now in town and businesses, smoking is restricted, and that is changing the attitude of smoking." Another former smoker concurred that bans "...helped [by] not allowing people to smoke in restaurants." Not all perspectives on smoking bans were positive, with some current and former smokers reporting feeling embarrassed about smoking or feeling less than human when they searched for a location to smoke. A current smoker shared, "I think that smokers have turned into outcasts. You can't smoke in restaurants or in so many feet of buildings. It is all understandable, but I feel ashamed in some situations because I feel like I'm the only smoker there. You feel embarrassed, but at the same time you have to smoke because you can't help it."

Discussion

Several new findings emerged from focus group and key informant interviews that we conducted to create a foundation for future community-based smoking cessation interventions. Many of these findings are relevant to other rural locales, which may suggest that Appalachians do not have unique and insurmountable cultural barriers to smoking cessation. Other findings, including transitions from pro-tobacco culture toward advocacy for tobacco cessation approaches, are culturally and regionally specific.

First, contrary to previously reported descriptions of the Appalachian Kentucky context, most participants strongly supported the implementation of smoking cessation programs in

their region. This was true regardless of participants' status as never, current, or former smokers (although never smokers were more likely to highlight challenges to getting others to quit whereas former and current smokers focused on personal barriers to cessation). Second, participants' description of smokers as outcasts is a very new phenomenon in a state that ranks 49th and 50th in the United States for adult and youth smoking, respectively.³⁶ Third, although a half century has passed since Appalachia was first highlighted as a region of severe resource deficiencies, such challenges continue to undermine access to cessation programs. Finally, our data corroborate recent national findings of the importance of social ties on cessation efforts. Less frequently reported is our participants' conclusion that health care providers support cessation not only by offering education and programming, but also through role modeling.

Despite the considerable progress over the past half century since the War on Poverty was launched from a cabin in Appalachian Kentucky in the 1960s, impeded access undermines cessation efforts. Challenges to accessibility may be present in other communities, but are of a much greater scope and intensity in Appalachian Kentucky given that the region has among the highest poverty rate,⁷ lowest educational attainment,⁷ poorest public transportation³⁷ and public health infrastructure, and persistent health care provider shortages,⁴⁵ along with some of the highest rates of smoking in the country.⁵

The absence of public transportation, combined with a relatively modest degree of car ownership in the region,³⁷ makes isolation and limited resources a tremendous challenge to programs that require sustained attendance. Lack of transportation and childcare have been identified as barriers to participation in health promotion programs in Appalachia,³⁸ and suggestions for addressing such issues have included using vans or buses (as churches in the region do) to provide transportation and including multiple generations in health-promoting activities.³⁹ Other program components such as incorporating social support,⁴⁰ providing NRT and other incentives,⁴¹ and including an educational component⁴² show promise for promoting healthy behaviors, including smoking cessation, in Appalachia.

Implementing programs at a variety of levels, from community-to provider-to policy-based initiatives, can foster smoking cessation in Appalachia. All local health departments in Kentucky offer smoking cessation programs,⁴³ with most offering the effective community-based Cooper/Clayton program.⁴⁴ Regrettably, fewer than 40 out of each 10,000 adult smokers in the region participate in such programming, likely due to impeded access.⁴³

Previous studies in Appalachia have indicated that provider-based interventions (including those involving physicians, nurses, dentists, and pharmacists) can successfully facilitate smoking cessation.^{21–22} Unfortunately, given the significant health care provider shortage in the region⁴⁵ the time available to provide counseling in health care settings may be limited. However, even brief advice from a physician has been demonstrated to move smokers to the next stage of readiness to change.⁴⁶ Physicians and other health care workers could be trained to encourage all of their smoking patients to quit although their own smoking behavior may affect their likelihood of doing so.⁴⁷ At the least, as participants in the current study suggested, physicians should role model the behavior they wish their patients to adopt.

Finally, policy-based efforts can also facilitate cessation. In 2007, 65% of the US population resided in areas with local or statewide smoking bans, whereas only 22% of Kentuckians lived in such regions.⁴⁸ Evidence indicates that smoking rates decrease significantly in response to such bans even when controlling for confounding factors such as age, gender, and socioeconomic status.⁴⁹ Only one county represented in the current study has a countywide ban on smoking in public places.⁵⁰ Because some study participants reported that smokers are willing to fight for their right to smoke in public, careful attention must be

paid to the needs and desires of residents if antismoking policies are to be implemented successfully.

Limitations

This manuscript is among the first of its kind to explore Appalachian residents' perspectives on smoking cessation programming in their region, a locale with some of the highest rates of smoking in the nation. Although some of the findings may not be unique to Appalachian Kentucky, to our knowledge, they have not been previously reported regardless of the region's high rate of smoking. Despite the significance of these findings, however, the study is not without limitations. Some of the negative attitudes about smoking and the positive perspectives toward smoking cessation programming derive from participants for whom smoking and cessation are salient (former smokers or health care providers, public health department administrators, etc). Even though we included current smokers, their willingness to participate may indicate a more critical perspective on smoking.

Additionally, because we were developing a foundation upon which future faith-based community cessation programming could be built, our findings might not apply outside that context. However, because the vast majority of Kentucky Appalachian residents have a church affiliation and many people (including African Americans) may be more willing to participate in research if recruitment occurs in a trusted environment, this venue maximized our access to residents in the study counties.

We found no differences in perspectives on cessation programming based on race; however, we had a limited number of African American participants. Although we intentionally over sampled African Americans compared to their representation in the region, future research might further examine minority perspectives on cessation programming. In addition, given our community intervention focus, we did not include questions regarding public policies, which might have elicited information useful for policymakers. Future work should consider residents' perspectives on increasing cigarette prices and taxes as well as clean air policies. Finally, although these FG and KI interviews took place in several counties in Appalachian Kentucky, because our sample included only Kentuckians, we do not purport to represent all Appalachian perspectives.

In conclusion, the challenges to smoking cessation in Appalachia represent an extreme version of what many other marginalized communities experience and, thus, offer insights on fostering cessation efforts. A novel finding—that although smoking is common in rural Appalachia, many residents, including current smokers, support smoking cessation programs and policies—is encouraging. It is essential to pay careful attention to program characteristics and components desired by Appalachian residents to enhance the efficacy of cessation programs. Through such attention, smoking cessation program developers are more likely to create appropriate programs and to facilitate higher and sustained quit rates among rural Appalachians and others.

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Table 1

Descriptive Statistics of the Participants

	Focus Group Participants (n=63)	Key Informants (n=23)
Variable	n(%)	n(%)
Sex		
Male	23(37)	4(17)
Female	40(64)	19(83)
Age -mean (range)	50(18–83)	51(24–75)
Race		
White	56(89)	23(100)
African American	7(11)	0(0)
Education		
Ninth grade or less	4(7)	1(4)
Some high school	10(18)	1(4)
High school graduate	18(32)	0(0)
More than high school	24(43)	21(91)
Smoking Status		
Never smoked	N/A	9(39)
Current smoker	36(57)	7(30)
Former smoker	27(43)	7(30)
Marital Status		
Never married	11(18)	1(4)
Married	29(46)	17(74)
Separated/Divorced	16(25)	4(17)
Widowed	13(11)	1(4)
Perceived Income Adequacy		
Struggle to get by	28(46)	7(30)
Enough to get by	22(36)	6(26)
More than I need	11(18)	10(44)
Actual income		
Under \$10,000	19(30)	0(0)
\$10,001–20,000	15(24)	4(17)
\$20,001–30,000	14(22)	2(9)
\$30,001–40,000	3(5)	0(0)
Over \$40,001	10(16)	14(61)

Focus Group Participants (n=63)		Key Informants (n=23)
Variable	n(%)	n(%)
Unable/unwilling to say	2(3)	3(13)
Perceived Health Status		
Excellent	2(3)	3(13)
Very good	14(22)	8(35)
Good	25(40)	7(30)
Fair	18(29)	3(13)
Poor	4(6)	2(9)

Table 2**Key Informant Interview Guide**

1	What programs have been successful here? Why were they successful? What programs bombed here? Why did they bomb?
2	If we were setting up a program here in _____ County to try to help people get more smoking cessation, what should we keep in mind?
3	These are some programs that have been popular in some communities. Can you let us know what you think about each of them? Cooper/Clayton classes Cooper/Clayton classes at church Tobacco treatment programs thru health dept or doctor's office Quit and win or other contest programs
4	What would we have to remember about setting up these programs? What about location? Time/schedule?
5	What have we missed? Is there anything we should have talked about regarding smoking cessation programs but didn't?
6	Out of all the things that were said here today, what is the most important point for us to keep in mind as we plan a tobacco treatment program for _____ County?
7	Is there anyone else you think I should talk to about this project?

Table 3**Focus Group Interview Guide**

Questions for all FG participants	
1	What led you to start smoking?
2	What were/are reasons it's hard to quit smoking? Probe for both internal (eg, feelings, beliefs, personal traits) and external suggestions (eg, influence of friends, family, community, available resources).
3	We want to understand what makes a tobacco treatment program fly in _____ County and what makes it crash. I'd like to ask you to think about different types of programs that have been offered in _____ County.
4	What programs have been successful here? Why were they successful? What programs bombed here? Why did they bomb?
5	If we were setting up a program here in _____ County to try to help people get more smoking cessation, what should we keep in mind? What about location? Times and scheduling?
6	What have we missed? Is there anything we should have talked about regarding smoking cessation programs but didn't?
7	Out of all the things that were said here today, what is the most important point for us to keep in mind as we plan a tobacco treatment program for _____ County?
Additional questions for former smokers only	
1	What caused you to quit?
2	What advice would you pass along to someone who is trying to quit smoking?
Additional questions for current smokers only	
1	What do you enjoy about smoking? What are some of the negative things about smoking?
2	Would you like to quit smoking? What are some reasons you would like to quit smoking?
3	What methods have you tried to help you quit smoking in the past? How did it go?
4	You each have a piece of paper in front of you. These are some programs that have been popular in some communities. Can you let us know how likely you would be to participate in these programs? (Listed included Cooper/Clayton classes, Cooper/Clayton classes at church, tobacco treatment programs through health dept or doctor's office, Quit and win or other contest programs.)