Review

Applying Anthropology to Eliminate Tobacco-Related Health Disparities

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Abstract

Introduction: Disparities in tobacco's harm persist. Declines in smoking among the general population have not been experienced to the same extent by vulnerable populations. Innovative strategies are required to diminish disparities in tobacco's harm. As novel tools, anthropological concepts and methods may be applied to improve the design and outcomes of tobacco cessation interventions.

Methods: We reviewed over 60 articles published in peer-reviewed journals since 1995 for content on anthropology and smoking cessation. The specific questions framing the review were: (a) "How can lessons learned from anthropological studies of smoking improve the design and effectiveness of smoking cessation interventions?" (b) How can anthropology be applied to diminish disparities in smoking cessation? and (c) How can qualitative methods be used most effectively in smoking cessation intervention research?

Results: Three specific disciplinary tools were identified and examined: (a) culture, (b) reflexivity, and (c) qualitative methods. Examining culture as a dynamic influence and understanding the utilities of smoking in a particular group is a precursor to promoting cessation. Reflexivity enables a deeper understanding of how smokers perceive quitting and smoking beyond addiction and individual health consequences. Qualitative methods may be used to elicit in-depth perspectives on quitting, insights to inform existing community-based strategies for making behavior changes, and detailed preferences for cessation treatment or programs.

Conclusions: Anthropological tools can be used to improve the effectiveness of intervention research studies targeting individuals from vulnerable groups. Synthesized applications of anthropological concepts can be used to facilitate translation of

findings into clinical practice for providers addressing tobacco cessation in vulnerable populations.

Introduction

Tobacco-related morbidity and mortality closely follow lines of inequality, disproportionately harming ethnic minorities and socioeconomically marginalized and vulnerable populations. Nationally, declines in smoking prevalence among the general population have not been experienced to the same extent by vulnerable populations (Okuyemi, Sanderson Cox, Choi, & Ahluwalia, 2004). Disparities exist along the tobacco use spectrum, from targeted marketing of cigarettes by the tobacco industry, smoking initiation, degree of dependence, duration of smoking, quit attempts, and successful cessation (Fagan, Moolchan, Lawrence, Fernander, & Ponder, 2007; Moolchan et al., 2007). Disparities persist in smoking cessation treatment (offering by providers, access, uptake) and outcomes (Cokkinides, Halpern, Barbeau, Ward, & Thun, 2008). For example, Latinos are less likely to receive advice to quit from their providers; African Americans quit 34% less often than Anglo Americans; and American Indians have the highest smoking prevalence of major ethnic groups, yet the lowest quit ratio (Okuyemi et al., 2004). Additionally, secondhand smoke exposure is more prevalent in African Americans compared with Latinos and whites, and in lower income persons and blue-collar workers compared with higher income persons and white collar workers (Centers for Disease Control and Prevention, 2009).

Almost 70% of smokers are categorized as poor, living under the 200% poverty level (Barbeau, Krieger, & Soobader, 2000). Certain vulnerable populations are characterized by extremely high smoking prevalence and heavy smoking levels. Examples include homeless persons, among whom smoking is a

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striking 70% (Okuyemi, Thomas, et al., 2006b), and persons with any mental illness diagnosis (Banham & Gilbody, 2010b) or with serious and persistent mental illness, with a high smoking prevalence of 70–88%; 50% of whom are heavy smokers (≥ 20 cigarettes/day; Piper et al., 2010). Internationally, smoking is increasing in lower and middle income countries (LMICs) where it is predicted that over the next 30 years, 80% of deaths caused by tobacco use will occur (Nichter, 2010). Clearly, one's vulnerable social position is closely linked with the likelihood of experiencing tobacco's harm.

From a perspective termed critical medical anthropology, achieving structural changes in socioeconomic inequalities and institutionalized racism will diminish tobacco-related disparities. However, in addition to structural changes, cultural particularities of disadvantaged groups must also be accommodated when designing cessation interventions. Vulnerable and disadvantaged populations differentiate themselves from dominant groups through cultural processes such as social identity and utility that can portend significant barriers to a one-size-fits-all intervention approach. Since in LMICs, smoking is not concentrated in vulnerable populations but practiced across different social classes, anthropological smoking research in non-Western contexts contains key cultural lessons for adapting interventions to the particular challenges of vulnerable groups in the United States (Nichter, 2009).

To diminish the increasing concentration of tobacco's harm in vulnerable populations, it is critical to understand in detail the cultural context (social and cultural utilities) of smoking and quitting. Due to its traditional emphasis on vulnerable populations (e.g., indigenous, non-Western people), anthropology provides a novel contribution to the challenge of disparities and changing demographics in tobacco control research. From published research, we examined a set of lessons—methods and concepts—that can be applied to understand smoking relative to the social and cultural dynamics that may prevent or facilitate smoking cessation among vulnerable and disadvantaged groups.

Methods

A systematic literature search within Pubmed and Google Scholar databases was conducted using the terms “anthropology,” “culture,” “smoking,” and “smoking cessation.” In the first submission, the number of sources cited totaled 55, which increased to 66 in the second submission due to additional suggestions by reviewers. The sources cited reflect a higher analytical value in peer-reviewed articles and empirical studies published in English across national and international contexts. We developed three framing questions for the review: (a) How can lessons learned from anthropological studies of smoking improve the design and effectiveness of smoking cessation interventions? (b) How can anthropology be applied to diminish disparities in smoking cessation? and (c) How can qualitative methods be used most effectively in smoking cessation intervention research? The first and third authors read the selected sources critically with the framing questions in mind. We applied inductive data analysis to examine how themes identified in anthropological studies articulated with the framing questions. In these readings, we sought to translate contributions from anthropological studies, which are often observational, to the

design of contextually relevant smoking cessation interventions. In an iterative process, coauthors met to discuss the analysis, specifically the relevance of results to smoking cessation disparities. Recommendations for interventions designed to diminish U.S.-based disparities were developed from lessons learned in international settings. To increase the practical applications, we further synthesized the analysis into research and clinical recommendations accessible to smoking cessation practitioners.

Anthropological Tools Relevant for Increasing Effectiveness of Cessation Interventions

In this section, we discuss three anthropological tools relevant to the development of evidence-based interventions: (a) culture, (b) reflexivity, and (c) qualitative methods.

Culture

From an anthropological perspective, culture is a dynamic influence observable in social interaction and constantly shifting contingent on changes in context (place and social composition; Abel, Fitzgerald, & Plumridge, 2002; Bottorff, Olliffe, Kalaw, Carey, & Mroz, 2006). Rather than the popular definition as a static set of beliefs, culture is conceived by anthropologists as a project in the making. By using culture as a dynamic concept, we can examine why people smoke when they smoke across particular cultural contexts (Nichter, 2003); as well as why they quit when they do (see Table 1). Furthermore, designing a smoking cessation intervention may benefit from using the vector control approach used in malaria and dengue fever prevention, which is attentive to space and contextual influences. According to the vector control approach, certain spaces can be considered “breeding sites” and may trigger the idea, craving, and practice of smoking; certain social relationships that lead to increases in smoking can be considered “vectors” (Nichter, Quintero, Nichter, Mock, & Shakib, 2004). To intervene effectively will require assessing and converting the breeding sites and vectors that foment smoking into those that encourage cessation. Relevant questions include the following (see Table 2): What are key elements to contexts that generate or limit the craving to smoke? Likewise, in what situations do people feel most motivated to quit? And, how can interventions target social relationships considered vectors of smoking dependence?

By relation, the influence of messages from kin and social relations to the smoker must be examined closely (see Table 2). Interpersonal messages are especially important for vulnerable groups characterized by collectivist culture (social groups take precedence over individuals), stronger patterns of social reciprocity, and systemic limits on smoking cessation treatment and support (e.g., due to lack of health care insurance, cost of Nicotine Replacement Therapy, and counseling). Qualitative research can provide insights into how messages might best be delivered and what kind of content and tone will yield actual positive changes in smoking behaviors. Smoking cessation messages will vary across cultures, be flexible enough to encompass intracultural variation, and provide ideas of cessation as equally normative to images of smoking. Relevant questions include the following (see Table 2): Are there certain categories of people whose messages are especially likely to motivate a given group of smokers to quit (e.g., political figures, religious

Table 1. Applying Anthropological Tools to Improve Cultural Targeting of Smoking Cessation Intervention Effectiveness Research

Research components	Intervention Design	Recruitment and Retention into Cessation Trials
Anthropological tools	How can anthropological concepts increase effectiveness of smoking cessation interventions?	How can anthropological insights improve recruitment and retention of vulnerable populations in cessation trials?
Culture	How does smoking reflect core cultural values?	Work through existing networks of community-based organizations to recruit study participants
	What are core concerns about smoking and quitting smoking?	Review recruitment fliers with members of the cultural group to ensure cultural appropriateness
	What are existing mechanisms (e.g., seeking support, treatment, or services) for making life changes?	Does the research study design honor core cultural values?
	What is the dominant explanatory model of smoking dependence?	Understand and address concerns about intervention
	What are the personal utilities of smoking in this particular group, how does the intervention address those?	Gauge cultural appropriateness incentives with potential study participants to determine the most culturally approved forms of incentive
	What are the dominant meanings and perceptions toward pharmacotherapy in this group?	
Reflexivity	How do cultural values and concerns around smoking and quitting among a particular group differ from those of the research team?	How do concepts of time and timeliness differ between the researchers and the participants from a particular group?
	How will those values and concerns influence the extent to which certain interventions are accepted?	What cultural values and messages may be evoked to interest and engage participants?
	How can interventions best harness the reflexivity of smokers to promote cessation?	What incentives will address any differences to motivate continuous study participation over time?
Qualitative methods	What are the main concerns and perceptions limiting or facilitating cessation in this particular group?	Conduct interviews and focus groups on the motivations to participate in research such as preferred forms of communication and incentives.
	What are the usual methods used to quit smoking for this group and are they reflected by the designed intervention?	Involve members of the cultural group who would be potential participants in all aspects of the research.
	What are the detailed everyday life circumstances of this particular group that need to be accommodated by the intervention?	Evaluate the influence of the intervention study using interviews and focus groups.
	Elicit explanatory models of nicotine replacement pharmaceutical aids.	

leaders, younger kin relations, parents, coworkers, health care providers, teachers)? For example, for low-income women, messages from their children invoked feelings of guilt and motivations to quit due to wanting to be viewed as a positive influence by their children (Nichter et al., 2008).

By examining culture as a dynamic concept, anthropologists have identified four utilities or cultural meanings of smoking: (a) symbolic utility, (b) social utility, (c) affective utility, and (d) physical regulation utility (see Table 2; Nichter, 2003). For persons in vulnerable populations, a thorough and detailed understanding of such utilities has been shown to shed light on the meaning of quitting and improve the effectiveness of targeted smoking cessation interventions (Nichter, 2009).

The symbolic utility of smoking encompasses the ways in which smoking figures into a person's social identity or portrayal of self to others. The symbolic utility of smoking varies depending on the cultural context. For youth, smoking may signify an initiation into adulthood (Kobus, 2003) and as a rite of passage in contexts where such transitions are not marked by

formal rituals (Abaunza et al., 2001). In the United States, youth use smoking to portray an image of being older, an adult, more mature, and more sophisticated (Bottorff et al., 2003; Gallois, Lennon, McDermott & Owen, 2005). In the United States, smoking figures into adolescents' efforts to belong to the "cool" group (Bottorff et al., 2003; Gallois et al., 2005).

In countries of the global economic South, smoking may be used to express an identity that is more Western, modern (Danardono, Padmawati, Prabandari, Nichter, & Ng, 2009), or globalized (Nichter, 2009). Smoking has also been linked to masculine gender identity—particularly dimensions such as independence, self-control, risk taking, and autonomy across national contexts of the United States, India, and Indonesia (Nichter, 2009; Nichter, Mock, Quintero, & Shakib, 2004; Payne, 2001). Yet, the perception of smoking as a way to express masculinity changes over the life course. While smoking may be perceived as enhancing masculinity for middle-aged men, it may be equated with weakness in older men. In one study, for example, smokers in Canada perceived smoking to be an acceptable method of regulating emotions and remaining stable in order to fulfill supportive fatherly, partner, and breadwinner

Table 2. Translation Activities: From Ideas to Smoking Cessation Interventions for Persons Experiencing Tobacco-Related Health Disparities

Relevant anthropological concept	Translation activities: from ideas to interventions	Intervention from translation
Symbolic-smoking identities: social identity informs smoking and quitting behaviors. Smoking behavior is mediated by how individuals see themselves and how they want to be perceived by others.	Observe local tobacco-related advertisements to interpret the smoking and nonsmoking identities being promoted by corporations and government agencies. Observe smoking in social contexts in order to discover how individuals use cigarettes to project images of themselves. Interview smokers and nonsmokers about their perceptions of smoking and nonsmoking identities, paying attention to detailed differentials of types of smokers.	Use social marketing to counter smoking identities. Addressing core cultural concepts engaged in smoking behaviors. Create positive associations for the nonsmoking identity. Nonsmoking identities must be equally normative to smoking identities. Eliminate guilt and shame as consequences of slipping since these can be counterproductive to quitting efforts. Show cessation is normative by using quitting testimonials by leaders in the cultural group.
Social utility: smoking is used by people to facilitate social interaction.	Observe smokers in socially relevant settings to interpret the social uses of smoking. Interview smokers in depth to understand the social utility of smoking and the most effective cessation messages (content and deliverer). Conduct focus groups with former smokers to understand their strategies for facilitating social interactions.	Replace smoking with other culturally sanctioned objects or behaviors to achieve the same social utilities. Introduce other ways to facilitate social interaction or social belonging. Restrict smoking in “breeding sites” (contexts encouraging smoking). Examine and highlight reflexive concerns about effect of smoking on others. Develop and train social relations in the smokers’ networks to deliver messages that motivate quitting and result in positive cessation outcomes.
Peer pressure: peer pressure may be negative and encourage adolescent smoking initiation or positive and limit adolescent smoking.	Talk to former smokers about how they coped with peer pressure to smoke. Conduct focus group or interviews to gather information about culturally salient figures or messages that contribute to peer and internal pressure in appropriate settings.	Examine and promote culturally appropriate forms of cigarette refusal. Replace exchange of cigarettes with other objects. Foster peer influence that is positive and limits smoking.
Affect regulation: smoking is used as a tool to reduce stress, boredom, and other affects.	Interview smokers to gather information about affect management and its relationship to smoking habits. Interview partners and close friends to collect observational data on how smokers use smoking to manage affect. Interview former smokers (and current smokers) about alternative ways to manage affect.	Target the different affects being regulated with alternative pre-existing coping mechanisms. Use detailed behavior documentation methods (e.g., journaling or ecological momentary assessment) to assist smokers with identifying specific affects at specific time points they are addressing with smoking.
Physical regulation: smoking is also used to regulate body rhythms (awake/sleep cycles, digestion)	Interview smokers about times when they smoke to raise awareness of why and when they perceive smoking triggers.	Promote other, culturally appropriate, forms of physical regulation.

roles (Bottorff et al., 2006, p. 3101). Yet postpartum, smoking was inconsistent with ideals of fatherhood, prompting men to limit their smoking in efforts to be a good role model, to save money, and preserve a positive social identity in the views of their children.

The social utility of smoking encompasses the ways in which smoking may facilitate social interaction (see Table 2). Smoking can be used to mark a special occasion (Nichter, 2003). In Sri Lanka, for example, smoking is sanctioned at celebratory

occasions such as “Jollies.” Refusing to smoke was considered antisocial or culturally dishonorable. However, smoking outside of the Jolly by young people was disdained, indicating the importance of context. Doing so would be considered a vulgar waste of resources, which is perceived as shameful in a resource-limited setting. Furthermore, smoking is used at funerals to commemorate the deceased, and the type of cigarette purchased may symbolize the intensity of condolences expressed to family members of the deceased (Mehl & Seimon, 1998). American youth have used smoking to fulfill several social utilities

(Bottorff et al., 2003; Gallois et al., 2005). For U.S. college students, while viewed as a sign of dependence during daytime hours, heavier smoking patterns (e.g., six cigarettes in 2 hr) at parties is viewed as an acceptable form of cultural play (Nichter & Stromberg, 2007); and as a way to facilitate interaction across genders (Carkoglu, Lloyd-Richardson, & Nichter, 2010).

The social utility of smoking extends to friendships and for some may create a sense of community. For U.S. youth in the culturally defined developmental time period of adolescence, a time of establishing independence from parents, “bumming” or sharing cigarettes facilitates emotional intimacy and a sense of community (Bottorff et al., 2003; Gallois et al., 2005). Smoking is used by college students to gain social interaction as a break from the social isolation of studying during exams time (Nichter, Nichter, Carkoglu & the Tobacco Etiology Research Network, 2007). Furthermore, adolescents have described the sense of control that comes with smoking—control over self (independence) and control over others through selectively sharing or withholding cigarettes as well as choosing where and when to smoke (Bottorff et al., 2006).

Transitions to increased smoking have been associated with peer pressure (Flay, Hu, & Richardson, 1998). Among college students, other people smoking were present in over 90% of “first cigarette smoked” experiences as elicited using real-time methodology (Acosta et al., 2008). The importance of smoking to style and image has been identified as stronger for American teen girls compared with boys. In New Zealand, smoking and social group membership differed by gender; while young men could attain an alternative to “smoker cool” through participation in sports, that option was not available to girls. In order to be cool, they felt more pressure to smoke (Abel et al., 2002). Yet, peers may exert dual pressures, both to smoke or not to smoke, placing limits on friends’ smoking as a show of support. Positive peer influence in which friends discourage smoking (through chiding or offering alternatives) should be fostered (see Table 2).

The affective utility of smoking has been discerned across cultural groups. Most commonly, individuals have used smoking to manage negative affective states such as stress and depression (Kassel, Stroud, & Paronis, 2003; Magid, Colder, Stroud, Nichter, & Nichter, 2009). Smoking as a way to self-medicate stress has been identified as a motivation to smoke by low-income pregnant and postpartum women (Nichter et al., 2007), new fathers (Bottorff et al., 2006), and college students. Smoking is used by individuals not only to cope with stress but also to symbolically signal to friends a stressful time (Nichter et al., 2007). Boredom, specifically, has been indicated as an affective state managed by smoking by disparate populations including homeless persons (Okuyemi, Caldwell, et al., 2006a), adolescents (Nichter, 2003), as well as men in India (Nichter, Quintero, Nichter, Mock, & Shakib, 2004). Modernity, as a sociohistorical state, foments dependence on nicotine in youth because of expectations for immediate gratification. Such a cultural concern is reflected in forms of entertainment currently popular with youth that occur in short bursts (e.g., texting, video games, instant messaging; Nichter, 2003). Anxiety in various forms is self-medicated through smoking as well. In Java, people use smoking as a way to cope with “thinking-thinking,” a state akin to the Western psychiatric concept of anxiety in which a person cannot calm one’s thoughts (Ferzacca, 2001).

Using anthropological tools to understand utilities (see Table 1) and then translate utilities into smoking cessation interventions (see Table 2) is a promising strategy for increasing the effectiveness of those intervention rates and improving smoking cessation rates among vulnerable populations, thus diminishing disparities.

Why do people quit?: how culture influences the utilities of smoking and quitting. Rather than assuming a single model of smoking cessation, anthropologists have emphasized the culturally particular utilities of smoking and quitting. By relation, there are existing strategies for quitting within communities that may be harnessed to make interventions culturally *compelling*, not simply culturally appropriate. According to an anthropological perspective, quitting smoking requires replacing smoking with other behavioral patterns that fulfill the utilities of smoking. Utilities may be addressed in different types of interventions: (a) through motivational interviewing, a counseling technique aimed at resolving ambivalence, with evidence of improving smoking cessation and being effective for ethnic minority populations (Hettema, Steele, & Miller, 2005); (b) through tailoring messages to the culturally specific utilities of smoking.

In light of stronger norms of social reciprocity and collectivist worldviews whereby social groups are prioritized over individuals in vulnerable populations, the social utilities of smoking and quitting are especially important to target with cessation interventions. Shifting investigations of health-based perceived risks to include social as well as individual risks posed by smoking and quitting is one step. Specifically, aside from *individual health* risks of smoking, anthropologists call for a consideration of how individuals perceive the *social* risks of quitting. Social risks of quitting may include losing friends, social isolation, or compromising a desired social identity (e.g., as a good mother or father). In China, antitobacco campaigns have emphasized the benefits of long life for one’s brother, son, or father from quitting smoking (Kohrman & Xiao, 2008). By relation, harnessing predominant forms of supporting behavior change within a particular group can have positive results. One example is leveraging collectivist culture and using group-based cognitive behavioral therapy to obtain high smoking cessation rates in African Americans (Webb et al., 2010).

Like smoking, quitting carries symbolic meanings that vary across cultural groups. In India, if someone quits smoking, it implies to others around him that the person is very ill because cessation is only promoted in a clinical setting in conjunction with a severe diagnosis. To be maximally effective, tobacco education materials should address local meanings of quitting, honor the details, and pay attention to folk wisdom (Okuyemi et al., 2004). Cessation promotional materials should use culturally appropriate and detailed explanations of the specific mechanisms by which smoking causes harm and further health complications.

Reflexivity

Reflexivity is acquiring a profound understanding of one’s own cultural background perspectives of persons from culturally distinct backgrounds, in this case perspectives on smoking and quitting. To do so, researchers may use explanatory models (Kleinman & Benson, 2006), a way to systematically elicit culturally informed experiences of an illness or in this case smoking dependence,

cessation, or treatment. Explanatory models are the culturally informed perceptions of causality, anticipated changes, and concerns regarding tobacco dependence and smoking cessation treatment. They can be used to understand cessation-related behaviors. While for tobacco control researchers only cessation “counts,” quitting strategies such as cutting back are perceived as reducing significant harm by smokers, even light smokers (Nichter et al., 2007).

By building upon existing reflexivity in smokers (see Table 1), smoke-free household interventions informed by anthropology have made smoking cessation a male responsibility and family health issue. Particularly relevant in LMICs where men’s smoking prevalence is much more significant than women’s, the consequences of smoking (secondhand smoke) for women and children must be analyzed in addition to harms posed for the smokers. In contrast to an emphasis on individual consequences of smoking by the tobacco industry, measured harms must include morbidity, suffering, expenses, and opportunity costs for kin and social relations as well as the smoker (Nichter, 2009).

Qualitative Methods

Qualitative methods and analysis can elucidate the specific meaning of addiction or dependence in a particular group (Bottorff et al., 2003; Gallois et al., 2005; Johnson & Moffat, 2001), the existing methods of behavior change, and the detailed everyday life circumstances of a vulnerable group that need to be accommodated by the intervention (Table 1). For example, at what level of smoking do persons in a particular group perceive themselves as addicted or dependent? By relation, what is the cultural definition of being quit? Qualitative methods also can be used to understand perceived benefits and drawbacks of smoking cessation treatment. In-depth questions can be used to examine the disjuncture between what participants report they do and their actual behavior (Moscicki, Nichter, Shiffman, & Thompson, 2002), important in tobacco research due to the stigmatization of smoking in many contexts.

Within smoking cessation intervention studies, qualitative methods can be used to assess whether the most appropriate measures are used and whether wording of items accurately elicits the intended data point. Specific to research with a disparities focus, qualitative research may be used to obtain reflexivity, design interventions that target the specific utilities of smoking, and evaluate throughout the effects of the research on the community involved (see Table 1).

Conclusion

According to recent clinical guidelines, the most effective way to assist smokers in quitting is to complement pharmacotherapy with sociobehavioral interventions (Fiore & Jaen, 2008). Decreasing persistent disparities in tobacco use and cessation requires careful attention to intervention design and overall, a transdisciplinary approach (Fagan, Fernander, et al., 2007). While the social utilities of smoking have been extensively developed by anthropologists, there remains a need to pay attention to collective and interactive aspects of culture as they relate to *quitting smoking*. Smoking cessation interventions must be delivered in the most appropriate language, be considerate of core cultural values, mindful of the specific barriers to treatment, and specifically describe the health risks of smoking, resources to quit, and existing community-based strategies for indepen-

dence from tobacco addiction (Okuyemi et al., 2004). They also must honor, understand, and provide thoughtful replacements for the cultural relevance of smoking.

Our literature review provides examples of how anthropological tools of culture, reflexivity, and qualitative methods can be used by researchers to design effective interventions that improve rates of cessation in vulnerable populations. These studies have shown how culture can be dynamic and encompass the symbolic, social, affective, and physical regulation utilities of smoking and quitting. Anthropological studies have also demonstrated how using a reflexive approach can enable researchers to make interventions culturally compelling; to do so, we must (a) appreciate local cultural influences on smoking and quitting, (b) understand the realities of study participants, and (c) determine how reflexivity may characterize motivations to quit. Qualitative methods have also been used to elicit culturally specific perceptions regarding smoking, dependence, and cessation over all phases of research and to obtain insights into the culturally informed perceptions and preferences regarding smoking cessation interventions (Daley et al., 2006). In concert, culture, reflexivity, and qualitative methods can be applied as tools to ensure recruitment and retention of ethnic minorities in cessation trials and design culturally tailored interventions (see Table 1). Furthermore, they can be leveraged in the process of translating specific dimensions of research on cultural influences on smoking into cessation intervention practice (see Table 2). As a set of novel tools, they represent the vanguard in tobacco control research, which is currently facing changing epidemiological patterns of smoking, disparities in the experience of tobacco’s harm, and a need for innovative and effective smoking cessation interventions for vulnerable groups.

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