

Voinovich Center for Leadership & Public Affairs

**VOICES OF THE POPULATION GROUPS DISPROPORTIONATELY
AFFECTED BY TOBACCO USE ON:**

Tobacco Use, Tobacco Control, and the Effects of Tobacco

Sponsored by the Ohio Department of Health

Qualitative Data Gathering Through Focus Groups

Populations Disproportionately Affected by Tobacco Use

Location of Focus Groups throughout Ohio

2005-2006

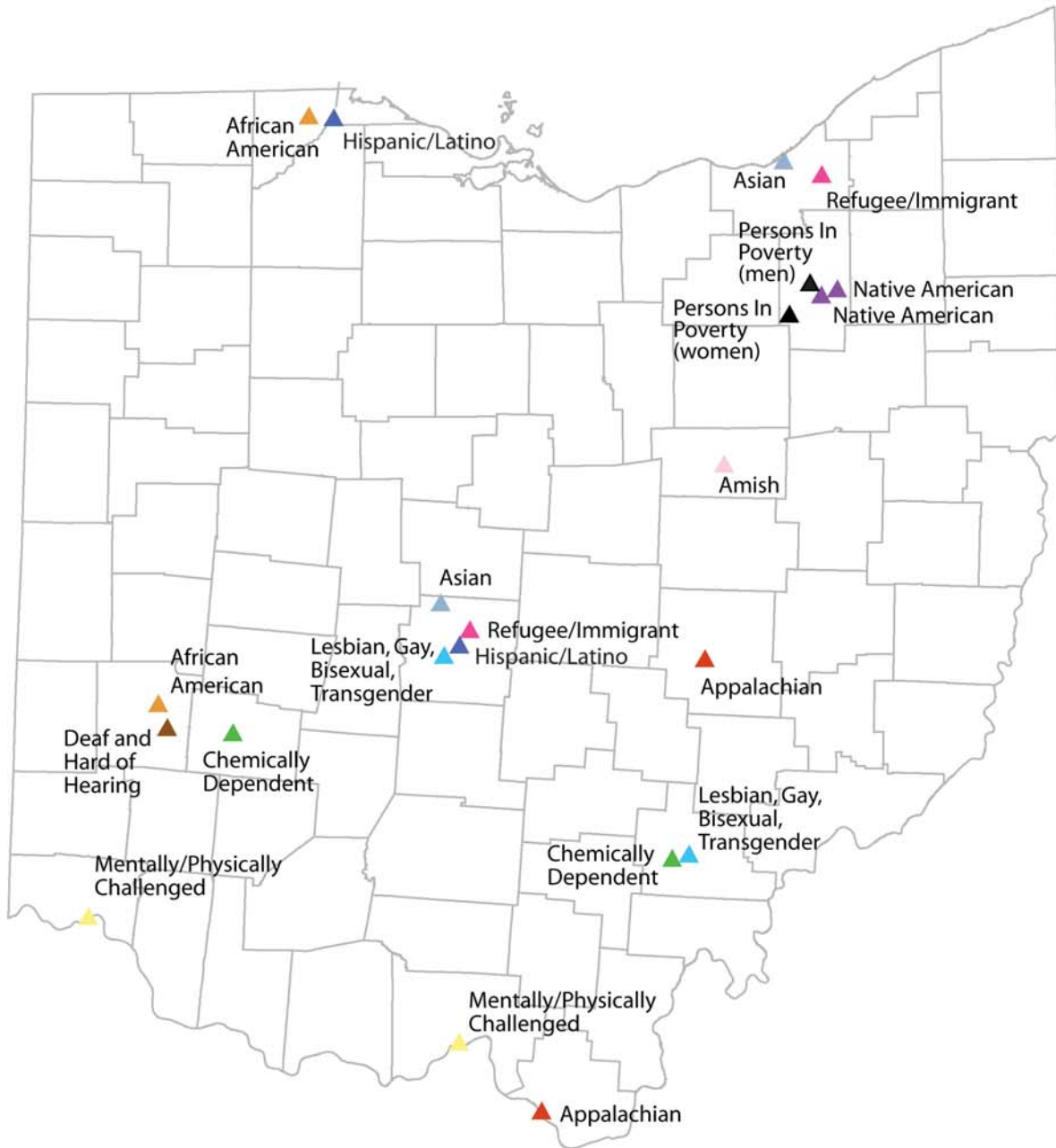


Table of Contents

| | |
|--|----|
| Acknowledgements | 3 |
| Introduction | 6 |
| Methodology | 7 |
| Survey Results | 13 |
| Findings | 17 |
| Conclusion | 22 |
| Attachment A: Focus Group Script | 24 |
| Attachment B. Tobacco Survey to Accompany Focus Group..... | 27 |
| Attachment C: Brief Description of Project | 28 |
| Attachment D: Consent Form for Group Participants | 29 |
| Attachment E: How to Plan a Focus Group..... | 31 |
| Attachment F: Focus Group Flyer | 32 |

List of Tables and Figures

| | |
|---|----|
| Table 1. Identified Population Groups for Data Gathering..... | 6 |
| Table 2. Categories of Information Drawn from Focus Group Discussion..... | 9 |
| Table 3. Agencies That Provided Access to Populations | 11 |
| Table 4. Demographic Characteristics of All Participants..... | 13 |
| Table 5. Participant Tobacco Usage | 15 |
| | |
| Figure 1. Data Sorting Model | 14 |

Acknowledgements

The following agencies and individuals were instrumental in organizing and implementing the focus groups. Without them, this project would not have happened.

AFRICAN AMERICAN

UMADAOP of Lucas County
2447 Nebraska Ave.
Toledo, OH 43607

Kathryn Grayson

Sankofa, Inc.
1 Elizabeth St.
Dayton, OH 45408

Carolyn Brooks

HISPANIC/LATINO

Adelante, Inc.
520 Broadway St.
Toledo, OH 43602

Grayce Shaw

Iglesia Vida Abundante
120 South Burgess Ave.
Columbus, OH 43204

Maria Carmen Lambia

ASIAN

Asian Services in Action
3631 Perkins St., 2C
Cleveland, OH 44114

Michael Byun

Asian American Community Services
7980 Harmill Dr.
Dublin, OH 43016

Lin Kang

NATIVE AMERICAN

North American Indian Cultural Center
111 West Ave.
Tallmadge, OH 44278

Jack Lyons, Jr.

Native American Indians and Veterans Center
P.O. Box 1319
Norton, OH 44203

Jack Lyons, Sr.

REFUGEE/IMMIGRANT

United Somali Refugees
3300 Cleveland Ave.
Columbus, OH 43224

Marian Ghedi

Jewish Family Services Association
24075 Commerce Park
Beachwood, OH 44122

Helen Tarkhanova

LESBIAN, GAY, BISEXUAL, TRANSGENDER

United Campus Ministry
18 North College St.
Athens, OH 45701

Mickey Hart

Stonewall Community Center
1160 N. High St.
Columbus, OH 43201

Kellye Pinkleton

CHEMICALLY DEPENDENT

Women's Recovery Center
515 Martin Dr.
Xenia, OH 45385

Gayden Fite

Health Recovery Services, Inc.
100 Hospital Dr.
Athens, OH 45701

Laura Hopstetter

MENTALLY/PHYSICALLY CHALLENGED

Shawnee Mental Health Center
901 Washington St.
Portsmouth, OH 45662

Cynthia Holstein

Cincinnati Association for the
Blind and Visually Impaired
2045 Gilbert Ave.
Cincinnati, OH 45202

John Mitchell

APPALACHIAN

Lawrence County Health Department
2122 S Eighth Street
Ironton, OH 45638

Debbie Fisher

Zanesville-Muskingum County Health Dept.
205 North 7th St.
Zanesville, OH 43701

Beverly Huth

PERSONS IN POVERTY

Haven of Rest Ministries
175 E. Market St.
Akron, OH 44309

Curt Thomas

AMISH

Your Human Resource Center of Holmes County
186 West Jackson St.
Millersburg, OH 44654

Mark Woods

DEAF AND HARD OF HEARING

Deaflink
211 South Main St., Suite 500
Dayton, OH 45402

Susan Fraker

Others we wish to thank are the leaders of the Goal #4 Participants, now known as the **Cross-cultural Tobacco Control Alliance**: Tracy Clopton, Lucinda Deason, Wendy Berry-West, and Surendra Adhikari.

We also wish to thank those who helped facilitate the groups, took notes and contributed to the writing and editing of the many pages of reports this project generated. Thanks go to: Aimee Collins, Kelly Cooke, Lucinda Deason, Ashley Demyan, Katey Foster, Anne Garrett, Sharon Hatfield, Lesli Johnson, Daniel Layman, Laura Milazzo, Barry Oches, Tom O'Hara, Todd Platt, William Tarter, and Brooke Watson.

Introduction

Goal four of the Centers for Disease Control and Prevention’s (CDC) *Best Practices for Comprehensive Tobacco Control Programs*¹ is to “identify and eliminate disparities related to tobacco use and its effects among populations disproportionately affected by tobacco use.” Sufficient data does not currently exist to determine the impact that tobacco use has on each of Ohio’s communities and what resources each community would identify as needed to reduce that impact.²

In 2005 the CDC awarded the Ohio Department of Health (ODH) Tobacco Risk Reduction Program a Disparities Supplemental grant to assist in gathering data related to racial/ethnic and other at-risk populations concerning their attitudes about tobacco use and tobacco use prevention. This prompted the ODH to distribute a Request for Quote (RFQ) for a qualitative data contractor to conduct focus groups on certain identified populations.

In the initial RFQ there were 11 populations identified. The RFQ specified conducting two focus groups of each population group. The populations were determined by the Tobacco Risk Reduction Program, which took into consideration race, ethnicity, geography and special needs of groups of people. The group designated chemically dependent or mentally/physically challenged was subsequently made into two separate groups. Midway through the project, an advocacy group representing the deaf population wanted the deaf and hard of hearing to be a separate group and not considered part of the physically challenged group. One focus group was then held of deaf individuals, and the number of Amish focus groups held was reduced to one. Table 1 shows a listing of the eventual 13 identified groups.

Table 1. Identified Population Groups for Data Gathering

| | | |
|----------------------|-------------------------------------|---------------------------|
| African-American | Deaf and hard of hearing | Persons in poverty |
| Amish | Hispanic/Latino | Refugee/Immigrant |
| Appalachian | Lesbian, Gay, Bisexual, Transgender | Veterans/Current military |
| Asian | Mentally/physically challenged | |
| Chemically dependent | Native American | |

¹ Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999.

² Ohio Comprehensive Tobacco Use Prevention Strategic Plan, 2004-2008; 2006 Update. Ohio Department of Health Tobacco Risk Reduction Program.

Altogether, 22 focus groups were held, involving 175 participants. Information from veterans and current military personnel was gathered by distributing the focus group questions printed on paper, with sufficient space between the questions for respondents to write their answers. Only one group each was held for the Amish population and the deaf population. The groups were held in the cities of Toledo, Cleveland, Akron, Columbus, Dayton and Cincinnati. Groups were also held in the rural areas of Appalachian Ohio, including Athens, Ironton, Millersburg, Portsmouth and Zanesville. The first group was held in December 2005 and the last group convened in June 2006.

Methodology

The purpose of the focus group study was to learn more about individuals' tobacco experience, awareness and perspective within certain Ohio communities for which little information currently exists in formal available literature. The project was also intended to inform the Goal #4 Participants,³ a statewide group of stakeholders who share an interest in identifying and eliminating the disparities related to tobacco use and its effects on population groups disproportionately affected by tobacco use. The ultimate goal was to achieve diversity, inclusivity and parity in the effort to reduce tobacco use, attain smoke-free environments and achieve equal access to health resources for all communities.

The first step in the process was to develop a script that would be used to initiate discussion among focus group participants. At the October 3, 2005, meeting of the Goal #4 Participants, members were asked what they wanted to learn from various identified populations. Draft questions were written down and then assessed as to whether or not they would elicit appropriate information from any group of people. The same questions would be used as discussion starters for all the focus groups, and the facilitator would be responsible for asking probing questions that would get information that could shed light on unique characteristics of specific population groups.

The three main categories of information included: (1) experience – i.e., what was their history of quitting tobacco use, what were the preferred products of the population group, what kept them from quitting and where were they most likely to use tobacco. When arranging for participants to be in the group, it was suggested that participants be current or recently quit tobacco users, but it was not a requirement. Within the focus group discussion, participants were

³ The term "Goal #4 Participants" will be used to refer to the group of stakeholders from around the state that met quarterly to discuss and provide input to the progress of this project. The group has subsequently been renamed to the Cross-cultural Tobacco Control Alliance.

not asked directly to share whether or not they currently used tobacco. This information was gathered through the anonymous survey handed out at the end of the group, although most participants shared about their use of tobacco within the first few questions. (2) Awareness – what they knew about media messages and marketing, and the health hazards associated with tobacco use. (3) Perspective on social behaviors – what their opinions and attitudes were on tobacco use and/or tobacco use prevention. Table 2 lists the categories and characteristics of each.

Prior to conducting the first focus group, the script and questions were tested on a group of college students at Ohio University. After the pilot, a debriefing was held to discuss terms, understandability of the questions and question order for the best flow. Revisions were made, and the script was distributed to the members of the Goal #4 Participants for their review and feedback. The focus group script can be seen as Attachment A of this summary.

A one-page survey was designed to gather the participants' demographic information including age, sex, race and zip code of residence. The survey also included information on the extent to which they used tobacco, product preference, age of initiation and other specifics. In addition, the Goal #4 Participants wanted to know the extent to which myths about tobacco use are believed by individuals. A list of 12 myths, documented in tobacco prevention research literature,⁴ was added to the survey as statements for the focus group participants to choose whether they were true or false. The survey can be seen as Attachment B to this summary. The overall results of the survey will be discussed in another section.

The most challenging part of the project was planning/organizing the focus groups. Advertising in print media for focus group participants was not considered a viable option because of the expense and time constraints. Instead, the agencies that work with the various populations around the state were contacted for their assistance. Of the 22 focus groups that were conducted, seven were arranged through members of the Goal #4 Participants group. Six others were arranged through grantee agencies of the Ohio Tobacco Use Prevention and Control Foundation (TUPCF). The remaining nine focus groups were arranged through agencies found in directories, through professional contacts or from Internet searches. Table 3 contains a list of the agencies who provided help with the focus groups.

⁴ Thomas R. Frieden, and Drew E. Blakeman. *The Dirty Dozen: 12 Myths That Undermine Tobacco Control*. American Journal of Public Health, American Public Health Association, vol. 95, no. 9 (2005 Sep): 1500-5. http://www.rednova.com/news/display/?id=229652&source=r_science.

Table 2. Categories of Information Drawn from Focus Group Discussion

| | |
|---|--|
| <p><i>Experience</i> (either their own or as a representative of the community)</p> | <ol style="list-style-type: none"> 1. Prevention and cessation activities in which participants were involved 2. Types of tobacco products used and popular brands 3. Perceived barriers to quitting 4. Environments and activities associated with tobacco use |
| <p><i>Awareness of tobacco influences</i></p> | <ol style="list-style-type: none"> 1. Current media messages about tobacco danger 2. Current marketing techniques by tobacco manufacturers 3. Availability of tobacco products to youth 4. Health problems associated with tobacco use; general and within family/friends 5. Danger of secondhand smoke |
| <p><i>Perspective on activities and behaviors associated with tobacco use</i></p> | <ol style="list-style-type: none"> 1. Reasons behind tobacco use 2. Differences of use habits among sub-groups of population 3. Effective messages to encourage prevention or quitting 4. Reasons behind using or quitting by individuals 5. Impact of modeling tobacco use on youth 6. Rights of nonsmokers 7. Current political campaigns for local/state clean indoor air ordinances |

One population group, current military and military veterans, was particularly difficult to access with this strategy. Ohio is home to a large air force base, Wright Patterson AFB in the Dayton area, and has numerous veterans’ medical centers. Much time was spent in providing the proper documentation to align with the research protocols required to access the military health-care system, which has active tobacco cessation programs for personnel and veterans. Ultimately, the deadline for ending the project forced abandoning this strategy. Instead, the focus group questions were distributed to known active military persons and veterans through the personal contacts of members of the Goal #4 Participants group.

Once a contact person agreed to help organize a focus group of a particular population, that person was sent additional information about the project. These documents are included as Attachments C, D and E. They include a brief, one-page description of the project, suggestions for setting up a focus group and a flyer that could be posted on a bulletin board in order to attract participants. The contact person was asked to provide access to two resources: group participants and a facility in which to hold the meeting. The contact person was also informed that the focus

group facilitator would bring snacks and soft drinks and two \$25 Wal-Mart gift cards⁵ that would go to two participants of the group as a result of drawing two names at random. The typical length of time it took from initial contact with an agency to actually conducting the group was between six weeks and two months.

Participants of the groups were not randomly selected; therefore the information they provided through the discussion and survey cannot be generalized to the population they represent. The cooperating agencies are typically set up to provide services to the population group under consideration. Of the sets of focus group participants, 13 of the groups consisted mainly of recipients of that agency's services. Seven sets of participants were friends and/or acquaintances of the contact person and were representative of the population group. Two sets of participants were gathered as a result of responding to an email announcement of the focus group distributed via the agency's mailing list.

Non-English Speaking Focus Groups

From the outset, it was expected that conducting focus groups with non-native speakers of English would be a challenge. Altogether, five focus groups were conducted in different languages: one in Somali, two in Spanish, one in Vietnamese and one in American Sign Language. For the Vietnamese group, the contact person thought all participants would be fluent in English. However, several persons came in addition and a person who was very skilled with both English and Vietnamese acted as both a participant and the interpreter. For the others, interpreters were arranged in advance and the consent form and survey were translated for participants. A definite challenge was the difficulty with asking follow-up and probing questions from participants. The interpreters attempted to translate verbatim each participant's responses; however, in this type of group discussion some of the group dynamic and flow was interrupted by the use of a third person.

With the deaf and blind groups, the consent form and the survey were sent to the contact person ahead of time so that the participants could have time to review them and have others help them with the information if necessary.

⁵ In three groups, a \$50 gift card was provided for one individual, and in another group, ten individuals received a \$5 Speedway gas card. The variation depended on what the contact person thought would work best as an incentive.

Table 3. Agencies That Provided Access to Populations

| Population | Agency | Location | Date |
|-------------------------------------|--|-----------------|-------------|
| African-American | UMADAOP of Lucas County | Toledo | 2-21-06 |
| | Sankofa, Inc. | Dayton | 6-22-06 |
| Asian | Asian Services in Action | Cleveland | 1-26-06 |
| | Asian American Community Services | Dublin | 5-21-06 |
| Hispanic/Latino | Ohio Hispanic Coalition | Columbus | 1-25-06 |
| | Adelante, Inc. | Toledo | 2-21-06 |
| Native American | North American Indian Cultural Center | Tallmadge | 4-4-06 |
| | Native American Indians and Veterans Center | Norton | 6-13-06 |
| Appalachian | Lawrence County Health Department | Ironton | 2-23-06 |
| | Zanesville-Muskingum County Health Department | Zanesville | 4-26-06 |
| Refugee/Immigrant | United Somali Refugees | Columbus | 12-7-05 |
| | Jewish Family Services Association | Beachwood | 5-10-06 |
| Mentally/Physically Challenged | Shawnee Mental Health Center | Portsmouth | 1-31-06 |
| | Cincinnati Association for the Blind and Visually Impaired | Cincinnati | 5-24-06 |
| Lesbian, Gay, Bisexual, Transgender | United Campus Ministry | Athens | 1-12-06 |
| | Stonewall Community Center | Columbus | 2-16-06 |
| Persons in poverty | Haven of Rest Ministries | Akron | 5-8-06 |
| | Haven of Rest Ministries | Akron | 5-8-06 |
| Chemically dependent | Women's Recovery Center | Xenia | 12-8-05 |
| | Health Recovery Services, Inc. | Athens | 4-10-06 |
| Deaf and hard of hearing | Deaflink | Dayton | 4-18-06 |
| Amish | Your Human Resource Center of Holmes County | Millersburg | 6-21-06 |
| Veterans/Current Military | (paper questionnaires distributed) | statewide | June 2006 |

Cultural Focus

The basis of this project has to do with recognizing cultural differences between various population groups and tailoring tobacco prevention and cessation efforts accordingly. The intent was to gather information from population representatives about the beliefs, attitudes and behaviors toward tobacco use of that population. For most population groups, participants did not like, nor could they understand the need for being separated out from the general population to answer questions about tobacco use. In addition, some individual participants could represent more than one of the population groups being studied. For example, a person living in Appalachia could also be living in poverty, a veteran, physically challenged and a Native American.⁶ His or her comments could be applied to any of the five different populations. To simplify however possible, the persons were considered members of a single group and their voices analyzed within that group only.

Another cultural issue faced was that the group facilitators were typically not of the culture having the discussion. A question brought up by the Goal #4 Participant group had to do with the validity and/or reliability of information elicited by facilitators; for example, Caucasian facilitators conducting a focus group with persons of color. Research on this issue shows that the effect of the facilitator on group participants can be lessened through efforts taken by the facilitator. David Morgan writes⁷ that the participants' interaction among themselves at the focus group will replace their interactions with the interviewer (p. 18). The desired atmosphere of the focus group is to be similar to a dinner table conversation. The subject gets raised and the people around the table respond with what they think about what is being said by others. The facilitator should consciously reduce his or her involvement in the group discussion. This is supported by Esther Madriz's article "Focus Groups in Feminist Research."⁸ She writes that the "multi-vocality of participants limits the control of the moderator" (p. 840). The facilitators in this project attempted to decrease their own involvement in the discussion through an introduction of how the focus group would be run. They then told the group that they had some questions that they would go through, but the participants were encouraged to respond and build on what other participants said. Each participant did not need to respond directly back to the facilitator for each question.

⁶ This is just an example. No such person was a participant of any group.

⁷ Morgan, D. L. (1997). *Focus Groups as Qualitative Research*, second ed. Thousand Oaks, CA: Sage Publications.

⁸ In Denzin, N. K. & Lincoln, Y. S. Eds. (2000). *Handbook of Qualitative Research*, second ed. Thousand Oaks, CA: Sage Publications.

Data Analysis

The data were collected from 22 focus groups plus eight questionnaires filled out by military personnel and veterans. This resulted in a large volume of qualitative data to be analyzed. As advised by Richard Krueger,⁹ the purpose of the project drove the analysis of the data. Researchers went back through the RFQ and other initial resources to identify the foundational purpose of the project. It is: to learn more about individuals' tobacco experience, awareness and perspective within certain Ohio communities for which little information currently exists in formal available literature.

To be systematic about the analysis and make it verifiable, the process started with the lead group facilitator and two graduate students coding the same transcripts and then comparing their findings. All started with the three main categories of experience, awareness and perspective, and then looked for subsequent themes that emerged. Afterwards, they got together to compare their findings. With some adjusting, they agreed upon sub-categories and topic areas within each. The topic areas were sufficiently broad so that information from each population could be coded. The model in Figure 1 shows the coding schema used for each population.

Survey Results

At the end of each focus group, a survey was distributed to participants that included five questions concerning personal tobacco use behavior, four demographic items and a list of 12 common tobacco myths for which they were to label true or false. In total, 165 of the 175 participants completed surveys. Table 4 below shows the demographic characteristics of the participants. When interpreting the data from the survey, one should remember that the respondents were not randomly selected.

Table 4. Demographic Characteristics of All Participants

| Population group: All populations | | Total responses: 165 | | |
|--|-----------|-----------------------------|-----------------|-----------------------|
| Sex | | Age | | |
| 47% men | 52% women | Range | Average | Median |
| | | 19 to 80 | 43.5 yrs | 44 yrs |
| Race of Participants | | | | |
| 9% Native American | | 16% African-American | | 4% Asian |
| 1% API* | | 51% White | | 18% Other or biracial |

* Includes Native Hawaiian and Pacific Islander.

⁹ Krueger, R. A., Casey, M. A. (2000). Focus groups: A practical guide for applied research, third ed. Sage Publications: Thousand Oaks, CA.

When asked to respond to questions about their tobacco usage, the proportion of participants who had used tobacco in the past 30 days was 55 percent. Two-thirds of these had used tobacco on all of the past 30 days. This rate is higher than the state average, but it is influenced by the request at the outset for the participants to be tobacco users or recent quitters. Table 5 shows this and other tobacco usage behaviors of the participants.

Figure 1. Data Sorting Model

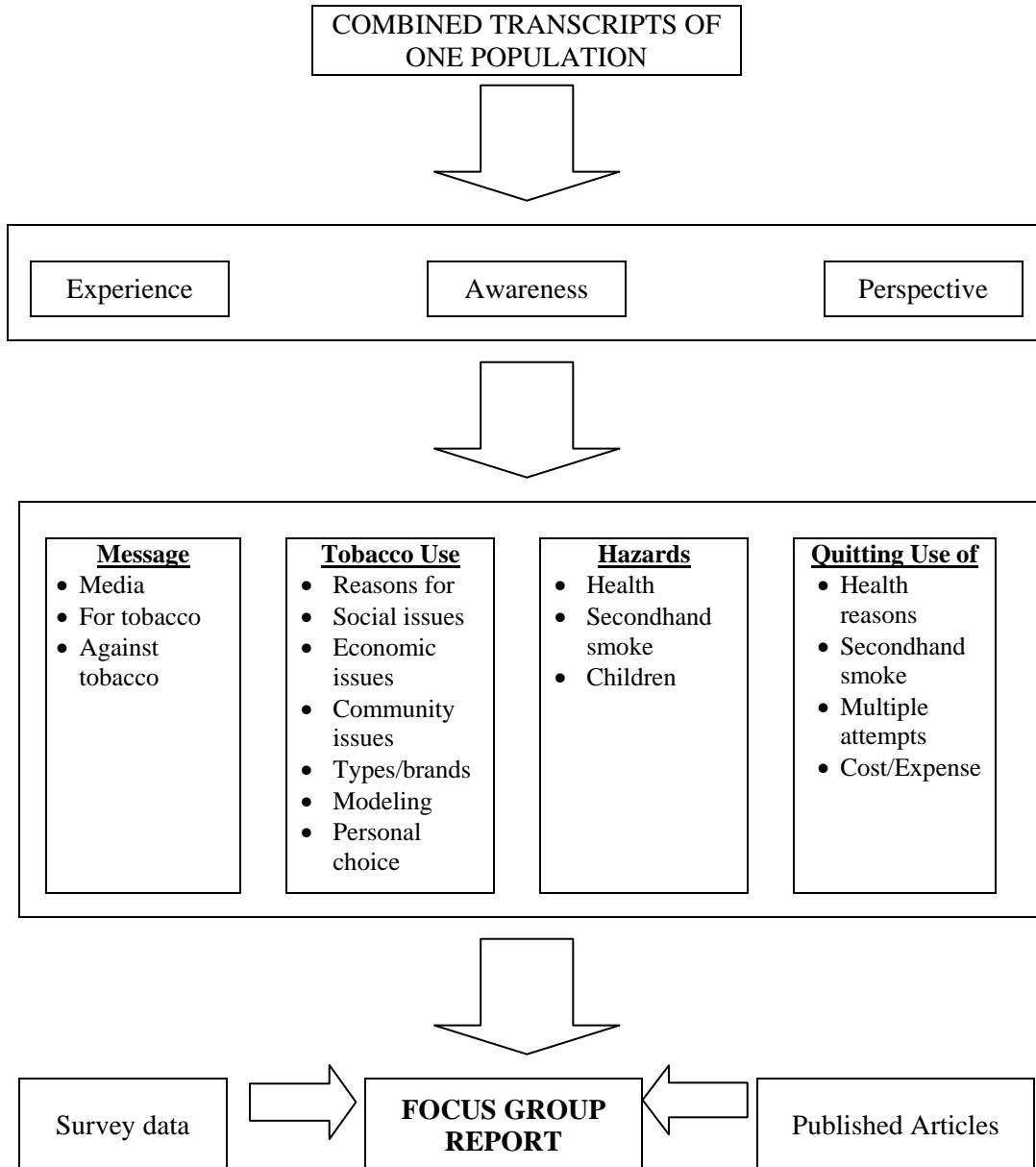


Table 5. Participant Tobacco Usage

| | | |
|---|---|-----------------------------------|
| Population group: All populations | | Total responses: 165 |
| Participants to use tobacco in past 30 days: 55 % | | |
| Participants' average age of initiation to tobacco use: 17.5 years | | |
| Proportion of Participants Who Intend To Use Tobacco in Next 12 Months | | |
| Yes, will definitely use 34% | No, will definitely not use 24% | Don't know/Not sure 19% |
| Yes, will probably use 13% | No, will probably not use 10% | |
| Proportion of Participants To Use Various Tobacco Products | | |
| Cigarettes 93% | Black & Milds, Philly Blunts, etc. 39% | |
| Smokeless tobacco 17% | Other 7% | |

Comparing the 61 participants who are current users (responded that they had used tobacco all 30 of the past 30 days) with the intent to use in the next 12 months, yields the following information: 36 (59 percent) said they definitely will use, ten (16 percent) said they will probably use, one (2 percent) said he/she will probably not use, two (3 percent) said they would definitely not use, ten (16 percent) said they did not know and two (3 percent) did not answer. Obviously, a very small percentage, five percent, of the participants who currently smoke daily feel they are willing to stop, at the time of the focus group. Comparing the 83 participants who used tobacco on three or fewer days in the past month (57 participants had not used any tobacco in the past 30 days) with the intent to use in the next 12 months, yields the following information: 15 (18 percent) said they definitely will use, 6 (7 percent) said they will probably use, 13 (16 percent) said they will probably not use, 32 (39 percent) said they would definitely not use, 12 (14 percent) said they didn't know and five (6 percent) didn't answer. Of the participants who are minimal or non-users, only a little over half of them intended to not use tobacco in the next 12 months.

Even though the health risks of tobacco use are widely disseminated through media campaigns, public education and even on the products themselves, myths concerning tobacco can sometimes encourage people to start smoking or keep them from quitting. According to Thomas R. Frieden, MD, MPH, and Drew E. Blakeman, MS, who work with the New York City Department of Health and Mental Hygiene, in an article cited earlier,

“Some myths stem from a misapplied understanding of what might seem to be common sense; others are deliberately promulgated by the tobacco industry to

induce people – especially children – to start smoking and to keep them smoking as adults. These myths are believed true not only by many smokers but also by some physicians and policy makers, a fact that hinders development of effective tobacco control policy and treatment for individuals who are dependent on tobacco.”

The 12 myths researched by Frieden and Blakeman were included on the survey as statements that the participants were to label as “true” or “false.” Participants’ responses to belief in each myth are listed below. The two myths that were strongly believed were those having to do with choice to smoke and common knowledge of smoking’s danger to health.

Myths believed by **more than half** respondents:

- People have free choice whether or not to smoke – **89%**
- Everyone knows how bad smoking is – **59%**

Myths believed by **more than a quarter** of the respondents:

- Smokers may die earlier, but all they lose are a couple of bad years at the end of life – **33%**
- Tobacco is good for the economy – **31%**
- Medications to help you quit smoking don't work, such as patches, gums, etc. – **26%**
- It's easy to stop smoking; if people want to quit, they will – **25%**

Myths believed by **fewer than a quarter** of the respondents

- Secondhand tobacco smoke may be irritating, but it isn't deadly – **22%**
- Once a smoker, always a smoker – **21%**
- Just a few cigarettes a day can't hurt – **18%**
- The tobacco industry no longer markets to kids or works against public health efforts – **16%**
- "Light" cigarettes are less harmful – **12%**
- We've already solved the tobacco problem – **9%**

The myths least believed give an indication that people are still thinking about the health effects of tobacco and the problem that they pose. Few (12 percent) believed that “light” cigarettes are less harmful and fewer still (nine percent) believed that the problem tobacco causes our society has been solved.

Findings

African American – The participants in the African-American focus groups were aware of televised tobacco prevention messages and could remember specific story lines from the commercials as well as the message. Others remembered billboards about tobacco prevention. They were also aware of the tobacco companies targeting African-Americans as customers. Ads for cigarette brands favored by African-Americans always have African-American models in them. Most participants had tried to quit multiple times and with multiples strategies. The strategies expressed included acupuncture, hypnosis, nicotine replacement therapy and stopping “cold turkey.” They were aware of the health hazards of tobacco use, but still, the habits of associating smoking with other activities and addiction to nicotine made it extremely hard to quit. One participant described the resistance of some to quitting smoking to be “stubbornness.” The use of menthol cigarettes is very prevalent among African-Americans. The community attitudes about secondhand smoke are changing from not even knowing it is bad, to knowing it is bad and changing one’s location of smoking because of the knowledge. Most were in favor of clean air ordinances because they are respectful to nonsmokers, but there was a concern expressed that the government should not be taking away personal rights.

Asian – Asian Americans do not have a strong awareness of television commercials about tobacco prevention that are targeted to the American culture. They are more aware of American television shows, such as Sex in the City, that have characters who smoke. They think that some in their culture can be influenced by such shows. However, this population is becoming educated about the hazards associated with tobacco use and is becoming more active in promoting the quitting of smoking. There are several barriers to cessation services for this culture. Asian persons will respond best to services provided in their native language, but that is problematic because there are many languages represented within the state of Ohio. Further, some of the recent immigrants who are not familiar with American health care systems exhibit a fear toward doctors who tell them they must quit using tobacco. They do not understand what will happen to them when they quit.

Hispanic/Latino – The Hispanic/Latino persons that participated in the focus group discussions generally agreed that the media messages about hazards associated with tobacco use were widespread. They knew that smoking was bad, as was being exposed to secondhand smoke. Several had attempted to quit, some multiple times, and had used patches and gum to do so. Cigarettes were the main products favored, but other products are known and tried somewhat.

The cost of the product was of concern to the participants. They noted that cigarettes are very cheap in Mexico, but here they need to look for coupons or special offers. They emphasized that there is a difference between a person who is an addicted smoker and one who just smokes occasionally in social situations. The former is really hurting his or her health while the latter is not. The fact that cigarettes and smoke are bad for children in the family is an effective deterrent to smoking in the home. They support the clean indoor air ordinances even to the point of saying that it will help them control their own tobacco use.

Native American – The Native American Indian participants had one perspective unique among all the groups: They use tobacco as an element in their religious rituals. They smoke a pipe as a part of their Pow-wow ceremonies and they also perform a ritual called “smudging,” which involves burning sacred plants in order to purify a place or object. Communication was facilitated after an acknowledgement of language was made. Use of tobacco is a practice that they feel strongly must be continued; abuse of tobacco is what is hazardous to person’s health. They are aware of media messages about preventing tobacco abuse. They had seen many billboards as well as television commercials. The barriers to accessing resources that will help persons quit tobacco abuse include lack of time and lack of awareness of the resources. Many participants had family members who had died from illnesses associated with tobacco abuse, but they were hesitant to claim that was the only issue their family member faced. On the topic of secondhand smoke they felt there needed to be a two-way form of respect: smokers need to respect that nonsmokers don’t want to breathe the smoke, and nonsmokers need to respect that smoking is still a legal activity practiced by many people because they enjoy it.

Appalachian – The participants of the Appalachian focus groups were knowledgeable about media messages for tobacco prevention to the point where they remembered specific details and story lines of the commercials. They related that the main message is that secondhand smoke is just as hazardous to one’s health and that smoking around children is very bad for their health. They also felt that resources to help people quit smoking are not being advertised as much as they could. The individuals in these groups had already sought out cessation services and so were familiar with multiple aids such as: group classes, individual counseling, patches, gum, lozenges, and Welbutrin. What they most appreciated in the desire to quit was the support they received from family and friends in the form of encouragement and caring.

The reasons for tobacco use they related include that they enjoy the flavor and the experience. Further, there is a tradition of tobacco use in this part of the state, especially that of smokeless tobacco. Male youth may prefer smokeless over cigarettes because they can more

easily hide it from authority figures. The participants acknowledged that even though some had parents who died early from tobacco-related illness, they still use tobacco. They are addicted. They know that secondhand smoke is hazardous. Even though participants think that people have a choice to not be around others who are smoking and would not want a clean air ordinance in their community, they would still vote for one because they know it is the right thing to do.

Refugee/Immigrant – The immigrants that participated in the focus group discussions generally agreed that smoking was a social activity they enjoyed. It was good to be around friends, talk, and smoke. Their product of choice is definitely cigarettes. They talked about their homeland where in Somalia many people chew tobacco and in the Ukraine where there is a particular product that is a paper pipe filled with strong tobacco. They think that the trend of tobacco use is on the decline, citing effective health education for children and media messages for adults. They personally do not use quitting aids such as patches or gum, but they know they exist. Different from many of the other populations, they are reluctant to relate tobacco use and the death of family members and friends. They know tobacco use has adverse health effects, but for those they know who have died, the participants maintain there were other problems as well.

Mentally/Physically Challenged – The participants of the mentally/physically challenged focus groups were aware of the media messages that try to get people to quit using tobacco. They could not recall many specifics of the messages, but what they remembered was that Phillip Morris, a producer of cigarettes, is running ads that tell people that smoking is bad for one's health. The reason mentioned most often that keeps the participants using tobacco is addiction. Nicotine has a control on their bodies that they cannot stop. Behavioral reasons to use cigarettes is that it is a habit and it helps them relieve stress. It is strongly associated with other behaviors such as drinking coffee or drinking beer. Many also talked about tobacco use being in their family; they grew up with parents who smoked daily. They thought an effective message to attract people to cessation programs would be that an organization would provide persons with the help they need to quit, whether it is patches or counseling or some other means. The person would get whatever he or she needs. Their attitude toward secondhand smoke is that they don't believe it is as dangerous as people say. They can understand that people do not want to be around people who are smoking, but they should just go somewhere else. They, as smokers, will do their part to not bother others with their smoke.

LGBT – The Lesbian, Gay, Bisexual, Transgender persons in the two focus groups were very familiar with the media messages about the hazards associated with tobacco use. They knew

terms such as the Great American Smoke Out and stand. They had heard or read the messages from television commercials and magazines, even recalling school assemblies on the topic. The messages they remembered were that tobacco is “not cool” and is bad for one’s health. The participants were familiar with a wide range of tobacco products such as clove cigarettes, flavored cigarettes, and mentholated brands, as well as paraphernalia like the hookah. Tobacco use was described as a ritual associated with other behaviors such as meeting in bars, socializing between acts in a play, or being on break at work. Some of the participants did not personally feel the health hazards of tobacco are a priority in their lives because they are exposed to lifestyle hazards that are much more serious. They did not consider smoke-filled environments to be unfair to non-smoking workers within that environment. They said that the worker knew the situation when he or she applied for the job and could have chosen to work somewhere else.

Persons in Poverty – The participants of the persons in poverty focus groups were generally aware of the health hazards associated with tobacco use. They were familiar with media messages against tobacco use, both on television and in magazines. Almost all users had tried to quit multiple times. Some tried nicotine patches, some quit “cold turkey.” They recounted the effects of quitting on the body, including migraines, withdrawal symptoms and being aware of not knowing what to do with their hands. Some told of externally-forced quit times such as when in jail. They thought that effective messages to get people to quit using tobacco centered on personal health, health of children and cost. They were in favor of smoking bans, but a ban should exclude bars, bowling alleys and pool halls, places where people can go to relieve stress.

Chemically Dependent – The participants in the chemically dependent focus groups were very aware of media messages about tobacco prevention. They could remember specific details and story lines of the television commercials. One of the topics that resonated with this group is that tobacco use is hazardous to children. They wanted their children to be in a safe environment, and they did not want their children to grow up to be smokers. Many of the group told of family members who had died as a result of smoking tobacco.

The reason they used tobacco was that it was an addiction that was legal. They associated tobacco use with alcohol and other drug use. The use of tobacco helps them cope with quitting the use of the other drugs. They are aware of the hazards of tobacco, but they acknowledge that trying to quit two or more substances at once is more than they can handle. They were not in favor of clean air ordinances, feeling that the government is taking away too many private rights. They do worry about the health of their children, thinking of their being

exposed to secondhand smoke, but they still feel that if people have a choice, they should be able to exercise it as long as others know to stay away from the smoke.

Deaf – People in the deaf community are generally not aware of media messages that explain the hazards associated with tobacco use. According to the research, the deaf community does not access communication media in the way the hearing community does. Because of this, they are not aware of tobacco company advertising either. Typically, deaf persons, who have been deaf since birth, have a lower reading level than the hearing population; therefore, printed materials explaining tobacco prevention services need to be in basic English. The participants were aware that tobacco use is hazardous to one's health, but they do not believe that it will cause cancer in every person who smokes. Modeling is an important way this community learns. They model deaf people older than themselves much more than they will model persons of the hearing community, even celebrities. They do not have strong feelings about secondhand smoke. They consider the issue to be more a matter of respect: Smokers should not smoke around nonsmokers, and nonsmokers should not criticize smokers.

Amish – Persons in the Amish culture are significantly separated from the surrounding culture by choice. Tobacco is used but it is believed that the prevalence is much lower than the state average. The Amish are not aware of many anti-tobacco media messages because they do not access typical media outlets. They do not have televisions and they typically subscribe to a common Amish newspaper. Similarly they are neither exposed to tobacco advertising. When youth are in their late teens they go through a phase of exploring the world around them. The information gathered supported that this is when Amish people are exposed to tobacco use and tobacco advertising. The Amish are aware of the physical ailments that are caused by tobacco use and lately they are becoming more aware of the hazards of secondhand smoke. They tend to be healthy because they have a lifestyle that includes natural foods and much physical activity associated with work. Another part of their culture that reduces tobacco use is their religion. They are devout Christians and consider tobacco use to be against the teachings of scripture.

Military/Veterans – The persons in the military or the veterans who responded to the questions were aware of media messages that communicated the health concerns associated with tobacco use, but they could not recall specifics about the ads or the messages. When asked about the demographics of smokers, they considered young people to smoke more than older persons and men and women to smoke about the same. Tobacco use is typically associated with other behaviors and activities, generally social in nature. The use of smokeless tobacco was reported

variously. Some respondents said it was rarely seen; others said that it was commonly seen. An important consideration of tobacco use is that it makes a person less physically fit, which is important in the military culture. Military personnel lead very busy lives, and it would be difficult to arrange time for cessation classes or counseling for those who desired those services. Secondhand smoke is not considered as hazardous as is said. Their opinion is that people should just respect the rights and wishes of others, both smokers and nonsmokers.

Conclusion

Ohio exhibits great cultural diversity. This is displayed in the breadth of racial and ethnic minorities, persons from around the world who have come to Ohio to live, work and become communities. Diversity is also evident in groupings having to do with persons' outlook, behaviors, occupation, religion and even where in the state they live or have come from. These communities are willing to work together collaboratively to solve common issues. One of the issues they all face is the health hazard that tobacco use brings to persons in their community. Through talking with each of the communities targeted by this project, it has been learned that there is as much diversity within each community as there is between the communities. Strategies to solve problems need to include diversity and be flexible, rather than place individuals into categories that are externally defined.

Each of the communities has its champions; organizations and agencies that provide resources and services to the community they represent. Often these organizations advocate for a common sense of identity among the community members that will help people understand that the community has a unique culture. The communities served by this type of organization include: African-American, Hispanic/Latino, Native American, Asian, LGBT, Deaf and Amish. Other communities are defined by current composition or occupation. Organizations providing social services are often arms of the state/national government, or receive governmental funds. These organizations serve the communities out of a commitment to meet the health/wellness needs of persons in the community who fit the established criteria for being part of the community. The communities served by this type of organization include: persons in poverty, chemically dependent, mentally/physically challenged, refugee/immigrant and military personnel/military veterans. The one community in Ohio that does not fit into the previous categories is the one that is defined by geography – Appalachian Ohio. Appalachian Ohio covers 29 counties in the southeastern part of the state, including the counties in Ohio where tobacco is grown. It is a federally designated area that is part of Appalachia, a region that covers all of West

Virginia and parts of 12 other states. Any social service organization within those 29 counties would, by definition, be serving Appalachians.

These community organizations that serve specific groups of individuals are critical to the successful accomplishment of Ohio's Comprehensive Tobacco Use Prevention Strategic Plan. Institutional capacity to provide services is the key element for eliminating the disparity that has existed in the access to health care services by various minority populations in Ohio relative to the mainstream. Networking among organizations and knowledge about specific populations will certainly increase the institutional capacity of the organizations that are committed to bettering the health and well being of all. An organization is merely a group of people intentionally organized to accomplish an overall, common goal or set of goals. This project set out to increase the information known about various groups of people so that other groups of people can use that information in ways that will increase the health of persons in Ohio.

Attachments

Attachment A: Focus Group Script

Ohio Comprehensive Tobacco Use Prevention Strategic Plan Achieving Parity through Tobacco Control for All Communities

Focus Group Script

Hello everyone and welcome to this discussion about tobacco use, tobacco control and the effects of tobacco on specific population groups in Ohio. My name is _____ and I work for Ohio University's Voinovich Center. We are helping the Ohio Department of Health, in their efforts to gather more information about patterns of tobacco usage in Ohio. My colleague _____ will be taking notes tonight.

I will be guiding today's discussion around tobacco usage and control among _____ (target population). This is one of two groups that will be providing information on this population group. There are eleven other population groups that are also having discussions.

We will be using a guided discussion, or "focus group" technique to collect your experiences, observations and suggestions. We hope that this discussion will take no more than an hour and a half. Please turn the name card in front of you so the others can see your name. That will make it easier for people to refer to others by name during the discussion.

We would like to hear from everyone here. We expect that people will have some similar experiences and opinions to share and some different experiences and opinions. We want to capture all of these, so it is okay to disagree or share a different perspective than someone else in the group.

We would like to tape our conversation so that we don't miss anything that you say. We want to be sure we hear all of your comments and the tape will help us to do that. No names will be used in our report of this conversation. Are there any objections to the taping?

Since we want to hear from everyone and we have a lot to cover, I may have to interrupt you at some point or I may ask you specifically to comment, if I haven't heard from you in a while.

We would like each person to answer the first question in turn, going around the table. The rest of the questions are to be answered as you feel led. Feel free to base your response to a question on the response of someone else. Please remember to respect each person's response as legitimate and valuable to our discussion.

QUESTIONS

1. What television commercials, print advertisement or billboards that tell about the health hazards associated with tobacco use have you seen? Please explain the message as you remember it.
2. Have you participated in any tobacco prevention or cessation activities in the past two - three years? If so, please describe if their focus was on youth or adults or included secondhand smoke information.
3. Why do _____ use tobacco?
4. What are some *differences* in tobacco usage within _____ and what are the causes of these differences?
 - a. Such as men vs. women?
 - b. Youth vs. adult use?
 - c. Persons in poverty vs. persons not in poverty?
 - d. Smoked vs. smokeless, etc?
5. What types of tobacco products are used? What are the brand names or labels? Which are the most popular?
6. What kind of messages work with _____ to help them quit tobacco use, or what do you think is the best way to reduce tobacco use among _____?
7. If you are a non-smoker, what has kept you from starting? Or, if you successfully quit smoking, what has kept you from re-starting?
8. Are there any specific barriers that keep _____ from accessing tobacco cessation programs?
9. If you are a tobacco user, what keeps you using tobacco?
10. When and where are _____ most likely to use tobacco? (at social events, at a bar, in stressful situations)

11. What do tobacco companies do to encourage _____ to start using tobacco products? What do you think would be a good counter strategy?
12. What is the impact on youth when tobacco is used on TV and in movies?
13. How do young people under 18 years old get tobacco products since it is illegal for them to buy tobacco?
14. What are some tobacco-related health problems? Do you see many of these among _____?
15. Do _____ think that secondhand smoke has a negative effect on their health?
 - a. Does this change their behavior? Why or why not.
16. Has a close friend or someone in your family died, or been diagnosed with a cancer or condition related to tobacco use?
 - a. Has it changed your outlook on tobacco use at all?
17. Do you consider non-smokers having to work in places, such as bars or bowling alleys that allow customers to smoke, to be unfair to the worker? Why or why not?
18. What is your opinion about city- or state-wide clean indoor air ordinances?
 - a. Would you personally support one by voting for it?
 - b. Would you show a lack of support by voting against it?
 - c. Would you get involved in a public campaign to either support an ordinance or defeat an ordinance?
 - d. How strong are your feelings on clean indoor air ordinances: very strong against, somewhat against, neutral, somewhat for, very strong for.
19. Does anybody have anything else they would like to say about tobacco use and _____?

Thank you very much for your participation.

Attachment B. Tobacco Survey to
Accompany Focus Group

1. During the past 30 days, on how many days did you use tobacco?
 Number of days _____
 None
 Don't know/ Not sure

2. If you have ever used tobacco, what type(s) have you ever used? (check all that apply)
 Cigarettes
 Black & Milds, Philly Blunts
 Smokeless (rub, chew, dip, etc.)
 Other _____
 I have never used tobacco

3. If you ever used tobacco regularly, what type did you use most often? (check only one)
 Cigarettes
 Black & Milds, Philly Blunts
 Smokeless (rub, chew, dip, etc.)
 Other _____
 I have never used tobacco

4. How old were you when you first started using tobacco **regularly**?
_____ yrs old
 Don't know/not sure
 I have never used tobacco regularly

5. Do you think you will use tobacco anytime during the next year?
 Definitely yes
 Probably yes
 Probably not
 Definitely not
 Don't know/not sure

6. Please mark whether you believe the following statements are **TRUE or FALSE**.

T F

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | People have free choice whether or not to smoke. |
| <input type="checkbox"/> | <input type="checkbox"/> | Everyone knows how bad smoking is. |
| <input type="checkbox"/> | <input type="checkbox"/> | Just a few cigarettes a day can't hurt. |
| <input type="checkbox"/> | <input type="checkbox"/> | "Light" cigarettes are less harmful. |
| <input type="checkbox"/> | <input type="checkbox"/> | It's easy to stop smoking; if people want to quit, they will. |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications to help you quit smoking don't work, such as patches, gums, nasal sprays, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | Once a smoker, always a smoker. |
| <input type="checkbox"/> | <input type="checkbox"/> | Smokers may die earlier, but all they lose are a couple of bad years at the end of life. |
| <input type="checkbox"/> | <input type="checkbox"/> | Secondhand tobacco smoke may be irritating, but it isn't deadly. |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco is good for the economy. |
| <input type="checkbox"/> | <input type="checkbox"/> | We've already solved the tobacco problem. |
| <input type="checkbox"/> | <input type="checkbox"/> | The tobacco industry no longer markets to kids or works against public health efforts. |

7. Do you consider yourself:

- | | |
|--------------------------|-------------------------------------|
| <input type="checkbox"/> | American Indian or Alaskan native |
| <input type="checkbox"/> | Asian |
| <input type="checkbox"/> | Black or African American |
| <input type="checkbox"/> | Hispanic or Latino |
| <input type="checkbox"/> | Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> | White |
| <input type="checkbox"/> | Other _____ |

8. Are you:

- | | | | |
|--------------------------|------|--------------------------|--------|
| <input type="checkbox"/> | Male | <input type="checkbox"/> | Female |
|--------------------------|------|--------------------------|--------|

9. What is your age? _____

10. What is your zip code?

**Ohio Comprehensive Tobacco Use Prevention Strategic Plan
Achieving Parity through Tobacco Control for All Communities**

The Ohio Department of Health, Bureau of Health Promotion and Risk Reduction – Tobacco Risk Reduction Program, is interested in learning about the unique cultural issues associated with tobacco use prevention around the state of Ohio. Ohio’s population is made up of diverse groups who view tobacco use through their own set of values and experiences. What is known at this point in time about cigarette and smokeless tobacco use is typically generalized across all population groups and may or may not reflect the usage patterns of each specific group. For this reason, The Institute for Local Government Administration and Rural Development at Ohio University in Athens, Ohio will be conducting group discussions called focus groups, across the state with twelve specific populations. The information gathered will be invaluable in developing strategies for future tobacco prevention programming with the hope of further reducing tobacco use and improving the general health status of the community.

A focus group is a discussion about a certain topic, led by a trained facilitator. The discussion is tape-recorded and written notes are taken to insure accuracy of what gets reported out from the discussion. Groups typically last from an hour to an hour and a half.

The twelve populations listed below were chosen as important sets of people within the state of Ohio who can contribute to the overall knowledge base about tobacco usage. This does not mean there is high tobacco usage across all of them. Rather, the selection was made in order to adequately hear the voices of persons who may not have equal access to tobacco use prevention and control programs.

The information gathered through this process will greatly increase the ability of public health agencies to serve specific groups according to their needs and characteristics, rather than having to serve all people with the same model.

| Specific Ohio Populations to have information gathered through focus groups | |
|--|--------------------------------|
| African American | Appalachian |
| Amish | Asian |
| Persons in poverty | Refugee/Immigrant |
| Hispanic/Latino | Native American |
| Chemically dependent | Mentally/physically challenged |
| Lesbian, Gay, Bisexual, Transgender | Veterans/Current Military |

Ohio University Consent Form

Title of Research: Qualitative Data Gathering through Focus Groups for Population Groups Disproportionately Affected by Tobacco Use

Principal Investigator: Barry Oches

Co-Investigator: Lesli Johnson

Department: Institute for Local Government Administration and Rural Development (ILGARD)

Federal and university regulations require signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study

ILGARD has been contracted by the Ohio Department of Health to conduct two focus groups per identified population disproportionately affected by tobacco use. This is part of the community planning and implementation process with statewide partners for the Ohio Comprehensive Tobacco Use Prevention Strategic Plan (2004-2008). The plan consists of five goals designed to change the social norm of tobacco use in Ohio. Goal #4 specifically focuses on identifying and eliminating the disparities related to tobacco use and its effects among certain population groups.

We have contacted various advocacy agencies to gain access to certain populations. The agencies are in no way related to this study, they merely provide access to individuals representing the specified population groups. After gathering sufficient participation, the focus groups are held in locations convenient to the participants.

The focus group session will last an hour and a half to two hours. There is no further requirement on the part of the participant after the focus group is finished, and the participants will not be contacted again as part of this study.

Risks and Discomforts

There are no risks associated with this study or discomforts other than those normally experienced while participating in a group discussion. No personal information will be required to be shared that the individual chooses to not share.

Benefits

Potential benefits to the individual participant will include learning about others' attitudes and beliefs concerning the topic of tobacco use and enjoying a friendly discussion with similar individuals. Each participant will receive a small gift and a drawing will be held for ONE focus group participant to win a \$50 gift certificate to WalMart.

Confidentiality and Records

No personal information will be recorded that in any way could identify an individual and connect him/her to something he/she said within the group in the analysis and reporting of the information. The recorder's notes and the audiotape will be kept in a locked cabinet until January 2007 at which time they will be destroyed.

Compensation

There is no compensation offered for time lost from work that may have occurred for someone to attend the group. The incentive mentioned above is merely an incentive.

Contact Information

If you have any questions regarding this study, please contact

| | | |
|----------------|--------------|-------------------|
| Barry Oches | 740-593-9799 | oches@ohio.edu |
| Lesli Johnson: | 740-593-9739 | johnsol2@ohio.edu |

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me.

Signature_____ Date_____

Printed Name_____

Attachment E: How to Plan a Focus Group

1. Arrange for a location in which to hold the focus group
 - a. Location should be convenient to the participants
 - b. Mode of transportation of participants to group should be kept in mind
 - c. There should be adequate parking for the participants
 - d. The room should not be difficult to find or, signs should be posted
 - e. The room should hold at least 15 people comfortably
 - f. A table around which everybody can sit is nice but a group can meet without one
 - g. The room should have a door that closes or be in a place where there is little noise or distraction
 - h. There should be a small table available for the snacks and drinks
 - i. If participants need child-care, it should be available (but there just isn't enough money in this grant for us to pay for it) in a separate room
2. Arrange for a time to meet
 - a. The focus group should take about 60 to 90 minutes
 - b. If the group is also a group that meets for another purpose, then the focus group can meet before, after or instead of the group. Whatever is best for the participants can be arranged.
3. Contact prospective participants
 - a. The ideal number of participants is 8 to 10. Groups with as few as four are possible but the range of opinions is then limited. Groups of 15 or 20 are difficult to get the opinions of everyone present.
 - b. An easy way to have a group is to connect with a group of people who represent the appropriate population and are already meeting for some other purpose.
 - c. For each prospective participant make sure they have a written invitation that includes the date, time and location of the group. Try to get contact information so that a reminder can be sent to them.
 - d. Call participants prior to group if possible.
 - e. Participants do not need to be users of tobacco, but it is preferred. Valuable information can be obtained from a group that has both users and non-users.
 - f. Get commitments from people that they will attend the group at the given time and place.
4. Things to avoid
 - a. A noisy room with other things going on – such as a gymnasium
 - b. A room with no chairs
 - c. Participants who don't know why they are there
 - d. An inconvenient time of day, such as after 8:00 pm or on weekends

Participants Needed for a Focus Group

on

cultural issues related to tobacco use

We are currently recruiting persons who are current tobacco users or recent quitters for a focus group to discuss attitudes and beliefs related to tobacco use and quitting.

Food and beverages will be provided!

A drawing will be held for TWO focus group participants to win a \$25 gift certificate to Wal-Mart.

We are looking for men and women who currently use tobacco products or have quit using them!

(place for contact information)