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Addressing the Needs of African American Male Smokers Through Community Outreach and Tailored Smoking Cessation Strategies

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Abstract

The prevalence of adult smokers within the state of Texas population is 19.2% with 25% of those smokers being African American. Although the smoking rate of African Americans in Texas is very high, they only represent about 18% of the calls to the Texas Tobacco Quitline. To investigate this phenomenon, researchers from Texas A&M University completed a qualitative study to investigate the social norms and awareness of the Quitline among African American males. Focus groups were conducted in a rural community to determine perceptions and attitudes towards smoking among the African American population, as this was an exploratory study. The focus group participants were 71% smokers and 90% identified as African American. Data collected during the focus groups revealed information three major themes which were derived from the research question. These themes were social norms of smoking, smoking cessation, and services needed for smoking cessation. Information learned was insightful because little information exists about successful smoking cessation strategies specifically for African American male subpopulations. With this information, data can be further synthesized and outreach strategies can be further developed to help decrease the gap in health equity as it related to African American males and smoking and increase calls to the Quitline.

Keywords

tobacco use, behavioral issues, access to care, health-care issues, community outreach, health-care utilization, social determinants of health, psychosocial and cultural issues

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Tobacco smoking and its associated diseases continue to be a major public health problem in the United States causing one out of every five deaths. Although the smoking rates have decreased since reaching their pinnacle in the early 1970s (43%), they remain an issue that plagues many citizens in the United States (Saad, 2012). Across the United States, 15 out of every 100 citizens are cigarette smokers, but even higher rates can be found among disparate populations. The first disparity can be seen among males and females, for example, men are more likely to be smokers than women with 17 out of every 100 men identifying as a smoker, compared to women with a rate of 13 per 100 women who identify as smokers. A cause for concern related to smoking within the United States is related to geography. Smoking rates are higher in the Southern United States (24.2%), and rural communities have higher rates (23.6%) than metropolitan cities (20.5%). Smoking disparities exist among different races and ethnicities. Within the African American subpopulation, 16.7% of individuals identified as a smoker, which is high compared to other minority groups like Hispanic subpopulations who have a rate of 10.1% (CDC, 2017).

Smoking disparities are a major concern because tobacco use can be linked to an increased risk of cancer morbidities and mortalities (American Cancer Society, 2016). In the United States, 23% of African American males die from cancer; of all cancers, prostate (1 in 23) and lung (1 in 16) cause the highest numbers of death,

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both of which can be related back to tobacco use (American Cancer Society, 2016). There are a variety of reasons that members of this subpopulation choose to smoke. A study conducted by Romano, Bloom, and Syme (2011) explained that psychological stressors among African Americans could increase their likelihood to smoke cigarettes. Some of these stressors include being out of work, having an illness or sustaining an injury from an accident, or not having a substantial amount of food or money. In addition, according to the CDC, African Americans attempt to quit smoking at a higher rate than Hispanic and White smokers, but are less successful at quitting because of lower utilization of cessation treatments such as cessation counseling or medications to aide in the quit process (CDC, 2017). Additional information is needed to understand why these cessation efforts are failing and to better tailor smoking cessation and outreach to these disparities populations.

In 2016, a research group at the Texas A&M's Department of Health and Kinesiology designed an exploratory, qualitative research study to investigate perceptions of smoking norms and barriers to smoking cessation among African American men in rural areas. Findings from the study were used to create outreach strategies that inform Tobacco Prevention and Control Coalitions in the State of Texas could use to target African American subpopulations. This study was part of a larger project aimed at improving smoking cessation and outreach to underserved populations in Texas. The purpose of the focus groups was to investigate the perceptions of smoking, barriers to smoking cessation, awareness of the Texas Tobacco Quitline, and possible resources needed that could help this population to quit smoking tobacco.

Methods

To conduct this qualitative study, the research team chose to use a focus groups methodology to collect data. This method was selected because the study was exploratory and aimed to investigate social norms and barriers to smoking cessation among African American males. Another rationale behind utilizing focus groups as the methodology for data collection was that focus groups capitalize on the communication between participants thus generating rich data (Kitzinger, 1995). It is important to note that theoretical assumptions of the research team are based in a constructivist paradigm. Ontologically, we believe that the real world exists and truths in science are discovered by observing members of the population of which are being researched (Carr et al., 1994). The COREQ (consolidated criteria for reporting qualitative research) is a 32-item checklist that aids researchers in the reporting of the research team, study materials, the context of the study, findings, analysis, and interpretations (Tong, Sainsbury, & Craig, 2007). The COREQ guidelines for qualitative reporting checklist was completed by the research team to fully explain the rationale behind the methodology of this study and can be found in Appendix.

Setting

Focus groups were conducted in a rural county in East Central Texas. The community has a population of 13,984 individuals and 20.3% of the population identified as African American (U.S. Census Bureau, 2010). This community was selected because of its rural designation, high smoking rate (25.5% with an 8.97% growth rate from 2016 to 2017) (U.S. Data, 2017) and large population of African American citizens. In addition, the target population, rural, African American men, can be a hard to reach population; therefore, a community-based approach was used in designing the study. By using a community-based participatory approach, the researchers were able to work closely with community members to design the study and recruit participants. This location was identified as the most promising community due to existing community ties and access to the target population.

Study Sample and Recruitment

A total of 21 participants were recruited to take part in the study. Participant recruitment was done through a community champion, employed at a local health resource center, who was able to identify potential participants within the target population and recruit them into the focus groups. Recruitment was conducted with individuals who attended various community churches, used social services provided by a health resource center, and utilized a local transportation program. The strength of focus groups is the ability to explore the depth and complexity of phenomena. The customary focus group size ranged from a minimum of 4 and a maximum of 12 participants per group (Krueger, & Casey, 2009; Morgan, 1997; Stewart, Shamdasani, & Rook, 2007). The range of 3 to 5 focus groups is recommended (Morgan, 1997). The sample size in the focus groups ranges from 10 to 11 per groups. The community champion was able to recruit more participants than planned; therefore, researchers decided to conduct two groups to keep the group size to approximately 10–11 individuals per group. This number was selected because past research indicates that focus groups work best when the number of participants does not exceed 12 individuals (Krueger, 1994).

Focus Group Discussion

A focus group guide was created that included an introductory script, consent form, five open-ended questions, and several probes to help facilitate more discussion, if

needed. The research question guiding the development of the interview guide was: what are the perceptions of smoking among African American men and what is their awareness of the Quitline? The focus group participants also completed a short survey. The survey collected demographic information like age, education level, race, sex, median household income, and frequency of cigarette use. The purpose of collecting data related to demographics was to be able to compare the characteristics of the focus groups and the characteristics of populations described in the existing literature that investigates the health disparity that exists for African American males in regards to smoking.

The focus group guide asked five open-ended questions. The first question was designed to capture context and social structure which influence tobacco use by asking, *how smoking was viewed among [participants] friends and people they hung out with*. Next, researchers asked three questions to determine the participant's knowledge of any type of services they would use to quit tobacco. These questions asked (a) *Do you know what programs or services are available to help people stop smoking?* (b) *If you or someone you care about were trying to quit, what services or programs would you us?* and (c) *What other information or services do you need to stop smoking or help someone stop smoking?* This question was asked last: *if they had ever heard of the QUITLINE or 1-800-QUIT-NOW*. Overall, use of the questions was to collect information about social acceptability and the type of services that participants would consider using if they decided to try to quit using tobacco or wanted to help someone else quit. The interview protocol was reviewed and approved by the Texas A&M Institutional Review Board prior to implementation (IRB2015-0638D). The questions within the interview guide were developed using a qualitative methods research guide by King (1994).

Data Collection

Each focus groups lasted between 35 and 40 min each and were facilitated by a trained member of the research team. The training completed by the research team was held prior to data collection, and for the training, the members of the research team extensively reviewed and became familiar with the interview guide and discussed scenarios that could take place in a focus group to prepare for data collection.

Prior to collecting any data, researchers collected participant consent in written form to collect data and record the conversations. All participants consented to the focus groups; however, one individual did not consent to be audio recorded. Only one of the two focus groups was audio recorded. The research team planned for this scenario by creating a note taking template prior to data collection that could be used to capture participant discussion. Field notes like these have been reported to be a viable way to collect qualitative data because not only can phrases be captured, but observations made by the research team can also be documented as well (Devers & Frankel, 2000). Two members of the research team captured notes to ensure that all of the discussion was documented. The other focus group was audio recorded so that transcripts could be produced for data analysis (Rabiee, 2004). Following each focus group, the participants received a $15 gift card as a thank you for their participation.

Table 1. Participant Demographics (N = 21).

Characteristic	Percentage
Race/Ethnicity	
Black or African American	90%
Two or more races	10%
Sex[a]	
Male	90%
Education level	
Less than high school	9%
High school	57%
Vocational school	4%
Some college	9%
2-year degree	14%
Bachelors or above	4%
Income level (yearly, 2017 U.S. dollar)	
Under $5,000	33%
$5,000–$9,999	28%
10,000–$14,999	9%
$20,000–$24,999	9%
$25,000 and above	17%
Marital status	
Single, never married	9%
Married	57%
Separated or widowed	13%
Divorced	14%

Note. [a]Female participation accounted for 10% of participation, but was not included due to the focus on African American male smoking habits.

Description of Participants

Focus groups were held at a local Senior Citizens Center. A total of 21 participants attended; 90% of the participants identified as being either Black or African American, while 10% of the participants identified with two or more races (Table 1). Males and females were both represented in the focus groups with 90% of the participants being males. Females were not recruited to the focus group, but several attended. Because the study's inclusion criteria did not require participants to be male, there were allowed to participate and were asked to speak about their

perspective as it related to smoking among African American men. All participants either smoked or knew someone who smoked that was a member of the African American community. Participant ages ranged from 22 to 73 years old with the mean age of 47.5 years and a standard deviation of 36.06 years. Approximately 57% of the participants had completed high school, 9% had not finished high school, 9% had completed some college, and 14% held a 2-year degree. Only one participant had a master's degree, and aside from that participant, no one had a bachelor's degree. Approximately 33% of the participants earned $5,000 or less per year, and 50% made less than $35,000 per year. Only 17% of the participants had an annual income of more than $35,000. Based on the demographic results, these focus group participants are considered to have a low socioeconomic status (American Psychological Association, 2017).

Data Analysis

To evaluate the focus group data, four trained members of the research team conducted a thematic analysis. This method of data analysis was selected because it is ideal for identifying themes that emerge from the data that help to describe and explain the phenomenon being researched (Fereday & Muir-Cochrane, 2006). An inductive, open-coding method was selected to prevent the analysis team forcing data into preconceived results (Bradley, Curry, & Devers, 2007). Each research team member underwent qualitative data analysis training prior to the analysis and was given an analysis handbook which describes the step-by-step process used. During the thematic analysis, members of the research team identified themes salient in the focus groups, then organized them into relevant categories, and determined emerging patterns (Bradley et al., 2007). The analysis was conducted in three steps. The first step was to code the data to dissect information that was meaningful to the questions being asked. The second step was to identify themes that had developed from the coded segments; and the final step was to create a network of themes that arranged the coded information into meaningful groupings (Seers, 2012). A coding tree was used which divided the data into three categories that aligned with the research question. The three categories were smoking perceptions/norms, facilitators to quitting, and services needed for quitting. Data saturation was met during the analysis as researchers began to discover reoccurring themes and no new themes began to emerge at the end of the analysis (Garcia, Martin, Garney, & Primm, 2017).

Results

During the focus groups, participants shared their perceptions about smoking behaviors, social norms, knowledge of the Texas Tobacco Quitline, and possible resources that would aid in cessation for African American men. Based on the main conceptual question guiding this study, which was: what are the perceptions of smoking among African American men and what is their awareness of the Quitline, three major themes emerged: (a) social norms, (b) smoking cessation and (c) services for smoking cessation.

Smoking Norms

The question used to collect data regarding social norms in relation to smoking was: "*how is smoking viewed among your friends and people you hang out with?*" and the prompts used to facilitate more discussion were "*What are the overall beliefs regarding smoking; including cigars and e-cigarettes?*" and "*How often do you see advertisements about smoking in your neighborhood? What about at gas stations? Or liquor stores? Or corner stores?*" To answer these questions, participants stated that family members, friends, and health-care professionals tried to discourage them from smoking. Family members, specifically younger individuals like participants' sons and daughters, had negative feelings about smoking. This familial influence to stop smoking resonated with the majority of participants. One individual said:

> I know my kids, my grandkids, they tell me I stink, and that kind of bothers me…and … make[s] you want to quit. I really want to quit when they say, "Papa, you stink." …And [the] people that don't smoke, they'll tell you the same thing.

However, another individual said that while they listened to their family member's request not to smoke around them, they would not stop smoking when in their own homes.

Health-care providers were more likely to discuss quitting smoking due to health concerns (e.g., heart disease).

> I talked to my doctor about wanting to stop smoking…. My heart doctor… They said I need to do something and stop because it's hard on my heart, smoking.

Similarly, other respondents echoed their medical professional advice of quitting smoking.

> The doctor told me to quit.

The respondents in the focus groups described how "quitting" is challenging regardless of the doctor's advice.

> You know, my doctor told me you need to stop smoking and I still don't stop smoking so—but that's I'm not, like what she was saying, but the patch. It's got to be something like that can you—to smoke, to make you do not want to smoke—… They just say you need to stop smoking. But now I ask my doctor

> why, he said, well that's about the healing process, you know to—I didn't figure out what the cause or reason. I believe the doctor tell me, if smoking got you killed— then I never quit. And then go get that one more cigarette. If I see I smoke one more cigarette, I'm gone. Then I quit. I don't think of one more cigarette.

Smoking Cessation

To gather information about smoking cessation among African American men, the research team asked, "*If and when you are (or someone you care about) ready to quit smoking, what things have you tried to help quit smoking?*" Respondents frequently mentioned that they did not rely on smoking cessation aids; instead, they would stop "cold turkey" and quit all at once. Other participants preferred to decrease their smoking overtime and taper off, rather than stopping immediately. Participants said that they tried to avoid triggers and used visual deterrents to continue being smoke-free, after they decided to stop. One participant said the most difficult part of quitting was the constant reminders that they wanted to smoke.

> Hey, a real smoker want a cigarette just before or right after you do anything. You go to the bathroom, we want one going. We want one right there and you want one when you finish.

Participants said it was important to stay away from smokers when they decided to stop smoking, so they would not be persuaded to start the behavior again. Frequently, family members who smoked encouraged them to start back if they tried to stop. One participant said:

> Oh, I think I can slow down [my smoking] a whole lot… Every time I have a cigarette, I might go a whole day [without one], and when my wife comes home in the evening time, she may hand me a pack or two and then I go back to smoking.

Participants said that other aids like nicotine replacements were sometimes helpful, but the cost could influence their decision to use this as a quit method. Tobacco products are less expensive than the nicotine replacement therapy, and participants felt that the cost of these was a barrier to smoking cessation. However, when funds weren't available to purchase tobacco products, the respondents would "bum" a cigarette from a friend or family member. One respondent mentioned how someone was picking used cigarettes from the side of the road.

> You know, we all leave here saying that we ain't going to smoke, and don't smoke, then that's the only way that I think, you know, because it's easy to smoke. You can bum one, you can buy one. I like to run over him [male friend] one night, he want a cigarette, you are in the middle of the road coming over here. "My cigarette butt. Oh, Lord. I won't go nowhere fast mean you both might not been about now."

Even though the majority of participants tried to stop smoking, many of the respondents were unsuccessful. The most frequently cited challenge to quitting was personal preference. The majority of individuals who smoked, simply did not want to quit. As stated between two of the respondents in the focus group:

> I've never tried to stop smoking

> I've been smoking after that about forty years ago. I did when I was in the hospital. And when I got out, I still won't quit. I smoked more cigarettes.

The respondents mentioned that tobacco products were very accessible within their neighborhoods and social groups. Other reasons to continue smoking were stress, financial concerns, boredom, and habits like smoking during meals.

Last, participants noted social and environmental cues, like advertisements, that encouraged them to continue smoking. Advertisements at corner stores were particularly frequent in this rural county, and these signs and products were said to be a constant reminder for participants to continue smoking.

Smoking Cessation Services. The majority of the participants could not identify resources for smoking cessation. Although one of the respondents had heard of the Texas Tobacco Quitline, they did not use it to help with smoking cessation. Other participants mentioned receiving health information (i.e., pamphlets and education materials) from health-care providers. However, these educational materials were not effective in helping them stop smoking. Educational materials were described as:

> Well, my doctor gave me papers on how to quit smoking… once I got…home, I laid [them] aside. I haven't picked [them up] since. [This] was about six months ago.

Focus group facilitators asked participants "*Do you know what programs or services are available to help people stop smoking?*" and that question was followed up with "*can you name some of these programs or services?*" Since the participants learned about the Texas Tobacco Quitline during the focus group from an individual who had heard of it previously, they said they would use the Quitline if more advertisements were available. Additionally, participants said that they would use nicotine patches to help them stop smoking, if they were available and if they were free.

Lastly, participants were asked, "*what other information or services do you need to stop smoking or help someone stop smoking?*" While some individuals still said they would quit "cold turkey" if they decided to stop smoking, others said they wanted a supportive environment—meaning they wanted prompts in areas that were highly advertised that reminded them not to smoke. They also said they wanted to learn about the difference between different types of tobacco, specifically e-cigarettes because they did not know if it was a healthier alternative to regular cigarettes. In addition, participants mentioned that increased messaging from well-known individuals, like the Surgeon General, would help encourage them to stop smoking.

Discussion

Data collected from the focus groups were very insightful because little information exists about successful smoking cessation strategies specifically for African American male subpopulations. To continue decreasing smoking rates within the United States, targeted outreach and cessation among these high-risk subpopulations is crucial.

These findings reveal that while social norms about smoking within African American communities do not promote the behavior, those norms do not necessarily encourage quitting, specifically among African American males. Instead of deciding to quit smoking because of pressure from family or social groups, participants compromised by not smoking around family member who disagreed with the habit, but felt like when they were in their own homes it was their right regardless of other's feelings. The social stigma did make some participants feel bad, especially when they were told they smelled bad by family member, but once again those stigmas were not enough to make them quit smoking. This is an interesting finding because while we see peer pressure being a frequent cause of smoking initiation, especially among youth (Kobus, 2003). The same peer pressure is not effective at getting individuals to stop smoking.

Other insights gleaned from this research show that environmental factors may be an important leverage point to be targeted for smoking cessation or outreach specific to African American men. Environmental cues like print advertisements were seen as an encouragement for smoking behaviors, and also identified as a potential quitting strategy. Outreach or policy that addresses placement of tobacco products and the availability of anti-tobacco messaging could decrease participant's exposure to environmental cues that remind them of their smoking habits. Furthermore, social environments like friend groups could be a potential leverage point because participants noted they would start back smoking when they were around friend groups who smoked. By focusing on group behavior changes, rather than individual behavior changes, there could be a potential for increased success in quitting.

Lastly, while participants said they had conversations with their health-care providers about why they should stop smoking, they did not consider those discussions as helpful in quitting. Rather, they frequently disregarded pamphlets or flyers given to them about quitting by their health-care providers. However, participants also noted that if they received information about different types of tobacco, like e-cigarettes, they might decide to quit traditional tobacco products in lieu for e-cigarettes if they were better for their health. While this is not an ideal scenario as there is limited research that reports e-cigarettes could be a good alternative for long-term smokers (Callahan-Lyon, 2014).

Next Steps and Limitations

To continue this work, researcher plan to further synthesize data gathered in these focus groups and develop outreach strategies specifically for African American male subpopulations. These strategies will be incorporated into a toolkit, which will provide step-by-step instructions related to policy, community, and individual factors specific to this subpopulation. With the assistance of the Texas Department of State Health Services, the toolkits will be disseminated to Tobacco Prevention and Control Coalitions across the state of Texas. In addition, outreach strategies will be shared with scientific and practitioners that conduct work related to smoking cessation, with the hope that this research and developing outreach strategies can reach a larger audience across the country.

As with many exploratory research projects, the sample used in this study was a convenience sample. It was selected based on community member recommendations and researchers feel that the data collected represented the unique needs of African American men as it pertains to smoking in rural Texas communities. However, the findings may not represent the views of other similar subpopulations like African American men who live in metropolitan areas. Therefore, the findings provide a way of understanding the needs of this specific target population. In addition, due to the size of the rural county, a smaller sample size was recruited to participate in the study. A limitation of this study was a lack of quantitative data, however, demographic statistics show that the participants were represent the most underserved and data saturation was met during the qualitative data analysis. Lastly, this study was developed specifically to identify outreach strategies for smoking in rural areas among African American men in Texas, as such, the content derived from the study is very specific is meant to be used to inform future

research. The study does not cover other important concepts like health-care access and availability, unemployment, or other community-level factors that indirectly affect tobacco use.

Appendix

COREQ Reporting Guidelines.

DOMAIN 1: RESEARCH TEAM AND REFLEXIVITY	
Personal Characteristics	
Interviewer/facilitator: Which author/s conducted the interview or focus group?	Shelby Launter[1] Whitney Garney, PhD, MPH[2] Idethia Shevon Harvey, DrPH[3]
Occupation: What was their occupation at the time of the study?	Graduate Research Assistant at Texas A&M University[1], Assistant Professor at Texas A&M Univeristy[2], Associate Professor at Texas A&M University[3]
Gender: Was the researcher male or female?	All female
Experience and training: What experience or training did the researcher have?	Research team training in qualitative data analysis and data collection[1], Doctoral level training and previous qualitative experience[2,3]
Relationship with participants	
Relationship established: Was a relationship established prior to study commencement?	No
Participant knowledge of the interviewer: What did the participants know about the researcher?	The participants knew what institution the researchers were from and their job title.
Interviewer characteristics: What characteristics were reported about the interviewer/facilitator?	Institution affiliation, job title, and purpose of study
DOMAIN 2: STUDY DESIGN	
Theoretical framework	
Methodological orientation and theory: What methodological orientation was stated to underpin the study?	Qualitative approach in a constructivist paradigm
Participant selection	
Sampling: How were participants selected?	Convenience sample recruited by a community champion
Method of approach: How were participants approached?	Community champion recruited participants from a local Community Health Resource Center and by phone
Sample size: How many participants were in the study?	21
Nonparticipation: How many people refused to participate or dropped out? Reasons?	0
Setting	
Setting of data collection: Where was the data collected?	The data collection occurred in a rural East, Central Texas county and meetings were conducted at a local senior center.
Presence of nonparticipants: Was anyone else present besides the participants and researchers?	Senior center staff
Description of sample: What are the important characteristics of the sample?	71% (n = 15) were smokers, or had smoked in the past and 90% (n = 19) identified as African American

(continued)

Appendix (continued)

DOMAIN 2: STUDY DESIGN	
Data collection	
Interview guide: Were questions, prompts, guides provided by the authors? Was it pilot tested?	An interview guide with open-ended questions was developed based on King (1994). The interview guide was pilot tested internally with the community champion to ensure cultural relevance. Prompts for questions were included as described in the paper.
Repeat interviews: Were repeat interviews carried out? If yes, how many?	No
Audio/visual recording: Did the research use audio or visual recording to collect the data?	Audio recording was used for one focus group, but not the second because one participant did not want to be recorded.
Field notes: Were field notes made during and/or after the interview or focus group?	Field notes were taken electronically and via flipchart during the focus groups. These were the primary source of data for the focus group that was not audio recorded.
Duration: What was the duration of the interviews or focus group?	30–45 min per focus group
Data saturation: Was data saturation discussed?	Data saturation was not discussed with focus group participants, but was identified during analysis
Transcripts returned: Were transcripts returned to participants for comment and/or correction?	No, transcripts were de-identified and used for the purpose of the analysis
DOMAIN 3: ANALYSIS AND FINDINGS	
Data analysis	
Number of data coders: How many data coders coded the data?	4 trained members of the research team
Description of the coding tree: Did authors provide a description of the coding tree?	Yes—A coding tree was used which divided the data into three categories that aligned with the research question. The three categories were smoking perceptions/norms, facilitators to quitting, and services needed for quitting.
Derivation of themes: Were themes identified in advance or derived from the data?	Themes were derived from the data by identifying patterns coherent with the research question and dividing those patterns into categories (Renner & Taylor-Powell, 2003).
Software: What software, if applicable, was used to manage the data?	As units of data were extracted from the transcripts/ field notes, they were entered into excel, sorted into categories, then organized into themes.
Participant checking: Did participants provide feedback on the findings?	No
Reporting	
Quotations presented: Were participant quotations presented to illustrate the themes/findings? Was each quotation identified?	Yes, quotes are included in the manuscript based on key findings.
Data and findings consistent: Was there consistency between the data presented and the findings?	Yes, data saturation was met during data analysis.
Clarity of major themes: Were major themes clearly presented in the findings?	Yes, themes were organized based on major categories derived from the data that were salient with the research question.
Clarity of minor themes: Is there a description of diverse cases or discussion of minor themes?	Yes—minor themes were incorporated into the discussion about major themes.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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References

American Cancer Society. (2016). *Cancer facts & figures for African Americans 2016–2018*. Atlanta, GA: American Cancer Society.

American Psychological Association. (2017). *Education and socioeconomic status*. Retrieved August 18, 2017, from http://www.apa.org/pi/ses/resources/publications/education.aspx

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research*, *42*, 1758–1772. doi:10.1111/j.1475-6773.2006.00684.x

Callahan-Lyon, P. (2014). Electronic cigarettes: Human health effects. *Tobacco Control*, *23*(Suppl 2), ii36–ii40.

Carr, M., Barker, M., Bell, B., Biddulph, F., Jones, A., Kirkwood, V., … Symington, D. (1994). The constructivist paradigm and some implications for science content and pedagogy. In P. J. Fensham, R. T. Gunstone, & R. T. White (Eds.), *The content of science* (pp. 147–160). London: The Falmer Press.

Centers for Disease Control and Prevention. (2017). *African Americans and tobacco use*. Retrieved August 18, 2017, from https://www.cdc.gov/tobacco/disparities/african-americans/index.htm

Devers, K. J., & Frankel, R. M. (2000). Study design in qualitative research–2: Sampling and data collection strategies. *Education for Health (Abingdon, England)*, *13*(2), 263–271.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), Article 7. Retrieved from http://www.ualberta.ca/~iiqm/backissues/5_1/html/fereday.htm

Garcia, K. M., Martin, E., Garney, W. R., & Primm, K. M. (2017). Qualitative analysis of partnerships' effect on implementation of a nationally-led community-based initiative. *Journal of Family and Community Health*. (Advance online publication). Retrieved from doi:10.1177/1524839918779378

King, N. (1994). The qualitative research interview. In C. Cassell & G. Symon (Eds.), *Qualitative methods in organizational research: A practical guide* (p. 17). Thousand Oaks, CA: Sage Publications.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *BMJ: British Medical Journal*, *311*(7000), 299–302.

Kobus, K. (2003). Peers and adolescent smoking. *Addiction*, *98*(s1), 37–55.

Krueger, R. A. (1994). *Focus groups: A practical guide for applied research* (2nd ed., pp. 36–45). Thousand Oaks, CA: Sage Publications.

Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage Publications.

Morgan, D. L. (1997). *Focus groups as qualitative research*. Thousand Oaks, CA: Sage Publications.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, *63*(4), 655–660. doi:10.1079/PNS2004399

Renner, M., & Taylor-Powell, E. (2003). *Analyzing qualitative data: Programme development & evaluation*. Madison, WI: University of Wisconsin-Extension Cooperative Extension.

Romano, P., Bloom, J., & Syme, S. (1991). Smoking, social support, and hassles in an urban African American community. *American Journal of Public Health*, *81*(1), 1415–1422.

Saad, L. (2012). *One in five U.S. adults smoke, tied for an all time low*. Retrieved August 17, 2017 from https://news.gallup.com/poll/156833/one-five-adults-smoke-tied-time-low.aspx

Seers, K. (2012). Qualitative data analysis. *Evidence-Based Nursing*, *15*, 2.

Stewart, D. W., Shamdasani, P. N., & Rook, D. W. (2007). *Focus groups: Theory and practice*. Thousand Oaks, CA: Sage Publications.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357.

U.S. Census Bureau. (2010). QuickFacts: Madison County, TX. Retrieved August 18, 2017 from https://www.census.gov/quickfacts/fact/table/madisoncountytexas/PST045217

U.S. Data. (2017). Madison County, TX. Retrieved August 18, 2017 from https://www.census.gov/quickfacts/fact/table/madisoncountytexas/PST045217