An Evidence-Based Cessation Strategy Using Rural Smokers' Experiences with Tobacco

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Tobacco use is the major cause of preventable disease and death in the United States, contributing to nearly 500,000 premature deaths annually.[1] More than 46 million US adults are current smokers (20.6%). Despite increasing efforts to provide tobacco-related programming and cessation assistance, the adult smoking prevalence did not change significantly from 2005 to 2009, suggesting a lull in the slight decline during the past decade.

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The burden of tobacco use in the United States is not evenly distributed. Nationally, higher smoking rates are found among men (23.5% vs 17.9% in women), as well as those with less than a high school diploma (28.5%) and those living below the federal poverty level (31.1%) or in the South (21.8%) and Midwest (23.1%).[1] According to the National Interview Survey (2007), national adult smoking prevalence among persons living in nonmetropolitan areas is 24.5%, higher than either the prevalence for small metro areas (20.9%) or large metro areas (17.4%).[2]

Rural smoking prevalence rates vary by state. Kentucky, a tobacco-growing state, is a national leader in rural adult smoking prevalence at 31.8%, which is higher than the state and national averages and the rates found in rural areas of other states. For example, rural areas of Utah have a much lower level of adult smoking prevalence, at 12.5%.[3] Low socioeconomic status (as measured by educational level, income, and employment) was associated with higher smoking prevalence in a national rural study and explained part of the disparity in tobacco use among rural residents. Regardless of location, rural populations are disproportionately affected by tobacco use, exposure to secondhand smoke, and smoking-attributable disease and death.[4]

Little is known about specific behavioral interventions that could enhance success rates among those who want to quit smoking, particularly those living in rural areas who are at higher risk and have less access to health care.[5] Nationally, most (70%) adult smokers report that they want to quit completely.[6] In 2008, an estimated 20.8 million (45.3%) adult smokers had tried to quit and had stopped smoking for at least 1 day during the preceding 12 months.[7] Although interventions designed to reach populations may have the greatest chance of success when they are tailored toward those at highest risk, they may not be as effective in rural areas because of limited access to health care.[5] However, innovative approaches have been tested in rural areas, including telephone counseling,[8] Web-based interventions,[9] and cessation contests.[10]

Unique cultural and social factors that exist in rural communities may affect tobacco use and treatment. For example, some communities may have social norms supportive of tobacco use (ie, tobacco-growing communities), or be exposed to tobacco industry marketing campaigns such as sponsorships of rural sporting events. Proximity to tobacco growing in rural areas is another potential barrier to tobacco control efforts.[5] Tobacco-growing regions of the country often have fewer tobacco-related laws and fewer antismoking programs.[11] However, all rural areas are not alike. Interventions that work well in one rural area may not necessarily translate to other rural areas.

Although rural communities are diverse, residents of rural communities tend to have strong family ties and close-knit social networks.[12,13] Participation in local organizations is high and neighborliness is valued. Tobacco interventions that tap into existing social networks, engage stakeholders, and gain the trust of rural residents could bridge the tobacco treatment gap in rural areas.[5] Because rural smokers are a population with a high potential for behavior change resistance, low levels of perceived vulnerability, and opposing social norms, they are an ideal population for an intervention based on the findings from personal narratives.[14]

Personal narratives are an innovative approach to reaching smokers in rural communities and motivating them to consider quitting. Hinyard and Kreuter[14] found that personal narratives are effective because they are personal, relatable, believable, and memorable. They cited 3 major reasons why personal narratives are effective: (1) the ability to reduce counterarguments, (2) the facilitation of observational learning, and (3) the ability to identify with the storyteller. Personal narratives have been used successfully with vulnerable populations to decrease tobacco, alcohol, and marijuana

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