HIV Client Focus Group Results

January 2016

Michigan held 14 statewide focus groups with people living with HIV (PLWH) who smoke cigarettes, generating 92 responses during May-July, 2015. The purpose of the focus groups was to learn more about tobacco use behaviors among PLWH and garner information about needs for quitting.

Michigan Department of Health and Human Services, Tobacco Control Program
January 29, 2016

Tobacco-related disease and death has affected me and my family personally. I am a strong tobacco prevention and treatment champion because many of us have had loved ones or a friend die from heart disease, cancer or stroke directly tied to tobacco use or exposure to second-hand smoke. These early and needless deaths can be prevented with improved and more effective tobacco education, equitable policy-changes, increased resources and greater access to tobacco dependence treatment.

Certain groups are more significantly impacted by using tobacco such as people living with HIV (PLWH). The goal of the Tobacco Control Program is to focus on populations with a very high rate of tobacco use and who are specifically targeted by tobacco industry marketing. From the research we learned that nationally PLWH smoke from 42-70% and dying 12 years sooner from smoking cigarettes than from AIDS complications. The Medical Monitoring Report, 2012 data was alarming stating that those PLWH in Michigan smoke at 68% - the highest rate of any other subgroup.

We approached the State of Michigan HIV Care and Prevention Section to partner and fund a pilot project and were successful. The goal of the Tobacco Reduction in PLWH Pilot Project is to increase health outcomes for those enrolled in HIV care and treatment through using the best available tobacco treatment grounded in science and evidence. This is a long-term science-based strategy that requires a progression of education and training in tobacco dependence treatment and ongoing health systems support for anyone who wants to quit.

These Focus Group Report findings was a project objective as we needed to learn more about the HIV+ smoking behavior. Specifically, we wanted to learn what had motivated PLWH to quit tobacco in the past and the quit tobacco support they might need in the future.

I am enthusiastic and supportive about the Tobacco Reduction in PLWH Project as a national promising practice. I want to thank my team and Report authors. Your dedication and passion will help improve the lives of those living with HIV. Thanks to Lynne Stauff, Project Coordinator; Farid Shamo, Evaluation Specialist; and Carrie Kirkpatrick, Public Health Consultant.

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Acknowledgements

Many individuals along with agency support has helped make this report possible. We appreciate the financial assistance from the State of Michigan’s HIV Care and Prevention Section. The overall project became a reality because of its trust in our ability to apply innovative methods to improve health outcomes for those clients living with HIV.

We thank the AIDS Service Organization employees funded through this project who were trained to implement and run the focus groups. They explored and implemented novel ways to recruit participants, increase focus group attendance, and respect the integrity of the process. Thanks to each focus group facilitator and recorder for setting aside personal opinions/perspectives to capture the essence of participant experiences and beliefs. With your partnership and enthusiasm we gathered meaningful data that can improve the lives of those living with HIV who are addicted to tobacco.

Thanks to the 92 focus group participants from around the state for their willingness to share opinions and experiences as tobacco users. We appreciate their trust and effort to be candid about personal behaviors. This is their story and we are grateful to them for sharing it. We thank Kolawole Ale, Intern, who reviewed the initial results and provided us with a first draft. Good luck with your future endeavors and thanks for your time and effort.

Finally, we appreciate the culture built by Orlando Todd, Manager, Tobacco Control Program (TCP) Section, Michigan Department of Health and Human Services (MDHHS). The environment you have created is one of empowerment, communication, and independence, has allowed us to thrive and work smarter and to our potential. Janet Kiley, Unit Manager, has contributed with her experience, good thinking, and tremendous help with edits. Thanks to both of these generous and passionate leaders for their many years of service in the tobacco prevention and control movement.
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Acronyms and Abbreviations

PLWH  People Living With HIV
TCP   Tobacco Control Program
MDHHS Michigan Department of Health and Human services
BRFSS Behavioral Risk Factor Surveillance System
HAART Highly Active Antiretroviral Therapies
ASO   AIDS Service Organization
LGBT  Lesbian, Gay, Bisexual and Transgender
MMP   Medical Monitoring Project
NRT   Nicotine Replacement Therapy
TDT   Tobacco Dependence Treatment
TTS   Tobacco Treatment Specialist
Executive Summary

Tobacco use is the leading cause of preventable disease and death in the United States as well as in Michigan. Tobacco use including exposure to second-hand smoke kills 17,000 people in Michigan annually. More people die from tobacco-related diseases than from homicide, motor vehicle accidents, suicide, crack-cocaine and heroin, HIV and unintentional injuries combined.

Fifty percent (50%) or one out of every two people living with HIV (PLWH) in Michigan (HIV Client Survey, 2015) are smoking cigarettes whereas the general adult population smokes at 21.4% (one out of five) [Behavioral Risk Factor Surveillance System (BRFSS, 2014)]. HIV has become a manageable chronic disease when treated with highly active antiretroviral therapies (HAART). Unfortunately, as with the general population, PLWH who use tobacco are dying of heart disease, cancer, and stroke. Ironically, they are dying from tobacco-related diseases 12 years sooner than from AIDS complications.  

The Michigan Tobacco Control Program (TCP) long term goal is to “identify and eliminate disparities specific to race/ethnicity, socioeconomic status, occupation, geography, gender, and sexual orientation”. PLWH are part of a vulnerable and at-risk group with disparately high rates of death and disease due to tobacco use. To fulfill its goal the TCP approached the State of Michigan’s HIV Care and Prevention Section to fund a pilot project for 3 years at $1.275 million annually to reduce the smoking rate of PLWH.

The TCP’s proposal was successful and funding was granted.

The first project year started January 2015 and focused on data collection and training. An employee needs assessment and HIV client survey were administered to gather baseline data. During May-June 2015, fourteen (14) focus groups were held with HIV client tobacco users at 11 AIDS Service Organizations (ASO) locations around the state; generating 92 participant responses.

The focus group responses confirms much of what the tobacco literature reflects regarding influence to quit and supports needed for a successful tobacco quit attempt. PLWH are motivated to quit tobacco by the same things that encourage others in the general population. Motivators to quit are: need for personal health and appearance; fear of illness and death of loved ones, especially children; more time to take care of themselves; the high cost of tobacco; and smoke-free indoor air laws limiting tobacco use.

Tobacco prevention education has had a significant impact on motivating people to quit; however, pro-tobacco marketing by the tobacco industry continues to have a powerful influence on (especially young people) starting to smoke. During the focus groups, tobacco education visual media examples were introduced to the participants. The current quit tobacco media messages were characterized as frightening and alarming and was off-putting to the participants. Media showing sick and disabled people along with the scare tactics - although memorable, are not necessarily effective. Their interest was to see
quit tobacco media showing healthy, empowered and happy people who have quit. Although, the sexy pro-tobacco messages seen years ago continues to be very memorable and nostalgic with the focus group participants, they preferred positive quit tobacco messages and images. This information confirms similar results in the Affirmations, Focus Group Findings on Tobacco Use in the LGBT Communities, 2014.

Focus group participants discussed support needed for successful quit attempts and what has worked in the past. Many of the responses were the same for these two different questions. Participants voiced a need for a more comprehensive range of services to support their tobacco quit attempts. They need: positive changes in their physical, mental and behavioral health; changes in their physical and social environment; support of family, friends, and health care providers; support groups; more tobacco treatment programs; information and access to nicotine replacement therapy (NRT) and other tobacco treatment medications; and tools and skills to deal with nicotine cravings. Participants also mentioned external factors that will support their quit attempt:

- Continued smoke-free indoor air laws and limited access to purchase tobacco products
- Helping others in their household to quit using tobacco
- Creating a tranquil home environment and avoiding Stressors

**Recommendations**

1. ASO provider support for tobacco dependence treatment (TDT) interventions
2. Increased number of support groups
3. Access to Medication and referral to Michigan’s Tobacco QuitLine
4. Sustainability - continue to fund Tobacco Treatment Specialists (TTS) through Tobacco Reduction in PLWH Project
5. Positive media advertising and marketing campaigns

**Background**

Tobacco use is the leading preventable cause of morbidity and mortality in the United States. Each year, an estimated 443,000 people die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million live with a serious illness caused by smoking. Every year tobacco kills more Americans than did World War II. Tobacco use is also a social justice and health equity issue, disproportionately affecting people who face discrimination and barriers to health based on their socioeconomic status, disability status, race and ethnicity, mental health, sexual orientation, geographic location, and nature of their employment and occupation.

As indicated above, health consequences of cigarette smoking are not borne equally among all populations. The prevalence of current tobacco use among PLWH is estimated between 42 and 70%, markedly higher than the 19% prevalence in the U.S. general population (US-BRFSS 2013).
For many PLWH, HIV disease has changed from fatal to a manageable chronic disease due to HAART. PLWH are now facing diseases similar to the general population which include cancer, heart disease and diabetes. Smoking is among the most prevalent problems affecting HIV-infected patients who have complex social, economic, psychiatric, and medical needs. These multiple complicated issues require enhanced interventions and responses to smoking behavior than is offered through standard smoking cessation interventions. According to the Medical Monitoring Project (MMP), 2012, the smoking rate among PLWH in Michigan was estimated to be 68%. This is the highest rate reported for any subgroup in Michigan. Few national studies have reported on the prevalence of smoking behavior in PLWH. In Michigan, only the limited MMP study was conducted. However, improved knowledge and understanding of tobacco use among PLWH will help to define methods for appropriate and specific interventions to increase the number of tobacco quit attempts and improve health outcomes.

The TCP at the MDHHS with funding from Michigan’s HIV Care and Prevention Section developed a pilot project to work with multiple statewide ASOs to help them assist PLWH who smoke and use tobacco to quit this dangerous health risk. The project is funded for three years and is comprised of four steps: 1) assess, 2) train, 3) implement, and 4) evaluate. The first year (Jan-Sep 2015) focused on assessing knowledge, beliefs, behaviors and barriers around smoking and tobacco use topic among PLWH.

Since this is a new project with minimal baseline data or any direct relationships with ASOs we administered surveys. A needs assessment survey was conducted initially for ASO employees in order to learn more about employee needs, to increase staff support for project activities, to broaden staff education and support beyond those specifically funded staff; and for the TCP to become aware of training needs. A total of 108 staff participated in this survey.

Appendix-4, figure-1 shows how frequently the staff used the 5As tobacco best practice protocols for their patients who are tobacco users (71% have not used them), and figure-2 shows whether training is a barrier to support the smoking cessation (82% said yes).

Following the staff needs assessment, a very comprehensive HIV client assessment survey was conducted to learn about knowledge, beliefs, behavior and barriers around the topic of smoking and tobacco use among the PLWH. With assistance from all project-funded ASOs 1,478 clients participated in the survey. The survey estimated the prevalence of smoking in a larger sample size of PLWH. The smoking rate was 50% as shown in Appendix-4, figure-3, and assessed smoking rates by their sexual orientation; findings indicated that 58% of LGBT are current smokers (as shown in Appendix-4 figure-4), and found 67% of the smokers did not use medications when attempting to quit (as shown in Appendix-4 figure-5). We also assessed some triggers like...
whether smokers are living with other smokers (51% of them live with other smokers as shown in Appendix-4 figure-6). The third assessment activity was to conduct focus groups among PLWH who are tobacco users in most of the ASOs that are serving these populations.

**Purpose**

The purpose of these focus groups is to generate range and depth of qualitative data on the tobacco use and behavior, and how to best educate and increase quitting attempts through effective media messages and prevention activities among PLWH.

**Methodology and Sample**

The TCP at the MDHHS, with the assistance from statewide local ASOs, conducted focus group sessions among PLWH who are tobacco users. The TCP contracted with a training company to provide general technical assistance and to create and deliver a Focus Group Facilitator and Recorder Training. Eleven ASOs agreed to hold focus groups and 22 ASO employees attended the 8 hour curriculum designed to prepare both facilitator and recorder teams to run a focus group session successfully and with standardization. All specific training objectives were identified and met over the course of the training.

The TCP trained the ASOs to select a random sample of participants from an already existing list of HIV clients in care in order to prevent any selection bias. To be eligible to participate in the focus group, an individual should be HIV positive, living in Michigan, 18 years and older, current tobacco user (have ever used tobacco products or smoked at least 100 cigarettes, plus smokes or uses other tobacco products now) and lastly willing to participate in the focus group. Randomly selected participants in the preexisting list were called to assess their eligibility and their willingness to participate. Participants were offered a monetary gift card, snacks at the session and transportation vouchers to and from the focus group.

All the focus group’s facilitators and recorders used standardized forms for data collection, reporting results, and demographic sheets. Fourteen focus groups were conducted by 11 unique ASOs; 7 organizations conducted 7 focus groups. The Lansing Area AIDS Network (LAAN) conducted 2 focus groups; Mercy Health Clinic with the Grand Rapids Red Project conducted 2 focus groups; and Wayne State University, Horizons Project conducted 3 focus groups. One of the ASOs purposefully held a female-only focus group because of the known challenges in recruiting females. All focus groups were conducted between June 3 and July 13, 2015.

Each participant received two forms upon their arrival; the first one was a consent to participate and confidentiality form; the second form was an anonymous demographics form. Participants signed the consent-confidentiality form, and completed the demographic form before beginning the focus groups. Each focus group addressed two main questions:
**Question 1, Part 1:** In the past, if you ever tried quitting tobacco – what made you want to quit?

- **Q1, Part 2:** What can you remember and share about specific media images in magazines, movies, on TV, or things like in music videos, or video games or even at concerts or other events that influenced your choice to QUIT using tobacco products.

**Question 2, Part 1:** If you decided to quit tomorrow, what support would you need?

- **Q2, Part 2:** What services or resources have helped you to quit in the past?

These qualitative data collected were analyzed by the Tobacco Reduction in PLWH project team with initial assistance from a Masters of Public Health student intern.

**Demographics**

Fourteen focus groups were conducted by 11 organizations, with 92 participants. Table-1 in the appendices shows the agency’s name, date, and number of the participants for each focus group. The average age of the participants was 41.7 years; 63.4% identified themselves as males and 33.3% as females; one participant identified as transgender. Black participants were 52% while white were 34.3% and others were either Hispanic, Latino or mixed.

Results for the sexual orientation question were: 41% identified-as gay/lesbian, and 7% -as bisexual, while 27% -as heterosexual. The remaining were missing, i.e. they did not respond to this question. The education level of the participants ranged from 12% with less than high school, 37% as a high school graduate, 46% with some college and only 4% have college and above. Responses to annual income: the majority (68%) of the participants have less than $20,000, 14% have $20-30,000 while 3% have $30-40,000, the rest who responded to this question (5%) have $40,000 and above. Employment status was also documented, the majority (50%) were on disability income; 16% were unemployed, and 32.5% were either employed or self-employed. Asking about how they rate their health, the majority (76%) answered good to excellent, and only 5% answered as having poor health. The estimated average years living with HIV was 10.2 years while the average years of using tobacco was 21.8 years; this indicates that participants used tobacco before contracting the HIV disease. Average number of quitting attempts per year among the participants was 1.8 attempts.

**Discussion Results**

**Prior Quit Attempts**

**Influence to Quit**

In 2013, approximately two thirds of adult smokers in the United States attempted to quit within the previous year. This number has continued to increase in most states since 2001. Tobacco treatment literature stresses the importance of assisting people who use tobacco to find their motivation to quit. While many more
smokers are choosing to quit, the motivators that prompt them to quit may vary. To better assist PLWH with successful quit attempts it was important to find out what had influenced them to quit in the past. Participants shared their experiences of previous quit attempts and what had motivated their decision. Many of the participants reported their reason for quitting was due to the negative health consequences of using tobacco. While some concerns were due to participant’s own personal struggles with health issues, others noted watching loved ones get sick with conditions like cancer, chronic obstructive pulmonary disorder (COPD), or even dying from tobacco related diseases:

"My younger brother died due to the complications that come along with smoking, so that definitely made me want to stop"

"I don’t want jaw cancer or an ugly death"

Alternately, some participants wanted to have a greater presence in their loved ones lives, particularly their children’s, by living longer as a result of quitting. Other participants discussed wanting to quit in order to improve their mental health, self-esteem or appearance. These same participants also talked about how much better they felt when they had quit in the past. While many participates admitted to using tobacco as a stress reducer, others acknowledged that quitting could allow them to better focus on addressing their mental health and having more time to simply focus on themselves:

"The need to smoke interrupts my sleep"

"I get annoyed because of how much smoking affects my daily routine"

"[when not smoking] I could think clearer, even see and hear better, I want that back"

Physical appearance was also a topic discussed by many participants, noting concern of premature damage to their skin, teeth and the odor caused by smoking. Not only was their physical appearance an important factor in influencing participants desire to quit, but also their perceived image by others. Being labeled as a smoker was discouraging to many participants. The stigma of smoking influenced one participant to avoid smoking around others:

"I walk 2 blocks past my church to smoke"

In addition to the previously mentioned factors in participants’ decisions to quit, other influences that emerged for many of the participants were external factors such as tobacco costs and policies restricting tobacco use. Participants discussed high tobacco prices as an influence in their
decision to quit. One participant even spoke of cost taking priority over other factors of quitting such as health:

"I'm not concerned about my health. Saving money comes first, then my health is second"

Others mentioned the effects of policy as a major factor in their decision to quit. Policies that prohibit smoking in bars and restaurants, incarceration in smoke free facilities, and private business’ decisions to quit selling tobacco:

"When CVS stopped selling tobacco products that made me want to quit, the other stores were too far [away]"

Whether influenced to quit by negative health consequences, persuasion of loved ones, high cost or tobacco-free policy changes, focus group data indicates that the majority of participants had made at least one quit attempt in the past. Other participants stated that they were not at that point yet and did not have an interest in quitting. This data not only aligns with current cessation trends within the United States but also is crucial in increasing quit attempts among PLWH through education and media messaging.

**Impact of Media on Quit Attempts**

In order to understand participant’s attitudes toward media messages informing consumers of the harmful effects of tobacco, participants were asked to discuss any messages that may have influenced them in their decision to quit. Mass media messages warning consumers of the harmful effects of tobacco use have existed since the 1970’s, which is fairly recent given commercial tobacco products have been around for over 150 years. Thus, it is not surprising when discussing anti-tobacco media messages with participants that they expressed being impacted by these messages. They had valuable insights regarding pro-tobacco advertisements and marketing strategies, and the appearance of tobacco use in popular culture and the entertainment industry. While many participants had been eager to discuss pro-tobacco media, the focus of the discussion was on anti-tobacco media, which also prompted participants to contribute helpful information. A large number of participants talked about anti-tobacco campaigns such as the TRUTH campaign, with many of them specifically referring to the campaign by name, indicating that they were familiar with these specific advertisements. The campaigns most discussed were those that use “scare tactics” as a form of reaching out to consumers. Participants indicated that these types of messages were impressionable but not necessarily effective in motivating them to quit.

"The ads nowadays are horrible, but you want one [cigarette] afterwards"
Participant discussions made it apparent that these media messages were memorable. Many of them had made detailed remarks from specific advertisements depicting tobacco users: with tracheotomies, amputated limbs, and small children suffering from second hand smoke:

"TRUTH commercials suck all of the joy out of cigarette smoking"

Some participants discussed remembering campaigns providing education, with one describing a poster they received that listed and explained all the chemicals in a cigarette. Other participants mentioned wanting to see more positive anti-smoking messages displaying attractive people, similar to many pro-tobacco media messages. Participants explained what was appealing about these ads -- sex appeal and positive images of people and characters, had encouraged some to begin using tobacco in the first place. Included in these descriptions were the Marlboro Man, Joe Cool, and popular culture celebrities:

"Marlboro was depicted as a macho man, showed what a ‘real’ man was”

Perhaps not so surprising, they also want to see more appealing visual cues in anti-tobacco media messages.

Marketing strategies such as collecting merchandise and coupons through the purchase of tobacco products was also discussed as a motivator to continue using tobacco. Some participants brought up an apparent shift in the appearance and frequency of tobacco advertisements. They noted a greater frequency of anti-tobacco campaigns in the media and less emphasis on pro-tobacco media than in the past. There was mention of the show “America’s Next Top Model” banning smoking due to the high incidence of young viewers. Although the purpose of this discussion was to focus on media which had influenced participants to quit, their insights provides important feedback regarding what pro tobacco media had the strongest impact on them.

Successful Quit Attempts

Needed Support for a Successful Quit Attempt

When asked what type of support would be needed in order to successfully quit tobacco, participants expressed a need to make positive changes in their physical, mental and behavioral health; they want to make changes to their physical and social environment; they want to elicit support of family, friends, health providers, and tobacco treatment programs, nicotine replacement therapy (NRT) and other cessation medications to be successful; and they want to use replacement activities and a reward system as motivators to succeed. Many of the participants stated that they would like to become more physically active by adding exercise into their daily routine. This would assist with keeping them busy and providing motivation to quit. Similar to this example, many participants’ responses intersected with other major themes of the overall
discussion, noting a need for a diverse plan of action:

"It takes more than one approach [to quit]"

Mental health issues were another topic of discussion. Many participants stated that by addressing their mental health issues, such as depression and anxiety, they would feel more confident in successfully quitting tobacco. Many acknowledge that they would like assistance with their coping skills and stress reduction. This is a matter of not only treating and managing mental health conditions but also focusing on behavior change to allow for a successful quit attempt. One participant wanted more tools for managing their “mood swings” while another went as far to say that they would need a “sensory deprivation room” indicating that environment is also a major factor as many other participants brought up:

"My partner smokes so he would have to quit"

These environmental changes discussed included: 1) making changes to the home environment by cleaning and removing the odor left behind by cigarette smoke, 2) changing surroundings, 3) creating alone time to get away from stress or other members in the household or other smokers, 4) finding opportunities to be surrounded by non-smokers and positive people, and 5) intentionally put themselves in smoke free environments. Another type of change participants mentioned was to find a “replacement” for smoking such as a hobby or an item such as a snack, candy, or toothpick to replace the physical motion of smoking a cigarette.

Another major topic that emerged was the need for positive support from family and friends, tobacco treatment specialists, ASOs, and providers. Support groups were discussed by many participants; they expressed feelings about lack of support from others in their social life, as they were also tobacco users. A support group could provide them with an environment that facilitates positivity and a shared motivation to quit:

"I need human being support who understands, and when looking for support, it should be genuine and not difficult to find"

Participants want their health care providers to initiate conversations about quitting smoking and provide more information regarding medications and NRT. Lastly, some participants support the idea of increasing the price of cigarettes and the creation of more smoke free environments. While the list of needs for a successful quit attempt appears to be quite lengthy, many participant needs can be accommodated by a comprehensive and integrated approach across disciplines to provide a “collective impact” in support of their quit attempt. These include addressing mental health, facilitating behavioral change, and increasing education regarding quitting.
What has helped in the Past?

Participants discussed what was helpful in the past when attempting to quit. Many of the discussion points in this portion of the focus group shared similarities to the previous discussion pertaining to participant needs for a successful quit attempt. This included the use of NRT, behavioral and health improvements, addressing mental health needs, and being in an environment conducive to quitting smoking. One component missing from this portion of the discussion, mentioned in the previous discussion, was the presence of social and professional support. While participants expressed a need for proper support from all healthcare providers and within their social support system, many stated that this type of support was not available to them in the past.

Physical activity was brought up again as a previously experienced method to cope with stress and keep their mind off of cravings:

"Let me hurry up and go to sleep to start again the next day with exercise"

"Something to do will help, walking or jogging"

Another important topic discussed was the need to equip themselves with the necessary coping skills to better manage cravings and stress. Once they master such skills they can maintain a positive mindset in order to increase their chance of a successful quit attempt. Even if a quit plan fails, participants stressed the importance of remaining positive and using the necessary tools they have learned to do so:

"Being serious about my decision and not cheating"

"Buying the pack of cigarettes is the hurdle I have to get over"

Provider support, cessation medications and NRT were also significant components to successful quit attempts in participants’ past. A need for accountability and facilitation with health care staff was expressed:

"Having accountability with someone like a nicotine nurse"

Others discussed successes with cessation medications such as NRT patches, lozenges and gum. Many participants had success with these forms of medication for some time but due to stressful life events or weight gain they began to use tobacco again. This finding supports the need for ongoing medical support since it can take as many as seven quit attempts to quit tobacco permanently.

Environmental changes were also noted as being helpful. As previously mentioned, the “quitter” needs to avoid other smokers by intentionally removing themselves from situations where others would be smoking. Being put into a smoke free environment through incarceration, or with making an effort to be
surrounded by non-smokers are both means to the same end:

"Find non-smokers. If you know someone who smokes you’ll hang out more and smoke more"

Lastly, social support such as support groups, educational seminars or classes, and substance abuse classes were cited as being helpful. The number of responses specifying having an adequate social support system available in the past was much lower than those expressing a need for this type of service offered in future quit attempts. Thus indicating a greater need for stronger and more reliable support systems.

**Conclusion and Recommendations**

More information is needed to support PLWH’s tobacco quit attempts (Browning, et al., 2013). In response to needed research, fourteen focus groups were held in Michigan to collect HIV client responses to decrease the high PLWH smoking rate. The combined results and quotes will be used to direct tobacco education and treatment efforts and design targeted media messages to increase quit attempts in PLWH.

**Influence to Quit**

Motivation to quit using tobacco in past attempts varied among participants but nothing unique or unusual emerged that was significantly different from motivation in the general adult population. The motivator themes to quit using tobacco were:

- Fear or dread - of disease, of death for themselves or loved ones, for the children in their lives;
- Self-respect - improve overall health and physical appearance;
- Guilt - embarrassment and shame of being labeled a smoker;
- Environmental- smoke-free indoor air laws which limit access;
- Financial - increasing cost of tobacco products; and
- Access - business and corporations choosing not to sell tobacco products, thus limiting availability.

Focus group participants did not like seeing the ads that scare them into quitting tobacco use. They want to see advertisements promoting healthy, empowered and attractive people living a smoke-free life and doing what they enjoy. These responses validate and confirm the Focus Group Findings on Tobacco Use in LGBT, Affirmations, 2014.

**Needs to Successfully Quit Tobacco**

- Positive changes in their physical, mental and behavioral health;
- Changes in their physical and social environment;
- Social support of family, friends, and health care providers;
- Increased tobacco treatment programs, specifically tobacco support groups;
- More information on and access to nicotine replacement therapy
(NRT) and other tobacco treatment medications; and
- Greater coping skills and tools to deal with nicotine cravings.

Participants also mentioned these external factors that will support their quit attempts:

- Continued smoke-free indoor air laws and limited access to purchase tobacco products;
- Helping others in their household to quit using tobacco; and
- Creating a tranquil home environment and avoiding stressors.

**Recommendations**

**AIDS Service Organization Support for Tobacco Dependence Treatment Interventions**

ASO providers support is invaluable to support their clients’ tobacco quit attempts. They should be trained as TTS and to work closely on the comprehensive array of services clients need: physical health, behavioral change, and mental health. Trained TTS can help to educate clients, empower and provide needed information on tobacco treatment medication use, along with referrals to the Michigan Tobacco QuitLine. Using the spirit of Motivational Interviewing (MI) (partnership, acceptance, compassion and evocation) skills TTS experts can work with clients through change talk into preparation and action on a quit attempt.

**Increased Number of Support Groups**

Support groups have long been a fixture within the HIV community – content supporting medication adherence, safe-sex practices and living with HIV. Stop Smoking Support groups or counseling paired with tobacco medications can substantially improve a tobacco quit rate success. For those HIV clients who are ready to quit, stop smoking support groups focus on providing them with peer support, tobacco medication information and accountability through their quit journey. Pre-contemplation support groups can also be formed for those needing more information on how tobacco use is negatively affecting their health making them more prone to illness and disease, especially as a PLWH.

**Tobacco Medication Access and Referral to Michigan’s Tobacco QuitLine**

PLWH who use tobacco need more information and access to TDT. Based on the HIV Client Survey, 2015, and focus group findings HIV clients aren’t aware of the medications, their efficacy or how to use them appropriately. The 7-approved Food and Drug Administration TDT (5 NRT’s, Varenicline and Bupropion) medications are highly effective. The TTS engaging clients at the ASO can assist with information on dosage, reactions and what is best for the client after completing a tobacco use assessment. The only state-wide tobacco treatment funded in Michigan is the Tobacco QuitLine. This LGBT-friendly and trained counseling call center funded through the TCP and
run by the National Jewish Health is a successful and accessible method to get quality tobacco treatment.

**Sustainability – Continue to fund Tobacco Treatment Specialists through Project Funding**

Continue to fund or expand the Tobacco Reduction in PLWH Project through the TCP working directly with trained TTS housed at ASOs. Tobacco Treatment Specialists are trained to comprehensively work with clients through motivational interviewing, medication use, support groups, behavior change, teaching life skills for coping with cravings, etc. AIDS Service Organizations should continue to fund TTS training for their employees to deliver high quality tobacco treatment as part of every tobacco user’s treatment plan.

**Positive Media Advertising and Marketing**

PLWH want to see positive and successful former smokers, ideally from their own population in the stop smoking media advertisements. They want to see healthy, attractive and empowered people doing what they love. The LGBT advocacy agency, Affirmations, used results from their Focus Group Report and subsequently created the What’s Your Why media campaign to meet this need for the LGBT community. The ASOs in the Tobacco Reduction in PLWH project are encouraged to work with Affirmations. The TCP should consider creating their own statewide media campaign focused on stop smoking efforts in the PLWH population.
References


Appendix-1

**Participant Demographic Sheet**

Agency Convening Focus Group: ________________  Date of Focus Group: ______

**Participants complete below:**

1. Age: ______________________
2. Gender Identity: ______________________
3. Race: _______________________
4. Sexual Orientation: ________________________

5. Self-assessment of Health:
   - □ Excellent  □ Good  □ Fair  □ Poor

6. Educational level:
   - □ Less than High School  □ High School  □ Some College  □ College and Above

7. Annual household Income:
   - □ Up to $20,000  □ $20,000 - $30,000  □ $30,000 - $40,000  □ $40,000 - $50,000  □ more than $50,000

8. Employment status:
   - □ Self-employed  □ Employed  □ Unemployed  □ Disability Income

9. How long have you been living with HIV? ____________ years

10. How long have you been using tobacco products? ________ years

11. How many quit attempts to tobacco use have you made in the past year? ____________

**Agency:** Please send this sheet to the Tobacco Control Program along with the recorder notes.
## Appendix-2

Table-1 The agencies which conducted the focus groups, date held and number of participants.

<table>
<thead>
<tr>
<th>Agency name</th>
<th>Date of the focus group</th>
<th># of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. AIDS Partnership Michigan</td>
<td>6/12/2015</td>
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<tr>
<td>2. Central Michigan DHD</td>
<td>6/16/2015</td>
<td>5</td>
</tr>
<tr>
<td>3. Community AIDS Resources and Education Services “CARES”</td>
<td>7/13/2015</td>
<td>9</td>
</tr>
<tr>
<td>4. Grand Rapids Red Project and Mercy Health-Hackley Campus.</td>
<td>6/22/2015</td>
<td>7</td>
</tr>
<tr>
<td>6. HIV/AIDS Resource Center “HARC” (female only focus group)</td>
<td>6/18/2015</td>
<td>4</td>
</tr>
<tr>
<td>9. LAAN-2</td>
<td>7/8/2015</td>
<td>6</td>
</tr>
<tr>
<td>10. Sacred Heart Rehabilitation Center</td>
<td>6/24/2015</td>
<td>7</td>
</tr>
<tr>
<td>11. Wayne State University-1</td>
<td>6/3/2015</td>
<td>4</td>
</tr>
<tr>
<td>13. Wayne State University-3</td>
<td>6/24/2015</td>
<td>8</td>
</tr>
<tr>
<td>14. Wellness AIDS Services</td>
<td>6/25/2015</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14 focus groups</strong></td>
<td><strong>92</strong></td>
</tr>
</tbody>
</table>
Appendix-3

(Focus Group Theme Report Form)

Date of Focus Group: _________________________

Administering Agency: ____________________________________________

Facilitator: ___________________ Recorder: _______________________
Location of Session: ___________ Actual length of session: _______

Summary of Notes

- Question #1

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<th>Theme</th>
<th># of matches</th>
</tr>
</thead>
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<td>5.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>7.</td>
<td></td>
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<tr>
<td>4.</td>
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<td>8.</td>
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</tr>
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</table>

Other relevant observations:  -----------------------------------------------
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- Question #2

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<th>Theme</th>
<th># of matches</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>5.</td>
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<tr>
<td>2.</td>
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<td>8.</td>
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</tr>
</tbody>
</table>

Other relevant observations:  -----------------------------------------------
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Appendix-4
Figures from staff and client surveys:

Figure-1

Staff Assessment Survey
How frequently do you use the 5 As protocol with your patients?

Figure-2

Staff Assessment Survey
Do you believe lack of training is a barrier to support smoking cessation?

Figure-3

Client Assessment Survey
Smoking status among the PLWHA-2015 survey

Figure-4