Health Disparities Program
Fact Sheet Series: Smoking

Smoking and Tobacco Use in Rural Populations

Rural communities account for about 90% of the land area in the United States and about 19.3% of the total population (U.S. Census Bureau, 2010). Compared to their urban counterparts, rural communities have higher rates of preventable diseases, such as obesity, diabetes, and cancer, and higher rates of risky health behaviors, such as smoking, physical inactivity, poor diet, and inadequate use of seatbelts (Eberhardt & Pamuk, 2004; Hartley, 2004). America’s rural population is more likely to use tobacco especially smokeless tobacco and is more heavily impacted by tobacco use. Rural Americans are also more likely to be exposed to secondhand smoke and less likely to have access to programs that help them quit smoking (American Lung Association, 2012).

Smoking/Tobacco Use Prevalence

- Rural county communities have higher rates of lifetime, past year and past month tobacco use than large and small metro county areas (SAMHSA, 2014 – Table 2.47B).

- Patients living in rural areas have higher rates of smokeless tobacco use, particularly rural residents aged 26-49 (American Lung Association, 2012).

- Rural residents are more likely to be exposed to secondhand smoke both at work and at home (Vander Weg, Cunningham, Howren, & Cai, 2011).

Health Consequences of Smoking

- Smoking increases risk for numerous health complications, such as chronic obstructive pulmonary disorder (COPD), lung cancer, hip fracture, and heart disease, and these conditions may be exacerbated in rural areas because of limited access to healthcare providers (Eberhardt, Ingram, Makuc et al., 2001).

- Heart disease and stroke are leading causes of death in rural populations (Eberhardt, Ingram, Makuc et al., 2001).

- Secondhand smoke (SHS) is a leading cause of childhood illness and premature death, especially in rural areas (Vander Weg, Cunningham, Howren, & Cai, 2011).
Risk Factors for Smoking

- Teenagers living in rural regions smoke more and at earlier ages than their urban peers. (Epstein, Botvin & Spoth, 2003).
- Pregnant women who reside in rural areas are more likely to smoke than their urban counterparts (Bailey & Cole, 2009; Bullock, Mears, Woodcock, & Record, 2001; Stevens, Colwell, & Hutchinson, 2010).
- Unemployed rural residents are more likely to smoke (American Lung Association, 2012).
- The tobacco industry has aggressively marketed to rural populations for decades and has more than doubled its expenditures on marketing of smokeless tobacco products between 2005 and 2008 (U.S. Department of Health and Human Services, 2012).
- Geographical location, low socioeconomic status, and lack of health insurance often bar access to preventative healthcare for rural Americans (Casey, Call, & Klingner, 2001).

Treatment

- Rural populations are more likely to be uninsured, have limited access to care, have fewer available health care providers, and have limited transportation options which pose barriers for rural residents to see their health provider on a regular basis (Eberhardt & Pamuk, 2004).
- The use of remote monitoring and reinforcement of smoking abstinence may enhance the accessibility and acceptability of cigarette smoking abstinence reinforcement programs, particularly in rural areas where transportation can be unreliable and treatment providers are distant. (Stoops WW, Dallery J, Fields NM, Nuzzo PA, et al, 2003)
- Among rural medically underserved worksite participants, educational interventions can increase knowledge regarding the dangers of tobacco use and secondhand smoke exposure. Among current tobacco users, these interventions also increase family rules regarding secondhand smoke exposure in their homes and vehicles. (Scott, Las Sala, Lyndaker, Neil-Urban, 2016)
- For rural providers, consistent, strong curricula education at all health provider levels and continuing education for new and more effective strategies is essential to empower health care providers to address smoking cessation interventions consistently and effectively. (Scott, Las Sala, Lyndaker, Neil-Urban, 2013)
- Rural, low-income women attempting to stop smoking benefit from social support systems that exist within the smoker’s social networks in lieu of social support interventions that offer support through more distant resources (telephone, internet, professional visits, etc.) (Mitchell, Kneipp, & Giscombe, 2015).
- Smoking in rural low-income women carries social stigma, which increases their social isolation. Social isolation connected to the stigma of smoking may decrease their opportunity to engage with community members and resources that facilitate the desire and ability to stop smoking (Mitchell, 2016).

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Resources

American Lung Association – resources, tools and information on how to quit smoking.

Centers for Disease Control and Prevention (CDC), Office on Smoking and Health-- lead federal agency for comprehensive tobacco prevention and control featuring latest research, tools and resources.

Media Campaign Resource Center (MCRC) - provides access to many CDC-licensed advertisements developed by more than 25 state health departments, nonprofit health organizations, and federal agencies

Pathways to Freedom: Leading the Way to a Smoke Free Community®, from NAAPTPN (National African American Tobacco Prevention Network)

Smoking Cessation Leadership Center (SCLC) – works with health professional organizations and institutions to increase their motivation and capability to assist smokers in quitting.

Smoking in Rural Populations – a webinar exploring smoking rates and smoking cessations effort in rural populations.


References


Centers for Disease Control and Prevention. A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Dept of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Community Health; 2013.


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