International Journal of Multidisciplinary Research and Development
Online ISSN: 2349-4182 Print ISSN: 2349-5979
www.allsubjectjournal.com
Volume 3; Issue 2; February 2016; Page No. 76-79

How effective are 5A's of counseling as a means of curbing tobacco addiction in the attendees of TCC (tobacco cessation centre), Ahmedabad: A descriptive follow-up study

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Abstract

Objectives: The aim of this study was to:
1) Analyze the effects of antismoking counselling on smokers.
2) To assess the external factors influencing tobacco consumption patterns.
3) To know the current knowledge about tobacco side effects in the community.

Methods: It is a Descriptive study .The study was carried out from July 2015 to July 2016. Tobacco cessation centre, civil campus, Ahmedabad, Gujarat state, India. Out of 124 attendees registered, About 109 attendees was followed up by telephone interview/whatsapp medium for three weeks, six months, and one year after undergoing counselling. Data entry was done in Microsoft excel 2007 and proportion, chi-square test done for analysis.

Results: The final analysis shows that 46.8% supply of tobacco products was done by friends,51.38% of our attendees were involved in smokeless tobacco consumption,34% of people continue tobacco use to relieve stress, male and female both show gradual tapering of tobacco after counselling, though females were lacking in awareness about counseling sessions.

Conclusion: It is an effective preventive strategy to help people quit tobacco consumption. Various myths/trends about tobacco are known and can be effectively dealt with. Awareness is needed to encourage people in attending the counseling sessions.

Implications of the study- Interventions are needed in adolescent age as habits are adapted during this age.

At primary level care, cessation centre's should be available in the community and strict legalization should be put in work to reduce selling of tobacco products.

Keywords: Anti-tobacco counseling, tobacco cessation centre, community awareness.

Introduction

While tobacco use is decreasing in many developed countries it is increasing in developing countries such as India. As per the latest nationally representative Global Adult Tobacco Survey (GATS), India had 275 million current tobacco users in the year 2009-2010 (over 35 per cent of adults): majority of them used smokeless tobacco (164 million) and 42 million used both forms of tobacco [1].

The WHO Framework Convention on Tobacco Control (FCTC) recommends comprehensive policies for tobacco control, including cessation or treatment of tobacco dependence. Offer to help quit tobacco use is one of the six strategies for tobacco control advocated by WHO under MPOWER and technical guidelines for tobacco cessation have also been developed for different levels of health care providers. However, despite the enormous health burden resulting from tobacco use, there were no organized tobacco cessation services in India until 2001 [8].

Recognizing the importance of tobacco cessation, 13 tobacco cessation clinics (TCCs) were started in 2002 by the Ministry of Health and Family Welfare, Government of India, with the support of the World Health Organization India Country office, and increased subsequently to 19 to provide tobacco cessation interventions.

TCC were launched in Anand, Bhopal, Bangalore, Chandigarh, Chennai, Cuttack, Delhi, Goa, Jaipur, Lucknow, Mumbai, and Patna in 2002. Tobacco cessation clinics were renamed to tobacco cessation centers in 2005.

Five more tobacco cessation centers were established in Mizoram, Guwahati, Kolkata, Hyderabad and Trivandrum. The services offered at the clinic include individual intervention in the form of behavioral counseling, medication, and nicotine replacement therapy. The centers also intend to create awareness among the general public about the negative effects of tobacco and about tobacco cessation through awareness programs, exhibitions training programs on tobacco cessation for various professionals, and information booklets & manuals aimed at specific groups of the population [7].

The objectives of these clinics were to evolve cessation strategies for smokers and smokeless tobacco users, to generate experience in tobacco cessation interventions and find out the feasibility of scaling up these intervention strategies. In the first five years, 34,741 tobacco users attended these clinics and baseline information was recorded for 23, 3203. Only behavioural intervention was provided for 69 per cent of the users and the remaining 31 per cent received both behavioural intervention and pharmacotherapy. At the sixth week follow up, 14 per cent reported to have completely quit tobacco and another 22 per cent reported harm reduction (reducing tobacco use by at least 50 per cent of the baseline use). 2If the current use of tobacco among adults is reduced to half by the year 2020,

180 million deaths due to tobacco could be avoided [5].

The Tobacco Cessation Clinic Resource Center (TCCRC), which is functioning in the National Institute of Mental Health and Neurosciences, (NIMHANS), Bangalore, is the national coordinating center for all the TCCs. The center in Bangalore runs an out patientclinic twice a week (Saturdays and Mondays) in the de-addiction OP section of the NIMHANS [7]

Materials and Methodology

It is a Descriptive study .The study was carried out from July 2015 to July 2016. Tobacco cessation centre, civil campus, Ahmedabad, Gujarat state, India. Out of 124 attendees registered, About 109 attendees was followed up by telephone interview/whatsapp medium for three weeks, six months, and one year after undergoing counselling. Data entry was done in Microsoft excel 2007 and proportion, chi-square test done for analysis.

During the first visit, the attendees underwent counseling by the mode of 5 Interventions namely:

1) **Ask** - Identify and document tobacco use status for every patient at every visit. (You may wish to develop your own vital signs sticker, based on the sample below).

2) **Advise** - In a clear, strong, and personalized manner, urge every tobacco user to quit.

3) **Assess** - Is the tobacco user willing to make a quit attempt at this time?

4) **Assist** - For the patient willing to make a quit attempt, use counselling and pharmacotherapy to help him or her quit.

5) **Arrange** - Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date [9]

Step 1: Registration of socio-demographics of the attendees were done during first visit.

Step 2: Interviews through telephonic and watsapp mediums using a tobacco checklist and the response was given by the attendees at their convenient timings.

Limitations of the study: Only those attendees who came to TCC were counselled, so the socio economic differences, about tobacco consumption in general community are not available.

Results

The final analysis shows that:

About 46.8% supply of tobacco products was done by friends, approximately, 51.38% of our attendees were involved in smokeless tobacco consumption, Out of all attendees, 34% of people continue tobacco use to relieve stress. The gender ratio of both male and female show gradual tapering of tobacco after counselling, though females were lacking in awareness about counseling sessions.

Most common prefered smokeless tobacco in the attendees is BUDDHLAL product with chuna. About 81% of the females who came at TCC were regular consumers of chinkni tobacco. Minimum age of initiation of tobacco habit was 10 years in males and 13 years in females. Among the attendees, 71.5% patients had knowledge of hazards of tobacco habit but only 46% had tried to quit the habit however when questioned about their willingness to quit 73.5% were willing to quit.

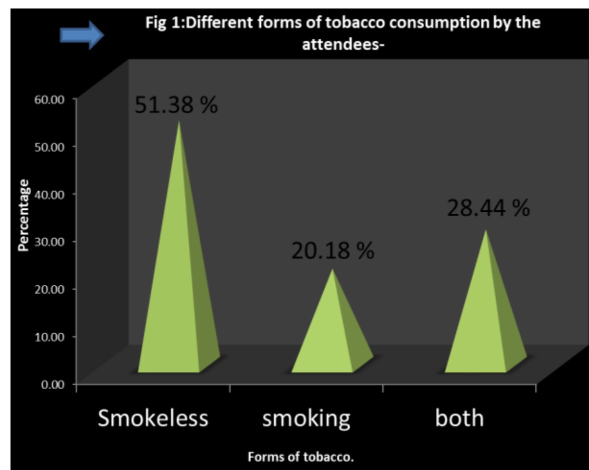
Results

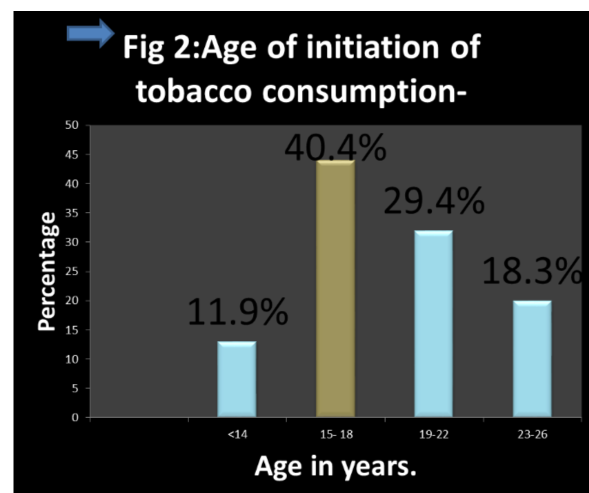
Table 1: association between gender and deaddicts products taken by the attendees

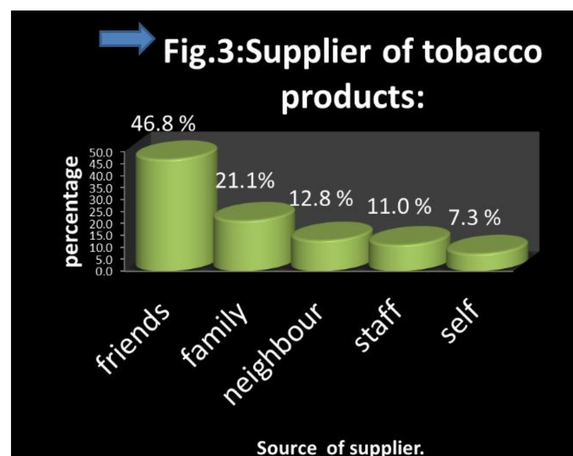
Gender	De-addicts products taken by attendees.		Total
	Helpful	Not helpful	
Male	79	8	87
Female	17	5	22
Total	96	13	109

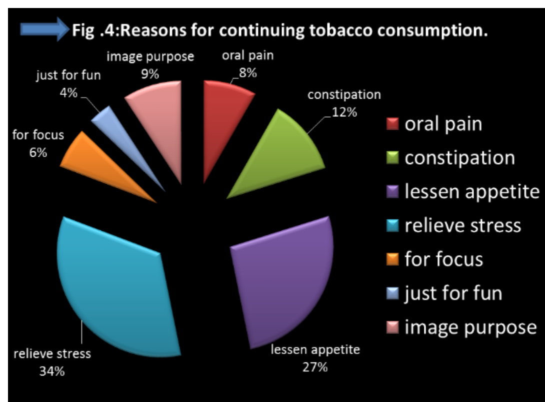
There was no significance between the effects of de-addict products taken between both the genders.

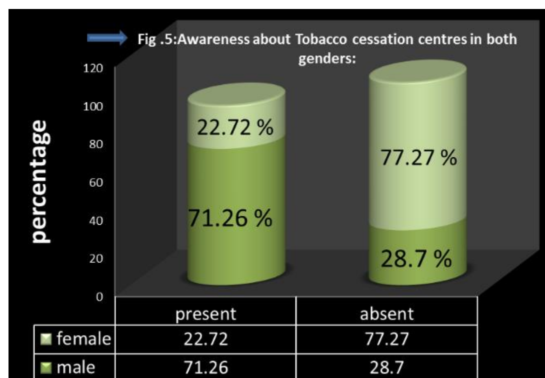
$X^2=3.061$ $p=0.08019$ at alpha=0.05

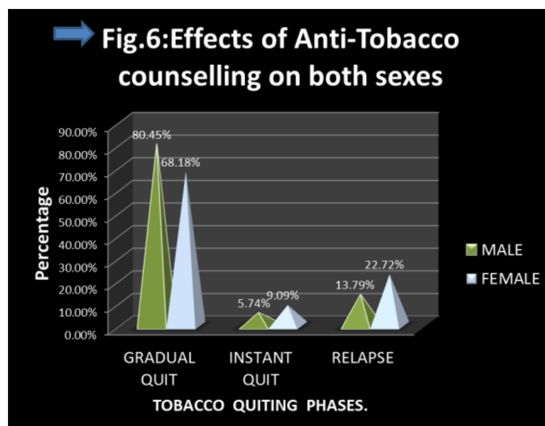


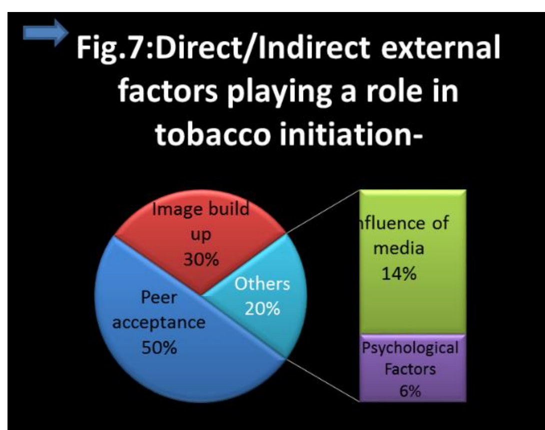












Discussion

Our study revealed the Myths prevalent in the attendees:

- People normally continue only one tobacco product for life time and don't switch on to others as they think cancer happens to those who eat tobacco varieties.
- Tobacco withdrawal symptoms may lead to chronic diseases.
- Tobacco consumption leads to increase in libido.

Smoking cessation intervention was reported among patients attending primary health centres in Kerala State. Patients were grouped into minimal intervention and augmented intervention groups. The minimal intervention group received doctor's quit advice and the augmented intervention group received additional brief intervention counselling for smoking cessation by a trained non-doctor health professional. At three months follow up, the quit rates were 16 per cent in the minimal intervention group and 21 per cent in the augmented intervention group [3].

Tobacco cessation needs to go beyond the health sector. The recent successful quit tobacco intervention carried out by teachers in the Indian State of Bihar is an excellent example of tobacco cessation intervention outside the health sector. The intervention comprised educational efforts, tobacco control policies and cessation support. Among teachers in the intervention group the quit rate of 20 per cent was significantly higher compared to the five per cent in the control group [6].

Even after a ban on production and sale of gutka effective since September 2012, studies have shown that there is not a significant dip in consumption in the city. Recent studies have shown that prevalence of tobacco consumption among females and the youth have remained largely unchanged.The ban on the manufacture, sale and publicity of gutkha may have been in effect for three years now, but that has not curtailed the consumption of nicotine in the state.Interestingly, shopkeepers have come out with an innovative way to sell tobacco — tobacco-less pan masala and gutkha sachets are being sold separately. For Rs 5, people can buy a sachet of pan masala with "no tobacco" printed clearly; a small sachet of tobacco is given complimentary. The contents of both the sachets have to be crushed between the palms and then chewed.

According to the Cigarette and Other Tobacco Products Act, 2003, sale of any cigarette and other tobacco products is prohibited within 100 yards of an educational institution city schools are struggling to curb the sale of tobacco products around their campuses. Tobacco products were easily available in grocery shops or inside shopping complexes within 100 yards of several schools.

Tobacco cessation in India needs to be implemented in multiple settings. Incorporating tobacco cessation training in medical and other health professional education, training of health professionals to offer cessation advice in their routine health care practice, disease specific counselling sessions in diabetes, TB and selected other specialties are likely to result in significant quit rates among current tobacco users. Effective implementation of the Framework Convention of Tobacco Control is likely to have impact not only on the prevention of initiation of tobacco use but also on tobacco cessation to a large extent [4]

Conclusion

Taking into consideration the high prevalence of tobacco use in India, community cessation intervention programmes should be integrated in the primary health care delivery services within a proper monitoring and evaluation framework. There is a reduction in tobacco consumption in the form of bidi and cigarette, but vice versa in amount of smokeless tobacco products. Drugs therapy embibing symptomatic treatment & placebo treatment is advantageous in combating craving and other withdrawal symptoms. Traditionally, use of snuff has been considered a safe form of tobacco use and is also culturally acceptable form of tobacco addiction in women with low literacy, agriculture & in labour divisions, this belief has to be eradicated by active involvement of public health professionals. The existing TCCs are not sufficiently equipped to take care of any population-based cessation scale-up programme. It would be critical to build cessation capacity in the medical and dental college hospitals, both to provide the needed training to the students and also to cater to the cessation needs of the population. Younger persons using tobacco, women users, rural populations and the economically underprivileged need to be more actively targeted.

References

1. International Institute for Population Sciences (IIPS), Mumbai. Global adult tobacco survey India (GATS India), 2009- 2010. New Delhi; Ministry of Health and Family Welfare, Government of India, 2010.
2. Murthy P, Saddichha S. Tobacco cessation services in India: recent developments and the need for expansion. Indian J Cancer. 2010; 47(Suppl):69-74.
3. Pradeep Kumar AS. Smoking cessation intervention program in Primary Health Centres in Palakkad district, Kerala. Unpublished PhD thesis, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram, Kerela, India; 2009.
4. Tobacco cessation in India: A priority health intervention: Indian J Med Res. 139 April 2014; 484-486.
5. Shafey O, Eriksen M, Ross H, Mackay J. The tobacco atlas, 3rd ed.: Atlanta, Georgia, USA: American Cancer Society; 2009.
6. Sorensen G, Pednekar MS, Sinha DN, Stoddard AM, Nagler E, Aghi MB, et al. Effects of a tobacco control intervention for teachers in India: results of the Bihar school teachers study. Am J Public Health. 2013; 103:2035-40.
7. https://en.wikipedia.org/wiki/Tobacco_cessation_clinic
8. 8)http://www.searo.who.int/publications/journals/seajph/media/2012/seajph_v1n2/whoseajphv1i2p159
9. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps