CONTINUOUS MEDICAL EDUCATION

Tobacco Cessation in India

Labani Satyanarayana[1], Smita Asthana[2], Sumedha Mohan, Gourav Popli

[1]Scientist G, Department of Epidemiology and Biostatistics, ICMR - National Institute of Cancer Prevention & Research, Noida, Uttar Pradesh
[2]Scientist D, Department of Epidemiology and Biostatistics, ICMR - National Institute of Cancer Prevention & Research, Noida, Uttar Pradesh
[3]Research Intern, Department of Epidemiology & Biostatistics, ICMR - National Institute of Cancer Prevention & Research, Noida, Uttar Pradesh
[4]Senior Lecture, Department of Oral & Maxillofacial Surgery, Subharti Dental College, Meerut, Uttar Pradesh

Abstract | Introduction | Methodology | Results | Conclusion | References | Citation | Tables / Figures

Corresponding Author

Address for Correspondence: Dr Labani Satyanarayana, Indian Council of Medical Research - National Institute of Cancer Prevention and Research, I – 7, Sector – 39, District Gautam Buddha Nagar, Near City Centre Metro Station, Noida, Uttar Pradesh 201301
E Mail ID: satyanarayanalabani@yahoo.com

Citation

Satyanarayana L, Asthana S, Mohan S, Popli G. Tobacco Cessation in India. Indian J Comm Health. 2017; 29, 2: 142-144.

Source of Funding: Nil **Conflict of Interest:** None declared

Article Cycle

Received: 04/04/2017; **Revision:** 15/04/2017; **Accepted:** 12/05/2017; **Published:** 30/06/2017

Background

Tobacco use is the most common cause of non-communicable disease related morbidity and mortality worldwide despite being preventable. Almost fifty percent or more than seven million tobacco users get killed each year and about 13 percent of them are non-smokers being exposed to second hand smoke (1). According to the recent National family health survey (NFHS-4) study for the year 2015-16, there were 38.9% men who use any kind of tobacco in urban while 48% in rural areas of India. On the other hand, 4.4% of women in urban and 8.1% in rural use any kind of tobacco. Prevalence of tobacco use in the ages of 13-15 among boys was 19% and girls 8.3 % according to global youth tobacco survey of 2009. The tobacco dependence was considered as disease by the international classification of diseases (ICD 10). Proportion of tobacco related cancers in comparison to all other cancers were reported to be as high as 25% in men and 18% in women (2).

To quite tobacco in first attempt is very difficult as it is a combination of behavioral cognitive and psychological phenomenon but still evidences are present that it is possible even in first attempt, through modification of personal behavior which is one of the most effective interventions and there are evidences for that. Apart from modification of personal behavior, studies have suggested that tobacco cessation is one of the integral part of tobacco control. There is a palpable need for the cessation framework to break the constraints of health sector (3). Community based interventions are based on dissemination of knowledge and educates educational support by World Health Organization (WHO) such as training for tobacco quit line counsellor and telephonic, a guide for tobacco users to quit etc., also plays an important role. Proper training of the health care professional and educators forms a necessary adjunct as the chances of quitting the tobacco uses increases to a large extent after being advised by the physician (4).

The benefits and hurdles of quitting tobacco, various approaches to tobacco cessation clinics initiative taken by Government of India in brief is as follows.

BENEFITS AND HURDLES TO QUIT TOBACCO

There are known benefits of quitting tobacco use. Those smokers who are at 50 years and at 60 years of age if quit smoking at their respective ages would reduce their risk of dying in next 15 years by 50% and

10% respectively (5). Effects of cessation are as follows: immediate decline in blood carbon monoxide levels, normalization of blood pressure and pulse rate, restoration of sense of taste and smell. Others are reduced risk of cancers and other Non-Communicable diseases including cardiovascular diseases. Tobacco users who successfully quit also, serve to spread the knowledge and support for cessation in their societal circle. There is a reduced exposure to second hand smoke, as well as reduced stimulus to initiate smoking for non-smokers.

The hurdles to quitting encompass - lack of general knowledge regarding the health effects of tobacco use, absence of adequate framework for advice and support, health professionals lacking in training and/or motivation to promote cessation and non-implementation of policies to curtail tobacco use.

APPROACHES TO TOBACCO CESSATION

According the NFHS 4 survey about 30% of tobacco users had tried to stop the habit during last 12 months. Efficient pharmacologic and counseling strategies act as pillars of tobacco cessation programs, and when taken in combination can achieve the highest rates of smoking cessation. Time spent in counseling sessions has relevance to cessation rates and can determine success of quitting. Taking care of health care and other needs to tobacco users to quit is effective. Picture warnings of Hard-hitting anti-tobacco graphic pack warnings will work for children to stop smoking and help smokers to quit. At least 7 to 16 percent lowering of tobacco consumption was observe in countries with a comprehensive ban on all tobacco advertising (1). India is one of the 29 countries of the globe that completely banned all forms of tobacco advertising, promotion and sponsorship. For young and poor people to reduce tobacco use tobacco taxes is effective method, an increase in tobacco prices by 10% decreases tobacco consumption by about 4% in high-income countries and 5% in low- and middle-income countries respectively. A high tobacco tax is rarely implemented. In India, tobacco products are becoming increasingly affordable over time as tobacco taxes are not adjusted for inflation regularly (1).

Clinical interventions that can be used with three categories of patients, as assigned by Clinical Practice Guideline for Treating Tobacco Use and Dependence are (6):

A) **Current tobacco users now willing to make a quit attempt**- These guiding principles recommend clinicians to provide both pharmacotherapy and counseling for every patient willing to make a quit attempt (7). The major steps in the brief encounter for this category are the 5 As: 1. ask if he or she uses tobacco products, 2. advise them to quit, 3. assess willingness to quit, 4. assist with pharmacotherapy or counseling, and 5. Arrange follow-up to prevent relapse.

B**) Current tobacco users unwilling to make a quit attempt**- These patients respond poorly to direct confrontation and the best motivator is an empathic and supportive tone. The major steps to address for patients in this category are (7): relevance (why quitting is relevant to their current health scenario), risks (of continued smoking to their current health), rewards (of cessation both in the short-term and long-term), roadblocks (help patient identify barriers to quitting (social situations, withdrawal symptoms), and repetition (most patients need multiple quit attempts).

C**) Former tobacco users who have recently quit**- Relapses are common in patients who have successfully quit tobacco dependence, and most relapses occur early, some patients will resume tobacco products months to years after the quit date. Withdrawal symptoms often peak 1 to 3 weeks after quitting, so nicotine replacement therapies (NRTs) should account for appropriate coverage. Various forms of pharmacotherapy are used for smoking cessation such as nicotine replacement drugs and non-nicotinic drugs. Nicotine replacement drugs are available in various preparations such as inhaler, spray and patch etc. These preparations are used for duration of 2wk to 12 wk. Non-Nicotinic drugs includes Bupropion (7-12wk) and Varenicline (12 wk duration).

TOBACCO CESSATION CLINICS BY INDIAN GOVERNMENT:

Recognizing the significance 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 World Health Organization India Country Office, and were increased to 19 in order to provide tobacco cessation interventions. They were set-up in diverse settings such as cancer treatment hospitals, psychiatric hospitals, medical colleges, NGOs and community settings to help users to quit tobacco use. The objectives of these clinics were to develop cessation

strategies for smokers and smokeless tobacco users. These establishments have met with limited success owing to low utilization by the users, especially by those hailing from rural areas (8). Moreover, the quit rates remain sub-par, possibly due to low quality of behavioral interventions, and limited use of pharmacological therapy.

To strengthen implementation of the tobacco control provisions under COTPA (Cigarettes and Other Tobacco Products Act) and policies of tobacco control mandated under the WHO FCTC, the Government of the India piloted National Tobacco Control Programme (NTCP) in 2007–2008. The programme is under implementation in 21 out of 35 States/Union territories in the country. The emphasis is now being laid on mainstreaming tobacco cessation in the health care delivery system by encouraging health care institutes to set up tobacco cessation facilities in their respective premises utilizing their existing infrastructure, where the Government and WHO will provide the requisite technical support. National Guidelines for Treatment of Tobacco Dependence have also been developed and disseminated by the Government in 2011, to facilitate training of health professionals in tobacco cessation. A study by Indian Council Of Medical Research-National Institute of Cancer Prevention and Research (ICMR-NICPR) government of India, observed poor compliance of COTPA for control of tobacco in and around schools (9), which further puts into question the implementation of the well-meaning initiatives put forward by the Government.

The world health organization framework convention on tobacco control (WHO- FCTC) was established in 2003 to halt the global tobacco epidemic. There are 7 WHO FCTC knowledge hubs across the world, working on different areas of tobacco control. In 2016, ICMR-NICPR was designated as a global knowledge hub on smokeless tobacco.

Tobacco users in developing world quit after they get some diseases. Therefore, doctors and other health professionals should address tobacco as a serious risk to public health. Its implementation requires incorporation of tobacco cessation training in medical and other health professional education, training of health professionals to offer cessation advice in their routine health care practice. Specific counseling sessions in diabetes, tuberculosis and selected other specialties are likely to result in high quit rates among current tobacco users. Healthcare professionals remain largely unaware of pharmacological options for cessation. Therefore, tobacco cessation in India requires effective and efficient leveraging of community-based educational and behavioral interventions. The execution of the Government policies, synergized with tobacco control initiatives by the civil society and community are pivotal in reduction of its use in the country

Keywords

Tobacco Cessation

References

1. WHO. Tobacco fact sheet. June, 2016. http://www.who.int/mediacentre/factsheets/fs339/en/ (accessed May 20, 2017)
2. Asthana S, Patil RS, Labani S. Tobacco-related cancers in India: A review of incidence reported from population-based cancer registries. Indian J Med Paediatr Oncol. 2016 Jul-Sep;37(3):152-7. doi: 10.4103/0971-5851.190357. PubMed PMID: 27688608; PubMed Central PMCID: PMC5027787. [Pubmed]
3. Thankappan KR. Tobacco cessation in India: a priority health intervention. Indian J Med Res. 2014 Apr;139(4):484-6. PubMed PMID: 25055394; PubMed Central PMCID: PMC4078486. [PubMed]
4. McKay AJ, Patel RK, Majeed A. Strategies for tobacco control in India: a systematic review. PLoS One. 2015 Apr 9;10(4):e0122610. doi: 10.1371/journal.pone.0122610. eCollection 2015. PubMed PMID: 25856462; PubMed Central PMCID: PMC4391913. [PubMed]
5. US Department of Health and Human Services. The Health benefits of smoking cessation. A report of the Surgeon General. 1990. P1-168.
6. A clinical practice guideline for treating tobacco use and dependence: A US Public Health Service report. The Tobacco Use and Dependence Clinical Practice Guideline Panel, Staff, and Consortium Representatives. JAMA. 2000 Jun 28;283(24):3244-54. Review. PubMed PMID: 10866874. [PubMed]
7. Black JH 3rd. Evidence base and strategies for successful smoking cessation. J Vasc Surg. 2010 Jun;51(6):1529-37. doi: 10.1016/j.jvs.2009.10.124. Epub 2010 Mar 11. Review. PubMed PMID: 20223623. [PubMed]
8. Murthy P, Saddichha S. Tobacco cessation services in India: recent developments and the need for expansion. Indian J Cancer. 2010 Jul;47 Suppl 1:69-74. doi: 10.4103/0019-509X.63873. PubMed PMID: 20622418. [PubMed]
9. Sayeed S, Labani S, Asthana S. Compliance of a Government Act on Cigarettes and Other Tobacco Products around Educational Institutions of Noida. Peertechz J BioinformBiostat. 2017: 001-003.