Cessation Efforts on Smokeless Tobacco Use with Disadvantaged Women

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Introduction
Smokeless tobacco is a "Class A" carcinogen and known to contain over 20 potential cancer-causing agents. Areca nut, an ingredient in some popular smokeless tobacco products in India, including gutka and mawa, confers taste as well as other harmful constituents to smokeless tobacco. Smokeless tobacco is responsible for the high incidence of oral cancers in India in both men and women. Women tobacco users in India are more likely to use smokeless tobacco (18.4%) than smoke (2.9%).

Tobacco cessation is an essential component for reducing mortality and morbidity related to tobacco use. Without active cessation interventions, tobacco control measures such as public awareness, smoke free laws, raising taxes and banning advertising, focussing only on prevention, regulation and enforcement, would not be enough to reduce tobacco use and the death toll will continue. A majority of tobacco-related deaths that can be prevented over the next 40 years will be among current users who can be persuaded to quit. Tobacco use is an addiction and cessation as a strategy and service should be a very important focus area for governments. In India, especially, cessation acquires an additional dimension as tobacco is used in both smoking and smokeless forms.

The WHO-FCTC also advocates for cessation services as a significant area to be addressed by governments working on in tobacco control. The "O" in WHO-MPOWER package emphasizes the importance of "offering help to people who want to quit" as a key policy intervention to reduce tobacco use.

In low and middle income countries like India, integrating tobacco cessation into primary healthcare and routine medical visits provides an opportunity to remind users of the hazards of tobacco use. It helps to mobilize health professionals and workers on the issue of tobacco control. Doctors, nurses, midwives, dentists, pharmacists, psychologists and counselors can be mobilized to help people change their behaviour. Their participation helps to reinforce the message and advice from health practitioners to increase abstinence rates. Although guidelines exist for health professionals in counseling tobacco users on quitting, most health care practitioners in India have not yet received training on how to do this. Also, in India, unskilled labourers rarely visit healthcare providers.

Hence, there is a need for ways outside of the healthcare system to reach people of low socio-economic status with tobacco cessation advice and counseling support. This study demonstrates how among certain rural populations, intensive small group sessions on quitting tobacco have been found effective. Group counseling has been found to be especially appropriate as it is least threatening and where there is a large socio-economic or cultural gap between the counselor and the participants. Face-to-face support provides opportunities for the counselor to assist the client in problem-solving and in building problem-solving skills. The more the contact between the
counselor and client, the more successful the tobacco cessation attempt is likely to be. The counseling concepts and methods used in this intervention fit well into behaviour change communication which is evolved and developed by involving the users.

**Materials and Methods**

Although 8 women and 15 men (co-workers or family members) came voluntarily for the workshop, on the request of their employers, only the women decided to participate. The eight women aged 22 to 37 years, all married, were daily users of smokeless tobacco. They used basic ingredients like tobacco, lime and areca nut, which they mixed in the palm of one hand with the thumb of the other. One woman chewed pan (betel quid). Most of the women said that they had been using tobacco since early adolescence. Typically, they had picked it up around 10 to 14 years of age and later on, when their employers informed them this was harmful, the women found it hard to give it up or were not ready to do so. Several of their employers had also shown resentment to their use of tobacco in their homes.

This intervention consisted of an initial 11-day workshop and 2 follow-up sessions in 2007. The workshop was carried out using a classroom approach and the duration of each session varied from 35-50 minutes depending upon the queries of the participants and the counselor's responses. On the first 3 days of the quit attempt, multiple sessions were scheduled to address problems encountered.

**Methods used in the sessions included:**

1. An ice-breaking session, which was used at the beginning to establish rapport and build trust in the group and with the counsellor. This was followed by 10 days of the actual intervention.

2. A preparatory lecture that provided information on the specific harms of tobacco use. The causes were designed to get the women to think about quitting. This was done in a non-judgemental manner.

3. A participative planning session to plan the programme to make women feel more committed to make the required effort to quit tobacco. To begin the planning session, the hazards and unpleasant effects of tobacco were reiterated to strengthen the intentions of the women to quit. Participants were encouraged to think for themselves.

4. Explanations on the experience of withdrawal the women were likely to face and how they should deal with it. The anxiety expressed by 3 of the women prompted the counselor to suggest they start with delaying tobacco use rather than abstinence. Accordingly, instructions on how to delay tobacco use were given. The importance of avoiding things associated with tobacco use, such as tea, for a while, was emphasized.

5. Group discussion meetings were held 2 to 3 times daily for the first three days of the simultaneous quit attempt, wherein individual experiences were heard and discussed in the group. Thereafter the group met once a day for the rest of the workshop. Strategies to cope with craving for tobacco were also suggested, such as a) wash face and mouth; b) drink water; c) do breathing exercises; d) chew gum; e) suck on lozenges, cardamom, cloves, or cinnamon; f) avoid carrying tobacco. Practical exercises were taught, including deep breathing and shoulder
exercises. Success stories (anecdotes) of how other women overcame their problems of tobacco use were used to help women cope with stress. Praise was freely given for abstainers and commitment to quitting was renewed daily.

After 10 days of daily intensive sessions, the counselor again renewed her commitment to help the participants and plans were laid to meet after 10 days.

Follow-up meetings: Two follow-up sessions were held 1) after a gap of 10 days from the last session and 2) after 6 weeks to assess performance and reinforce the content of the workshop in order to help each participant stay on track. The purpose of the follow-up sessions was mostly to build self-confidence in the participants to confront difficult situations during their quit attempt and in future.

In the first follow-up meeting, the group discussed domestic conflict as the main obstacle in staying away from tobacco. Chewing tobacco at the time had been a source of solace for the women. The counselor encouraged them to think of other things to do when domestic conflict arose, like going out to fetch water, washing their face and gargling or cutting vegetables. These alternatives would usually be mentioned in little stories (anecdotes) about how other women have coped, rather than through straight instructions.

Results
At the second and final follow-up meeting held 6 weeks later, 4 women were congratulated for continuing to abstain from tobacco successfully. The intermediate results are described as follows:

Within the group, 6 of the 8 women had come without any intention of quitting tobacco use. The only motivation mentioned by two of them was that the employers had said they did not like them to be chewing tobacco. They had sporadically mentioned that tobacco smelt bad and can also cause diseases. Thereby, two of the women expressed a desire to know more about tobacco.

The preparatory lecture on the serious health hazards caused by tobacco was a turning point that helped those women, who were not contemplating quitting, to at least consider it. And soon enough, the women who were not contemplating quitting on the first day, all quickly progressed to thinking about quitting and prepared themselves to do so, but at different times. Progress towards preparation to quit was helped along by interaction among the participants and mutual persuasion. However, when all were ready, a simultaneous quit attempt was begun.

To support the women during their quit attempt, three sessions per day were arranged for the first three days. In each of the multiple, daily sessions, the women brought up the personal problems they were facing just prior to the meeting. They shared the fact that tobacco is their only refuge to escape the tension, fatigue and to bear the rebuke of others. It emerged that even at home during quarrels, they would get beaten up, so they had learnt to start chewing tobacco as a coping strategy to reduce stress and avoid arguing. During the quit attempt, the women were very responsive to the anecdotes explaining how others have coped without tobacco, especially in conflict situations and they began practicing new ways of coping.
At the first follow-up meeting, after a gap of 10 days, 3 out of 8 women had successfully abstained and the others remained motivated, though with some difficulties. At the end of the programme, 6 weeks later, 4 women had successfully abstained from tobacco use.

Discussion

The fact that the women started to think seriously about quitting after being informed of the specific harms tobacco can cause, is similar to findings from other studies with low socio-economic populations.² ³ ⁴ ⁵

Although small, the size of this group was ideal for tobacco cessation counseling. Personal interaction was easy: the leader (counselor) was able to form a caring bond with the participants and they motivated one another. This experience of face-to-face counseling in a small group for tobacco cessation confirms the benefits reported about such efforts in the literature.⁶

It is important to note that the initial exercises in postponement rather than total abstinence from tobacco might have helped the contemplators among the women to get started and prevented their dropping out from later sessions.

Domestic problems were a source of stress that made quitting tobacco difficult. This could be overcome in most cases through empathy and encouragement in counseling and the practice of special breathing and relaxation exercises. Tobacco users among low socio-economic status who are attempting to quit have to control their withdrawal symptoms, as well as deal with highly stressful lives.

A high frequency of sessions - 15 intensive interactions over a period of 11 days set the whole group of women on track. This intense schedule of meetings was effective, with no room for long gaps or laxity.

The interest generated in husbands and friends to quit tobacco use shows the potential for snowballing such efforts, with the availability of appropriate personnel. It is likely that the spread of such efforts would help to change social norms to make tobacco use less acceptable.

This experience demonstrates that community-based small group interventions for tobacco use cessation among the lower socio-economic strata can be effective in India. Existing community health workers in India need to be trained in this area to fill in the gap for low-cost and accessible cessation services. A special manual has been prepared under the National Tobacco Control Programme to guide health workers in tobacco cessation counselling.⁷

Conclusion

The tobacco problem in India is complex due to the varied nature of tobacco use. Cessation in Indian settings needs a multi-sectoral approach. It must include preventive, curative and rehabilitative care. In India, clinical settings are few in number with a smaller number of trained professionals. Availability and affordability of medication required for cessation is also a severe constraint. Here, local community-based organizations and trained counsellors who can bring in non-clinical, behavioural methods of counselling, using a sensitive, compassionate approach are essential to rural grassroots level settings. However, to spread this activity, dedicated workers are required, including volunteers and paid workers. Public health organizations and civil society agencies working in the area
of tobacco control can complement these efforts further with more intensive group counseling programmes with tobacco user groups in their settings, using trained counselors.

References


About the Authors

Dr. Mira B. Aghi, Ph.D, is a freelance consultant on Behavioural Sciences and Communication. Cecily S. Ray, MPH, is a Public Health Researcher.

Dr. Mira B. Aghi is the Luther L. Terry Award 2012 winner in the Outstanding Community Service Category

The American Cancer Society Luther L. Terry Awards are held in honour of the pioneering US Surgeon General who, in 1964, published a landmark report linking smoking to lung cancer and other serious health issues. Although he released a storm of controversy with this report, Dr. Terry's determination to pursue this groundbreaking work that established the foundation for tobacco control is commendable. This award honours those who follow in his footsteps in the fight against tobacco. Dr Aghi will receive the award at a special ceremony on March 21, 2012 in Singapore during the 15th World Conference on Tobacco or Health.