# MASTER OF PUBLIC HEALTH

**Johns Hopkins Bloomberg School of Public Health & IIHMR University**

# PRACTICUM REPORT

**By**


**Dr.Nikky Ramawat**
**Cohort-3**
**2015-17**


Under the Guidance of

**Dr. Nutan Jain**

**Professor**
**IIHMR University**

# TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Nikky Ramawat,** student of Master of Public Health Program offered by Institute of Health Management Research IIHMR University, Jaipur in cooperation with Johns Hopkins Bloomberg School of Public Health, Baltimore has undergone Practicum Training at Indian Institute for Development Initiative, Jaipur on the topic Tobacco control Program in Rajasthan: A study from 13-01-2017 to 29-04-2017.

The Candidate has successfully carried out the study designated to him during practicum training and his approach to the study has been sincere, scientific and analytical.

This Practicum Training is in fulfillment of the course requirements.

I wish him success in all his future endeavors.

Sd-
**Dr. Nutan Jain**
Practicum Advisor

## CERTIFICATE BY SCHOLAR

This is to certify that the Practicum Project titled submitted by me, Nikky Ramawat with Enrollment No. **IIHMR-U/07/2015-2017/0009** under the supervision of Dr. Nutan Jain for award of **Master of Public Health** carried out during 13-01-2017 to 29-04-2017 embodies my original work and has not formed the basis for the award of any degree, diploma associateship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Nikky Ramawat
MPH Candidate 2015-17

पंजीयन सख्या 5 जयपुर

दिनांक 18.1.99

# इंड़ियन इन्सीट्यूट फार डवलपमेन्ट इनीसीऐटिव

बी 174 मालवीय नगर जयपुर (ट्रस्ट एक्ट के तहत 1999 से पंजीकृत)

क्रमांक : 22

दिनांक 29/4/17

## To Whom So Ever It May Concern

This is to certify that **Dr. Nikky Ramawat S/o Mr. Narayan Ramawat**, student of Master of Public health offered by Johns Hopkins University Bloomberg School of Public Health, Baltimore, USA in Cooperation with IIHMR University, Jaipur India, Has Undergone Practicum Training for **Tobacco Control Programme** from 13 January 2017 to till date in Indian Institute for Development and Initiative Organization. He has successfully completed 200 hours of Practicum training in our organization. He has actively participated in conducting Tobacco users survey, awareness generation & education Programme for tobacco users attending Yagya Narayan Hospital, kisangarh, and Deep Hospital, Jhotwara, Jaipur. He has actively involved in tobacco cessation activities of Yagya Narayan and Deep hospital through tobacco users treatment, advice and follow up. He bears good moral character.

This Practicum Training is in fulfillment of the course requirements towards the MPH program.

I wish him success in every walk of life.

Yours sincerely

K.L. Pokarna

**Dr. K.L. Pokarna**

**Chairman, IIDI**

**B174, Malviya Nagar**

**Jaipur**

## Tobacco Control Program

- Title of Project: Tobacco control Program in Rajasthan: A study
- Name of Organization:  Indian Institute for Development Initiative

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***Introduction:***

Tobacco is the foremost preventable cause of disease and death in the world today, killing half of the people who use it. Use of tobacco and it's consequences in the form of various communicable diseases and non communicable diseases are presently major public health problems. Tobacco kills more than AIDS, illegal drugs, road accidents, murder, and suicide. No other consumer product is as dangerous, or kills as many people.[16] (WHO,2008)

Tobacco use kills nearly six million people worldwide each year. According to the World Health Organization (WHO) estimates, globally, there were 100 million premature deaths due to tobacco in the 20th century, and if the current trends of tobacco use continue, this number is expected to rise to 1 billion in the 21st century [1].

This global tobacco epidemic kills more people than tuberculosis, HIV/AIDS and malaria combined.[2] This epidemic can be resolved by becoming aware of the devastating effects of tobacco, learning about the proven effective tobacco control measures, national programs and legislation prevailing in the home country and then engaging completely to halt the epidemic to move toward a tobacco-free world.[2]

India is the second largest consumer of tobacco globally. In India One million people die annually due to tobacco use. As per global adult Tobacco survey (2010 GATS) India estimated the number of daily tobacco users to be 231.9 million (167.7 million males and 64.2millions females) . According to GATS 2010 India more than (35%) of the adults(15 years and older) are using tobacco in the country from which 47.9% were males and 20.3% were females.[3] Among them 21%

of Adults used only smokeless tobacco,9% only smoked and 5% smoked as well as used smokeless tobacco. Over all tobacco use is much higher among Indian males 48% but is also a serious concern among females among whom pre valence is 20%.[8] One in two males and one in ten females in India use tobacco in some form or other. About one third of adult males smoke and /or chew tobacco.[4] The prevalence of smokeless tobacco use is 26% while 14% are adult smoker.[5]

GATS report shows that 60% tobaccos consume first tobacco of the day with half an hour of waking up. An ample proportion of daily smoker consumer more than 10 cigarettes or *bidis* per day.[4]

As per the Global Health Professions Student Survey (GHPSS), India, 2009, 6.5% third year dental students cigarettes and 8.65 used other tobacco products.[9] Among medical students, 13.4% third year medical students smoked cigarettes and 11.6% used other tobacco products.[9] These figures are alarming because these professional students will themselves lead the war against tobacco, and because earlier initiation increases chances of long term dependency.

The prevalence of tobacco use among all the states and union territories ranges from highest of 67% in Mizoram to the lowest of 9% in Goa. Prevalence of tobacco use in Arunachal pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Sikkim, Tripura, Assam and west Bengal is higher than the national average. In most of the states or Union territories, the prevalence of both smoking and smokeless tobacco use among males is higher than among females with expectations in Pondicherry, Tamilnaadu, Meghalaya, Tripura and Mizoram, where prevalence of smokeless tobacco is higher among females than males.. In India, *Khaini* or tobacco lime mixture(12%) is the most commonly used smokeless tobacco product, followed by gutkha, a mixture of tobacco, lime and areca but mixture(8%), betal quid with tobacco(6%) and applying tobacco as dentifrice(5%).

Among both males and females, the prevalence of cigarette smoking is higher in urban areas but the prevalence of other product is higher in rural areas. The prevalence of each of the smokeless tobacco product is higher in rural than urban areas. On an average daily cigarette smokers in India smokes 6.2 cigarette sticks per day, and a daily bidi smoker smokes 11.6 bidi sticks per day

India has one of the highest rates of oral cancer in the world, with over 50% due to smokeless tobacco use.[6] Tobacco consumption continues to grow at 2-3% per annum. As per the WHO Global Report on "Tobacco Attributable Mortality" 2012, 7% of all deaths (for ages 30 and over) in India are attributable to tobacco. By 2020 it is predicted that tobacco will account for 13% of all deaths in India. Within non-communicable diseases group, 9% of deaths are attributable to tobacco, of which 58% of deaths due to trachea, bronchus, lung cancers caused due to tobacco use. In addition, 25% of deaths caused by respiratory diseases and 28% of deaths caused by Chronic Obstructive Pulmonary Disease (COPD) are attributable to tobacco. As per the Report on Tobacco Control in India (2004), nearly 1 million people die every year in India due to diseases related to tobacco use.[7]

Jha *et al*. have estimated that around 1 million deaths a year in India will be attributable to smoking by the early 2010s.[12] Gupta *et al*. have estimated the tobacco-attributable mortality among Indian men and women from their Mumbai cohort study. Based on these estimates, nearly 23.7% of the deaths among men (527,500) and 5.7% of the deaths among women (83,000) aged 35–69 years are due to tobacco-attributable illnesses.[11] Another cohort study from southern India reported mortality risks of 0.98 (0.86–0.94) and 1.22 (1.04–1.44) for all-cause and tobacco-related cancer mortality, respectively, for tobacco chewing, while with smoking, the respective mortality risks were 1.31 (1.24–1.39) and 1.68 (1.36–2.08).[10]

There are 10.5 million tobacco user in Rajasthan in which 32% are Adult. 210 people die every day in Rajasthan. 75 thousand people die every year in Rajasthan.

*Identify the importance of data in shaping public health issues:*

To identify the incidence and prevalence of disease due to use of tobacco is very important and urgent need of today to initiate appropriate measures for control of tobacco use and cessation of tobacco in our country and in the state of Rajasthan.

Keeping in view about the scenario there is a need to collect a data about tobacco use in vulnerable population specially labors, poors and other skilled and unskilled workers in urban and rural areas.

*Awareness plans:*

Awareness in organize and unorganized including education institution namely school, college and other training center to prevent tobacco use among students, teachers and other workers attached with education initiation. Then for unorganized group education for labors, workers, Rikshapuller, Taxidrivers, industrial workers by involving their unions and associations for creating awareness about the harmful effect of tobacco use on health and also providing awareness and education regarding Cigarette and Other Tobacco Products Act (COTPA) act.

We should start awareness and education activities for tobacco control program in medical care institution, health care institution namely hospital, community health centre, primary health center and other health care provider center in urban and rural areas.
Need of awareness creation for health hazards of tobacco use for Panchyat Raj Institution(PRI) members and local self government institution like *nagarpalika, nagarparishad, nagarnigam.*

Comprehensive and sustainable health education and awareness for preventive and control of tobacco use in some areas like kachi basti, poor localities and backward communities is also be organize to prevent tobacco use diseases, disabilities and death.
We can provide awareness by uses of Mass media, mass meeting, group discussion, using audio visual advertisement and IPC for tobacco users

***Connections and collaborate with key stakeholders to promote health:***

The tobacco growers, processors, manufactures (Industries), suppliers, governments and medical profession and NGO's are the stake holder for tobacco control program.
Government based agencies "In order to implement a tobacco control strategy that is successful... strong leadership at governmental level and an integrated approach involving all relevant policy areas and the civil society is needed."

The government should take responsibility for tobacco control:

- Developing and implementing a comprehensive national tobacco control strategy and programme;
- Creating a regulatory framework conducive to or supporting people to follow a smoke-free way of life;
- Establishing a centre to coordinate the country's tobacco control initiatives;
  the setting up of an intersectoral body to coordinate the involvement of ministries, various government-based agencies and other sectors into tobacco control activities;
- Establishing financial mechanisms to provide secure, long-term and sustainable funding for community-based tobacco control efforts.

NGO's:

Numerous voluntary organizations like the HRIDAY-SHAN, CPAA-Cancer patients aids association, the Salaam Mumbai Foundation, HealthBridge, Voluntary Health Association of India, etc. are actively involved in tobacco control activities in India. Healis is actively engaged in conducting quality research in tobacco control. In addition, it is involved in media mobilization for tobacco control, public education, conducting workshops for different stake holders and conducting scientific conferences and meetings of national and international level

Intersectorial and community participation approach need to be adopted for initiative tobacco control measures and its consequences on for social and economic sectors.

To initiate and implement tobacco control measures is not only the responsibility of health department but there is a crucial need of involvement of different departments namely education, PRI local self, Police, law and social development sectors for effective implementation of COTPA act, effective involvement of police department is must, education other department as mentions above need to take responsibilities for effective implementation of COTPA act

beside this primary stake holders that is tobacco users and secondary stakeholder that is service providers and others must also be involved for effective implementation of various activity to prevent and control tobacco use to promote health of the community and individuals.

**Role of government in health promotion:**

The Government of India has become increasingly engaged with India's tobacco problem over recent years. Some relatively small-scale preventative policies were introduced between 1975 and 2000. The more comprehensive Cigarette and Other Tobacco Products Act (COTPA; addressing tobacco use in public places, tobacco advertising, and sale and packaging regulations) was introduced in 2003.[13]

***The key provisions of COTPA -2003 are as follows:***

- Prohibition of smoking in public places (including indoor workplaces). This has been implemented from 2nd October 2008 in the whole of India.
- Prohibition of advertisement, direct and indirect (point-of-sale advertising is permitted), sponsorship and promotion of tobacco products.
- Prohibition of sales to minors (tobacco products cannot be sold to children less than 18 years of age and cannot be sold within a radius of 100 yards of any educational institutions).
- Regulation of health warning in tobacco products packs. English and one more Indian language to be used for health warnings on tobacco packs. Pictorial health warnings also to be included.
- Regulation and testing of tar and nicotine contents of tobacco products and declaring on tobacco products packages.

Article 14 of WHO FCTC( Framework Convention on Tobacco Control) prescribes demand reduction measures concerning tobacco dependence and cessation. India is a signatory to the FCTC. Under FCTC, WHO has established MPOWER, the policies which are proven to reduce tobacco use.

M- Monitor tobacco use and prevention policies

P- Protect People from Tobacco use

O- Offer helps to quit the tobacco use

W- Warn about the danger of the tobacco

E- Enforce bans on tobacco advertising, promotions and sponsorship

R-Raise taxes on tobacco

This World Health Organization (WHO) treaty commits signatories to the implementation of wide-ranging measures to limit demand for tobacco, aid cessation of use, protect minors and non-users, regulate tobacco products, minimize the contraband market, and limit the negative influence of the tobacco industry.[14] It promotes various control strategies including pricing and taxation measures, smoke-free policies, tobacco product legislation, appropriate labeling of products (including health warnings), tobacco related education, prohibition of advertising and other promotion methods, provision of cessation programs, control of illicit tobacco product trade, control of tobacco sale to/by minors, and support for alternative employment strategies for tobacco workers. Soon after committing to the FCTC, the Indian Government drew up a National Tobacco Control Programme (NTCP)to help achieve its provisions.

NTCP aimed to establish tobacco cessation centres, training programs for teachers, health workers and others, educational interventions for schools and the general population, and mechanisms to monitor enforcement of tobacco control legislation, at the district level. State and national-level monitoring of these initiatives was also planned, as well as research activities regarding alternative livelihood options, establishment of tobacco product testing facilities and production of mass-media awareness campaigns.[13] A pilot has been undertaken, but the results, and information about the planned expansion of the program, are not widely available .[13] Various aspects of this programme, and other control measures, have featured in the eleventh (2007–2012) and twelfth (2012–2017) Government of India Five Year Plans .[15] In line with the current Five Year Plan, the

current Government has increased taxes on cigarettes, and announced plans for further strengthening of anti-tobacco legislation following a period of review.

***Relevance of project:***

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. India is the 2nd largest producer and consumer of tobacco and a variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, *bidis* and cigars, a plethora of smokeless forms of consumption exist in the country.

Tobacco is available in many forms in India and is widely used by all social groups. It is more prevalent among the disadvantaged and people who live in rural areas, and is common among women of all ages, including reproductive age. There is a wide spectrum of morbidity and mortality related to tobacco use, but tobacco use has not yet received the attention it deserves as a public health problem. [6] Tobacco control policies have not been sufficient to curb its use. Tobacco use is high not only in India, but also in South East Asia and many other countries globally

***Aim of Project:***

- To control tobacco consumption and to prevent death& minimize the disease caused by it.

***Objectives of project:***

- To create awareness of harmful effects of various type of tobacco use among labors.
- To identify, and treat oral health problems because of tobacco use among tobacco users.
- To assess the tobacco dependency by using fagerstrome test among the tobacco users.

***Workplan:***

**Identification listing of tobacco users by recording their history of tobacco use and length of tobacco consumption and it's effect on health of the tobacco users**

**Discussion and interaction with tobacco users and identification of tobacco dependency level by using questionnaire for those tobacco user who are ready to quite tobacco consumption.**

**Identification of health problems of tobacco user by through medical examination**

**Smokeless tobacco users** **Smoking tobacco users**

**(*Gutkha, khaini, Shruti*)** **(*Bidi,cigarette,Pipe*)**

**Consequences of health Problem in tobacco users**

**Remedial Measures**

**1. Behavior Change by counseling, Interpersonal communication and pictorial presentation)**

**2. Pharmaceutical Management on the basis of tobacco dependency level**

**3. Keeping record of each tobacco user by providing remedial measure and follow up.**

**4. Follow up by personal interaction and on telephone.**

Area of Project: Kishangarh area of Ajmer District:

I visited Yagya Narayan hospital and R.K marble industries for conducting surveys of tobacco users in Kishangarh area from 13th of Jan 2017. There I have been interacting with patients and labour using tobacco namely

a) Smokeless tobacco: Gutkha, Chenni, Shruti
b) Smoke tobacco : Cigrette, *Bidi*, Pipe and Hukka

My **responsibilities** are:

1) Conducting survey

2) Physical and oral examination of tobacco users:

3) Providing education and awareness to tobacco users about the harmful effects of tobacco

4) Providing Remedial measure (Behavior change and pharmaceutical management)

5) Follow up:

6) Maintain records:

In survey I found 90 patients in Yagya Narayan hospital during 20th January to 10th February. In which 70 were male and 20 were female patients who are having a habit of tobacco. From those patients 40 patients were treated.

There tobacco users were the patient as well as their attendant who were using tobacco specially smoking and visiting the OPD of the Yagya Narayan Hospital.

By interacting the above patients and their attendant regarding the use of tobacco as they were having respiratory tract infection specially bronchitis, asthma along with poor oral hygiene and

periodontal disease with the help and support of the training physician of the Yagya Narayan hospital in OPD every day.

Mostly tobacco users were 40 plus age group and having a habit of smoking for last 15 to 20 years. Some of them were using both type of tobacco (smokeless tobacco and with smoke tobacco). They were having the education level primary to secondary level. All were married and residing with their parents in the joint family. Some were business men and mostly they were skill and unskilled labors coming from rural community nearby Kisangarh and Jaipur. Some were farmers also.

I surveyed 250 labors of R.K marble industries. In which 150 patients were having a habit of tobacco, from those patient 71 patients were undergoing in treatment.

First I identify the tobacco user by taking proper history and length of tobacco consumption and what are it's effect on the health users.

Then discussion and interaction with tobacco users and identification of tobacco dependency level by using questionnaire.

Fagerstrome test is used as a screening test for the physical aspect of tobacco(nicotine) dependence. These are score for both smoking and smokeless tobacco. Based on the score, the level of addiction can be low (score less than 4), medium (score4-6),or high score more than 7.

After it I did their physical examination (measuring their blood pressure, Pulse rate, respiratory rate, history of chronic disease in including communicable disease and non communicable disease and weight and height) and oral examination(any sign of leucoplaquia , erythroplaquia , mucosa and sub mucous fibrosis)

Then in treatment part:

***Behavior change:***

- Brief advice: This consists of advice to stop using tobacco, usually taking only a few minutes given to all tobacco users, usually during the course of routine consultation and interaction.

- Behavioral support: This involves support, other than medication, aimed at helping people stop their tobacco use. It can include all cessation assistance that imparts about tobacco use and quitting, providers support and developing skills and strategies for changing behavior.

***Strategies for tobacco cessation:***

Those who were ready to quit the tobacco use, formula 5 'A's were advised.

The five A's(Ask, Advice, Assess, Assist and Arrange) and Five R's(relevance, Risk, Rewards, Repetitions, Roadblocks) is a fifteen to forty minutes research based counseling approach is used.

**Step1**: Ask: systematically identify all tobacco users at every visit. This is be an essential part of evaluation that for tobacco user at every consultation, tobacco use status be queried and documented. The individual questionnaire starts with consent statement:

a). Background characteristics*:* Questions on sex, age, education, occupation.

2. Tobacco smoking*:* Questions in this section cover patterns of use (daily smoking, less than daily smoking, not at all), former/past smoking, age of initiation of daily smoking, daily/weekly smoking of different tobacco products (cigarettes, *bidi*, hookah, pipes, cigars and other smoked tobacco), time to the first smoke of a day after waking up and attempts to quit.

3. *Smokeless tobacco:* Questions include patterns of use (daily consumption, less than daily consumption, not at all), former/past use of smokeless tobacco, age of initiation of daily use of smokeless tobacco, consumption of different smokeless tobacco products *(*betel quid with tobacco, *khaini, gutkha, paan masala* and other smokeless tobacco products .

**Step 2**: Advice: advised them to a clear message, strong message and personalized message.

- Clear message: "I think it is important for you to quit tobacco now and I can help you. "Cutting down while you are ill is not enough".
- Strong message: "As your health career, I need to advise you that quitting tobacco/smoking/sniffing is the most important thing you can do for your health and families' health". "I can surely help you in this matter."

- Personalized message: Relate the tobacco use to current health/illness, and /its social and economic cost, motivation level to quit or the impact of tobacco use on children and other in households.

After ask and advice I told to tobacco users about the benefits of tobacco quitting:

Benefits of tobacco quitting:

Begin thus- From the moment you quit smoking, It only takes 20 minutes for your body to start undergoing beneficial changes

*20 minutes:* Blood pressure drops to minimal, pulse rate drops to normal, temperature of hands and feet increase to normal;

*Within 8 hours:* Carbon monoxide level in the blood drops to normal, oxygen level in blood becomes normal.

*Within 24 hours to 48 hours*- chance of heart attack decrease. Nerve ending start regenerating (Ability to smell and taste begins to improve)

*Within 72 hours*- Bronchial tube relax, making breathing easier

*Within 2 weeks to 3 months*- Circulation improves, Lung function improve up to 30%

*Within 6 months*- Coughing, sinus congestion, fatigue and shortness of breathe decreases. The lungs function better as congestion reduces.

*Within 1 year*- risk of coronary heart disease decreases to half that of a smoker

*Within 10 years*- Risk of dying from lung cancer is reduced to half.

*Within 15 years*- Risk of dying from a heart attack is equal to a person who never smoked.

Health benefits: no bad breath, reduced risk of cancer, improved capacity of taste and smell

Financial benefits: money saved, reduced health care expenditure

Social benefits: Tobacco free generation, No negative impact on children, you will be a good role model for your children

Assessment of nicotine dependence: If tobacco user is in the ready stage:

First tobacco dependency level is measured by Fagerstrom Scoring. The tool has six simple questions. Based on the score, the level of addiction can be low (score less than 4), medium (score4-6), or high score more than 7.

***Table1:Fagerstrome test:***

| Fagerstrome test for smoking | Fagerstrome test for smokeless tobacco users |
|---|---|
| 1 how soon after you wake up do you smoke your first cigarette /*bidi*?<br>Within 5 minutes 3<br>6 to 30 minutes 2<br>31 to 60 minutes 1<br>More than 60 minutes 0 | 1 how soon after you wake up do you use your first dip/ chew?<br>Within 5 minutes 3<br>6 to 30 minutes 2<br>31 to 60 minutes 1<br>More than 60 minutes 0 |
| 2 Do you find it difficult to refrain from smoking in places where it is forbidden?<br>Yes 1<br>No 0 | 2 How often do you intentionally swallow tobacco juice?<br>Always 2<br>Sometimes 1<br>Never 0 |
| 3 Which cigarette or *bidi* would you hate give up the most?<br>The first one in the morning 1<br>All others 0 | 3 Which tobacco chew would you hate give up the most?<br>The first one in the morning 1<br>All others 0 |
| 4 how many cigarette or *bidi* do you smoke per day?<br>10 or less 0 | 4 How many cans/pouches of tobacco do you use per week?<br>More than 3 3 |

| | |
|---|---|
| 11-20 1<br>21-30 2<br>31 or more 3 | 1-3 1<br>Less than 1 0 |
| 5 Do you smoke more frequently in the first hours after walking up than during the rest of the day?<br>Yes 1<br>No 0 | 5 Do you chew tobacco more frequently in the first hours after walking up than during the rest of the day?<br>Yes 1<br>No 0 |
| 6 Do you smoke when you are soo ill that you are in bed most of the day?<br>Yes 1<br>No 0 | 6 Do you chew tobacco when you are soo ill that you are in bed most of the day?<br>Yes 1<br>No 0 |
| Total Score: | Total score: |
| Level of dependence:<br>1. 7 or more than High<br>2. 4-6 Moderate<br>3. Less than 6 Low | Level of dependence:<br>4. 7 or more than High<br>5. 4-6 Moderate<br>6. Less than 6 Low |

From this test I found 238 tobacco users were highly addict, 68 tobacco users were moderately addict and 34 tobacco users were mildly addict out of 340 tobacco users.

Highly addict tobacco users: 70%

Moderately addict tobacco users: 20%

Mildly addict tobacco user: 10%

**Step 4**: Assisst the following strategies were suggested to assist tobacco users in motivational stages:

| Action | Strategies for Implementation |
|---|---|
| Help in making a **quit plan** | Preparations for quitting:<br>• Set a quit date; ideally date should be with in 2 weeks.<br>• Tell family, friends and co workers about quitting, plan and seek their support.<br>• Anticipate challenges to planned quit attempt, particularly during the critical first week. These include nicotine withdrawal symtoms.<br>• Remove tobacco product from surroundings.<br>• Avoid smoking or using tobacco in places where a lot of time is spent. eg: workplace |
| Provide practical cancelling (Problem solving/skill training) | • Past quit experience-Identify what helped and what failed in previous quit attempts.<br>• Anticipate triggers or challenges in upcoming attempt- Discussing challenges and how user will successfully overcome them.<br>• Other tobacco users in the household/workplace: Quitting is more difficult when there is another smoker/tobacco user in the household/workplace.other housemates/coworkers/peers should also be encouraged to quit. |
| Provide intra-treatment social support: | • Provide a supportive environment by encouraging tobacco users in their quit attempts |
| Recommend Pharmacotherapy: | By explaining how the medications improve success rates and reduce withdrawal symtoms. |

| | |
|---|---|

***Pharmacotherapy:***

Nicotine replacement therapy (NRT): It is a method of substituting the nicotine in tobacco products by an approved nicotine delivery product so that the tobacco user does not have uncomfortable withdrawal symtoms upon stopping the tobacco product. In NRT, nicotine gum and nicotine patch and are used. In India nicotine gum is commonly used.

We used nicotine gum in our treatment procedure which comes in a name of nicotex.

- It should be used orally as a chewing gum and not swallowed.
- Treatment is usually depends on tobacco user nicotine dependency level. If in fragerstrome test dependency level is high the treatment is started from 4 mg nicotine gum. If the nicotine dependency level is medium or low then treatment is started from 2 mg nicotine gum.
- Then advised the patient
    - that gum should be chewed slowly,
    - don't chew nicotine gum too fast,
    - don't chew more than one piece of gum at a time
    - once the tingling is almost gone ,start chewing again
    - don't chew more than 30 pieces of 2mg gum in a day if under supervision.
    - Gradually reduce the amount of nicotine gum use after 2-3 months, which prevent nicotine withdrawal symtoms.

Withdrawal symtoms:

These were the commonly experienced withdrawal symtoms when tobacco user stopped tobacco taking:

- Depressed mood
- Insomnia
- Irritability, Frustration, anger
- Anxiety

- Craving and difficulty in concentration
- Restlessness
- Cough, constipation

  For these withdrawal symtoms I used following coping strategies:

| Symtoms | Coping Strategy |
|---|---|
| Irritability | Take walk, take bath, relax and talk to friends, listen to favorite music, do breathing exercise or yoga |
| Fatigue | Relax, increase intake of fluids |
| Insomnia | Avoid tea, coffee, after 6pm; develop habit of reading book |
| Cough | Drink plenty of fluids, use lozenges, steam inhalation |
| Dizziness | Change positions slowly, relax |
| Lack of concentration | Plan workload, avoid stress, time management |
| Constipation | Add fiber to your diet through fresh fruits, vegetables etc; drink plenty of foods |
| Headaches | Drink plenty of fluids, and practice relaxation eat small snacks |
| Craving for tobacco | Four D's method-<br>• Deep breathing<br>• Distract yourself: read, exercise, talk to your family or friends<br>• Drink more water<br>• Delay in crave |

**The five 'R's approach:**

For tobacco users who are not ready to make a quite attempt, provide a brief intervention designed to motivation to quit and information about harmful effects of tobacco. The tobacco user may have fears and concerns about quitting, or demoralized because of previous unsuccessful attempts and relapse.

I used both the strategies 5 ‘A’s and 5 ‘R’s. I used these strategies with 5 ‘A’ formula for those tobacco users who were willing to quit the tobacco use after advice and in depth discussion with them. This strategy of 5 ‘A’ formula was found effective those who were willing to quit the tobacco.

Another strategy of 5 ‘r’ formula was applied for those tobacco users who were not willing for quit the tobacco use. For this constant efforts and counseling and follow-up is needed. With the application of 5 ‘R’ formula only 2% were agreed to quit the tobacco but again constant monitoring and supervision is needed. For this I requested the health care provider of Yagya Narayan Hospital, especially paramedical workers to have constant and regular follow up.

Five ‘R’ are: Relevance, Risk, Rewards, Roadblocks and Repetition

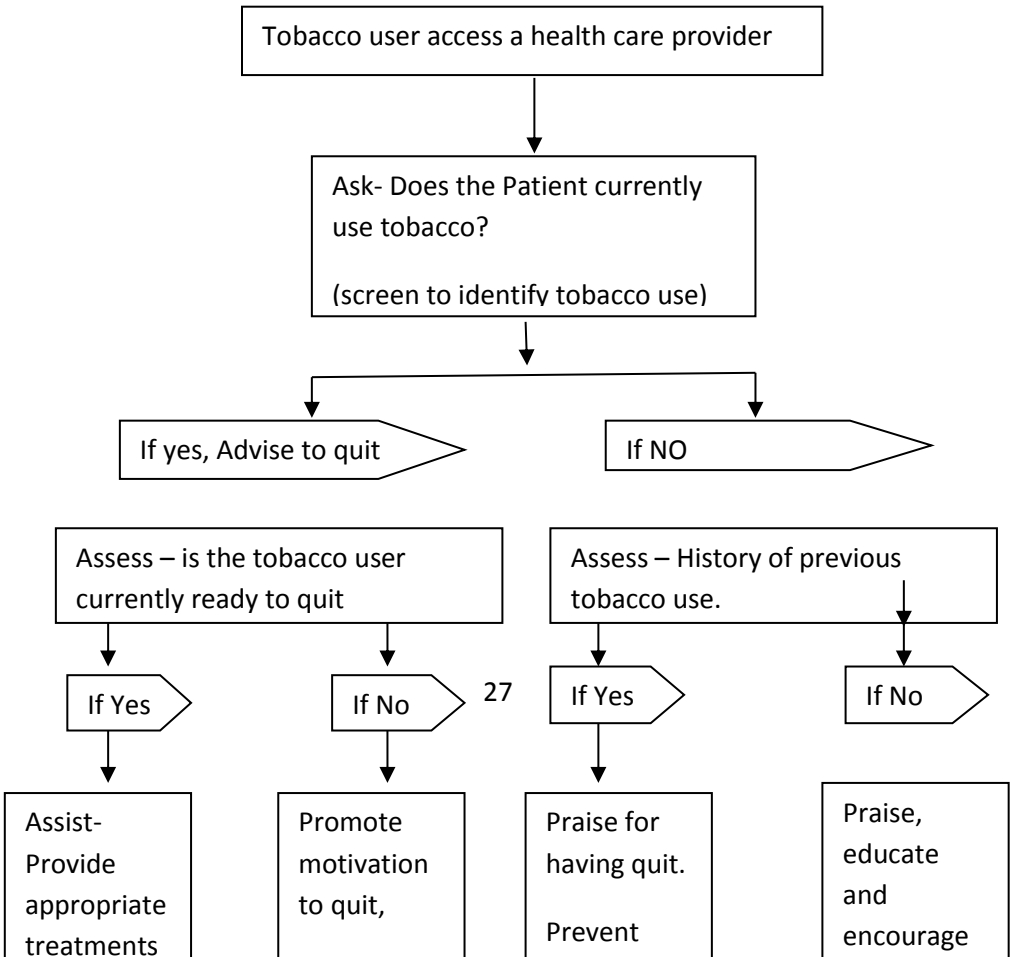
| | |
|---|---|
| Relevance | Encourage the tobacco user to consider the personal relevance of cessation. Take into account the disease status (if any), family or social situation, health concerns, age and gender. |
| Risk | Discuss short term, long term and environmental risks of continued tobacco use , including effects of exposure to second hand smoke on the family member especially children. Relate with symtoms |
| Rewards | Encourage tobacco user to identify benefits of cessation. These may include withdrawal symtoms, fear and concern associated with quitting, depression, lack of social support, weight gain etc. |
| Roadblocks | Barriers that the tobacco user may face in his or her quit attempt should be identified. Withdrawal symtoms, fear and concern associated with quitting, depression, lack of social support, enjoyment of tobacco are some of the barriers that the tobacco user may face in an attempt |
| Repetition | This information should be reviewed regularly with tobacco users who are not yet ready to quit. It is also important for tobacco users who have not yet successfully quit to understand that most people attempting cessation quit several time before finally succeeding in quitting. |

**Step 5**: Arrange:

Arrange schedule a follow-up contact:

Prepare a proper schedule for follow up. Follow up can be done by personal interaction or telephonically.

***Intervention Method Algorithm for quitting tobacco use*:**



***Results:***

Out of these 40 patients, 8 patients were treated by behavior change therapy and 25 patients were treated by pharmaceutical therapy and 7 patients were treated by using both the therapy.

I surveyed 250 labours of R.K marble industries. In which 150 labors were having a habit of tobacco, from those patient 71 labours were undergoing in treatment.

These 71 labors have stopped tobacco using and follow up being done. Out of these 71 labors, 14 labors were treated by behavioral therapy, 9 labors were treated by pharmaceutical therapy and 48 labors were treated by behavioral and pharmaceutical therapy both.

Tobacco users who were easily accepted our advice through counseling of applying 5 'A' strategy they were only 7% and for this also regular follow up is need. Follow up responsibilities has been assigned to nursing personnel and paramedical staff working in the hospital.

Monitoring and follow up has been done by interacting and asking to nursing personnel and paramedical staff of the hospital by the undersigned through telephonic communication and visiting the hospital periodically and also observing the record maintenance for the tobacco users.

Those tobacco users who were not ready to quit they were repeatedly contacted by the paramedical staff on their visit to hospital.

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