World Health Organization
Regional Office for South-East Asia

Tobacco cessation

A Manual for Nurses, Health Workers and other Health Professionals

Tobacco Cessation:

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Foreword

The WHO South-East Asia Region carries nearly one quarter of the global burden of tobacco-related deaths and diseases. The vast majority of projected deaths caused by tobacco use in the near future will be among people who are currently using tobacco products. This fact creates a strong imperative to scale up tobacco cessation services to reduce mortality and morbidity from tobacco use.

The WHO Framework Convention on Tobacco Control (WHO FCTC) contains specific obligations concerning tobacco dependence and cessation. It imposes on Parties the obligation to endeavour to design and implement effective programmes aimed at promoting the cessation of tobacco use, in such locations as educational institutions, health-care facilities, workplaces and sporting environments.

Tobacco Cessation: A Manual for Nurses, Health Workers and other Health Professionals is designed to build the competence and skills of health professionals in taking up the challenging job of tobacco cessation in different community settings. Actually, tobacco use is primarily a way of self-administering nicotine, which is an addictive substance provoking nicotine dependence. Cessation requires a range of interventions including provision of information, counselling, motivation and continuous support to users to make attempts to stop and access treatments that are available. This document has addressed the barriers to implementing tobacco cessation activities holistically and develops a comprehensive outline for tobacco cessation interventions pertinent to health professionals at the community level.

Although this document focuses on community interventions designed to help tobacco users to quit, I hope that these interventions will be embedded within a comprehensive tobacco control strategy and will be integrated into the primary health-care systems of the Member States of the Region.

Samlee Plianbangchang

Dr Samlee Plianbangchang
Regional Director

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Chapter 1

What we need to know about tobacco use in the South-East Asia Region?

Objective

To summarize the extent and patterns of use of tobacco products and the related health burden in the WHO South-East Asia Region, which will highlight the need for intervention by health professionals.

The WHO South-East Asia (SEA) Region comprises 11 Member States: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. While the SEA Region occupies only 5% of the earth's landmass, it has over a quarter (26%) of the world's population. In 2000 the population in the SEA Region was estimated at 1.57 billion. It exceeded 1.69 billion in 2005 and is projected to reach 2 billion by 2025.[1,2]

The SEA Region is thus home to a sizeable proportion of the world's population, and in recent times has made major strides in health, education, the economy and other areas of human endeavour. At the same time, it is also affected by several maladies that have a considerable impact on its overall progress and economy. This *Manual* focuses on one such malady – the use of tobacco and its products by the people of the SEA Region. Today tobacco use has encompassed our lives in all spheres – social, occupational, economic and political.

Let us take a quick look at some key facts pertinent to the use of tobacco products in the WHO SEA Region:

More and more people are using tobacco

In recent years, the SEA Region has undergone, and is still undergoing, significant demographic and socioeconomic changes that have made it a fertile ground for tobacco use, and thus a lucrative market for the tobacco industry. The Region's steady population growth coupled with the tobacco industry's unwavering targeting of potential consumers ensures that millions of people become addicted each year.

> Tobacco use has encompassed our lives in all spheres – social, occupational, economic and political. Currently 5.1 million people die every year globally from tobacco use, of which 1.2 million are from the SEA Region alone.[1]

In 2003 it was estimated that 1.3 billion people used tobacco in some form or the other globally.[3] India occupies second and Bangladesh eighth position among the 10 top tobacco-consuming countries in the world. Nearly **two thirds of the world's smokers live in the SEA Region.**[4] Of the top 20 **countries with the highest male tobacco-using populations in the world, five belong to the Region. In the SEA Region, India ranks first.**[5,6]

In addition, the tobacco consumption scenario in the Region is very different from other areas of the world. There is great variation in the patterns of tobacco use, both in smoked and smokeless forms. While smoked tobacco comes in various forms such as *bidis, kreteks* and *shisha (or hookah)* apart from cigarettes, about 17% of the total population in the SEA Region uses oral smokeless tobacco. Of this, 95% belong to India and Bangladesh.[7]

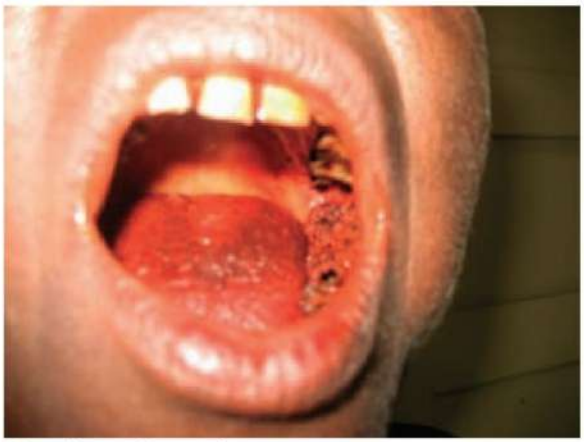
Smokeless tobacco use also remains high in Myanmar and Nepal although it is very low in Thailand and Sri Lanka, except in certain areas. Smokeless products include *paan masala*, betel quid with tobacco, *gutkha*, tobacco dentifrice, etc. used in different ways such as chewing, sucking and applying tobacco preparations to the teeth and gums. Increasing use has been reported not only among men but also such vulnerable groups as children, teenagers and women of reproductive age.

Our Region is also one of the largest producers of tobacco products. Global **tobacco leaf production figures for 2007 indicate that 16% of the production** is from South-East Asia.[6] Indonesia continues to be the largest producer of cigarettes in the SEA Region, followed by India, Thailand and Bangladesh.

Consequently, there is considerable tobacco-related morbidity and mortality in our Region. Of the 5.1 million global deaths each year from tobacco use, 1.2 million occur in the SEA Region alone.[1] It is projected that by 2020 tobacco will kill more than 8.4 million people annually worldwide, 70% of whom will be from developing countries.[8]

Women are being affected

The adult female population in the SEA Region was estimated at about 460 million in 2000 and is expected to increase to 700 million by the year 2030.[9]



Chewing tobacco is common among women in the Region, leading to diseases of the oral cavity.

In 2000, more than 120 million women in the SEA Region used smoking/smokeless forms of tobacco. In 2001 in Bangladesh alone, there were 8.5 million women smokers, most of them smoking *bidis* (small hand-rolled leaf cigarettes typically smoked in India and other South-East Asian countries).[9] In India, it was reported that one third of its population. used tobacco (smoking/smokeless forms)[10]. Female smokers in India die an average of eight years earlier than their non-smoking peers.[11]

Smoking is also prevalent among women, though it is less common than among men.

On the whole, chewing tobacco and using other forms of smokeless tobacco are more popular among women of the Region than smoking forms of tobacco. In several SEA Region countries, particularly India, smoking by women is not looked upon favourably by society but there is no such taboo against smokeless tobacco. However, such cultural inhibitions have weakened recently due to various strategies being used to market tobacco products. In this context the recent rise in the use of tobacco products among

young girls and women in the SEA Region is to be viewed with extreme concern.

> Women face the burden of tobacco use as well as the dangers from exposure to smoking by men. In addition, many of them work for the tobacco industry to earn their living. They work hard without realizing they are helping to make products which one day their own children may use to their detriment. They work without comprehending that they might have to shell out much more than the paltry sum they earn from each *bidi* they roll on tobacco-related consequences that may impact future generations of children.

In addition to using tobacco products, many women are also working for the tobacco industry to earn their living. These activities may range from planting, weeding, picking, binding and tying of tobacco leaves to rolling of *bidis* and *cheroots* (a type of cigar with cut flat ends). In India alone, in 2007 it was estimated that around 10 million workers were employed by the tobacco industry, approximately 60% of them being women and 12% to 15% of them children, mainly young girls. A lot of this work involves working at home (e.g. *bidi*-rolling).[12]

Many women who work in *bidi* industries suffer from various adverse health problems. They work hard without realizing they are helping to make harmful products which one day their own children might be exposed to. They work, without comprehending that they might have to shell out much more than the paltry sum they earn from each *bidi* they roll on the tobacco-related consequences that may impact future generations of children.

Many of these women in many *bidi* industries – including young girls – are also deprived of their labour rights. A huge percentage of them are illiterate, and are paid less than men, with children being paid the least of all, for the same work. Thus, not only do women work to promote the manufacture of poisonous products at the cost of endangering their life and health but they are also victimized and exploited in the process.

A large number of women are part of the workforce of the tobacco industry.

Women in the SEA Region who neither smoke nor work for the *bidi* industry are not spared the ills of tobacco consumption either! These women are still

exposed to the effects of tobacco by living in smoking environments and inhaling the tobacco smoke emitted by their men. According to 2007 WHO statistics[13], since most adult male smokers smoke inside homes and in public places, children and women, pregnant mothers and other non-smokers are exposed to considerable second-hand smoke in our Region. In fact, such effects are more pronounced in our Region where the high levels of nicotine and tar in smoked tobacco, coupled with the poor implementation of smoking bans and high incidence of indoor smoking, put non-smokers as well as women and children at conspicuous risk of tobacco-related consequences.

In addition, it must be considered that millions of women in the SEA Region are already living in disadvantaged circumstances; most of them are poor, malnourished, have poor reproductive health, low levels of literacy, and are in many cases subjected to domestic abuse and violence of all kinds. At the same time they have enormous responsibilities. Apart from their regular household chores of cooking, walking miles to fetch water and firewood, and caring for children, the elderly or the sick in the family, many of them also work outside the house without any remuneration. All this domestic labour goes unpaid and unrecognized. Their health status is also poor: most of them are anaemic and malnourished and frequently suffer from various infections.

In most parts of the SEA Region there is poor coverage by health services, and services to meet women's specific health needs are sparse, impeding their access to much-needed health care. Even as the health-care system moves towards specialist services and multispeciality hospitals, many women in villages are still not able to survive basic natural phenomena such as pregnancy and childbirth. The key question then is: do they really need tobacco on top of all this?

Children are being affected

Children are facing a huge threat from tobacco in the Region. In SEA Region countries, adolescents (10–19 years) constitute 18% – 25% of the population while there are around 325 million youth aged between 15 and 24 years.[14]

Many children are smoking at a tender age.

Source: World Bank

The findings of the Global Youth Tobacco Survey in 2007 reveal a high prevalence of

tobacco use among youth in SEA Region countries.[15,16] While one in every ten youth surveyed smoked cigarettes, another one in ten used other forms of tobacco products. Half of the school students were exposed to second-hand smoke in public places. Tobacco use among girl students was also on the rise. In the SEA Region, adult male smoking rates were found to be ten times higher than the adult female smoking rate *but among 13–15-year-olds, the male smoking rate was only about two and a half times higher.*

Even children those who do not smoke are victims of second-hand smoke. In 2007 an estimated 25 million schoolchildren were exposed to second-hand smoke in public places in the Region.[13] In almost all cases, they have no choice in the matter and are unable to protect themselves. In addition, like women many children are also employed by the tobacco industry to ready a product that is ultimately going to harm them as well as other children like them. Many poor children work in the tobacco industry so that they and their families can survive. They either sell cigarettes, or are involved in their cultivation. Growing tobacco requires hard labour for long periods of time, resulting in high rates of absenteeism from school during the tobacco planting, harvesting and curing seasons. Thus, they miss out on educational opportunities that could help lift them out of poverty.

Though a major proportion of the population of the SEA Region comprises **children and young people, they remain significantly disadvantaged, as revealed** by these grim facts: A large number of children have a disadvantaged start in life, such as low birth weight (25% –33%), and are brought up in environments that do not provide safe and nurturing conditions to foster healthy growth and development. Acute respiratory infections, diarrhoeal diseases and vaccine preventable diseases, notably measles and tetanus, still constitute the major medical causes of death for children in the Region. Over three fourths (79%) **of the world's malnourished children live in the SEA Region.**[17] In 2000, the Region accounted for 3.1 million out of the 10.6 million deaths of children **under the age of five globally.** Over half of these deaths were due to communicable diseases compounded by malnutrition.[17] Estimates also show that less than 20% of sick children receive adequate health care.

A large number of children of the Region are continually threatened by malnourishment, disease and death, and Tobacco use will only add to their burden. Young tobacco users will become addicted before they are old enough to realize the consequences. By the time they reach middle age, they may learn otherwise but **will find themselves unable to come out of** the *web* of tobacco addiction.

Under-five children face adverse environmental conditions characterized by inadequate and unsafe drinking

water, poor sanitation, indoor air pollution, and injuries and other risk factors, which contribute to various forms of disability and illness that can continue for prolonged periods of the child's life.

To sum up, a large number of our children are continually threatened by malnourishment, disease and death, and **tobacco is only adding to their burden**. Young tobacco users will become addicted before they are old enough to realize the enormity of the consequences. By the time they reach middle age, they may learn otherwise but will find themselves unable to come out of the trap of tobacco addiction that has closed in around them.

The poor are being affected

Tobacco consumption among the poor, uneducated masses is increasing rapidly. Incidentally, the South-East Asia Region accounts for nearly half of the world's poor and tobacco use is highest among them.[18]

At the individual level, for poor families money spent on tobacco means money not spent on basic necessities such as food, shelter, education and medical care. Several studies in the SEA Region, including Bangladesh, Myanmar and Nepal, have demonstrated that poor smokers spend up to 40% of their income on smoking at the cost of their basic needs which, in turn, thrusts them deeper in a vicious cycle of poverty.[19] As observed by Efroymson and colleagues[20], "if poor people did not smoke... potentially 10.5 million fewer people would be malnourished in Bangladesh."

This has been reflected in other studies in the SEA Region as well. For instance, a Path Canada, India project study[21] conducted on 400 streetchildren in Mumbai found that they used tobacco at the cost of their food. They spent four times the amount they would spend on nutrition to buy *gutkha*, a chewable form of tobacco. The authors observed that "instead of buying carcinogens, the money might be used to buy desperately needed additional calories and nutrients".

> Instead of buying carcinogens, the money might be used to buy desperately needed additional calories and nutrients.

In addition, the poor are much more likely than the rich to become ill and die prematurely from tobacco-related diseases. Early deaths of primary wage-earners can have disastrous consequences on poor families and communities. As observed by WHO: "Lost economic opportunities in highly populated, developing countries – many of which are manufacturing centres of the global economy – will be severe as the tobacco epidemic worsens, because half of all tobacco-related deaths occur during the

prime productive years. The economic cost of tobacco-related deaths imposes a particular burden on the developing world, where four out of five tobacco deaths will occur by 2030. The net economic effect of tobacco is to deepen poverty.[22] The industry's business objective – to get more users addicted – disproportionately hurts the poor."

A major health concern that is inextricably linked to tobacco use and poverty is the rising incidence of tuberculosis in the SEA Region countries. About 80% of all new TB cases are seen in 22 countries across the globe[23]; more than half are concentrated in the five countries of Bangladesh, China, India, Indonesia and Nigeria. Tuberculosis, being an opportunistic infection, occurs predominantly among socially and economically disadvantaged people and in immune-compromised individuals. Smoking decreases immune defenses and increases susceptibility to pulmonary tuberculosis. Thus, both poverty and tuberculosis are closely linked to the use of tobacco in our Region.[24]

Apart from this, tobacco has been implicated in the causation of several life-threatening illnesses. Public health researchers have been discovering more and more evidence about the disease consequences of tobacco use for more than 50 years. Let us now take a look at some of these health risks associated with tobacco use:

Adverse health effects of tobacco use

> Tobacco is the single most preventable cause of death in the world today. It is the ONLY legal consumer product that kills up to half of those who use it as intended. By 2030, it is estimated that tobacco use will account for more deaths than the total from malaria, maternal conditions and injuries combined.[25]

In the 20th century, the tobacco epidemic killed 100 million people worldwide, and **it could kill one billion people during the 21st century**.[22] Tobacco kills a third to half of all people who use it, on an average 15 years prematurely. Worldwide, tobacco use causes 1 in 10 deaths among adults. By 2030, many of these deaths will occur during the prime years of an individual's life as a consequence of the addiction being acquired in youth.

Tobacco is thus the single most preventable cause of death in the world today, and is the only legal consumer product that kills up to half of those who use it as intended. By 2030, it is estimated that tobacco use will account for more deaths than the total from malaria, maternal conditions, and injuries combined.[25]

The smoker's body

Established health consequences of smoking tobacco:

1 - Psoriasis
2 - Cataract
3 - Skin Wrinkling
4 - Hearing loss
5 - Cancer
6 - Tooth decay
7 - Emphysema
8 - Osteoporosis
9 - Heart disease
10 - Stomach ulcers
11 - Discoloured fingers
12 - Cervical cancer and miscarriage
13 - Deformed sperm
14 - Buerger's Disease

Source: World Health Organization 2004 [26]

Tobacco use causes a wide range of major diseases which impact nearly every organ of the body.[26] Tobacco-related illnesses such as cancer and cardiovascular and respiratory diseases are already major problems in most countries in the SEA Region. The reason for such disease and debility is **straightforward enough: nearly 3000 chemical constituents have been identified** in smokeless tobacco while close to 4000 are present in tobacco smoke, most of which are carcinogenic. Some of these include nicotine; anatabin; anabasin; aliphatic hydrocarbons present in the waxy leaf coating and isoprenoids that give the typical smell to tobacco; phytosterols such as cholesterol, campesterol, etc; alcohols, phenolic compounds, chlorogenic acid, rutin, carboxylic acids and several free amino acids; a wide range of toxic metals such as mercury, lead, cadmium, chromium and other trace elements; naphthalene and polycyclic aromatic hydrocarbons (PAH); volatile aldehydes including formaldehyde, acetaldehyde and crotonaldehyde; volatile N-nitrosamines, N-nitrosamino

acids, lactones, and polycyclic aromatic hydrocarbons; some metals and polonium-210, which is radioactive. In addition, smokers ingest a highly toxic gas, carbon monoxide, which combines with haemoglobin in the blood and reduces its oxygen-carrying capacity.[27]

Smokers are not the only ones killed by tobacco. Second-hand smoke also has serious and often fatal health consequences. Second-hand smoke has 4000 different chemicals, 50 of which are known to be associated with cancer. Second-hand smoke also has twice as much nicotine and tar and five times the carbon monoxide than the smoke that smokers inhale.[28]

Given that tobacco contains the above-mentioned range of chemicals, there are many dangerous health risks that tobacco use poses:

Vascular diseases

The major constituents of tobacco smoke which are responsible for vascular effects are nicotine and carbon monoxide. Other chemicals that cause vascular injury include nitric oxide, hydrogen cyanide and tar, with cadmium, zinc and carbon disulphide being minor contributors. Smoking causes endothelial dysfunction, alterations in blood lipid levels, and increased platelet adherence.

Tobacco use, especially in the form of smoking, has been implicated in such illnesses as coronary artery disease, sudden cardiac death, cardiac arrhythmias, cerebrovascular accidents, thromboangitis obliterans, abdominal aortic aneurysms, and renal artery stenosis. In the WHO South-East Asia and Western Pacific regions, upto 30% of cardiovascular fatalities can be attributed to smoking[29]. In a study conducted in Bangladesh, those smoking 11-20 *bidis* per day were seven times more likely and those smoking > 20 *bidis* per day were 34 times more likely to suffer from thromboangitis obliterans compared with those smoking < 10 cigarettes per day. [30] A case control study in Bangalore, India, found that the most important predictor of acute myocardial infarction (MI) was current smoking of cigarettes or *bidis*.[31]

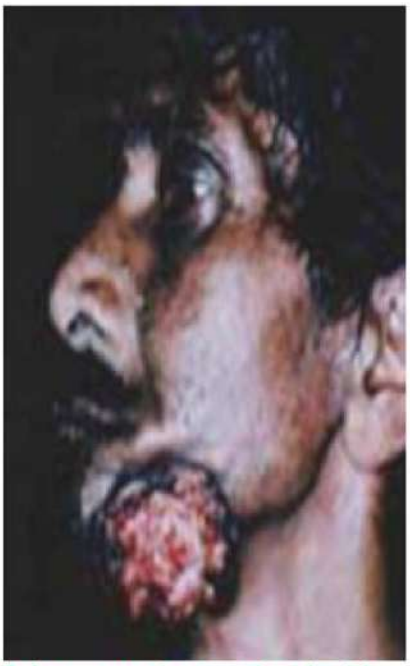
In addition, tobacco places its users at a higher risk of diabetes, which itself damages blood vessels by accelerating atherosclerosis. Thus, smoking affects the entire vascular system, leading to severe debility and life-threatening consequences.

Cancer

An International Agency for Research on Cancer (IARC) monograph[32] states that tobacco smoking is the major cause of lung cancer, and is associated with oral cancer, and cancers of the oropharynx and hypopharynx, oesophagus,

stomach, liver, pancreas, larynx, nasopharynx, nasal cavity and nasal sinuses, urinary bladder, kidney and cervix, and myeloid leukemia. In addition, exposure to second-hand tobacco smoke has also been conclusively shown to cause lung cancer.

Tobacco-related cancers account for about half of all cancers among men and one fourth among women in the Region[33,34]. Oral and pharyngeal cancers, caused due to direct contact with carcinogens in smokeless tobacco products and tobacco smoke, have a high incidence in the SEA Region even among women, due to the prevalence of smokeless tobacco use in various forms.

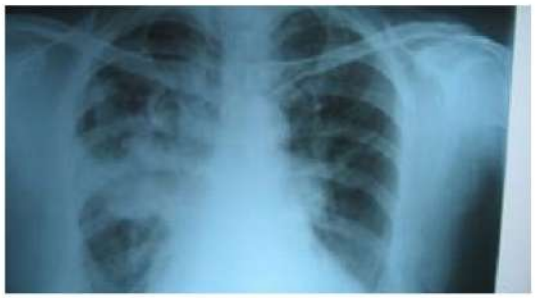


Tobacco use is associated with cancers of multiple organs. The picture above shows a case of oral cancer.

In an evaluation of epidemiological studies on the carcinogenic risk of non-smoking tobacco forms, the IARC Working Group concluded that there was sufficient evidence to demonstrate that chewing betel quid containing tobacco and tobacco mixed with lime are carcinogenic to humans.[35] Following this, several case-control studies from the Region have provided additional evidence of the oral cancer risk to those who chew betel quid with tobacco.[36] Precancerous lesions such as oral submucous fibrosis (OSF), leucoplakia, and erythroplakia of the oral cavity – all of which have high malignant potential – have also been linked to chewing areca nut and its mixtures, as demonstrated by numerous epidemiological studies.[37]

Respiratory diseases

Tobacco smoking affects pulmonary function by damaging the respiratory mucosa, and impairing host resistance to infection. The effects of tobacco on the respiratory system include illnesses such as pneumonia, bronchitis and other acute respiratory infections. Tobacco smoking is now included as an important criterion for the diagnosis of chronic obstructive pulmonary disease (COPD). The adverse effects of tobacco smoking in those with asthma are also well



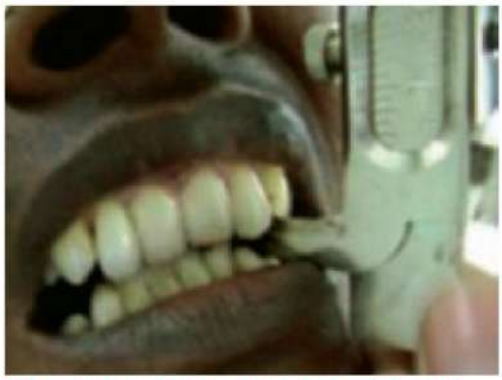
This picture of the lung shows pulmonary tuberculosis, now shown as a common association with chronic smoking. Other lung complications of tobacco use include pneumonia, bronchitis, emphysema and chronic obstructive pulmonary disease (COPD).

Photo courtesy: Dept of Pulmonology, Narayana Institute of Medical Sciences, Bangalore

established. The role of tobacco in tuberculosis causation has already been mentioned. In Nepal, the high incidence of respiratory tract infections among **under-fives is linked to smoke from cigarettes and cooking in enclosed** areas.[39]

Dental

Tobacco-related oral mucosal lesions have been discussed earlier. Tobacco use has also been implicated in the causation of periodontal disease in the SEA Region.[40]



The picture shows a patient with oral submucous fibrosis, a complication of tobacco chewing due to which the person is unable to open her mouth. Other oral complications include pre-malignant lesions, cancers and periodontal diseases.

Photo courtesy: Government Dental College and Research Institute, Bangalore

Reproductive effects

In men, tobacco use can cause erectile dysfunction or impotence due to atherosclerosis and endothelial dysfunction of the internal pudendal and penile arteries. In women, tobacco use has been associated with decreased fertility, increased incidence of stillbirths, pre-term deliveries and low-birth-weight babies.[39]

Genetic damage in humans

Cytogenetic studies among tobacco users have shown that the frequency of chromosomal damage denoted by chromatid breaks and gap-type aberrations **is significantly higher among those who chew tobacco than among non-users.** Chromosomal damage is also known to occur at a higher frequency in the lymphocytes of smokers, workers employed in cigarette factories, and those engaged in tobacco processing for the manufacture of *bidis*.[27]

Green tobacco sickness (GTS) among tobacco harvesters

The agricultural practices followed during tobacco cultivation lead to the smearing of thick, gummy plant sap on the hands of workers and other parts of their bodies that come into contact with tobacco leaves. This leads to the absorption of nicotine through the dermal route. Workers engaged in various processes suffer cuts and abrasions on their palms and the skin around their nails gets peeled off, facilitating nicotine absorption. GTS is characterized by

headache, nausea/vomiting, giddiness, loss of appetite, fatigue, weakness and sometimes fluctuations in the blood pressure or heart rate. Although not associated with any long-term morbidity, GTS can cause considerable discomfort.[27]

In addition to adverse health consequences, tobacco and its products are a major impediment to the economic development and the environmental sustainability of the SEA Region.[41] Tobacco intensifies the effects of poverty, diverts money from the family and results in huge spending on treatment for tobacco-related illnesses, or kills people in the prime of their lives with consequent loss of productivity. Again, it is the poor who suffer these consequences more than the rich, and national budgets cannot handle this burden of tobacco-related diseases on the poor.

On the environmental front, it is not just second-hand smoke that is polluting the environment. Tobacco growing and curing contributes significantly to deforestation, on account of the use of wood fuel for curing and clearance of forest land for tobacco cultivation. Additionally, tobacco is a sensitive plant prone to many diseases, especially during early growth, and the heavy use of pesticides associated with tobacco farming pollutes the groundwater. High levels of pesticide use may also lead to the development of resistance in mosquitoes and flies. Tobacco growing depletes soil nutrients at a much faster rate than many other crops, thus rapidly decreasing the fertility of the soil.[27]

Thus, viewed from *any* angle, tobacco use is one of the most devastating health problems affecting the SEA Region. Should not health professionals know all the facts about the use of tobacco and tobacco products and its consequences?

Doubtlessly, tobacco use is deadly. Many users may want to quit but are not able to because of their dependence on a highly addictive substance. [42]*The role of nicotine in the compulsive use of tobacco products is now known to be equivalent to that of cocaine, ethanol and morphine.*

WHO SEA Regional Training Workshop on Tobacco Cessation, November 2009.

Photo courtesy: Dr Pratima Murthy, NIMHANS, Bangalore

Health professionals should also know in detail the consequences of tobacco use on account of the following reasons:

- the health and well-being of the people is at stake due to tobacco use.
- health professionals meet these individuals who have problems with tobacco almost every day, irrespective of setting or specialization.
- tobacco addiction can happen to anyone – the next victim could be a son, daughter, neighbour, acquaintance, close friend, relative... no one is exempt.
- health professionals can make a difference!

This *Manual* is intended to equip you, the health professional, to effectively **fulfill your role in preventing tobacco use and help people, particularly those** who are dependent, to give up tobacco. The next few chapters will focus on some of the ways in which this can be accomplished. As echoed by WHO in 2005[43], "the failure to use available knowledge about chronic disease prevention and control endangers future generations". It is hoped that this *Manual* will help you effectively deal with the growing problem of tobacco use and dependence in the Region, and in so doing, secure the future of many generations endangered by it.

Key messages

- The use of tobacco and its products is rising in the WHO SEA Region. The worst hit are women, children and the poor.
- Tobacco use causes debilitating illnesses impacting every organ in the body. Adverse consequences related to tobacco use are not limited to the health arena alone. Tobacco use is also responsible for severe economic loss and environmental damage, endangering the population at large.
- Health professionals should be cognizant of the use of tobacco and its consequences, and be able to assist individuals to overcome their problems with tobacco use/dependence.

Chapter 2

How we can help users quit?

Objectives

(1) To help health professionals identify tobacco use in patients with whom they come into contact.

(2) To underscore the importance of brief interventions in tobacco cessation.

(3) To delineate some tobacco cessation strategies that health professionals can employ with their patients.

We have seen in the previous two chapters that tobacco use has emerged as a significant public health issue in the WHO SEA Region, accounting for a substantial proportion of the total disease and disability. However, as a health professional you have a crucial role to play in reducing its impact, and your active interventions with every tobacco user you see is central to this role.

In this chapter, we have outlined certain important principles which might help your inquiry into your patients' tobacco use, and in your delivery of care as appropriate. As you can see, it is critical for health-care systems to support the consistent and universal delivery of anti-tobacco interventions as part of routine clinical care for effective treatment of tobacco dependence.

I. Identification of tobacco use

Tobacco cessation efforts start with the successful identification of tobacco use. It is important for you to remember that tobacco users might commonly present themselves to primary health settings, and are more likely to be seen by a doctor. They may present themselves with a medical condition, such as persistent cough, dyspnoea, wheezing or oral lesions (e.g. with chewable tobacco).

Thus, you need to be alert to the presence of any underlying tobacco use in your day-to-day practice. More so because, unlike alcohol or illicit drug use, neither tobacco users nor their families may view tobacco use as a problem since it may not be accompanied by behavioural problems such as frequent fights, violent behaviour and so on. This makes it all the more imperative that you inquire about tobacco use.

Whom should you ask?

Today, tobacco use is seen in all walks of life. We recommend that you ask EVERY patient you treat if he/she uses tobacco in any form – smoking or non-smoking.

When should you ask?

During your initial contact with the patient, or when you perform your routine assessment of collecting history, performing a physical examination or checking vital signs, or during any other interaction with your patient.

Where should you ask?

In any setting you are working in – hospital (irrespective of the type of unit/ speciality), community or any other.

What should you ask?

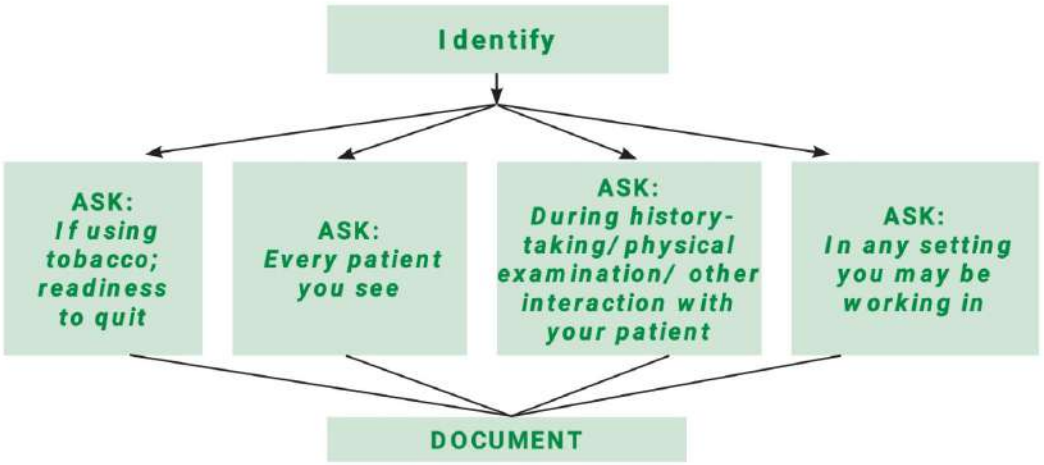
Two pieces of information may be useful. First, does he/she use tobacco currently? Elicit a brief smoking history on lifetime and current smoking; use of chewable tobacco products; quantity (e.g. number of cigarettes/*bidis* smoked, or amount of tobacco chewed, in a day); and duration of use. This information needs to be obtained in more detail if there is reason to believe that the patient's presenting a complaint may be associated with tobacco use or that it may be getting aggravated by it, e.g. chronic obstructive pulmonary disease. For example, if a patient comes to you with a simple cough, ask him/her: "Do you smoke?" Don't just dispense the medication prescribed and send the person away.

Often, use of smokeless tobacco tends to go unnoticed in such routine assessments. When you examine patients, it is not enough to ask them about smoking, you also need to ask about tobacco-chewing habits. The tell-tale staining of gums and teeth can alert you, for example, about the use of smokeless tobacco by your patients. As we have seen in the previous chapter, the use of smokeless tobacco products is a major problem in the Region, so **don't forget to include this in your inquiry.**

Second, as part of eliciting these details you may also attempt to tap **into the patient's views on tobacco use, as well as the likely association** between such use and current health condition. Also, did the person ever think of quitting or attempt to quit before? The aim here is to get an overall **picture of the person's current level of readiness to change his/her tobacco** use behaviour.

Additionally, it is important to consistently *document* **details of the patient's tobacco use in the health file, along with information such as vital signs and other findings of the health assessment.**

Asking for tobacco use should become an integral part of your practice as a health professional. Utilize all opportunities of patient contact to enquire **about his/her tobacco use. You don't have to be an addiction specialist to ask,** because tobacco invades ALL domains of the medical-surgical arena! Almost any symptom in your patient could be related to probable tobacco use. For instance, if you treat bronchitis, or a cardiac ailment, without addressing an underlying tobacco use problem, then your efforts may not be completely **fruitful. Please remember: tobacco use is an important aspect of a person's** overall health status.



Take-home message: BE ALERT AND ON THE LOOKOUT!
Keep your eyes and ears open
Tobacco use is there all around you!
so ASK, just ASK!

II. Intervening with the tobacco user

Once you have successfully identified a tobacco user, the next most important issue is: what should you do about it? In other words, identification should be followed by active interventions for every tobacco user seen in your setting. Physicians can provide simple and effective advice on tobacco cessation to their patients as part of the treatment. When this advice is reinforced by the interventions of the other health team members, then the chances of quitting can be very high. Let us look at some basic, direct steps about what you can do.

The various techniques of intervention have been summarized from a wide and diverse set of resources on the management of tobacco, alcohol and other drug abuse and dependence.[44-55]

A. Brief intervention

First visit

- If the patient had sought treatment for a medical problem, e.g. bronchitis, then obviously your first responsibility is to ensure treatment for the primary medical problem. Any active interventions addressing underlying tobacco use should be reserved for after your patient has obtained relief from the acute symptoms.
- However, if the patient is an active smoker and it is likely that smoking may have contributed to the current symptoms, then you should convey a strong personalized message about this possible link and tell the patient in direct, concrete terms to *stop further tobacco use*.
- On the other hand, you may encounter patients whose tobacco use may not be severe, or those who may not be suffering from problems directly associated with tobacco use. In these patients, it may be that any tobacco use might have been discovered as part of routine history-taking. For such patients, it would be more appropriate to provide brief advice on the health risks of tobacco use, together with some practical tips on tobacco cessation.

Addressing any tobacco use has relevance to the health of patients, so most patients would benefit from such brief interventions. Brief advice is particularly important if the patient is not likely to come for further visits. So don't wait! Every patient who uses tobacco should be offered at least brief treatment. It takes only a few minutes to give this message, and it may even be possible that the patient may quit/reduce tobacco use with this advice alone. *In that case it can prove to be one of the most cost-effective health*

interventions, because you could be saving lives, reducing disability and improving quality of life with just one simple message. It has been shown that nurses and health-care workers have been effective in tobacco cessation in cases where simple advice, administered alone, has produced quit rates of 5% –10% per year. Thus, *you are bridging the gap between primary prevention and more intensive treatment for individuals with long-standing and more severe addiction to tobacco!*

Further visits

- During future visits, focus on providing more detailed interventions for tobacco use (described later) while continuing to treat for the medical symptoms. The extent to which you would need to provide these interventions would depend on the severity of the patient's use. Patients who are currently dependent on tobacco, or those suffering from an acute respiratory problem, would need active tobacco cessation efforts as an integral part of their treatment.
- A very practical measure would be to slip in anti-tobacco messages as part of the medical prescription and general health-related advice that the patient would need to follow for his medical problem. For example, when you tell a patient with asthma/angina to avoid triggers that are likely to bring on an attack, tell the person as part of this advice that he/she needs to stop tobacco use as well. And whenever you follow up with the patient, build in anti-tobacco interventions along with this medical advice. Patients are more likely to listen if you do it this way! Don't make them feel like they are being compelled to give up tobacco!
- Also, put up no-tobacco use signs and posters depicting health risks and other anti-tobacco messages in simple terms in the local language in the patients' waiting room, consultation room, corridors, etc. If feasible, have an announcement made through the hospital sound system at intervals. When patients accompanied by their relatives come for a consultation and are waiting to see you, let them get an opportunity to listen to or view this information. It can make an impact!

Follow-up

Whatever be the extent of the interventions you may need to provide, arrange for regular follow-up contacts with the patient as successful remission is rarely achieved with initial intervention. Set up specific follow-up dates, give the patient the clinic's telephone number and ask him/her to call if needed. Take his contact number/address, and post a card or make brief telephone calls. More information on follow-up is provided later.

B. Working with patients not ready to quit

This may be a common encounter in your practice. Patients might not have thought about quitting, or may not be willing to quit even if they had. What would you do in such situations?

1. Some preliminary steps you can try

- Indicate to the patient that though he/she may not be ready to **quit tobacco, talking about it might help him/her to reflect on** tobacco use a little more clearly and think about the impact of **tobacco on one's life and family.**
- Do not focus too much on quitting. Instead, engage the patient in a general conversation about health, life and family. Try cautiously and ask, as part of the conversation: "Have you ever felt concerned about any tobacco-related health problems? Or have you ever been bothered by your family being concerned about your tobacco use?" Or use any other questions as may be relevant to the situation.

2. Once you have set the tone, help the person weigh the pros and cons of tobacco use

Why should the person quit?

- Link the medical condition, actual or potential, to tobacco use, providing a strong personalized message. Provide relevant educational materials. If illiterate, show striking pictures, e.g. of oral or lung cancer, in detail. *Most users are really unaware of the health risks of tobacco.* They may know in a general sort of way, but not enough to personally apply it to their own health **status. It helps to know about specific health risks of tobacco use** from a health professional! It really does! And your information has the greatest impact when you provide it in the context of **your patient's disease status or risk, family or social situation** (e.g. having children in the home), health concerns, age, gender and other important patient characteristics (e.g. prior quitting experience, personal barriers to cessation).

Try the following exercise:

- Encourage the patient to make a list of the good things/bad things about smoking/tobacco use, as well as the good and bad fallout about quitting. Help the patient weigh the pros and cons of each; a clear analysis of all these may help facilitate a decision between continued tobacco use or staying away from it. A sample exercise has been worked out below:

Pros/ cons of tobacco use

Good things about tobacco use	Bad things about tobacco use
It relaxes me. *It helps me concentrate and work better.* *It helps me socialize better.*	*It may ruin my health.* *My family will get hurt.* *I will waste my money.*
Good things about quitting	**Bad things about not quitting**
I will be healthier. *I'll feel better, breathe easier, cough less.* *My risk of lung cancer and other health problems will come down.* *My gums/teeth will be healthier, and my breath will be fresher.* *My appearance will improve, and wrinkles and ageing of skin will reduce.* *I won't have to worry about impotence.* *I will save money.* *My family wants me to quit, so they will be happy if I do so.* *I will set a good example for my children.* *My family will not get affected by passive smoking. My children will have fewer ear and respiratory infections. My spouse will be less likely to develop heart disease or lung cancer.* *I want to prove I can do it. I don't want tobacco to control me.*	*I may lose friends.* *I may suffer from severe withdrawals.* *I might get easily tensed and stressed.*

- As the patient goes through this exercise, suggest and highlight those that seem most relevant to the patient, in order to make it personally meaningful. In effect this is like a continuous balancing game with the patient see-sawing from one decision to another. As a health professional, your role is to be able to help him tip the balance in favour of the decision to change.

You could also try comparing the patient's tobacco use with a medical illness:

- Choose diabetes/hypertension/coronary artery disease, since they **require major, and more or less similar, lifestyle modifications.** Cite the example of a person with any of these illnesses who has been suggested numerous changes in lifestyle such as cutting down on sugar and fatty foods, reducing weight, medication, etc. How would this person react before complying with such a regimen? Have the patient give you inputs as you go through the following:

Good things about sugar and my present lifestyle (S&PL)	**Bad things about S&PL**
Good food relaxes me, it's a stress buster. *I love sweets.* *I love adding lots of salt to my food.* *I love to eat!*	*I might harm my health. Since I already have diabetes (or hypertension, heart problem), continuing to eat these foods can kill me.* *My family will get hurt, my children need me.* *I will waste my money on medical expenses, money which I can otherwise use for my children's education.*
Good things about giving up S&PL	**Bad things about giving up S&PL**
I will be healthier. *My risk of acute health complications will come down.* *I will save money.* *My family will be happy.* *I want to prove I can do it. I don't want my disease to control me.*	*I will have to give up, or at least drastically cut down, all that I loved to eat for so long.* *My doctor has asked me to lose weight as well, and the regimen is so strenuous. I cannot take all those walks, or do all that exercise!* *I will not be able to enjoy life as much as before.*

- Now consider telling the patient: *"Any person with diabetes, for example, would go through a grieving process at the prospect of having to give up so many things that gave pleasure for many years. However, such temporary pleasure comes with longer-term pain. For example, how long would eating sweets continue to give pleasure if the person ends up in coma brought on by high sugar levels, or if it causes palpable damage to eyes, brain, kidneys? It's the same in your case! I agree that tobacco gives you pleasure and helps you relax. Unfortunately, both the good and bad aspects of tobacco use come together a package. Ultimately, the BAD THINGS OUTWEIGH THE GOOD. Just think: if your health deteriorates, would you still be able to say that tobacco gave you pleasure or relieved stress? How long can tobacco continue to give you enjoyment if it ultimately is going to disable/kill you? Please THINK: Is there anything you can do?"*

We have found from experience that this exercise helps. Patients respond better when you don't raise a hue and cry about tobacco use or insist that it should be stopped. They respond better when you help them realize that tobacco addiction is like any other chronic illness which inevitably requires lifestyle changes. Like any other medical illness it necessitates changes that should be maintained for the rest of the lifespan. Tell your patients that they are not responsible for having got afflicted with the "disease" of tobacco dependence. But they are definitely responsible for fighting it! That is, before tobacco fights them, and wins.

Be direct!

- Although you need to motivate and help the patient reach a decision, there are also times when you might need to be more direct. Don't beat around the bush. Think of a patient whose health is at stake because of smoking. Or a patient who has come to you seeking help for a tobacco problem, or was brought by family members who are concerned about the person's tobacco use. In instances like these, don't hesitate to tell patients point blank: "**YOU MUST QUIT**!" Remember that many times patients do want concrete, direct advice. So don't use too much of expressions such as "would you like to…," or "do you think you should…," etc.

A word of caution, though: Make sure you don't scare the person away, so that he/she decides never to come back. Use your discretion.

3. Behaviour change plan

If the patient has decided to quit, help him/her make a behaviour change plan. The following format may be useful:

Change plan worksheet

- The changes I want to make are:
- The most important reasons why I want to make these changes are:
- The ways in which other people can help me are:
- Some things that could interfere with my plan are:
- Some ways to overcome the above obstacles are:

Note: Patients who are illiterate should be engaged in a discussion with their active participation about the pros and cons of quitting, as well as making a change plan. If possible, enlist the help of a family member who may be literate and have them note down the changes agreed upon. Alternatively, *you* can make these notes and read them out to the patients (and family members, if available), and give it to them when they leave the treatment centre. Retain a copy with yourself (let them know you have one, too) and encourage them to bring the notes along with them whenever they visit the treatment centre. Such strategies can increase accountability and commitment for change, and promote adherence to the treatment plans.

4. Some problems that you may encounter:

More often than not, the process of change may be quite difficult in actual practice! Here are some problems you might face, and some possible ways you can deal with them:

Query: *I have been smoking for many years without any health problems, plus my grandfather smoked two packs a day and lived to be 90. So how does it matter?*

Consider saying something like:

"There are certainly people who smoke for many years without apparent tobacco-related diseases. But it's also true that about half the people who smoke will die from a tobacco-related illness. It is also a fact that smokers live 10 years less than non-smokers. Some people are more sensitive to tobacco than others, and there is no single right answer that will fit everyone as to

how long it takes to develop these health risks. I know it is hard to quit, but please think if that is any reason to gamble with your health when you know that there is a 50% chance that you will die from a tobacco-related disease?"

Query: *If I am going to die 10 years earlier, that's okay. If a non-smoker is likely to live till 80, then that means I'll live to be 70. I think that's fine. Since I am going to die anyway, I might as well have the pleasure of smoking till 70 and then die. I don't mind!*

"You are absolutely right! Since we are all going to die some day, it's important to get what we want while we are still alive. But consider this: how we die is also important. Smoking is known to cause a slow, painful death due to rotting lungs brought on by years of smoking. It's not a happy thing if someone has to fight to breathe and yet cannot breathe before he finally dies – it's terrifying to even imagine. It's not funny to watch someone die from a heart attack or some other life-threatening illness. It's a very painful thing for the victim, as well as for the loved ones. Please consider if you need to suffer so much from self-inflicted damage. Smoking may be fun, but a slow, painful death is not. I am not scaring you, or implying that these things will happen to you. But you need to know the facts. I want you to live, and have a good life. I don't want your life to get snuffed out by tobacco smoke."

Query: *I only chew tobacco. Since I'm not emitting smoke, I am not really harming my family or others.*

"Maybe not, at least, not directly. But tobacco, whether chewed or smoked, is known to damage health. Chewed tobacco, for example, can cause deadly oral lesions, including cancer. Oral cancers progress rapidly, and can cause a very painful death. Please remember, chewed tobacco is NOT a safe alternative to smoked forms. So while you may be protecting others from lung cancer due to second-hand smoke, you will be exposing them to other losses. The most important of such losses is the loss of your health and life, the love and support you can give to your family, and the contribution you can make to society."

Query: *I don't want to quit, but I would like to reduce tobacco use.*

In such cases, although total cessation is the goal, any change is welcome. At least it will reduce harm and disability. Help the person set targets, such as cutting down on the number of cigarettes smoked, or the amount of tobacco chewed, in a day. Who knows, you might still be able to help the person quit totally in future. Take it one step at a time.

What happens if you can't find a single thing in your patient that you can use to motivate him/her to change? Or he/she seems to have none at all?

This usually is not the case. It is true that for some their health may not be a top priority. Take a young smoker, for example. A young student, or someone who has just joined work in a leading company. You might find it more appropriate to talk about his future goals, and whether it will be possible to achieve them given the way he has been going with tobacco.

You might say: "What would you like to accomplish in your life? What are your goals about your work, finances, family? Do you think your tobacco use might interfere with your ability to reach these goals? For instance, to accomplish these, you need to be fit and healthy in the first place! People who had once been toppers or leaders in college or in their profession, may reach a point where they are no longer able to lead and have no one to follow them because of their tobacco use. You are a topper, and a leader, and obviously you want to stay this way. Do you think you need to reconsider in this light, as far as your tobacco use is concerned?"

For a middle-aged smoker, family responsibilities may be more of a priority. Ask him how long he wants to be around his family, watch his children grow and succeed in their lives (strike an emotional chord), and then ask what plans he has made to give up tobacco.

As you can see, health *is* a concern for all these people, whether it is for educational/occupational success or for the family. It's just that they haven't thought about it from this angle. Just steer the conversation to suit their life situations, identify a motivating factor, and zero in on that.

What happens if nothing works? Your patient just doesn't seem to care, and you feel you have reached a blank wall?

It's okay! Just say "I can understand you are not ready yet. If you decide you want some help in the future, or if you just want to talk to us, please call and fix an appointment. We would be glad to help you. Whether or not you decide to quit is a different matter altogether. But I have just given you some food for thought, so promise me that you will think along these lines. You might take this paper with you, with the good/bad things about your smoking (i.e. if he/she has gone through this exercise)." Don't use scare tactics or death threats, and don't exaggerate, or push too hard. Be non-judgemental, give a contact number, and send the person back with the message that quitting is worth it.

C. Working with patients who are ready to quit

1. Congratulate the patient on the decision to quit.

This is really important! For many, giving up tobacco is like giving up a part of their lives, so it's important that they are genuinely appreciated for their courage in taking such an important decision – for their own good, and for the good of those they love.

2. Assist the patient in setting a Quit Date.

Don't let the person postpone. Ask for a DECISION: "I will leave it on ____ day". Ask the person to mark this date on a calendar. Some patients might choose a date which holds some special significance, such as a religious occasion, a family member's birthday, etc. However, remember the patient can just pick a random date. What is more important is that he/she picks a date soon. Tell the person: "Picking a date too far in the future gives you time to rationalize and change your mind." So commit the person to choose a date within two weeks.

3. Suggest that significant others are involved in the decision

It may be helpful to involve significant others in the decision to quit. For example, he can announce to his colleagues that he will be quitting next Monday, or a mother can tell her daughter that she will be quitting on her birthday.

4. Encourage to take help!

Encourage the person to accept the need for external help (family/friends/colleagues). Think: "Who can help me in quitting tobacco?"

5. Help the patient choose a method for quitting

There is no one right way to quit. Some tobacco users prefer to quit by "cold turkey", that is, stop completely and all at once. They use tobacco until their "Quit Day" and then stop totally. Others may cut down on tobacco for a week or two before their "Quit Day". Ask the patient what he would prefer.

Advice for the patient choosing Option A: Tapering off slowly:

- *Progressive reduction:* Every day cut down on one or more cigarettes/*bidis*/packet than the previous day.

  E.g. if you are currently smoking 20 per day, cut down to 15 in the first week, then 10 in the second week, etc. When you come down to the fifth day, take some time before making it 0 per day.

- *Postpone use:* Try putting off the first use of the day by one or two hours. Start, for example, with no tobacco use until 9 o'clock (assuming you used to smoke your first cigarette in the day around 7 in the morning). The next day, make 11 o'clock the earliest you light up a cigarette... Go as long as you can without giving in to a craving (desire to smoke). Start by trying for at least 10 minutes, then longer and longer as you near your Quit Day. Pick your three worst triggers (e.g. after waking up, after coffee, after food) and stop smoking or chewing at those times. This will be hard at first, but practise will make it easier.
- Don't stock! Buy only the number of cigarettes/sachets that you plan to smoke/chew each day.
- On your Quit Date, stop tobacco altogether and begin your life as a non-tobacco user.

Advice for the person choosing Option B: Cold turkey (stopping all at once):

- Set your "Quit Date".
- Before the "Quit Date", make the following changes:
  - Clean up the place! Get rid of reminders of smoking/chewing (ash trays, empty packets, etc.).
  - Change your routine. For example, don't smoke/chew during your regular tobacco using times (e.g. the after-lunch cigarette) or at regular places (bathrooms, workplace, with friends, etc.).
  - Buy the brand you dislike.
  - Keep a record of the amount and frequency of tobacco used.
  - Decrease the number of puffs while smoking.
  - Leave large stubs.
  - Do not inhale deeply.

However, you may also clarify to the patient that the best evidence available is in favour of stopping altogether rather than trying to reduce gradually.

6. "Quit Day"

Whatever the method chosen, on the "Quit Day" the patient would need active support and be adequately prepared to deal with urges and withdrawals. The patient also needs to know that health professionals are available should he/she need any assistance. If the patient lives close to the treatment centre, it may be advisable to fix an appointment as part of the plans made for the "Quit Day".

Here are some guidelines you can use to intervene with your patient on his/her "Quit Day": Advise the patient as follows:

- **The day before "Quit Day"**:
  - Keep substitutes handy to put in your mouth, like cloves, sweets, anything you would prefer.
  - Plan a new routine to do first thing in the morning, such as going to a place of worship, gym, yoga class. Let this be something different from your usual routine, so that it keeps your mind away from your regular tobacco use.
  - Ask a family member to be with you. Remind family, friends and coworkers that this is your "Quit Day" and ask them to help and support you.
  - Call and fix an appointment with us!
- **On your Quit Day, begin your life as a tobacco non-user. Follow these suggestions:**
  - Take an oath, a "sacred" oath, that you are not going to touch tobacco again. You may do this at a place of worship. This may sound absurd, but do it if it helps you. Anything that will help cannot be called absurd!
  - Celebrate! Because this is a most important decision you have made in your life.
  - Follow through on the routine you planned the day before.
  - Keep busy and find new things to do, spending as much time as you can, in non-smoking places and among non-smoking people. Do things out of the ordinary that don't remind you of tobacco.
  - Avoid situations where the urge to use tobacco is strong, such as passing by a tobacco shop or interacting with friends who smoke.
  - Avoid alcohol/soft drinks. It increases the urge to smoke/ chew.
  - Drink plenty of cold water, fresh juices, *lassi*, etc. as substitutes.
  - Don't skip food. Eat small amounts at multiple times (but avoid fatty foods and sugar!).
  - Learn to relax: Try slow deep breathing if you get tensed.

- Come and see us! Or call us in case of an emergency. If the urge is very strong and you are afraid you may smoke/chew, come to us BEFORE you do so. Let us support you on this most important day in your life.

Group-based intervention

One effective strategy that can be employed in the treatment setting is to conduct group-based interventions for tobacco cessation, which can either serve as an alternative to, or supplement, individual counselling for those who need it. Groups may consist of, for example, adolescents, women with a tobacco chewing problem, men seeking support for smoking cessation, or a group of families where at least one member of the family has a tobacco use problem. Efforts should be made to identify these groups as part of your clinical consultation work. Specific days and time need to be designated to suit the convenience of the identified group members, with a specified agenda for the meetings.

Such groups provide a unique opportunity for social learning, generate emotional experiences, and facilitate the acquisition of new skills through the sharing of information among members. Group sessions can also help to analyse the motives behind tobacco use behaviour among the group members, deal with faulty cognitions, and identify as well as correct myths and beliefs related to tobacco use.

In the following section, we have described some tobacco cessation interventions in more detail. Apply them as relevant, depending on the patient's readiness to change, severity of his tobacco use, the time available to you, and perhaps even the setting where you work. Thus, using them would require your flexibility and discretion. However, we have provided the following guidelines:

D. Specific tobacco cessation strategies

Pharmacotherapy

Numerous agents for tobacco cessation now exist, such as nicotine replacement agents (gum, patch, inhalers, intranasal sprays, etc.), bupropion SR, varenicline, clonidine and nortriptyline. Despite varying routes of administration or treatment regimens, research shows that use of these agents significantly increases tobacco abstinence.[56]

For example, there is clear evidence to demonstrate that use of nicotine replacement therapy (NRT) is more effective in increasing smoking cessation rates compared with either placebo or no NRT. Thus, patients should be informed about available pharmacotherapies and their use should be recommended with everyone attempting to quit tobacco, in conjunction with any behavioural strategies that may be employed (see below).

Evidence-based pharmacotherapies currently available for nicotine dependence include the following:

- Nicotine replacement treatments
  - Gums
  - Patches
  - Inhalers
  - Lozenges
  - Sprays

Non-nicotine pharmacotherapy:

- Bupropion
- Varenicline
- Others (clonidine, nortryptiline)

Pharmacotherapy is currently not available, or only limited forms are available, in most SEA Region countries.

Dealing with high-risk situations

Once the patient has quit, it is extremely important that he/she is prepared to deal with situations which can increase the desire to re-use tobacco. Certain things like being in the presence of people who use tobacco or being in places where tobacco is available, and so on, can trigger feelings of "craving".

In order to prevent a return to tobacco use after quitting, the patient needs to first find out the situations in which he/she is most likely to use tobacco. These are called as "triggers or high-risk situations". The first step is to identify them and then form specific plans to handle each one of them. Some guidelines are provided below:

1. Identify specific high-risk situations (tobacco re-use triggers):

Suggested clinician script**:** *"We are going to discuss how you can deal with 'certain situations' which can increase your likelihood of reusing tobacco. We call these high-risk situations. What we want to find out is what kind of situations are triggering or maintaining your tobacco use. Then we can try to find out how you can deal with them, without resorting to tobacco. This involves learning specific skills and strategies to use when confronted with these situations."*

Ask for specific examples of triggers. Some common examples of triggers can be:

Withdrawal symptoms; waking up in the morning; drinking coffee, tea; after food; being with other smokers (peer pressure); taking a break while at work; feeling bored; watching TV; passing by a tobacco shop; family/ occupational or other forms of stress; feeling lonely or depressed; anxiety and falling concentration levels.

2. Empower to deal with identified triggers:

Triggers cause extreme CRAVING, which is normal and is most often experienced early in treatment. It is thus very important that the patient is **assisted to come up with a specific plan of action when confronted by these** triggers.

First of all, it will be useful to help the patient understand the concept of craving:

"Once you have quit, you should be prepared to experience 'craving'. By craving, we mean a strong desire or longing, and an uncontrollable urge to use tobacco again, after you have quit. However, the good news is that craving is like a wave. That is, rather than increasing steadily until it becomes unbearable, it usually peaks after a few minutes, and then dies down like a wave. Craving is thus time-limited. It lasts only for a few minutes or at most a few hours.

***"Your cravings will be strongest in the first week. You may also experience 'rapid-fire' cravings where they follow each other in rapid succession. As** the days pass, the cravings will get farther and farther apart. On the whole they may last 3–4 weeks, although mild occasional cravings may last for six months."*

"Craving is an acquired habit of tobacco use. As it is a learned habit, it can be unlearned and replaced by healthy habits. By avoiding tobacco use, the habit is weakened, and the chances of craving decrease. Waves of craving become less frequent and less intense as you learn how to cope with them. Skills required for dealing with craving include relaxation, and diversionary and escape techniques until the wave passes."

Some ways to handle craving (try any that may apply to you):

- Stop and recognize that this is a "trigger" event in your case (have a list of likely triggers ready).
- Talk to a non-using friend or family member, tell them you feel like using tobacco and need help not to do so. Have a list of supportive persons whom you can depend on.

- Remember that withdrawal symptoms (e.g. difficulty in concentrating, restlessness, sleeplessness, irritability, anger and frustration) can be very strong in the first few weeks after you quit. However, also remind yourself that this discomfort is temporary, and is in fact a good sign that your body is recovering from the effects of smoking and flushing out harmful tobacco chemicals. Try the 4Ds (see below) to distract yourself when the withdrawals are troublesome.

- **4Ds:**
  - **Delay:** Delay acting on the urge to smoke. Remind yourself that cravings are temporary. The urge will pass in a few minutes. Don't give in. Count till 20 or more until the urge passes.
  - **Distract yourself:** Take your mind off tobacco use. Focus on the task you're doing, get up and move around, or refer back to your list of reasons to quit. Remind yourself why you decided to quit tobacco. Go back to your reasons for quitting and read them over again. Anything that shifts your attention away from tobacco use for a few minutes can help. Talk with a friend about your urges and what you are doing about them. Exercise.
  - **Drink water:** Sip the water slowly and hold it in your mouth a little while. Or use other oral substitutes: carrots, apples, chewing gum, all may help to stop the psychological need.
  - **Deep breathing:** Breathe deeply.

4Ds to manage craving:
- Delay
- Distract
- Drink water
- Deep breathing

- Think positively. Repeat motivating statements such as "I am strong; I can get through this without using tobacco" in your mind.

- Recall the negative consequences of returning to tobacco use – damaging your health, hurting your family, financial loss; recall every detail. Challenge your thoughts when experiencing craving. Many people have a tendency to remember only the positive effects of tobacco and often forget the negative consequences of its use. Therefore, when the temptation to use tobacco is strong, you may find it helpful to remind yourself of the benefits of NOT using, and the negative consequences of using, tobacco. For example, who is going to get hurt? Besides yourself, how about your family and those who depend on you and respect you?

- Postpone the use of tobacco for a day. If the desire to use tobacco is very strong, then the 24 hours in a day can be further broken down to smaller durations. For example, you can decide not to use it for one hour... one more hour... and so on.
- Change old routines. For instance, take a different route while going home from your office if a tobacco shop is on the way, especially if it is the one you used to frequent before.
- Get on the Internet and surf for "tobacco cessation", "dealing with smoking triggers", or something similar.
- Go to a place of worship – a church, temple or mosque.
- Seek the company of non-using friends and colleagues. As far as possible avoid staying alone, at least in the first few weeks. Alert a family member or someone close to you about your decision to quit, so that they can support you in your efforts.
- Cheer yourself up by buying something special for yourself. Congratulate yourself for your determination and effort. Reward yourself frequently, but not with tobacco! Also, collect the money saved from each pack of cigarette or paan masala. You can buy a gift for your family with all that money. Above all, remind yourself that your real reward will come later ... in the form of several extra years of health.

> Beware of "warning signs": continued irritability, increased thoughts of having just one smoke/chewing one packet. Remember that reuse can happen if these occur. These signs are meant to give you a warning. Have someone to support you, or contact us if needed.

- Beware of "warning signs": continued irritability, anger and restlessness, increased thoughts of having just one smoke/or chewing just one packet, and feeling very tense and tired are all warning signs. Remember that tobacco use can happen again if these recur. As correctly labelled, these signs are meant to give you a warning. Have a family member to support you, or contact us if needed.

In addition, smoking or chewing tobacco is commonly associated with other behaviours such as watching television, eating, drinking alcohol, etc. THIS PAIRING SHOULD BE BROKEN, and it is important to prepare patients beforehand:

Facing the mornings:

- It might well be that lighting up a *bidi*/cigarette is your first event of the day, so be on your guard in the morning! The previous night

make a specific plan about what you would do instead soon after you wake up that will not remind you of tobacco use. Make a list of early morning triggers, and avoid them. For example, plan a different waking up routine. Start the day with a pre-planned activity that does not involve tobacco but that will keep you busy for an hour or more. For example, pray or read a book, even if it's not part of your regular routine.

- Also remember that your morning tea or coffee will not taste the same without tobacco. Between sips of coffee or tea, take deep breaths to inhale the aroma. Breathe in deeply and slowly while you count to five, and breathe out slowly, counting to five again. As you drink your coffee, make plans for the day and think pleasant thoughts. If the urge to use tobacco is very strong, drink your coffee or tea faster than usual, and then change activities or rooms.

After food:

- Remember that you may feel the desire to use tobacco after having your food. In the early days after quitting, it may be useful for you to know what kinds of food increase your urge and stay away from them.
- Also, plan a different "after-food routine". For example, wash your own plate after eating — you can't smoke with wet hands! Brush your teeth right after you finish eating. Also, if you have the habit of walking around in your garden after food and having a smoke, avoid that. Stay indoors and talk to your family instead!

When you are tired after a hard day's work:

This is another important trigger. It may be your usual tendency to relax after a hard day at work by "having a quiet smoke". Think of other ways of relaxing instead. Read a book, snooze for a while in your armchair, or talk to your family over coffee. Or think of anything else that suits you!

Watching TV:

TV shows or advertisements may provide you with many "triggers" to use tobacco, i.e. movies that show tobacco use, etc. The time of the day that you watch TV may also be a tobacco-use trigger. For example, you may be used to smoking or chewing when watching a news programme or a late night show. Have salty snacks handy or fruit juice that you can have instead. If possible, ask a family member to watch the programme with you. Change the channel if there are high trigger-content shows, i.e. channels which depict people using tobacco.

Having a drink:

It is quite usual for smoking and drinking to co-exist. As a smoker, you may feel a strong urge to smoke when drinking alcohol. Know this upfront if you are going to drink. Switch to non-alcoholic, non-caffeine drinks during the first two weeks of withdrawal, especially fruit juices. Stay away from your usual drinking places for some time. As a rule, it's advisable to give up both alcohol and tobacco as each is known to increase the craving for the other. Additionally, alcohol has many deleterious long-term effects on the body as well!

Remember that whichever technique/s you may decide to apply, the underlying principle is the same: *Craving is time-limited, however unbearable it may be. All you need to do is distract yourself until it passes.*

There is another very important point that you need to bear in mind! If you do happen to "slip", that is, you smoke again, stop with that one smoke. Don't continue. Call us immediately! Come over for a visit if you can. Or ask a family member or non-smoking friend to stay with you until the urge passes. Also remember that any of the above tips can be implemented during such slips too. We are not saying a slip can occur. But in case it does, it does not mean you should resume tobacco use! Moments of weakness can happen to anyone, and it's definitely not the end of the world!

Please remember that giving up tobacco can be very challenging, because your body has become used to maintaining a certain amount of nicotine (a drug found in tobacco) in the blood over a period of time. When you try to cut back, it is going to react by throwing up severe withdrawals and causing an intense desire to use tobacco again. But, giving up tobacco once and for all will be one of the greatest challenges you have ever undertaken, for your own good and that of your family, and indirectly for the good of the society in which you live!

Practice exercise

At this point, have the patient carry out the following exercise. This exercise should be individualized, and based on each patient's unique list of identified tobacco use triggers. The plan need not be elaborate; what is important is that it should be formulated with the patient's active participation on what will work and what will not, based on his/her life circumstances. As you take the patient through the exercise, probe him/her, have the person vividly imagine life situations and form a plan to deal with triggers. Don't be satisfied with "yes" or "no" responses! We have found in our experience that this exercise, coupled with the "Recovery Calendar" (see below), is extremely invaluable in empowering patients to deal with craving and preventing relapse.

Managing my triggers

Triggers	My plan of action
1. When I wake up in the morning. 2. When I talk to my friend next door in the evenings. 3. When me and my spouse have an argument. 4. When I think of my financial situation. 5. When I take a mid-morning coffee break at work. 6. When I come back home in the evenings.	*(As far as possible, have the patient make an individual plan to deal with* ***each*** *identified trigger. The patient can choose from any of the strategies listed earlier, or think of new ones that he feels might work better, in which case you can add these to your own list when you talk to your next patient.)*

If I feel an urge, I will meet/ call:

If I do happen to use tobacco again, my plan of action:

(1) People whom I'll meet/call (be specific, and include phone numbers if they are not immediately reachable):

(2) Other measures I will take:

Ways in which my family (or other support persons) can help me:

Recovery Calendar

In addition, encourage the patient to maintain a "Recovery Calendar" at home. You may say the following:

Practice maintaining this calendar every day following discharge. If, on any day, you face (or are likely to face) a trigger/warning sign (or both), place a tick mark (√) in the box provided. Then elaborate on the trigger/warning sign, and what you did to overcome (or avoid) it, in the following format:

Recovery Calendar

S.No.	Date	Particulars of trigger	What I did to overcome it

Note: As mentioned earlier, please remember that patients who are illiterate should be engaged in an active discussion to identify triggers and come up with individualized plans to handle them. Keep a copy of the triggers to refer to them again every time the patient comes for follow-up.

Saying no to tobacco (refusal skills)

Suggested clinician script: *"Let us look at another situation which can act as a trigger for tobacco use, and how you can handle them. As you recover from tobacco dependence, your ability to say 'no' in situations where you are asked to smoke (trigger situations) is important to decrease your chance of returning to tobacco use."*

This ability to say "no" tobacco is called "tobacco refusal skills".

Some ways to strengthen tobacco refusal skills:

(1) **Say "no" first. Remember that those individuals who offer you** tobacco are not thinking of your best interests.

(2) **Respond rapidly, don't hesitate. Saying things like "maybe later",** "we shall see", just make it likely that they will ask you again.

(3) Body language is important. Make good eye contact and look directly at the person when you answer. Your expression and tone should clearly indicate that you are serious.

(4) Do not make excuses. Many people feel uncomfortable or guilty about saying "no", and think they need to make excuses for not using tobacco any more. This allows for the possibility of future offers.

(5) Do not prolong the conversation for more than a few minutes. The longer the talk on the subject, the more likely you will give in.

(6) Suggest an alternative if you want to do something else with that person (e.g. taking your children to the park together, or going to a gym).

(7) If the person continues to push you, leave the situation immediately. **Leave by saying politely, "I can see that you won't take no for an answer, so I think we had better stop meeting". You don't have to hurt anyone. Just refuse politely, but firmly.**

Additionally, whenever feasible, you could try and have the patient and a family member enact a role-play to practise the above skills. Consider the following exercise:

Tobacco refusal scenario (role-play)

Tell the patient to recall a situation he/she had experienced before, when he/she was asked by a friend or colleague for a smoke. How had he/she responded and what happened next? Now ask him/her to imagine a situation which he/she anticipates can take place where he/she might be approached by a friend with whom he/she had smoked before. "Can you think of how **you would respond now 'assertively' so you don't hurt him but at the same** time do not get persuaded to smoke with him either? We will try to enact this refusal scenario, so that you are prepared to handle such situations in future."

Guide the patient and family member as they practice this scenario. If no family member is available, you could even try your hand at acting! Or at least have the patient repeat to you how exactly he would say "no" assertively. Provide corrective feedback, and encourage the patient to think of all the situations he is likely to encounter when he may need to practice being assertive, and be prepared to deal with them beforehand.

Dealing with faulty cognitions

Although the patient may encounter several triggers which may cause him to use tobacco again, on many occasions such triggers are self-invited, i.e. one's own thoughts or cognitions may place a person in these high-risk situations. The following are some of the faulty cognitions that patients who have recently quit are often confronted with. Engage the patient in an active discussion. As each thought is first put to him/her, help him/her to reason out. Here are some examples of what you can get the person to think to overcome such cognitions:

- ***I stopped smoking/chewing tobacco but still my life is so bad.***
  - Challenge this thought: Even if my life is bad, will tobacco really help to improve things? Or will my life become more "bad" than before?
  - If I don't use tobacco at least my life will not become worse, even if nothing else improves.
- ***Nobody cares, though I stopped smoking. They still suspect that I smoke. Why should I bear all this? I may as well use tobacco again.***
  - What proof do I have that nobody cares?
  - What about all these years when I continued to smoke without caring for their repeated requests? Maybe they are just very hurt, and finding it difficult to forget the past.
  - They may suspect because they are afraid that I may go back to tobacco use. This, in fact, can be proof that they are actually concerned about me.
  - They have been patient for so long, so let me be patient now till they begin to trust me again.
  - And even if they don't, is it really worth starting to use again? This is my life and my health, and let me keep away from tobacco for my own sake.
- ***This problem is too terrible. I need a good smoke to relax me at least this once.***
  - Will tobacco really give me the relaxation I need?
  - Even if I succeed in relaxing for a while, how long can I do that? For a few hours, until the effect lasts. And after that? Should I go on using tobacco to continue to have that effect?
  - What useful purpose does that serve, except to ruin my health and family and put me in an even worse position than I was before?

- There are many people whose lives are full of problems. Does that mean all should start using tobacco and make life even worse?
- Let life run its course, it's not under my control, but let me not add tobacco to it.

- ***I am a worthless person because of my tobacco addiction.***
  - Am I really that worthless? Where is the evidence that I will never improve?
  - It's my bad luck that I've been affected by this disease of addiction. Does that make me worthless? What about my other abilities: my love for my family, my work capacity, all that I could do before I became addicted?
  - When individuals who have high blood pressure or diabetes, which are lifelong illnesses, cannot be called worthless, why should I allow my addiction to make me feel that way? Like those individuals should manage high blood pressure, I should try to manage this too.
- ***My spouse started the argument and it ended up in this big fight. I got fed up. Who can blame me for using tobacco again under such circumstances?***
  - Did tobacco solve the problem? Arguments may continue to arise; should I end up smoking each time? Won't it worsen the situation? Instead, could I have tried to reason with my spouse, or tried to see his/her point of view?
  - And if that didn't work out, could I just have walked off from the situation and tried to sort it out later when we were both cool? And if that didn't work either, how is tobacco going to help solve the problem, except to make matters still worse than they were before?
- ***The craving for tobacco is stronger than my will power; I am not strong enough to stop.***
  - What is so bad about experiencing craving? Who said quitting would be easy? I have been using tobacco for so long, and so these urges will continue for a while. Of course I can survive them – with time, they'll pass.
- ***I have become boring to others after I stopped using tobacco. People don't enjoy me that much. Everything is boring and dull without tobacco.***
  - Where is the proof that I have become boring, or that people don't enjoy me as much as before?

- Do I need a harmful substance like tobacco to make my life enjoyable?
- And if my health, family, money and respect get destroyed, will people enjoy me, and will my life continue to be enjoyable then?
- Instead, can I try to cultivate other interests and hobbies to make my life enjoyable?

- ***This is a very important get-together – we are all meeting as friends after a long time. I deserve to use tobacco just this once. Otherwise my friends will think me strange, or they may feel hurt.***
  - What evidence do I have to think that my friends will think me strange if I don't use tobacco with them?
  - Am I feeling the desire to smoke myself and using my friends as an excuse to smoke again?
  - Let me just explain to my friends that I have made a decision to quit. If they really want my good, they will respect my wishes and not compel me. If they don't understand and feel hurt, then there's nothing I can do about it.
  - If I smoke along with them I know I will not be able to stop, and I will be in the same position as I was before. And that will hurt me and my family more than it will hurt those friends.
- ***I bought a new tractor yesterday. I need to celebrate, my friends are expecting me to join them for a bidi this evening. Maybe it's okay, just this once.***
  - Do I need a *bidi* to celebrate? And what if this one *bidi* brings back my cravings and lands me in the same position as before? Don't I need to be more careful? If I really want to celebrate, then I just need to think of a new way to do so – it doesn't necessarily have to be tobacco! How can a product which can destroy help me celebrate? How would a non-smoker celebrate if *he* bought a tractor? Let me go ask a non-smoking friend how he would have celebrated instead!
- ***I lost all my crops this year. The monsoon failed. This situation is terrible. I need to use tobacco, I just don't care any more.***
  - It's a terrible thing to happen. Crops and monsoons fail, for tobacco users and non-users alike. The situation is bad enough already. I don't need tobacco now to add to my problems. I need to think of some way to cope with this, just like anyone else would do, without thinking of tobacco.

- ***We used to have a lot of fun in our circle in the past when we were smoking*** (nostalgia).
  - Were we really having fun? Can a harmful product be a source of fun?
  - Is it fun if it killed my 40-year-old neighbour. He died of a heart attack. I hadn't realized it was because of his 18 years of smoking.
  - And even if tobacco helped me have fun because of the kick it gave me, what about the other negative effects it had on my life? Am I forgetting all that and remembering only the fun part of it?
  - What will happen if I entertain such thoughts? I may end up contacting those friends again and smoking or drinking with them. What next? I'll be in the same situation as before, with all its problems. Then will life continue to be fun?
  - Instead, can I think of alternative activities to have fun – go out with my family, go to a restaurant with a non-smoking friend for some good food, or engage in some sport?
- ***I can stay away from tobacco. Nothing can tempt me*** (testing personal control). ***For example: calling up and interacting with people with whom I had used tobacco before.***
  - What proof do I have that nothing can tempt me?
  - Should I take this as a warning sign that I may be thinking of using tobacco again, and contacting these friends can actually become the starting point for using again?
- ***I tried to stop many times before, but it didn't work out. Where is the guarantee that I will succeed this time*** (self-doubt)**?**
  - When my tobacco use habit is causing me so much harm, then why shouldn't I keep trying till I come out of it?
  - What is the guarantee to anything in life? Does that mean one should give up, because past attempts have failed? I can learn from my past mistakes and try again this time. If I don't, it can destroy me.
- ***After all these months of staying away from tobacco, I used it yesterday. So I may as well use it today.***
  - If I do that, what will be the ultimate end? I made a mistake by using again, but does that mean I should continue with that mistake?

- What are the ways in which I can rectify this? It's okay if I took it once, let that remain a lapse, let me not allow it to become a continued pattern again.
- If there's the danger that I may go back to tobacco, can I seek medical advice again? The time and money I'll have to spend if I did so will be less than what I'll spend if I continued using, besides destroying my health and family life.

In a nutshell, recommend the following:

- **Recognize these thoughts as DANGER SIGNALS**.
  - Challenge them.
  - Repeat "statements of conviction":
    - "God is with me; He will help me not to touch tobacco."
    - "My life is too precious to be destroyed by tobacco."
    - "I want to live and be useful to my family and society, and I refuse to allow my tobacco habit to prevent me from achieving this."
    - "There are others who have overcome their tobacco addiction, so my problem can be solved too."
- **Consider the consequences of using tobacco:**
  - My health will be affected.
  - I may not be able to work properly.
  - I will lose the trust of my family again.
  - I may lose respect.
  - Once I start using, I may not be able to stop, and I will be in the same situation as I was before. So what's the point?
- **Consider the consequences of NOT using tobacco:**
  - I protect my health, and my self-respect.
  - My family relationships improve.
  - If I don't smoke now, I'll be proud of myself. I'll also be more confident when I'm faced with similar situations in future.
- **Distract yourself, using the anti-craving techniques you have learnt before.**
- **Ignore – remain passive. Treat the thought as a foreign body, a harmful agent, that's best ignored until it loses its force and passes.**

Handling negative mood situations

Suggested clinician script: "Negative mood states, including depression, may be quite common when you are recovering from your tobacco addiction. These negative moods/emotions may be of various kinds – anger, anxiety, fear, depression, guilt, getting upset or bored easily, irritability, tiredness, restlessness, and so on.

Negative mood states are highly likely to push you to tobacco use again. However, returning to tobacco use is not an effective way of coping with depression and other negative emotions. There are many different ways to cope. Negative moods can be dealt with effectively, by changing the way one thinks and behaves."

Some ways of changing one's thinking can be:

- Be aware of your depressed and self-defeating way of thinking. Inhibit the immediate tendency to use tobacco in response to negative emotions. Stop and think before you act.
- Challenge your negative thoughts: If I use tobacco, will my sadness reduce? Perhaps I will be able to forget for some time, but after that? Should I keep on using tobacco to forget? What is likely to happen if I do that?
- Consider the consequences of NOT using tobacco.
- Rethink the situation and reason. For example, you may tell yourself: "Being depressed is not really harmful, but using tobacco to cope with my depression can worsen the problem."
- Think of other alternatives. For example, can you seek medical advice, talk to a friend, or approach anyone else for help?
- Above all, even if nothing else seems to solve the problem for the moment, let time be the healer. Ask yourself if bringing in tobacco will help, or will it complicate things further?
- **Keep yourself busy. Don't give yourself time to brood.**
- Accept yourself as you are, with all your strengths and weaknesses. Have realistic expectations. Above all, refuse to succumb to such **moods. Don't let them ruin all your hard work. Stay strong, stay positive. Don't give up!**

Coping with stress

Suggested clinician script: **"It's possible that until now, tobacco use was for** you a major way of coping with stressful circumstances. However, as we have **seen, it's not a healthy way of coping. Clearly, tobacco does not solve your**

problems. Rather, it compounds them. Stress is a part of everyday life. And unless you learn to cope, it can cause you to use tobacco again."

Before we talk about coping with stress, involve the patient in the following exercise:

(1) *Can you think of certain common stressful events in life?*

Some of them can be:

- Family problems.
- Job stresses.
- Tiredness and fatigue.
- Small everyday problems and frustrations that blow up when **things don't go your way.**
- Life events that cause grief and pain (such as death of a loved one).

(2) *Now, if you really look at this list, would you say only tobacco users experience these stresses?*

No! These are common to everyone. So you are in no way different from non-users! Then where does the difference lie? IN THE WAY YOU HANDLE THEM! For example, think of family problems. Some ways that a non-tobacco user would deal with them can be:

- Talk to relevant family people to resolve the issue.
- Fight/argue.
- Seek support from a friend/family member who can help.
- Distract oneself, take the kids and go watch a movie.
- Cry.
- Pray to God for help.
- Just wait for time to resolve things, if nothing seems to be working!

Or let's look at something else: physical tiredness and fatigue. A non-user might handle it by:

- Eating something nourishing, or having coffee.
- Watching a movie.
- Meditating.
- Reading a book.
- Sleeping, relaxing, going for a walk.

(3) But if you are a tobacco user, though you may do the above, your **first instinct might also be to reach for a cigarette/tobacco satchet.** How does that help you? Maybe it calms you down for a while. But for how long? The problems do not go away. In fact, you will be adding to them by harming your health. *The principle here is to BREAK THE LINK between these normal, everyday stresses and tobacco use, and gradually learn to deal with them the way a non-user would!*

For example, don't keep blaming family tensions as a reason for continuing to use tobacco! The fact is that tobacco use has become a way of life and you should change that. We are not going to assure you that your life will become wonderful if you stop using tobacco, or that all your problems will go away. They may not. In fact, new ones may crop up. But we **can definitely assure you** this: stopping tobacco use will improve your physical and mental health, and leave you better equipped to deal with them!

> The key to stress management is to BREAK THE LINK between normal everyday stresses, and gradually learn to deal with them the way a non-tobacco user would.

Some guidelines to help you manage stress:

(1) Attitude is the key – be positive!

(2) **Begin and end your day with prayer and reflection.**

(3) Believe in yourself, that you will get through your hurdles, big or small.

(4) Cultivate a best friend whom you can really trust.

(5) Stay away from negative people who tell you it cannot be done, and **constantly criticize you. Minimize peer influence that is adverse.**

(6) Pursue a hobby – something you have always wanted to do. Take time out for recreation.

(7) Take a healthy balanced diet. Iron **deficiency and other nutritional deficits can disturb sleep, cause** other health problems and lower your vitality.

(8) Exercise regularly.

(9) **Get sufficient sleep.**

(10) Plan your time effectively. This will minimize the stress and

> The world we live in can be a very stressful place, and stress can leave us feeling overwhelmed and helpless. **We can't always control the** circumstances causing stress in our lives, but we can control our response to them.

confusion brought on by last-minute hassles. Don't over-schedule. Keep realistic deadlines and allow an extra hour for everything you do.

(11) Laugh deeply and often. Look for the lighter side of life. Read a humorous book. Exchange jokes with a friend. Watch a funny movie. Remember, laughter is truly the best medicine.

(12) Above all, keep in mind: life may not always be a bed of roses, but tobacco is definitely not the answer!

Positive lifestyle changes

Suggested clinician script: In general, maintain a healthy lifestyle and good nutrition, do adequate exercise, keep an optimum balance between work and relaxation, develop new friendships and networks with non-tobacco using friends, and engage yourself in activities that do not involve tobacco use. Normal joys in life come from good food, exercise, sports and so on. Now you need to slowly re-learn to enjoy these joys just like people who don't use tobacco. Let abstinence from tobacco become a way of life. Think like a non-user. Don't think of yourself as a smoker/tobacco-user trying to quit. Rather, think of yourself as a non-tobacco user, and soon you will be one!

Weight gain as a special concern:

For some patients, this is a real issue, so do not deny that weight gain is likely and do not dismiss patients' concerns about it. For now, recommend that patients focus on smoking cessation efforts and avoid intensive weight control measures until they feel confident about maintaining abstinence. Suggest some general measures such as eating plenty of fruits and vegetables, and limiting foods with fat content. Also tell them that walking is a great way to be physically active, which would help control weight.

They might consider doing exercises, which are great stress-busters, besides increasing their chances of staying away from tobacco. For example, they might set a goal of 30 minutes of physical activity for five or more times a week. Reassure the patient that as long as his/her eating habits haven't changed drastically, weight gained when he/she quits will come down as the body adjusts. So there is no need to worry about the 2–3 kgs he/she might gain when trying to quit smoking!

Dealing with boredom:

The substantial lifestyle changes needed to abstain from tobacco require that individuals make productive use of their time. They should be informed that they need to plan and schedule events and activities, so that they have little

idle, high-risk time available. As part of the treatment, help individuals draw up time schedules, both on a day-to-day basis as well as for the long term, including a list of activities they want to accomplish.

One of the best ways of making productive use of time is to be engaged in satisfying employment. Encourage individuals to be involved in some productive work without worrying too much about monetary gain. The important issue here is that they should develop the work habit so that they are able to keep thoughts about addiction at bay.

Some patients get overwhelmed with the number of changes and amount of effort required to ensure that they stay away from tobacco. Reassure them that this will not be for long. Tell them that with the passage of time they will find that they need to place lesser and lesser effort into maintaining these changes, and that they will soon be able to enjoy life as other non-smokers without having to worry about craving or tobacco-use triggers all the time!

Before closing, we would like to say that not all the tobacco cessation strategies we have described here might be useful for all patients. However, please try them as relevant to your setting, and to the patients who seek treatment in your setting. Above all, remember your patients come to you from all walks of life – rich/poor, young/old, rural/urban, educated/illiterate. Whatever their differences, all have one thing in common: they come to you in states of disease and disability of varying degrees. And sickness and suffering certainly do make people more amenable to advice, especially when it comes from a health professional – that is, you. It is true that a minority of individuals dependent on tobacco are able to stop magically – that is, they are able to quit on their own. Such individuals don't need our help! It's the ones who cannot do it by themselves that do! Quitting does not happen in one step, but remember: you, as a health professional, can make a difference, EVERY step along the way.

Key messages

- Ask every patient you see, in any setting you may be working in, about tobacco use.
- Do not miss any opportunity to provide at least brief intervention.
- Help patients resolve their uncertainties about changing, and tip the balance so as to favour a decision to quit.
- Work with patients willing to quit using various tobacco cessation strategies as appropriate.

Chapter 3

How important is follow-up in tobacco cessation intervention?

Objectives

(1) To detail some points to be reviewed at follow-up.

(2) Outline some barriers to follow-up and how they can be overcome.

Follow-up is a continuing care approach to treatment. Systematic follow-up is extremely valuable in maintaining the improvement achieved for a longer period of time. As discussed earlier, patients run a high risk of returning to tobacco use following cessation due to craving, severe withdrawal, and because of numerous other triggers.

Therefore, good treatment requires longer periods of continued contact with patients to address many issues, including fluctuating degrees of motivation, poor compliance with medication or prescribed lifestyle changes, and other problems that can arise over time.

A. When should you follow-up?

- During the initial month when the patient has **first quit, we recommend that you see the** patient once in two weeks, or even once every week if feasible. Thereafter, arrange to see him **at least once a month for the first six months.**

Have the patient maintain a follow-up card and note these dates regularly.

- Make weekly/mid-month phone calls, depending on the date of next follow-up. For example, if the patient is going to come to the clinic two weeks from now, make this call after a week, or if his next visit is after a month, make this call two weeks from now. Use this call to **track his progress and offer support as required. You will actually find that you will be increasing patients' determination and commitment** towards abstinence when you stay in touch this way!

However, give the patient and his family these standing instructions:

"If your urge becomes unbearable, or if you happen to smoke, or in the event of any other situation you feel you cannot handle on your own, CALL US IMMEDIATELY AND COME OVER!"

Till today, follow-up care remains the cornerstone of treatment for any addiction. It is our experience, and of scores of other treating professionals, that follow-up contacts are of equal (if not more) value as the initial intervention itself, in achieving positive outcomes. In the following section, we **shall see briefly what you need to look for during these follow-up sessions.**

B. What to review at follow-up?

(1) *Current status:* Ask the patient at every follow-up visit for tobacco use and document this status clearly in the clinical record, along with any other relevant clinical information, for example, vital signs. **Accordingly, the patient's status would be: no change/reduced use/** stopped use/lapsed/relapsed/lost to follow-up.

Points for review at follow-up

High-risk situations faced since last visit and ways in which they were dealt with; in case of lapse, engage in problem-solving to prevent future occurrences	☑
Compliance with medication prescribed	☑
Predominant mood state/thoughts and feelings	☑
Biological functions: appetite, sleep, any physical complaints	☑
Time management, job functioning	☑
Any continuing stress sources: family, social, occupational, financial	☑
Reinforcement for all positive changes made	☑

If the patient has been abstinent:

- Congratulate the patient on efforts made at staying abstinent.
- Discuss the Recovery Calendar, and engage in a detailed discussion on: high-risk situations faced since last visit, and ways in which they were dealt; consequences of his/her successful dealing with the triggers (e.g. felt good about himself/herself, interpersonal relationships improved, etc). Please remember: reviewing the Recovery Calendar is a very important part of follow-up sessions.

If a lapse had occurred:

- Help the patient understand the situation in which the lapse occurred. Helpful questions include: Where and when did it occur? What was he/she thinking and feeling? What were his/her expectations about what tobacco use would do for him/her? What will happen if he/she continued to use?
- **Following identification of the high-risk situations and consequences,** the patient should be next engaged in problem-solving: What can he/she do between now and the next visit so that lapses do not recur? What did he/she do in the days he/she did not use tobacco that kept him/her from lapsing? Which of the coping strategies that he/she had been practising may be especially useful?
- Also check if the person has followed through with the plans made during the treatment phase. For instance, if the initial plan was that the person should get in touch with you directly if a lapse occurred, ask: "Last time we made a plan that you will call us if this happens, **why didn't you do it?"**

Reformulate the plan in the light of all these, if required. As you will see, good follow-up will ensure that patients come back to you sooner even if they do use tobacco. Thus you will be reducing the greater damage that can occur if the patient continues to smoke/chew and comes to you months later with a full-blown relapse, or worse still, never comes back.

(2) *Compliance* with any medication prescribed: Non-compliance with medication can occur due to a variety of reasons: belief that one does not need the medication; that one is substituting one addiction for another (in the case of NRT); the side-effects of medication; cost and availability of the medication.

Medication needs to be taken long enough for it to work (with medications such as bupropion and varenicline, quitting smoking is advised two weeks after starting the medicine). NRTs prevent exposure of the individual to the many toxins present in smoking and smokeless tobacco. Common side-

effects of medication are usually temporary and the patient needs to be reassured that the side-effects from continued tobacco use far outweigh the side-effects of medication.

However, patients on medication must be cautioned about the side-effects with each medication, particularly neuropsychiatric side-effects like agitation and suicidal thoughts, before starting on the medication. They should be told about each side-effect and how to deal with it. Patients who develop serious neuropsychiatric side-effects must immediately stop the medication and get medical help.

(3) *Predominant mood state/thoughts and feelings:* emptiness, sense of loss, grief, restlessness, boredom, anger, frustration, depression, etc.

(4) *Biological functions*: appetite, sleep, any physical complaints.

(5) *Time management, job functioning.*

(6) *Any continuing stress factors:* family, social, occupational, financial.

(7) Provide reinforcement for all positive changes made.

Group networking for follow-up

One strategy that can be tried is to build a network among patients and arrange group follow-up sessions with them. For example, patients belonging to a particular geographical location can be encouraged to form a group and meet the health professional on a specified date for the follow-up. Group discussions on the Recovery Calendar, as each member (accompanied by a family member, if possible) relates his/her experiences in dealing with various triggers, can be invaluable in preventing lapses and relapses among the group members.

One of the members can take the responsibility to make notes during the meetings for discussion in future gatherings. Members can also be encouraged to stay in touch with each other during the intervening period before the next follow-up date and provide support as may be required, for example, bringing a group member who has resumed tobacco use to the health professional at the earliest.

C. Barriers to follow-up

As a nurse/health worker with countless other duties, you are extremely busy!

We agree that follow-up is a taxing process and would make great demands on your time and energy, because you have plenty of other duties to attend to. But try! *Don't* let time constrain you! Maintain a register with **details of patients' follow-up dates, so you know when the patients are due** for follow-up, and if they were compliant with these appointments. Then spend some time following up with these patients, including calling up those who do not come. Consider: what does it help if the time you already spent with the patient, or the gains you achieved with the initial intervention, are **not sustained? So call, it'll be worth your time and effort.**

Patient is non-responsive, forgets appointments, does not attend follow-up

Take care to make repeated calls to those patients who are not compliant with their follow-up appointments. Drop a reminder postcard, or send an email if the patient has access. Make home visits to track patients who do not respond to any of these.

Patient is too far away, and cannot come regularly for follow-up

This is all the more reason for you to maintain contact through the telephone or letters! Fix appointments further apart if the patient cannot come frequently, and maintain contact through the telephone during the intervening period. **During the first contact, tell the patient that you or your colleague will be** making a weekly/mid-month telephone call to ask how he/she is doing.

Although this mode of contact may not give you as much information as face-to-face contact would, in many cases it will prove to be the most convenient way of keeping in touch with your patients for prolonged periods of time. Additionally, it will also ensure that patients keep coming back to you, even if less frequently. We have also found patients themselves calling us back several times, and even reminding us that they were coming on this particular date for their follow-up!

Patient comes, but health professionals are too busy and preoccupied or even lethargic

This is the biggest barrier of all, and perhaps the most insurmountable ever! Patients will come back for follow-up if they have something to come back **for! Many a time, due to heavy workload, lack of sufficient personnel on a shift, and other practical constraints, it might make it difficult for you to pay** enough attention to your patient when he comes for follow-up. But in fact, good follow-up does not really mean you need to spend an hour with your

patient! Even if 10 minutes is all you can afford, make sure you enquire into his/her triggers and look at the Recovery Calendar. Ask how life is like without tobacco in the picture.

Also, please remember that when a follow-up appointment is made and health professionals are preoccupied when the patient comes, making some hurried notes in the case file in response to the patient's answers and sending him/her away saying "come again next month" will actually nullify all that we have built so far. More than anything else, a sympathetic approach towards patients is important, like in any other area of medicine/nursing, and the development of trust is central to the treatment of not just tobacco but any substance dependence.

We would like to close this chapter with the words of Miller (1989): *"Follow-up takes time and involves some complex problems and issues. Nevertheless it is, I believe, one of the very best investments on staff time. Can't afford to do follow-up? The truth is that we can't afford not to include follow-up in our regular practice. The cost to our clients and to our own learning – of working without reliable feedback, is just too high."*

Key messages

- Follow-up is the mainstay in the treatment of tobacco use problems.
- Arrange to see the patient weekly/once in two weeks/monthly, depending on the proximity of date of quitting, motivational levels, number of triggers, presence of social support, as well as distance from the treatment setting.
- Telephone support is extremely valuable to sustain treatment gains, especially when frequent face-to-face contact is not feasible.
- Follow-up with your patients, come what may! You'll find it's the best investment of time and effort you ever made!

Chapter 4

How can we address the challenge of relapse?

Objectives

(1) To highlight the role of the health professional in preventing relapse following tobacco cessation.

(2) To outline some common problems encountered and suggest ways to overcome them.

Tobacco dependence is a chronic, relapsing condition. By relapse we mean returning to a continued pattern of substance use (tobacco, in this case) after the individual has been abstinent for a while. Recovery from tobacco dependence requires a drastic change in lifestyle, values, social circles, thinking and feeling patterns. Smokers often go through a grief reaction that includes denial, anger, bargaining, sadness, and finally, acceptance. However, the risk of relapse under stressful circumstances remains for a lifetime.

What causes a person to relapse?

When an individual abstains from tobacco, he/she is faced with several problems. To start with, there are distressing withdrawal effects. Medical treatment helps to reduce these effects. There are other difficulties that include coping with stresses at home and work, however

minor they may be. Such difficulties keep driving the person back to tobacco. However, the ex-tobacco user should be helped to realize that these difficulties are temporary, and that returning to tobacco would only serve to aggravate and not solve them.

Three distinct stages indicating the onset of a relapse (warning signs of relapse)

(1) *There is a change at the thinking level.* The recovered person gets back to old thought patterns; for example, starts thinking constantly about smoking, and if it's possible to just take "one puff".

(2) *There are changes in behaviour and lifestyle.* The person starts relating again to the set of people, places and activities which centre around tobacco use. These include meeting with tobacco using friends; a sense of overconfidence that relapse will never occur, and testing personal control by being with tobacco users with the belief that one will never succumb.

(3) *There can be a return to tobacco use.* The previously stated changes will definitely lead the person back to tobacco use.

Since relapse occurs in these stages, it is possible to recognize and arrest the process at any stage. The key point here is: relapse is preventable if identified and treated early.

For the user who has recently quit: Preventing relapse

On account of the chronic relapsing nature of tobacco dependence, you need to provide brief and effective relapse prevention treatment for recent quitters. This includes reinforcing the patient's decision to quit, reviewing

the benefits of quitting, and assisting the person in resolving any residual problems arising after quitting. These interventions can be delivered by means of either scheduled clinic visits, telephone calls, or at any time you encounter the individual.

Although most relapses occur early in the quitting process, some relapses occur months or even years after the quit date. Therefore, it is important to engage in relapse prevention interventions even with former tobacco users who no longer consider themselves actively engaged in the quitting process. Thus, as part of your follow-up, it is important to have a systematic mechanism to identify recent quitters and contact them to deliver relapse prevention messages effectively.

What if the patient does use tobacco after the Quit Date?

This is a possibility you should consider. The patient must be helped to realize that relapse following treatment is quite common, predictable and preventable. It may not be possible to succeed the very first time, and it is common to have some setbacks. One try may not do it, it may take two, or even five. But each try brings the person closer to getting free.

It is extremely important for the health professional to help the person to identify the trigger that caused relapse, and find ways of dealing with it effectively. Drawing parallels between medical illnesses and fighting tobacco dependence also helps. You may tell the ex-user that just as people with chronic medical diseases such as diabetes or hypertension must adjust their lifestyles and assume responsibility for managing their own care on a daily basis, so should individuals who have once been dependent on tobacco.

On the other hand, if individuals recovering from tobacco dependence continue to believe that any return to tobacco use means it is hopeless, then they are defeated even before they get started. The fear of failure keeps them from trying again. Relapse just means the individual needs to seek help immediately, and start again.

When patients slip, it is usually within the first few weeks or months after quitting, when resisting the urge to use tobacco can be especially challenging.

First of all, help the patient to distinguish between "lapse" and "relapse". "Lapse" can be viewed as a shortcoming or just a "slip", and hence an opportunity for prompt treatment and further learning. On the other hand, "relapse" is a pattern of regular use after a period of abstinence.

Next, if the patient lapses, here are some strategies that can help you get the patient back on track:

(1) *Realize you slipped*

Acknowledge you slipped, and that you have had a small setback. That does not make you a tobacco dependent again. Feel good about all the time you went without using. Focus on strengthening your coping skills, and do not be too hard on yourself. But then, do not be too easy on yourself either. It is important to get back on the non-tobacco track right away. Here is how you can do that:

(2) *Understand why you slipped*

Find the trigger. Exactly what was it that made you smoke/use tobacco? On the day you lapsed, what exactly happened? What warning signs did you have – for example, were you feeling angry, irritable, stressed?

(3) *Learn from your experience*

What has helped you the most to keep from using tobacco? Make sure you do that on your next try. Visit us immediately for help. Or talk to your family or friends. Follow through with the plan you made with us when you initially underwent treatment.

(4) *Do not stop medication*

If you have been prescribed medication, do not assume it is not working and stop. Stay with it, and it will help you get back on track. Seek help immediately.

Should the patient be alerted to the possibility of lapse/ relapse as part of the initial treatment?

This is a question that treating professionals sometimes ask. Should we or **should we not mention the risk of relapse when you first implement tobacco** cessation strategies? We have also encountered family members telling us, "no, please do not say that, he will think it is okay to smoke again." But the fact is, lapses (and relapses as well) are almost inevitable, and we know that they are bound to occur in a majority of cases. We, therefore, recommend that if **this is the patient's first quit attempt ever, then you just slip in this information** about a lapse without laying too much emphasis on this possibility.

Otherwise, first-time quitters are usually enthusiastic and serious about their quit attempt, and can get totally disillusioned and lose all hope when a lapse happens. We have had several of our alcohol-dependent patients saying,

"we couldn't show our face to you any more", upon being brought back by family members with a full-blown relapse several months later. The same can be the case with tobacco users. So you need to mention it, although you also need to ensure the patient doesn't become complacent or take home the message that it is okay to have a smoke or two after the quit date!

On the other hand, patients who have had multiple relapses would need more focused relapse prevention strategies, with active identification of triggers and reformulation of the plans that were made during the initial intervention.

Some common problems encountered in practice

Patient's sagging motivation

Patients' motivation levels can fluctuate. It is even possible for patients to start reconsidering their decision to quit, as their initial enthusiasm wears off and they face the discomfort of acute withdrawals and craving. This further emphasizes the need for continued follow-up! Go over his reasons for quitting, potential benefits of quitting, and the change plan. Provide reassurance and continue to encourage the patient as required. As the weeks go by and the urges diminishes, the person's outlook will improve and gradually change to that of a non-user. Above all, help him/her realize that cessation leads to comfort, and not suffering. It is not withdrawals all the time!

In fact, when individuals are in the habit of regular tobacco use they are always "on the edge", i.e. constantly fighting off a feeling of discomfort or an urge for another smoke/chew. This actually spoils the fun many times, as they are unable to enjoy happy occasions without nicotine. For example, they cannot stay at a gathering with friends for a long time because they are always anxious and irritable and trying to escape for a few minutes to have a quick smoke or pop a packet! And even when they get to use tobacco, it keeps off the discomfort only for a short time and soon they are again left craving for another! So cessation is actually an experience of great relief and freedom once they get through the initial weeks of quitting.

Feeling hopeless and experiencing extreme loss of control following lapse

This is a common problem health professionals have to deal with. Tell the patient: "Do not be discouraged if you slip. It is not a lost cause. One cigarette is better than an emptied pack. But that does not mean you can safely use tobacco now and then ever. One smoke or packet may seem harmless, but it can quickly lead you back to your old habits. How you interpret a slip is

important. You can use the slip as an excuse to go back to using tobacco, or you can look at what went wrong and renew your commitment to stay off tobacco for good. So learn from it, and get back in control. There's no such thing as too late!"

A point needs special mention here. Patients commonly tend to look at abstinence as an "all-or-none phenomenon". That is, either they stay totally abstinent, or give in to total despair if they smoke once, feeling they have blown it. So they think they might as well smoke the rest of the pack or go back to their previous state. No! Tell your patients to concentrate on getting through each hour, each day, without using tobacco. Tell them to take things ONE DAY AT A TIME.

Above all, tell them: "It takes time, and the road may be tough. But be patient and persevere. With time you will find that things are taking a turn for the better. Remember, no cigarette is worth your health, or the health of the people around you!"

Your patient keeps coming back with multiple relapses

Find out what the person's expectations from you are. How can you help him/her better? And how can the person help himself/herself? Ask the person to think it over and let you know in a day or two. Again, make sure he *comes* back in a day or two. Don't put him off!

You are discouraged!

Relapse is a cause of burnout among health professionals dealing with patients dependent on tobacco or other substances. It is a human tendency to expect some results from your intervention. And it is difficult to go through the whole intervention again with the next patient when the previous patient has already started using substances soon after the consultation. But do not get discouraged! Keep up *your* mental health! Refer to the stress management skills listed before! Remember, any intervention is better than none. And your efforts will definitely have some benefit somewhere along the way, even if you never come to know.

So do not let any dislike for the relapsing individual or belief that nothing will work for those who relapse (therapeutic nihilism) creep in! If you are able to postpone a patient's lung cancer for some more time, if you are able to delay chronic obstructive pulmonary disease by a few more years, if you are able to help just one patient or one family, then that is a good start. Change your perception of what you mean by treatment success. Just do your best, that is the principle! If you have done this, then you have already succeeded! Do not worry about lack of resources or time. Fact is, we are in a helping profession and that's what we can do best ... help.

Key messages

- Relapse following treatment for tobacco dependence is very common.
- Lapse is a "slip", and therefore an opportunity for further learning. Relapse, on the other hand, is a pattern of continued tobacco use following a period of cessation.
- The quicker the patient returns to you following a lapse, the lesser are the chances of going on to have a full-blown relapse.
- Ensure regular follow-up, continue to address triggers, and give the patient an opportunity to discuss life after stopping tobacco as well as any difficulties faced. All this helps to decrease the likelihood of relapse.

Chapter 5

What is our role in preventing tobacco use in the community?

Objective

To provide an account of some strategies that can be implemented at the community level for tobacco cessation and control.

Tobacco dependence has a vast potential for prevention[50] and you, as a health professional, have a prominent role to play in this regard. In the previous chapters, we have seen this role predominantly in a hospital setting. Working for the broader community is an extension of your hospital-based role in tobacco cessation. In fact, in order for tobacco cessation activities to be maximally effective, action at the community level is mandatory.

Specific anti-tobacco programmes initiated and implemented at the community level would vary, depending on the setting and the population towards which they are directed. However, it is critical that such programmes are socially and culturally acceptable, and are developed based on the distinct cultural profiles of targeted population groups.

Some general actions at the community level are outlined below:

Hospital outreach

- For effective community action it is essential for you to know about the population you wish to target, which entails conducting a detailed community survey on the patterns of tobacco consumption, attitudes towards tobacco use, and social environment (daily life activities, use of leisure time, occupations, housing, education and network of social contacts). This would give you an understanding of what can be some really important sociocultural determinants of the community's tobacco use, which is absolutely necessary for achieving optimal results.
- One way to accomplish community-level action would be to capitalize on the manpower resources available to you at the primary health centre (PHC) to branch out into the community. This manpower can include fellow health workers, midwives or their equivalents in other countries, social workers, health inspectors, and other contingency staff working in the PHC.

  You may start by getting to know about your staff's tobacco habits, if any; their attitudes towards tobacco use; knowledge about health risks involved; and the like. Staff who help with the deliveries you conduct at the PHC may be tobacco chewers themselves, for example. Once such staff are helped, they can be used to identify other tobacco chewers in the community and initiate a dialogue with them.

  Currently in India, under the National Rural Health Mission there are Accredited Social Health Assistants or ASHAs, and other countries in the Region are likely to have equivalents. Capitalize on such staff to identify prospective community leaders who can support your anti-tobacco efforts. Developing such contacts can be invaluable in building an effective anti-tobacco movement in the community.
- Conduct home visits at regular intervals in order to obtain first-hand information about response to treatment, psychosocial environment of the family, stress factors for relapse, etc. This is a very effective way of advocating for tobacco cessation through early case-finding and providing anti-tobacco messages during the visits.
- Invite local practitioners in the village, such as physicians, gynaecologists, paediatricians and dentists, for a brief meeting at the PHC. This meeting may be used to sensitize them about identifying potential tobacco use by their patients and slipping in anti-tobacco messages at the suitable opportunity. For example, a local dentist can always enquire about oral tobacco use and provide health education as relevant to his patients.

- Organize specific hospital outreach programmes at local youth clubs, educational institutions and recreational facilities to inform the public about the dangers of tobacco use. Such a programme on signs of tobacco-related cancer conducted through a large cancer hospital in India over several years, approximately doubled the out-patient attendance for oral examination and early detection of pre-cancerous lesions. Ever since, it has been attracting users of tobacco (both smoking and smokeless) to its cessation programme.
- With active public support, organize campaigns to establish smoke- and tobacco-free schools, restaurants, offices, shops, and recreational facility premises. In fact, workplaces offer a wonderful opportunity where both tobacco prevention and cessation activities can be undertaken. Hold brief focused programmes in settings like the local post office, bank, a school/college, an insurance office, etc. In rural areas such meetings can be held in schools, village headman's meeting places, fairs and weekly markets.

  The overall aim of such interventions would be to enhance awareness about the dangers of tobacco and banning smoking within the work premises, and informing users about the support available at the hospital to assist with tobacco use problems. You may also provide a supply of posters conveying anti-tobacco messages which can be put up in public places, for example. Such measures would benefit the employees as well as the customers they serve.
- Advocate for bans on smoking in all workplaces and public spaces. For smoking bans to succeed, enthusiastic endorsement by and active participation of the community and an awareness of the health consequences of exposure to second-hand smoke are needed.
- A problem arising from oral tobacco use is spitting, which is an important public health hazard. Oral tobacco users have to spit and they do so in public, increasing the spread of communicable diseases. Tuberculosis is one of them, and is already a problem in the SEA Region. Organize campaigns on promoting a clean environment. Obtain the support of local leaders and have notices put up saying that public spitting is prohibited. The notice can say, for example (suitably modified to suit local circumstances): *"Do not spit here. Spitting causes the spread of diseases such as tuberculosis. Tobacco chewers often spit. If you are a chewer, then you are endangering public safety. You are also placing yourself at health risks including mouth cancer, because of your tobacco habit. Stop tobacco use. Promote health, life, and a clean environment for all."*

- Have the dangers of tobacco use broadcast on in local television channels. Several villages and towns have channels which cater to more localized populations, which can be effectively made use of to disseminate such information. Explore ways of speaking through such channels and personally communicating the anti-tobacco message to the public.

  In fact, availability of the television is widespread even in **rural homes, and is thus an effective way of influencing** public opinion. Also, write articles in local newspapers and magazines that are published periodically. In all countries of the Region, there are several magazines in local languages which are hugely popular; the stories that are published in these magazines, usually serialized, together with information on cooking, home management, clothing, etc. are a good source of entertainment, especially for women. In fact, you can reach out to many female smokeless tobacco users this way!

- Explore the possibility of launching a 24-hour helpline with professionals specially trained in providing tobacco cessation advice, working in shifts on a part-time basis. In collaboration with an NGO you might be able obtain the help of psychologists, social workers and other personnel who can provide this service. Helplines have been shown to be cost-effective strategies in many parts of the world.[57]

- Implementing many of these strategies requires not only community involvement but also support from local regulatory bodies. Today, many villages are becoming highly self-reliant, with their own **elected local leaders. These leaders exert a lot of influence at** the local level, and are able to facilitate community consensus on **issues identified as important for the people. These decisions are** vital for formulating local rules and setting community norms. Thus, obtaining the cooperation of these local leaders is an essential component for the success of any anti-tobacco programme.

A small group community intervention

Additionally, developing **partnerships with women's and** youth associations; the media; schools; government programmes for rural development, women and child development, and tribal welfare; nongovernmental organisations (NGOs); police; and

district commissioners is vital to deal with tobacco-related problems in the community and to achieve extensive coverage of the anti-tobacco movement at the grassroots level. Intersectoral collaboration should be a constant process to sustain tobacco cessation efforts, involving regular meetings, interactions and task assignments in close contact with local leaders and community representatives.

Home-based intervention for tobacco cessation: Evidence from India

The effectiveness of home-based interventions was demonstrated in a joint tobacco cessation programme conducted by two NGOs from India – NOTE-India, actively involved in the prevention of tobacco-related cancers, and Lifeline Foundation, working for AIDS control.[58] The project was carried out in rural Goa, India, from June 2003 to August 2004. Four medico-social workers (MSWs) trained in tobacco cessation identified 1027 tobacco users (850 men and 177 women) in the village.

Home visits were made by the MSWs weekly in the first month, once in two weeks in the second month, once a month during the third and fourth months, and then at intervals of two months up to the 12th month. At each meeting, behavioural counselling for tobacco cessation was imparted, and a record of current tobacco use was made. By August 2004, 507 out of the 850 men (60%), and 118 out of the 177 women (67%) had quit tobacco. Overall, quit rates were 31% within four months, and 49% within eight months, and reached about 61% by 12 months. By the end of the project, all those who had quit had been abstinent for at least the past two months and had not re-started using tobacco.

Community tobacco cessation programme: Evidence from Bangladesh

Ekhlaspur Centre of Health (ECOH), an NGO in Bangladesh, started a tobacco cessation programme among women through community and clinic-based activities in 2001 with WHO support. It carried out an evaluation of a tobacco cessation intervention carried out by community health workers in 2006.[59] A follow-up of tobacco use status was carried out every six months and further counselling provided. A further follow-up was carried out after 18 months. Of the 184 tobacco users, 25% had quit tobacco after 18 months. This project demonstrated that a tobacco cessation programme can be delivered by trained health workers at the grassroots levels.

Tobacco Quit Lines

In a few countries including the USA, UK and Australia, dedicated Quit Lines exist that offer free help to individuals who wish to quit tobacco. Trained professionals help callers make a quit plan, provide encouragement, and send individualized Quit Guides as supplemental information. Services also include helping individuals get started on quitting even when they are not quite ready to do so (motivating), and providing telephone support to those who have already quit.

In developing countries, although resource and time constraints may sometimes make it impractical to implement, telephone-based counselling can be effectively employed as an alternative to, or supplement, hospital-based treatment.[60] The wide use of mobile phones makes this a practical strategy.

Such Quit Lines can reduce the stigma associated with seeking hospital services, as well as save time for those who cannot afford to make hospital visits for treatment sessions. They also provide timely help to those who have quit, but may be struggling to cope with withdrawals and craving that is common during the early post-quitting period. Finally, evaluating the effectiveness of such telephone-based services in our settings is an exciting topic for researchers seeking to explore what works best for promoting tobacco cessation.[57]

Vulnerable groups that require special attention

Women

Frequently tobacco interventions address mainly men who are smokers. It is important that cessation activities also address tobacco chewers, both men and women, as well as women smokers. When women come to the primary care centre seeking health advice for themselves or their children, use this opportunity to enquire about their tobacco use, for example, during the first prenatal visit. Integrate tobacco cessation interventions into maternal and child health and routine primary health care.

Due to lack of information many women continue with smokeless tobacco use during pregnancy believing it to be harmless, leading to low birth weight among children born to them.[61] Families with pregnant women need to be counselled and educated that both smokeless tobacco use as well as smoking are detrimental for the health of babies *in utero*. Husbands of pregnant women who accompany them need to be reminded to stop smoking to avoid harm to the fetus. Put up notices in the PHC in the local language saying: "Protect your child from tobacco!" with appropriate pictures to illustrate your point. Encourage private doctors, especially paediatricians and obstetricians, to follow this practice as well.

Conduct workshops at local women's associations, child-care centres and other suitable venues where you can reach women with such messages, including information on stress management, raising self-esteem, and all-round personality development.

In addition, address any of the myths and facts (discussed later) as relevant.

Children and youth

Childhood and adolescence, the period when peer influence is at its peak and many habits that usually last for a good part of one's lifetime are initiated, are the years targeted by tobacco companies. Various channels such as film, television and billboard advertisements are being employed for this. Therefore, the youth should also be the target for the health industry, though for an entirely different purpose. Despite the impact of movies and television or any other adverse influences, health workers can still exert the GREATEST positive influence in children's lives!

> Children are the main target of the tobacco industry to get more and more users for their business. But remember: despite such influences, you, as a health professional, can still exert the GREATEST degree of influence in children's lives!

It takes time to achieve tobacco control through strong legislation and other measures as suggested by the WHO MPOWER policy package.[22] But meanwhile you, as a health professional, can empower children through education – directed towards both the children as well as their parents. Utilize the education system to spread information, shape attitudes and strengthen skills as relevant to tobacco control. Use schools and colleges for primary prevention as well as early for case-finding and active cessation efforts among those who have already initiated the habit.

WHO MPOWER Policy for Tobacco Control [22]

Monitor tobacco use and prevention policies.

Protect people from tobacco smoke.

Offer help to quit tobacco use.

Warn about the dangers of tobacco.

Enforce bans on tobacco, advertising, promotion and sponsorship.

Raise taxes on tobacco.

Identifying the social influences that are promoting tobacco use among youth in the community (such as adverse peer influences,

parental smoking, effect of mass media), educating about health hazards associated with tobacco use, teaching tobacco refusal skills, and training in life skills including stress are some of the components that can be included in such programmes directed towards children and youth. Actively lobby with the education system at the state and national levels for inclusion of tobacco-related information into the regular curriculum. This can be a very effective measure.

Parents

Teach parents to raise children to respect themselves for who they are and support activities that raise their self-esteem and sense of belonging. This will make them less susceptible to peer pressure. Parents must also support their independence in age appropriate ways so that children will not have to use smoking as a means of asserting their autonomy. Let parents know that it is important to tell children the truth! Tell them not to get deceived or confused by movies or any other strategies employed by the tobacco industry. Instead, encourage parents to talk to their children directly about the risks of tobacco use, keep lines of communication open and help them develop a variety of ways to cope with stress.

In addition, tell parents to seek professional help immediately if there is any problem they feel they cannot cope with in their children, before it becomes chronic and less amenable to change. Use all opportunities you get to interact with parents, for example, at the treatment centre, a school awareness programme, or a public anti-tobacco campaign to sensitize them to these issues.

Emphasis should also be laid on the educators, i.e. the teachers, for effective prevention of tobacco use. The Global School Personnel Survey 2008, revealed that three in ten male school teachers smoked and two in ten used smokeless tobacco products, 40% of teachers did not have access to teaching and learning materials on tobacco control, and only 16% of teachers surveyed had received training on tobacco control.[62] Therefore, teachers, who **have a major role to play in children's lives during their growing years, need** to be helped to overcome their own problems, if any, of tobacco use and also trained to impart anti-tobacco education to children in schools. They can thus become important role models to guide and shape values and behaviours.

Working through groups

- The community as a whole will provide you with the required resources for an effective mass tobacco cessation programme, provided larger sections can be reached and mobilized into action. One very practical

way to achieve a successful anti-tobacco movement in the community is to base all your efforts on identifying groups within the community, and channelize interventions through these groups. Members of these groups should be actively engaged in planning the implementation of all key components of the anti-tobacco movement, and should be encouraged to assume a leadership role in conducting the activities.

- Next, enhance community participation through meetings with the identified groups. Some of these groups can be a group of students from a local educational institution, women who meet at local women's meets, a group of young women who come for antenatal checkups at your clinic, groups of families, and more important, groups of former tobacco users who might have already been benefited by the hospital programme.

  Within each of the identified groups, single out influential members who can make a major impact on public opinion. These members should be popular, committed, and be able to build upon the capacities of the community in achieving a tobacco-free life for their own welfare and that of their families. An example of such a member can even be a housewife who is able to influence the women in her neighbourhood by virtue of her being able to give expert advice on home remedies for their children's ailments.

- Initial meetings for such groups can focus on the following questions:

  - Who are the tobacco users they know, including their own family members, neighbours and other acquaintances?
  - What do they think are the causes why these individuals smoke? Is it a habit they picked from others, or are there other causes as well?
  - What are the general attitudes that people have about using tobacco? For instance, do they think smoking is attractive? What is their opinion on the advertisements and movies they have seen? What do the youth think, in particular? What are the movies that were featured in the village cinema theatre recently? Can they think of some scenes in them and how they might have affected people's attitudes?
  - What do our women think about their husbands smoking? What do they think about oral tobacco use?
  - What do our men think about smoking? Does it make them feel manly and superior?

- Do the people in general think using tobacco is dangerous, or are they not sure, or they don't really know? How is the community being affected by tobacco use among its members? For example, children and women getting affected by second-hand smoke and parents acting as negative role models for their children? Have they noticed the impact that the cost of tobacco has on the family budget?
- Do we have people within our own community who are influencing others to use tobacco? How are they doing it? For example, do they propagate ideas such as people who don't use tobacco are weaklings, and so on? Are there people among us who are making fun of the dangers of tobacco that would make tobacco users justify or mentally minimize the risk they are taking with their own lives? Is there a tendency to underplay the benefits of quitting and exaggerate its difficulties?

- Set up a system, for example, a regular meeting, to discuss observations and the steps to be taken. But remember: regular meetings do not have to be formal events with an agenda and a special meeting place. In fact, they can be built into peoples' regular day-to-day lives. For instance, one group could be those who wait for a train, another of those who come to the playground to relax, and a third of those who gather at the local women's club.
- Next, ask the group to think of specific measures to be implemented. For example, what can families do to reduce tobacco use in the community? How can our young people be dissuaded from harbouring ideas that promote tobacco use? How can more enlightened members be used to influence those who are less receptive? Can former users help those who are still trying to quit? Remember that former smokers are a wonderful resource to help others do so too, since smokers relate to them better. These are individuals who have struggled with, and conquered the same habit. So they are the best people to dispel pessimism and better empower tobacco users to quit.
- Cancer survivors are also very powerful motivators for tobacco prevention. A peer-counselling approach doubled the chance of childhood cancer survivors to quit smoking.[63,64]
- Evaluate impacts: Discuss with local community leaders and set indicators that can be used for later comparison to evaluate the effectiveness of the community movement. Not only do such indicators foster enthusiasm and increase accountability, they also help to work towards concrete goals and provide overall direction to the programme. Some of these indicators can be: reduction in consumption and sales of tobacco, a visible change in people's attitudes towards tobacco use, and in the long run, a drop in

occurrences of diseases and deaths caused by tobacco use.

- Finally, celebrate achievements and give credit for all positive changes made, big or small! Do not let tobacco users feel everyone has ganged up against them to force them to stop, or condemned them for "bad behaviour". Encourage ex-users to speak at these meets of the benefits they have experienced, including the money they have saved, by quitting. Ask tobacco users to bring this money along so it can be used for some real fun or enjoyable activity. Appreciate them with genuineness, sincerity and realistic praise for their courage. Let the occasion convey to the whole community that it is possible to shake oneself free of such suffocating habits!

Role of health education

- Dissemination of anti-tobacco messages through mass health education using appropriate audiovisual aids is still one of the most effective ways of achieving tobacco cessation.[65] Educational materials that convey anti-tobacco messages (both smoking and smokeless, *and* second-hand smoke) in simple language and attractive, reader-friendly style to command and retain the attention of the public need to be developed.

  These notices should be illustrated with suitable pictures to make your point, and convey the message very clearly and directly without no mincing words! Put up these notices in bus-stands, railway stations, restaurants and other public places where large groups of people are likely to gather. At the same time, include information about the smoking cessation programmes offered at the hospital/primary health centre along with a phone number they can call.

- Use any channel that can be used to enhance this health education, for example, public and private agencies, NGOs and even religious leaders. Tobacco is not an issue of puritanism. Religion does play a major role in our society, and spiritual leaders can have a powerful influence on monitoring public attitudes.

Education campaigns in India

- A most effective strategy for tobacco prevention through aggressive health education campaigns is the involvement of children and young people in anti-tobacco advocacy. Prevention efforts are better led by young people who are most at risk of starting to use tobacco, and using them as change agents is the best way to empower other youth as well as the population at large. Besides, these youth who take part in such campaigns are less likely to use tobacco themselves!

In addition, we have included some myths as well as facts associated with the use of tobacco products, and addressing these is an integral part of any health education campaign.

Myths and facts related to tobacco use

Amazingly enough, awareness of the hazards of smokeless tobacco use is quite low in our population. In fact, here are some myths that still prevail among our people.[66] Not all of them are prevalent among all, and different ones may apply to different segments of the population. Therefore, the settings where these myths need to be addressed would also vary – it may be at the health clinic or hospital, a home, an educational centre, a local youth club, a place for recreation, or any other community institution. We present below some of these myths, and some lines of thought along which you may address them:

Smokeless forms of tobacco are less dangerous

Smokeless forms of tobacco contain around 3000 harmful chemicals which erode into the oral tissues causing deadly damage. So you need to beware of these smokeless tobacco products. Sometimes it is difficult to distinguish between products that contain/do not contain tobacco. Take *gutkha*, for example, which contains areca nut, slaked lime, catechu and condiments, and powdered tobacco. The same mixture without tobacco is called *paan masala*. However, the brand names of paan masala and gutkha are identical and the packaging also nearly identical. These dangerous products sold in small, brightly coloured packets, in fact, hold a special appeal for children. These smokeless forms are in no way less dangerous than smoked tobacco. Be warned: Tobacco, in ANY form or disguise, is DEADLY.

If I smoke, I may be caught, but if I chewed tobacco, no one would know

This is not entirely true. With time, oral tobacco use stains teeth and gums, causing tell-tale marks that often give the user away. Even if these are missed, when your oral cavity starts succumbing to the devastating impact of tobacco, it will definitely not go unnoticed! Stop and think: WHO are you deceiving?

Bidis, kreteks and shisha, etc. are less dangerous

These products are a different form of tobacco, and often do not include the same warning labels, or carry the same taxes and other restrictions slapped on standard cigarettes. This causes people to wrongly assume they are less dangerous. In fact, *bidis* produce three times more carbon monoxide and nicotine and five times more tar than regular cigarettes. Thus, like cigarettes, these products are also deadly. There is no such thing as any type of tobacco being more dangerous or less dangerous than the other. We reiterate again: tobacco, used in any form, is PLAYING WITH FIRE.

Cigarettes specifying a "low tar content", "mild", or labelled "ultra mild", or "light" are less dangerous than regular cigarettes

Beware of tactics used by the tobacco industry that are false, deceptive and misleading. There is NO epidemiological or scientific evidence for any valid estimate of exposure to these substances that can be considered safe. Remember, it is ultimately the tobacco companies that will benefit – at the cost of your lungs, your health, your life.

Tobacco is good for the teeth, and helps in cleansing them

Various tooth powders and tobacco-based pastes are being marketed as toothpastes. Such products are advertised as having antibacterial activity, and being good for the teeth and gums. Often, women are seen using such products to clean their teeth, and tending to hold them in their mouths, as they slowly become addicted to the nicotine content. In fact, manufacturers of tobacco pastes recommend letting the paste linger for a while in the mouth before rinsing it out. This will no doubt enhance the dependence.

The truth: Tobacco does NOT clean your teeth. Used in any form, it erodes your gums and the soft tissues of your oral cavity, cuts into your cheeks, wounds and disfigures. Such chronic abuse finally results in the activity of the tissues changing, and they start multiplying in a bizarre manner. The end result: debilitating oral malignant lesions of various kinds with very low potential for cure.

Tobacco has some medicinal value for curing common discomforts such as toothache, headache and stomach ache

Tobacco causes, and does not cure, any of these.

Smoking helps to have a free movement of the bowels in the morning

Maybe it does, or maybe it does not. This connection between the two is not the issue. The fact is that over many years the act of smoking has gone hand in hand with many day-to-day-activities, and the morning toilet ritual is one of them. Such behaviour patterns become hard to change, and can actually serve to maintain your tobacco habit. Instead, find out from non-smoking people how *they* relieve themselves in the morning without any assistance from tobacco. Or consult a doctor.

Smoking improves sexual performance

Hardly. Smoking damages penile blood vessels, causing impotence. Improved sexual performance is next to impossible, no matter what these tobacco promotion gimmicks convey.

Smoking adds to style, and makes you look manly

Maybe this one came from all those advertisements of film stars sporting cigarettes. But the fact is having your teeth go yellow, suffering bad breath, coughing your lungs out, and eventually leading a sick life will not add to style. And losing erectile function will definitely not contribute to manliness.

Maybe the film star looked manly on the screen with a cigarette. Remember that even if the actor developed some tobacco-use related illness, the impact on him will be entirely different from that on you. He is in a better financial position to get health care, even if at a huge cost. But common people who pick up the habit cannot afford this. And their suffering or death will definitely not make headlines. Unlike the film star's.

Who are our heroes? On one side we have schoolchildren who march the streets on World No Tobacco Day every year holding anti-tobacco slogans. We have individuals who bravely withstand their craving and withdrawals and overcome their tobacco addiction. We have our courageous doctors and surgeons who fight every day to save lives affected by tobacco-related illnesses. On the other hand, we have all those who work to promote tobacco, sometimes even for a living.

Who are the real heroes? It's high time we made a choice.

Modern, upper-class girls smoke; it makes them look young and sexually attractive

Tobacco accelerates the ageing process, causing early wrinkling of the skin and other age-related changes. Smokers often look much older than someone of the same age. Be very sure of what your concept of modernity or fashion is. Smoking is hot, but in a completely different direction, because it will ultimately burn into every system of your body, depriving you of your youth, health, energy and vitality.

Tobacco helps you lose weight, stay slim

Sure it will, by wasting you away! It will damage your taste buds, suppress your appetite, and make you eat less. Then it ravages your body systems, and sooner or later leads you to chronic debilitation. You might then find you got slimmer than you ever bargained for. There are plenty of other ways to stay slim and attractive! Eat right and exercise, for instance. You will then not only stay slim, but also add years of life and health.

Boys/ girls who use tobacco have more friends

Depends on who those friends are. Think how many would be willing to be your friend when you start experiencing the problems from tobacco use. In fact, your habit may keep some non-tobacco using friends from getting too close to you. It is difficult to stay around a person who is lighting up all the time.

Also, the bad odour that usually clings on to smokers' clothes, and hair as well as the clothes and hair of those who move closely with them can put many people off. It is also difficult to step into a smoker's room; the smell of tobacco hits you the moment you do. This can seriously put non-smokers off, especially if they are afraid of the second-hand smoke effect.

Smoking is doing your own thing, and involves "breaking the rules"

Glamourizing smoking as an adult habit, and an act of rebellion and non-conformity, is yet another tobacco promotion strategy. Such ideas appeal highly to the young. But remember, once the habit is initiated it rapidly leads to dependence on a lethal product. You cannot do your own thing then, because tobacco will ENSLAVE you.

The community interventions suggested in this chapter are not new; most of these have been advocated for decades. Nor is the list exhaustive; there are many other innovative ways you can think of, depending on the setting

and the resources available, for the promotion of tobacco-free lifestyles and cultures in the community. Above all, it is important for the community to recognize that the anti-tobacco movement is in their hands, and their active participation is required. It should not be viewed as something initiated by the health professionals as a hospital programme. Because tobacco control is not a health issue alone; it is a social and an economic one as well. In other words, it is an issue concerned with human development.

Key messages

- Effective coverage of tobacco cessation services requires branching out into the community to reach the maximum possible population.
- Some interventions that can be useful for implementation at the community level include hospital outreach programmes, working with groups, and health education using appropriate audiovisual aids, including addressing any prevalent myths concerning the use of tobacco.
- Working in the community requires multisectoral action and active networking, negotiating and liaisoning efforts, and maximum utilization of available resources to achieve optimum results.

Chapter 6

What do we need to know about tobacco control?

Objectives

(1) To summarize tobacco control laws and policies in different countries of the South-East Asia Region.

(2) To suggest some ways in which you, in your role as health professional, can advocate for tobacco control.

The main focus of any tobacco control programme is to bring down the use of tobacco products, reduce their social acceptability, create smoke-free environments, and eventually eradicate tobacco production in any form. The long-term results of such efforts are reflected in the improved health and well-being of the population, and the reduction in poverty and other tobacco-related harm. However, tobacco control raises a gamut of issues requiring concerted action at various levels, including active support of the law, both for the formulation of rules as well as their enforcement.

A major milestone in global tobacco control was the drafting of the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) in response to the globalization of the tobacco epidemic.[67] The World Health Assembly of WHO adopted the Framework

Convention at its Fifty-sixth session on 21 May 2003. It entered into force on 27 February 2005, becoming a binding international law for its first 40 Contracting Parties. Of the 11 Member States in the SEA Region, nine have ratified the Convention (Bangladesh, Bhutan, India, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste). This is the highest proportion of countries from any WHO region to have ratified the Convention. The provisions of the Framework Convention, which set an international minimum standard for tobacco control with provisions on tobacco advertising and sponsorship, tax and price increases, labelling, illicit trade, and second-hand smoke, among others, are binding on these nine countries.

In most countries of the SEA Region, comprehensive legislation for tobacco control exists. In this regard, the WHO Framework Convention played a monumental role in raising people's awareness about tobacco control laws as well as the specific measures to be implemented in individual countries in accordance with national policy. In the SEA Region, Thailand has earned the distinction of being the first country that has successfully implemented national tobacco control measures with significant results. Several other SEA Region countries have also enforced effective policies in recognition of the harmful impact of tobacco use. [68] A brief account is given below:

In 1975 the Government of **India** enacted the Cigarettes (Regulation of Production, Supply and Distribution) Act, which mandated that statutory health warnings be displayed on all packages and advertisements of cigarettes. In April 2003, the Indian Parliament passed the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Bill, 2003, which became an Act on 18 May 2003. Most of the provisions contained in the Framework Convention were incorporated in this national legislation, which is applicable to the whole country and covers all tobacco products. Key provisions of this Act include:

- prohibition on direct and indirect advertisements of tobacco products, with the exception of advertising at the points of sale and on tobacco packs; ban on gifts, prizes, scholarships or sponsorship of sports or other cultural events using the trademark or brand names of tobacco products;
- prohibition of smoking in public places;
- prohibition of sale of tobacco products to persons below the age of 18 years;
- prohibition of the sale of tobacco within a radius of 100 yards of educational institutions;
- legible and conspicuous display of health warnings, including pictorial warnings, on not less than one of the largest panels of the

tobacco package with the text of the warning appearing in the same language(s) as the language(s) used on it; and

- indication of the tar and nicotine contents of the tobacco products on the package.

Some of the provisions of the national legislation, namely the ban on public smoking, sale to minors and advertising were enforced from 1 May 2004. Rules regarding the remaining provisions, namely packaging and labelling, regulation of tar and nicotine contents of tobacco products, and ban on sale of tobacco products near educational institutions are also now in place, with the state governments directed to strictly implement them. During 2004–2005, the role of the National Tobacco Control Cell (NTC), located in the Ministry of **Health and Family Welfare, New Delhi, was intensified and continued support** was extended to existing tobacco cessation clinics in the country. Active effort was also made for capacity-building among NGOs.

Other areas of focus included creating greater awareness among the people, including those in rural areas, about the ill effects of tobacco use and related health messages. A National Tobacco Programme has been initiated, which includes various components such as setting up state tobacco control cells, organizing district-level tobacco control initiatives, setting up tobacco cessation clinics and school programmes, setting up laboratories to determine tar and nicotine content, etc. Under the 2007 Five Year Plan, additional cessation centres have been proposed in 450 districts.

In **Bangladesh,** through an Executive Order issued in 1988, restrictions were imposed on advertising tobacco in the government mass media, including radio and television. Through the same Executive Order, the government prohibited smoking at the Presidential House, hospital premises and on **all domestic flights of the national airliner. The Tobacco Control Act 2005** brought about several changes: the end of virtually all TV and newspaper advertisements and advertisements on most billboards and eventually signboards, greatly reduced levels of smoking in public places, and enhanced cigarette warnings.

The *Bangladesh Anti-Tobacco Alliance* (BATA) comprising 15 member organizations is playing an active role in tobacco control. One of its members, Work for a Better Bangladesh, in association with PATH Canada, conducted several studies on tobacco in Bangladesh. Nongovernmental organizations such as the Ekhlaspur Centre of Health, Dhaka Ahsania Mission, and Bangladesh Integrated Community Development (Rajshahi) have been involved in tobacco cessation activities.

In **Bhutan,** there is a complete ban on tobacco advertisement, promotion and sponsorship. Other measures include raising taxes on tobacco, issuing of an Executive Order declaring tobacco-free spaces on flights, on all public transport, and in government institutions. Tobacco advertising through all media channels is banned, and 18 of the 20 districts have banned the sale of tobacco. Furthermore, tobacco sales in duty-free shops are banned in line with the provisions of the Framework Convention, and there is also a ban on tobacco sales to minors.

In **Indonesia**, government regulations exist for controlling nicotine and tar content, issuing disclaimer/warnings about health problems caused by tobacco, ensuring limitation of sales through vending machines, restriction of tobacco advertisements, and designation of smoke-free areas. The National Committee for Tobacco Control was established with 23 member organizations including the Indonesian Heart Foundation, which is active in tobacco control. Other organizations such as the Indonesian Smoking Control Foundation, Indonesian Cancer Foundation, consumer groups, and Indonesian Women Against Tobacco are playing an active role in the anti-tobacco campaign.

Most NGOs focus on health education, school-based anti-tobacco campaigns, advocacy through all forms of the media, and lobbying against the tobacco industry, including monitoring tobacco advertisements and reporting any breach to the government. The country has also prepared a Draft National Plan for Tobacco Control.

The tobacco control policy in **Maldives** is reflected in the Health Master Plan 1996–2005, and is defined as one of the objectives of the Health Education Programme. Tobacco control is also integrated into the Health Education Policy, and policies related to noncommunicable diseases and oro-dental health. In addition, tobacco control is also incorporated into the Sixth National Development Plan as part of an integrated strategy on noncommunicable disease control and health education.

Tobacco control regulations in the Maldives include: regulation on tobacco advertising (1984), regulation on sale of tobacco products to minors (1991) and regulation on smoking in public places and government buildings (1993, 1994, 1997). In most of the islands, women's development committees are playing an important role in tobacco control. This led to the total cessation of tobacco use by women in seven islands that were declared "women's tobacco-free islands" and were awarded a special certificate by the Ministry of Health in recognition of this achievement. More islands are following suit.

Other steps to combat the tobacco epidemic include the school health anti-tobacco programme which was started in 2000, initiating health facility-

based tobacco cessation programmes, introducing graphic labels in the local language on cigarette packs, conducting awareness campaigns, increasing coordination between relevant authorities including NGOs, and improved surveillance, monitoring and enforcement.

Myanmar officially launched the National Tobacco Control Programme in 2000. The strong political commitment became more evident when the Office of the State Peace and Development Council officially formed the National Tobacco Control Committee in March 2002, headed by the Minister for Health and including heads of departments and local NGOs as members. This Committee sets guidelines for tobacco control measures to be implemented in the country. The Ministry of Information has prohibited the advertisement of tobacco on television, radio and all electronic media since 1997.

Following the guidelines set by the National Health Committee and National Tobacco Control Committee, tobacco advertising billboards were completely banned from the vicinity of schools, hospitals, health facilities, sports stadiums and maternity homes since May 2002, and all tobacco advertisements were completely banned in April 2003.

Many national NGOs are involved in anti-tobacco campaigns. The Maternal and Child Welfare Association has members in all the townships and villages in the country, and is the largest NGO that has formed a partnership with the Ministry of Health in many health programmes including advocacy and community awareness campaigns for tobacco control. Other NGOs advocating tobacco control include Myanmar Medical Association, Myanmar Nurses Association, Myanmar Anti-Narcotics Association, Myanmar Health Assistants' Association, Myanmar Music Association, Myanmar Film Association, etc.

In **Nepal,** the National Health Education Information and Communication Centre of the Ministry of Health and Population drafted the Smoking (Prohibition and Control) Act, 2058 (Nepali Calendar), which incorporates many provisions of the Framework Convention such as prohibition of smoking in public places and restricting the sale of tobacco products to minors. The draft Bill has been placed before Parliament.

Several tobacco control measures such as an increase in tax, ban on advertising, ban on sale of tobacco products to minors, and prohibition of smoking in public places are in place. Hospitals and public institutions such as the B.P. Koirala Memorial Cancer Hospital, Mrigendra-Samjhana Medical Trust, Nepal Cancer Relief Society, Janak Memorial Service Centre and the National Front Against Tobacco are actively involved in advocating for tobacco control.

Some of the tobacco legislation policies in **Sri Lanka** include the Consumer Protection Act No. 1 of 1979 which includes compulsory government warnings on cigarette packs; Railway Services Act No. 20 of 1971 which prohibits smoking and chewing of betel in railway premises; Transport Law No. 19 of 1978 which prohibits smoking in buses; Children and Young Persons' Ordinance which prohibits sale of tobacco/cigarettes to persons under 16 years; and the Public Administrative Circular No. 08/99 which prohibits smoking in state institutions.

Efforts on tobacco control have yielded good results, especially in the area of deterring children from smoking. In addition, the average age at which smoking is initiated starts has increased from 17 to 19 years. Taxes on tobacco products were increased every year except in 2002 and 2003. Tobacco control has also been incorporated into clinical settings treating noncommunicable diseases, and in outpatient departments in various hospitals. In 2006, the country enacted the NATA (National Authority on Tobacco and Alcohol Act No. 27 of 2006). A free national quitline has been initiated.

In **Thailand,** health warnings on cigarette packages appeared in 1974. In 1985, cigarette advertising through the electronic media was banned, and smoking was banned in the House of Representatives. The National Committee for the Control of Tobacco Use was established in 1989. In 1992, two laws were enacted: Non-smokers' Health Protection Act and Tobacco Products Control Act. Under these laws, all public places were designated as non-smoking areas. Taxes on tobacco products were increased gradually from 55% in 1994 to 75% in 2001; 2% of the tax on cigarettes and tobacco is levied for the Health Promotion Fund.

In 1994 the "Thai Women Do Not Smoke Project" was set up with the objective of reducing smoking among women. More recently, the Ministerial Announcement of 2006 on the Non-Smokers' Health Protection Act B.E. 2545 (2006) has notified a complete ban on smoking in schools, public transport, most public places and workplaces. However, the Act also provides for a ban limited to air-conditioned areas such as cultural centres, hotels, food courts and some more public places and workplaces. The Act has also made provisions for the ban on smoking in places including administrative agencies, state enterprises and some private workplaces, public transport stations and airports, and in some areas in hospitals and universities.

Thailand has banned smoking in health settings with some exceptions. Some hospitals have taken the initiative to declare themselves completely smoke-free. With the intervention of the government and the private sector, many workplaces in Thailand have been declared smoke-free. Such comprehensive tobacco control measures have resulted in Thailand receiving

international acclaim as one of the success stories for tobacco control from the SEA Region. A Thai Health Professional Alliance Against Tobacco (THPAAT) has been formed with 17 allies from medical, nursing, traditional medicine and other health professional organizations.

In **Timor-Leste**, the Ministry of Health has conducted various anti-tobacco campaigns in the country, such as "healthy living" in May 2002, with the slogan "*cigaru ia diak*" or "tobacco is bad". Other activities include a survey on oral health which provided data on tobacco smoking. Although comprehensive strategies for tobacco control are lacking in the country, several efforts in this area include encouraging the government to limit the import of tobacco by raising the price and taxes on tobacco products, especially those targeting children and women; setting up regulations on the tobacco trade in Timor-Leste; formulating special regulations banning smoking in public places, schools, hospitals and workplaces; and cooperating with the health and related sectors in spreading awareness on the ill effects of tobacco.

As evident from the above, tobacco control laws exist in most SEA Region countries and have been enforced by each country to the extent possible in line with the provisions of the WHO Framework Convention. Several recommendations have also been made by various professional bodies to governments, civil societies, NGOs, international organizations, and human development sectors as to how the spread of tobacco use may be controlled. However, tobacco use has permeated all areas of human life and endeavour, and intense, concerted action is needed that encompasses various sectors such as education, agriculture, trade, fiscal regulations and foreign policy before effective tobacco control can be achieved.

In addition, lack of resources and political will to translate policies into action, poor awareness among the public about the ill effects of tobacco and existing laws, resistance from tobacco companies and other practical difficulties have constrained our ability to eradicate the tobacco epidemic completely.

This Region has already been under peril, from natural disasters – earthquakes, tsunamis, cyclones, floods. How long do we spend, fighting a meaningless, manmade disaster like tobacco? With the right tools and continued effort, it should end soon, and our Region should be able to divert all of its resources to achieving the WHO's Millennium Development Goals (MDGs)[69] – eradicate poverty and hunger, achieve universal primary education, promote gender equality and women's empowerment, reduce child mortality, improve maternal health, combat HIV, malaria and other diseases, and ensure environmental sustainability – unhindered by tobacco use and related harms.

More importantly, no tobacco control programme can be effective until adequate steps are taken to reverse the effect of the tobacco industry targeting the most vulnerable groups – children, women and the poor. The situation in the Region has worsened because a majority of our children and women belong to the poorer sections of society. In many of our villages there is limited access to potable water. Many villages have no schools or hospitals. A good proportion of our children are denied the basic right to education. But in several areas, they are still able to buy a *bidi*/cigarette easily from a shop. Targeting these vulnerable groups is thus an important anti-tobacco strategy that will ensure that the demand for tobacco is reduced.

We need to work around contentions that banning tobacco will cause loss of employment and revenue for the government, or banning onscreen smoking will curb artistic liberty and creative freedom, and so on. There seems to be a fatal flaw in such arguments. Do we need a product that maims or kills in order to produce revenue, or in order to be creative and to communicate? Do we even have time for such debates? This Region has already faced, and is under constant peril from, the recurring threat of natural disasters such as earthquakes, tsunamis, cyclones, floods. How long shall we fight a meaningless, man-made disaster like tobacco?

With the proper tools and continued efforts, it should end soon, and our Region should be able to divert *all* of its resources to achieving the health-related Millennium Development Goals (MDGs)[69] – eradicate poverty and hunger; promote gender equality and women's empowerment; reduce child mortality; improve maternal health; combat HIV, malaria and other diseases; and ensure environmental sustainability – unhindered by the burden of tobacco use and related harms. Right now, tobacco is an impediment to the achievement of these MDGs, because in the first place it is a major contributor to impoverishment, illiteracy, ill health and environmental degradation. Therefore, the MDGs would be much easier to accomplish without tobacco in the picture.

We conclude this chapter with some suggested ways in which you, in the role of a health professional, can contribute to tobacco control advocacy:

- First, be a tobacco-free role model yourself. As echoed by the WHO Tobacco Free Initiative, "health workers function as exemplars and educators for their patients, and consequently should set an example by abstaining from tobacco."[70,71]
- Be familiar with the legal control measures pertinent to the area you are working in; advocate for such laws, such as banning smoking in health-care facilities, public smoking, prohibiting sale of tobacco products to children and the like.
- Support and encourage local governments in their policy formulation

and implementation.

- Be in touch with journalists, especially health-care professional journalists, appraise them about current issues in tobacco control and seek their support in tobacco control advocacy.
- Organize campaigns to increase compliance with existing laws, work with local politicians (such as a Member of the Legislative Assembly), and invite them to speak at meetings addressing tobacco control issues.
- Talk to medical and dental students as well as trainees in all health specialties, particularly nursing, pharmacy, social work and psychology, and sensitize them on matters pertaining to tobacco control. Speak at medical/nursing colleges, speak of your experiences in your hospital or community, and speak about your successes. Ask for volunteers to work in tobacco-related projects, prevention cessation services, conducting surveys, etc. Through the engagement of such medical/nursing students in tobacco control you are preparing FUTURE health professionals who will also advocate for tobacco control.
- Write letters to the editors of newspapers on tobacco control matters. We need the media to be on our side for successful tobacco control.
- Within your limits, support litigation by testifying as a witness in matters of medical evidence of tobacco as having caused a particular disease.
- Increase your participation in research on issues related to tobacco control, such as monitoring tobacco use among different population groups, evaluating effectiveness of interventions, non-compliance

Active role of nursing professionals in tobacco control in Thailand

In a study among 342 nurses in Thailand in 2007, 48% reported **that they assessed their patient's** tobacco use, 20% documented tobacco status and 10% **assessed the patient's readiness to quit. Lack of nurses' training in** counselling skills (57%) and lack of adequate knowledge (54%) were recognized as barriers to nursing intervention in tobacco cessation.[72]

Since 2007, more than 1100 nurses actively participated **in the country's tobacco control** programme.

Activities have included training of nurses in tobacco cessation, enforcing smoke-free environments, promoting a tobacco-free culture, integrating tobacco cessation in substance abuse treatment and rehabilitation programmes, and spreading awareness among the public.[73]

with laws, and tobacco industry tactics.

- Get involved with local tobacco control groups and nongovernmental organizations lobbying for tobacco control.
- Above all, remember that if the tender minds of children and the poor and illiterate sections of our society could be reached by messages **of disease and suffering carefully camouflaged as pleasure, you can** reach them as well with your health messages!
- Thus, you have the unique potential to contribute to tobacco control, and you can make a BIGGER impact than any tobacco advertisement, movie scene, or any other industry gimmick. In fact, you are the **most influential leader of all, and you have a much broader role to** play than just treat the illnesses caused by tobacco and its products. Because, tobacco control is a pro-child, pro-woman, pro-health and, consequently, pro-nation issue.

Key messages

- Countries in the SEA Region have implemented tobacco control laws to a considerable extent. However, resource constraints and **other practical difficulties have limited the intended complete ban** on tobacco products.
- Being familiar with existing legal measures, supporting and lobbying with local governments for successful law enforcement, working with the media and local NGOs, and participating in research on issues related to tobacco control are some ways in which you as a health professional can function in tobacco control advocacy.

Chapter 7

Can we use tobacco cessation as an integral part of promoting a healthy lifestyle?

Objective

To synthesize a holistic approach to achieving tobacco cessation as an integral part – and not as an isolated entity – of adopting healthy lifestyle habits and patterns.

"When meditating over a disease, I never think of finding a remedy for it, but instead, a means of preventing it." *Louis Pasteur, 1822–1895*

Down the years on the health front, the SEA Region has grappled with infectious diseases, malnutrition and problems of poor maternal and child health. However, in recent times, the Region has also witnessed a rapid upsurge of diseases for which lifestyle habits and patterns are recognized to be major contributing factors. It was estimated that these noncommunicable diseases (NCDs) will cause approximately 35 million deaths worldwide in 2009.

Globally, NCDs account for over half of all deaths, and the majority of deaths due to NCDs occur in low- and middle-income countries. Today, noncommunicable diseases (NCDs) have emerged as a major public health challenge in the SEA Region. Increased globalization,

industrialization, expanded levels of education, and rising incomes may be responsible for this growing prevalence of NCDs, exposing the population to many lifestyle risk factors such as improper nutrition, sedentary life, and alcohol and tobacco use. Some of these major NCDs include cardiovascular diseases, cancers, chronic respiratory diseases and diabetes mellitus.

In the WHO Stepwise Approach to NCD Risk Factor Surveillance (STEPS)[74,75], it was revealed that high prevalence, low age at initiation and long duration of tobacco use was a well established norm among people of the SEA Region. The findings also pointed to inadequate consumption of fruits and vegetables, rising body mass index, decreasing levels of physical activity and increased consumption of high-calorie foods, increased rates of arterial blood pressure particularly after age 34, and a rise in instances of diabetes mellitus. On the whole, all SEA Region countries reported a high prevalence of major risk factors for NCDs not only in urban but also rural areas.

In the context of the NCD epidemic in SEA Region countries, of particular concern is the fact that young and middle-aged adults are increasingly being affected during the most productive phases of their lives. Again, it is the poor, especially women, who are the most vulnerable because of unhealthy living conditions, social inequalities, poverty, and limited access to resources, including health care.

The key issue in NCD prevention is that they are linked by common lifestyle risk factors, the most important ones being tobacco use, unhealthy diet and physical inactivity. The prevention of NCDs should, therefore, have a common focus of targeting these risk factors in an integrated manner. According to WHO, if these risk factors were eliminated worldwide, at least 80% of all instances of heart disease, strokes and Type-2 diabetes and over 40% of cancers would be prevented. These diseases are thus being targeted by WHO in the SEA Region for integrated prevention and control in the next few decades. Behavioural interventions including those for tobacco cessation, and increased physical activity and dietary change with the promotion of weight loss if appropriate, have been identified as being most effective for achieving control over NCDs in the Region.

In general, public awareness regarding the link between health and lifestyle habits being an important reason for the emergence of NCDs is still limited. In the previous chapters, the role of tobacco use in the causation of the four major NCDs – cardiovascular illness, hypertension, diabetes, and cancer – has been well highlighted. Given the focus of this *Manual*, we address briefly the importance of tobacco cessation as an integral part of achieving an healthy lifestyle, reducing disease occurrence and complications, and improving the quality of life among the people you serve.

Your role in this could be summed up as follows:

- Gathering information on the incidence of, and possible underlying determinants of, NCDs in your community and monitoring trends over time.
- Integration of NCD prevention activities into primary health care: NCD preventive measures implemented by the health worker at a primary health centre is the most cost-effective strategy to address the challenge of sustainable NCD prevention. This intervention at the grassroots level reaches the disadvantaged sections of the population who need these services the most, and who may not be able to otherwise afford it. Remember, the majority of our population is still dependent on the services of a primary health centre.
- Community efforts: Focus on community-based interventions, using culturally appropriate methods and messages. Organize and strengthen public awareness and education campaigns across settings such as child-care centres, schools, workplaces and other local venues. Such efforts facilitate community mobilization and participation, help communities to define their health goals and take decisions regarding their health, and empower them to have control over their own health.
- Active involvement in local community organizations, offering technical inputs and assistance as required.
- Promotion of research on NCD prevention and management.

Tobacco cessation advice as part of chronic disease prevention by the health worker at a primary health centre is one of the most cost-effective anti-tobacco strategies available. Remember, the majority of our population is still dependent on the services of a primary health centre!

By way of an example, let us look at the following situations where you may incorporate tobacco cessation advice into the corpus of overall care:

(a) Consider a patient who visits your health centre with angina, and is also a current tobacco user

Your treatment would comprise a comprehensive assessment of this patient's risk profile, through a history, physical examination, and an array of laboratory investigations. In addition, you would also obtain a history of lifestyle patterns: dietary habits, sleep, tobacco and alcohol use, body weight, and current awareness of illness. You would then proceed with medical treatment for the underlying condition, guided by the findings of your assessment. Your treatment would also constitute educating him about his health condition along with the precautions he needs to follow. You may say the following:

"The pain you are experiencing is because the blood vessels of your heart have become narrower, and are therefore not able to supply enough blood and oxygen to your heart. To treat this problem, the doctor has prescribed --- *(name of the medicine)*. This medicine will increase the lumen of your blood vessels, increase oxygen and blood supply to your heart, lower your blood pressure, slow down your heart rate, and reduce its workload. You will now be able to breathe easier and work better, without experiencing any pain. Take this medicine regularly in the dose that has been prescribed for you.

"In addition, you will also be required to make some changes in your lifestyle. For example, you will have to reduce oil and salt in your diet, cut **down on fatty foods, and increase the quantity of fibre in your diet** *(name foods that are locally available with these properties, based on his eating preferences)*. **Take sufficient rest, and as your condition improves you can** gradually increase your activities. Also try to avoid situations that can upset or stress you out *(provide other stress management tips as relevant)*.

"More importantly, you need to stop smoking. Tobacco reduces the opening of your blood vessels so that oxygen and blood supply to your heart gets reduced. Tobacco also increases your blood pressure, and your heart will have to pump harder against this resistance, and with time it will fail. So what use is it going to be if you are going to reduce the effectiveness of all the other measures you take to keep your disease under control by continuing to smoke? You are also spending time and money to come here for your check-ups, and to buy the medicines that are being prescribed for **you. Don't let all this trouble run to waste!**

In addition to damaging your heart, tobacco will also cause you a lot of other health problems, which can prove to be dangerous *(name them as relevant)*. So you need to give a careful thought if it is worth spending your money on something which is going to place your life and health at risk. Right now, it is very important that you stop smoking to prevent further damage **to your heart and blood vessels. Otherwise, it can prove very difficult for** you."

Note:

- Take care to *integrate* anti-tobacco advice into the rest of your health education, do not say it as an afterthought.
- Use local language and colloquial terms, not medical jargon.
- Use visual aids to show pictures showing progression of coronary artery diseases (CADs), and the occlusion of arterial lumen. Keep the description simple, yet vivid and real, and *medical* – providing medical rationale for tobacco cessation really helps.

(b) When you conduct a tobacco cessation programme in a school

- Speak about the adverse health effects of tobacco.
- Address myths and facts associated with the use of tobacco and its products. Invite and clarify all questions, leave no scope for misconceptions or misinformation.
- Emphasise healthy habits – good nutrition, including avoiding junk food, adequate physical activity, good study habits, and the need to balance study and rest.
- Provide practical tips on stress and coping: handling examination pressure, peer conformity, other stresses, improving self-esteem, building a positive self-image, etc.
- **Correct faulty ways of asserting one's autonomy. Emphasize every child's worth as an individual, unique in his/her own** right, and help them realize their potential. Consider saying the following:

"This country has made quite a few advances in recent years, and yet it is also true that we are still faced with obstacles that are hindering our progress. Our people are facing a lot of burden from various diseases, lack of food, poverty, illiteracy. In addition, we also have diseases which are mainly brought on by some of our lifestyle habits. Some of these include **faulty eating patterns, use of tobacco and alcohol, lack of sufficient physical** activity. Such habits have a major role to play in causing diseases such as diabetes, diseases of the heart and blood vessels, increased blood pressure, and various cancerous conditions. We are losing — (give *number pertinent to the country)* of people to such diseases annually.

"Tobacco use itself is a major cause of all these diseases *(elaborate)*, but not everyone is aware of this. Many young people are beginning to smoke or use tobacco in other forms such as *(name the chewing forms of tobacco in your country)*, without realizing that they can get addicted and develop illnesses early in their lives. What is disturbing is that these people are dying young because of such habits, so that our country is losing people who can really contribute to its growth and economy. In fact, we are losing more than **five million people worldwide every day because of health problems caused** by tobacco use."

We do not want you to join the ranks of tobacco users and meet with such consequences. Do not get confused by the messages you get from advertisements and other media, or that from peers who may convey that smoking is an adult, independent thing, or that it helps you feel relaxed and happier. It does not. What will make you an independent and respected

adult in society is education, hard work, character, and giving your best to everything you do. This country needs boys and girls who grow up strong, and are in sound physical and mental health. Nobody can substitute for you or the contribution you can make to our country. It will be a pity if we lose even one of you to this stick of poison. You are meant to live, work, build a home, family, society. You are the future of this country, and we need you to take it forward!"

Note:

- Supplement with relevant audiovisual aids.
- Make the discussion lively, relate examples from your experience. Ask the children to contribute actively as appropriate.
- Include parents and teachers in the session and incorporate their inputs as well.

(c) Consider the women you treat/ interact with in the community

For example, at an antenatal clinic, integrate antenatal advice with anti-tobacco messages – dangers of tobacco use (both smoking and smokeless forms), harmful effects on the baby, effects of second-hand smoke, etc. Include both the husband and wife when you provide this information, and provide clarifications as necessary.

Conduct workshops on health, the importance of education, stress management, self-esteem enhancement, and all-round personality development at suitable venues such as local women's clubs, women's meets, child education and development centres, etc. Convey the message that women and mothers are the foundations of our society, and they need to stay strong and healthy for themselves, for their children, and for the furtherance of society's welfare.

In conclusion, tobacco cessation is one of many lifestyle changes required ***for a healthy living. The significance of including tobacco as a risk factor*** *for public health has been proved beyond doubt, in terms of the morbidity, mortality and disability arising from various chronic illnesses associated with its use.*

Tobacco cessation and control is thus not an isolated campaign but one involving a holistic, multisectoral approach to further the cause of human welfare and development. The role of tobacco in impeding this cannot be ignored – the cost from tobacco to our life, health and well-being, and the future of our children and the sustenance of this planet, is simply too high!

Key messages

- In recent times, the SEA Region has witnessed a rising incidence of noncommunicable diseases (NCDs) such as cardiovascular diseases, cancers, chronic respiratory illnesses and diabetes mellitus, for which lifestyle habits and patterns are well-recognized to be major contributing factors.
- The key issue in NCDs prevention is that they are linked by common lifestyle risk factors, the most important ones being tobacco use, unhealthy diet and physical inactivity. Preventive efforts should, therefore, have a common focus of targeting these risk factors in an integrated manner.
- The role of tobacco in the causation of NCDs such as cardiovascular disease, hypertension, diabetes and cancer has been proved beyond doubt. Emphasis should be laid on tobacco cessation as an integral part of a healthy lifestyle to reduce disease occurrence and complications and improve the quality of life.
- Overall, your role in NCD prevention includes integrating all efforts into primary health care, focusing on community-based interventions, networking with local organizations, and actively involving in research related to NCDs prevention and management.

References

1. Rahman K, Ramaboot S. *Regional summary for South-East Asia Region*. New Delhi: WHO Regional Office for South-East Asia. (http://www.searo.who.int/LinkFiles/Regional_Tobacco_Surveillance_System_SEARO_summary.pdf - accessed 31 March 2010).
2. World Health Organization, Regional Office for South-East Asia. *Health Situation in the South-East Asia Region 2001-2007*. New Delhi: WHO SEARO, 2008. World Health (http://www.searo.who.int/en/Section1243/Section1382/Section1386_14672.htm - accessed 31 March 2010).
3. World Health Organization. *The World Health Report: Shaping the future 2003*. Geneva: WHO, 2003. (http://www.who.int/whr/2003/en/ - accessed 31 March 2010).
4. World Health Organization, Regional Office for South-East Asia. *Implications of the agreement on the South Asian Free Trade Area on tobacco trade and public health in the SAARC Region*. New Delhi: WHO SEARO, 2008. (http://www.searo.who.int/LinkFiles/Tobacco_Free_Initiative_SAFTA.pdf - accessed 31 March 2010).
5. World Health Organization. *Tobacco statistics*. Geneva: WHO. (http://www.who.int/tobacco/statistics/tobacco_atlas/en/ - accessed 31 March 2010).
6. Shafey O, Eriksen M, Ross H, Mackay J. *The Tobacco Atlas*. 3rd edn. Atlanta: American Cancer Society, 2009.
7. Sinha D. *Report on oral tobacco use and its implications in South-East Asia*. New Delhi: WHO Regional Office for South-Asia, 2004. (http://www.searo.who.int/LinkFiles/NMH_OralTobaccoUse.pdf - accessed 31 March 2010).
8. World Health Organization. *Trade, foreign policy, diplomacy and health*. Geneva: WHO. (http://www.who.int/trade/glossary/story089/en/index.html - accessed 31 March 2010).
9. Kyaing NN. *Regional situation analysis of women and tobacco in South-East Asia*. New Delhi: WHO Regional Office for South-East Asia. (http://www.searo.who.int/LinkFiles/NMH_regSituationAnalysis.pdf - accessed 31 March 2010).
10. Gupta PC. *A database on tobacco in the South-East Asia Region*. New Delhi: WHO Regional Office for South-East Asia, 2008.
11. Jha P, Jacob B, Gajalakshmi V, et al. A nationally representative case-control study of smoking and death in India. *N Engl J Med*. 2008; 58(11):1137-47
12. Parbhudas Kishordas Tobacco Products Limited. *All India Bidi Industry Federation*. Ahmedabad. (http://www.who.int/tobacco/framework/public_hearings/F2000196.pdf - accessed 31 March 2010).
13. World Health Organization, Regional Office for South-East Asia. *Profile on smoke-free environments in South-East Asia Region*. New Delhi: WHO SEARO, 2007. (http://www.searo.who.int/LinkFiles/World_No_Tobacco_Day_SEARO2007Brochure.pdf - accessed 31 March 2010).
14. World Health Organization, Regional Office for South-East Asia. *Brief profile on tobacco and youth in the South-East Asia Region*. New Delhi: WHO SEARO, 2008. http://www.searo.who.int/LinkFiles/World_No_Tobacco_Day_TFI_Brief_Profile.pdf - accessed 1 April 2010).
15. World Health Organization, Regional Office for South-East Asia. *Global Youth Tobacco Survey: data from South-East Asia*. New Delhi: WHO SEARO. (http://

www.searo.who.int/LinkFiles/Publications_and_Documents_gyts01July06.pdf - accessed 1 April 2010).

16. Warren CW, Jones NR, Perugi A et al. Global Youth Tobacco Surveillance, 2000-2007. *MMWR Surveill Summ* 2008; 57(1): 1-28. (http://www.ncbi.nlm.gov/pubmed/18219269 - accessed 1 April 2010).

17. World Health Organization, Regional Office for South-East Asia. Child *health and development: main areas of work*. New Delhi: WHO SEARO. (http://www.searo.who.int/en/Section13/section37/section376.htm - accessed 1 April 2010).

18. International Fund for Agricultural Development. *IFAD strategy for rural poverty reduction in Asia and the Pacific.* 2002. (http://www.wfp.org.in/ifadindia/Publications/Rural_pov_Redu_Strategy_IFAD.pdf - accessed 1 April 2010).

19. World Health Organization, Regional Office for South-East Asia. Tobacco, poverty and Millennium Development Goals (MDGs). New Delhi: WHO SEARO. (http://www.searo.who.int/en/Section1174/Section2469/Section2476.htm - accessed 1 April 2010).

20. Efroymson D, Alam SM. *Enforcement of tobacco control law: A guide to the basics*. Ottawa: Healthbridge, 2009. (http://www.healthbridge.ca/assets/images/pdf/Tobacco/LawEnfrcmnt_Bklt.pdf - accessed 1 April 2010).

21. John S, Vaite S. Efroymson D. Eds. *Tobacco and poverty: Observations from India and Bangladesh*. Path Canada 2002. (http://www.wpro.who.int/NR/rdonlyres/F1BA5FDA-0D22-4F14-B0A3-B1DFDA8A5909/0/tobacco_poverty.pdf - accessed 1 April 2010).

22. World Health Organization. *WHO report on the global tobacco epidemic, 2008: the MPOWER package*. Geneva: WHO, 2008.

23. World Health Organization. *WHO report 2002: Global tuberculosis control: Surveillance, planning, financing*. Geneva: WHO, 2002.

24. World Health Organization, Regional Office for South-East Asia. *Tobacco smoking and tuberculosis*. New Delhi: WHO SEARO. Available at: http://www.searo.who.int/LinkFiles/Tuberculosis_right4.pdf

25. World Bank. *Tobacco control in developing countries*. (http://www1.worldbank.org/tobacco/tcdc/fact_sheets/TobaccoFacts1-6.pdf - accessed 1 April 2010).

26. World Health Organization. *The smoker's body*. Tobacco Free Initiative. Geneva: WHO. (http://www.who.int/tobacco/research/smokers_body/en/ - accessed 1 April 2010).

27. Reddy KS, Gupta PC. Eds. *Report on tobacco control in India*. New Delhi: Ministry of Health and Family Welfare, 2004.

28. National Cancer Institute. *Secondhand smoke: questions and answers*. (http://www.cancer.gov/images/Documents/3770da1d-1c3a-4a1c-905f-944140049158/Fs10_18.pdf - accessed 1 April 2010).

29. Martinuuik ALC, Lee CMY, Lam TH et al. The fraction of ischaemic heart disease and stroke attributable to smoking in the WHO Western Pacific and South-East Asian regions. *Tob Control*. 2006; 15: 181-8.

30. Rahman M, Chowdhury AS, Fukui T, Hira K, Shimbo T. Association of thromboangiitis obliterans with cigarette and bidi smoking in Bangladesh: A case control study. *Int J Epidemiol*. 2000; 29: 266-70.

31. Pais P, Pogue J, Gerstein H et al. Risk factors for acute myocardial infarction in Indians: A case-control study. *Lancet*. 1996; 348 (9024): 358-63.

32. International Agency for Research on Cancer. *Tobacco smoke and involuntary smoking*. IARC Working Group on the Evaluation of Carcinogenic Risk to Humans

IARC volume 83. Lyon: IARC, 2004 (http://monographs.iarc.fr/ENG/Monographs/vol83/mono83-1.pdf - accessed 1 April 2010).

33. Centers for Disease Control and Prevention. *Tobacco or health: A global status report. India.* (www.cdc.gov/tobacco/who/india.htm - 1 April 2010).

34. Samarasinghe D, Goonaratna C. Tobacco–related harm in South Asia: High mortality but some promising initiatives. *BMJ.* 2004; 328 (7443): 780.

35. International agency for research on cancer. *Chemicals, groups of chemicals, mixtures and exposure circumstances to be evaluated in future IARC monographs : report of an ad hoc working group, Lyon, 4-6 April 1989.* Lyon: IARC, 1989. Volume 89. (http://monographs.iarc.fr/ENG/Monographs/vol89/mono89.pdf- 1 April 2010).

36. Gupta PC, Ray C. Tobacco–related cancer-its impact on the health economy. *Health Administrator.* XVII(1): 85-92. (http://medind.nic.in/haa/t05/i1/haat05i1p85.pdf - accessed 1 April 2010).

37. Centers for Disease Control and Prevention. *Betel quid with tobacco: smokeless tobacco fact sheets.* (**http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/betel_quid/** - accessed 1 April 2010).

38. Ait-Khaled N, Enarson D, Bousquet J. Chronic respiratory diseases in developing countries: the burden and strategies for prevention and management. *Bull World Health Organ.* 2001; 79:10.

39. **World Health Organization, Regional Office for South–East Asia.** *The Framework Convention on Tobacco Control in the South-East Asia Region.* Regional Committee Fifty-third session, document no. SEA/RC53/14. New Delhi: WHO SEARO, 2000. (**http://www.searo.who.int/LinkFiles/RC_53_rc53-14.pdf** - accessed 1 April 2010).

40. Sumanth S, Bhat KM, Bhat GS. Periodontal health status in pan chewers with or without the use of tobacco. *Oral Health Prev Dent.* 2008; 6 (3): 223-9.

41. Kyaing NN, Perucic AM, Rahman K. *Study on poverty alleviation and tobacco control in Myanmar.* HNP Discussion Paper. Economics of Tobacco Control Paper No. 31. Washington: The International Bank for Reconstruction and Development/The World Bank, 2005. (http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/MyanmarTobaccoFinalSm.pdf - accessed 1 April 2010).

42. Hatsukami DK, Stead LF, Gupta PC. Tobacco addiction. *Lancet.* 2008 Jun 14; 371(9629): 2027-38.

43. World Health Organization. *Preventing chronic diseases: a vital investment*: WHO global report. Geneva: WHO, 2005. (**http://www.who.int/chp/chronic_disease_report/en/** - accessed 1 April 2010).

44. Ranganathan T.T. *Alcoholism and drug dependency – the professional's master guide.* New Delhi: Ministry of Welfare, 1989.

45. Miller WR. *Manual for form 90: a structured assessment interview for drinking and related behaviors.* Project MATCH Monograph Series, Vol. 5. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1996.

46. **O'Farrell T.J., Choquette KA, & Cutter HSG. Couples relapse prevention sessions** after behavioral marital therapy for male alcoholics: outcomes during the three years after starting treatment. *Journal of Studies on Alcohol and Drugs.* 1998; 59: 357-370.

47. *Smoking cessation guidelines: How to treat your patient's tobacco addiction.* Toronto: A Pegasus Healthcare International Publication, 2000. (http://www.**smoke-free.ca/pdf_1/smoking_guide_en.pdf** - accessed 1 April 2010).

48. Fiore MC, Bailey WC, Cohen SJ, et al. *Treating tobacco use and dependence.*

Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000. (http://www.surgeongeneral.gov/tobacco/tobaqrg.htm - accessed 1 April 2010).

49. Kennedy CSW, Birke BS, Fals-Stewart W, Birchler GR. *Learning sobriety together: A couple's workbook*. Buffalo, NY: Addiction and Family Research Group, 2003.

50. Samarsinghe D. *Prevention and cessation of tobacco use: A manual for clinic and community based interventions*. New Delhi: WHO Regional Office for South-East Asia, New Delhi. (http://www.searo.who.int/LinkFiles/Publications_and_Documents_manual_clinics.pdf - accessed 6 April 2010).

51. Benegal V, Isaac M, Murthy P. Eds. *Manual for tobacco cessation*. New Delhi: Ministry of Health and Family Welfare, Directorate General of Health Services, 2005.

52. Murthy P. *Individual counselling for drug dependence (addiction)*. New Delhi: United Nations Office on Drugs and Crime, 2005. (http://www.unodc.org/pdf/india/publications/Thematic_Pamphlets_Reprints/3_individualcounselling.pdf - 6 April 2010).

53. Murthy P, Nikketha BS. *Psychosocial interventions for persons with substance abuse: theory and practice*. Bangalore: National Institute of Mental Health and Neuro Sciences, Deaddiction Centre, 2006-2007. (http://www.whoindia.org/LinkFiles/Mental_Health_&_substance_Abuse_psychosocial_Interventions_for_persons_with_substance_abuse.pdf - 6 April 2010).

54. Tobacco Cessation Centre. *Tobacco use: A smart guide on WHY you should stop, and HOW*. Bangalore: National Institute of Mental Health and Neuro Sciences, 2007.

55. Prasanthi N. *Individual versus dyadic relapse prevention among alcohol-dependent individuals in de-addiction unit at NIMHANS* [unpublished dissertation]. Bangalore: National Institute of Mental Health and Neurosciences, 2008.

56. Fiore MC, Jaen CR, Baker TB et al. *Treating tobacco use and dependence: 2008 update. In: AHCPR supported clinical practice guideline*. Rockville, MD: US Department of Health and Human Services. Public Health Service, 2008. (http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.28163 – 6 April 2010).

57. Murthy P, Subodh BN. Current developments in behavioral interventions for tobacco cessation. *Current Opinion in Psychiatry*. 2010 March ; 23(2): 151–6.

58. Salkar SS, Naik UD. *Home–based intervention for tobacco cessation: Evidence from India*. Unpublished document, 2004.

59. Ahmed J, Choudhury SR, Zaman MM. *Tobacco cessation among rural women by community health workers in Bangladesh*. Unpublished document. 2007.

60. McAfee T. *Improving quit rate in the population level: Strategies and approaches -quitlines as a public health approach to increasing treatment reach and effectiveness*. 14th World Congress on Tobacco or Health 2009. (http://www.14wctoh.org/abstract/abstract.asp?SessionID=205&DayID=11 – 6 April2010).

61. Gupta PC, Sreevidya S. *Smokeless tobacco use, birth weight and gestational age: Population based, prospective cohort study of 1217 women in Mumbai, India*. Mumbai: Tata Institute of Fundamental Research.

62. Centre for Diseases Control. *Global School Personnel Survey* 2009. (http://www.cdc.gov/tobacco/global/gtss/tobacco_atlas/pdfs/part4.pdf- accessed 6 April 2010).

63. Stead LF, Lancaster T. Group behaviour therapy programmes for smoking cessation. *Cochrane Database of Systematic Reviews*. 2005. (http://www2.cochrane.org/reviews/en/ab001007.html - 6 April 2010).

64. Emmons KM, Puleo E, Park E et al. Peer-delivered smoking counselling for childhood cancer survivors increases rate of cessation: the partnership for health study. *J Clin Oncol*. 2005; 23(27): 6516-23.

65. World Health Organization, Regional Office for South-East Asia. *Brief profile on tobacco health warnings in the South-East Asia Region. New Delhi*: WHO SEARO, 2009.: (http://www.searo.who.int/LinkFiles/World_No_Tobacco_Day_profile.pdf - accesed 6 April 2010).

66. Tobacco Cessation Centre. *Did you know...the facts and myths of smoking and chewing tobacco*. Bangalore: National Institute of Mental Health and Neuro Sciences, 2007. http://www.whoindia.org/LinkFiles/Tobacco_Free_Initiative_Manual_For_General_Public_Do_you_Know.pdf - 6 April 2010).

67. World Health Organization. *WHO Framework Convention on Tobacco Control*. Geneva: WHO, 2004. (http://whqlibdoc.who.int/publications/2003/9241591013.pdf - accessed 6 April 2010).

68. World Health Organization, Regional Office for South-East Asia. Effective implementation of the WHO Framework Convention on Tobacco Control through the MPOWER policy package. *TFI Newsletter*. 2009; 2(2). (http://www.searo.who.int/LinkFiles/Tobacco_Free_Initiative_NL_vol_2_no_2.pdf - accessed 6 April 2010).

69. World Health Organization. *Health and Millenium Development Goals*. Geneva: WHO, 2005.(http://www.who.int/hdp/publications/mdg_en.pdf - accessed 6 April 2010).

70. World Health Organization. Tobacco–Free Initiative. *Mayo report on addressing the worldwide tobacco epidemic through effective, evidence-based treatment*. Implementing treatment. Geneva.: (http://www.who.int/tobacco/resources/publications/mayo/en/index3.html - accessed 6 April 2010).

71. World Health Organization. *The role of health professionals in tobacco control*. Geneva: WHO, 2005. (http://www.who.int/tobacco/resources/publications/wntd/2005/en/bookletfinal_20april.pdf - accessed 6 April 2010).

72. Preechawong S. Thai nurses and tobacco cessation activities in clinical practice. Thai J Nurs Res. 2007; 11(1): 62-72.

73. Srimoragot P. Role of Thai nurses on tobacco control. Presentation at the 14th World Congress on Tobacco or Health. (http://www.14wctoh.org/abstract/abstract/Trident/10%20-%20March/1330%20-%201500%20hrs/Regal%20Ballroom%20II/Role_of_Thai_Nurse_on_TobaccoControl_March1.pdf - accessed 6 April 2010).

74. World Health Organization. The WHO STEPwise approach to chronic diseases risk factor surveillance. Geneva: WHO 2005.

75. World Health Organization, Regional Office for South-East Asia Scaling up prevention and control of chronic noncommunicable diseases in the SEA Region: Capacity for noncommunicable disease prevention and control in countries of the South-East Asia Region: Results of a 2006-2007 survey. Report of the Regional Committee, Sixtieth session,Thimphu, Bhutan. Document no. SEA/RC60/7 Inf. Doc.1 New Delhi: WHO SEARO, 2007.

Tobacco Cessation: A Manual for Nurses, Health Workers and other Health Professionals is a comprehensive manual on tobacco cessation. It provides a detailed overview of the extent and patterns of use of tobacco products in the South-East Asia (SEA) Region and the related health burden. Among the top 10 countries globally with the highest levels of tobacco use among males, as many as three are from the SEA Region. The *Manual* highlights the need to provide tobacco cessation interventions by nurses, health workers and other health professionals, and graphically depicts the adverse health effects of tobacco on almost all organs of the human body.

In the section on interventions, the *Manual* reiterates that tobacco cessation efforts start with the successful identification of tobacco use. It provides effective tools and techniques for tobacco cessation interventions, including visits and follow-up of patients, listing of pros and cons, worksheets, group-based interventions and pharmacotherapy.

Apart from the usual methods of cessation such as tapering off and abrupt cessation ('cold turkey'), the *Manual* also lists new and innovative interventions such as the 'Recovery Calendar'. Above all, the *Manual* highlights the importance of recognizing the dangerous effects of tobacco use, the benefits of quitting and the need to provide effective follow-up to prevent 'lapse' and 'relapse'. It includes a series of succinct, ready-to-use methods, counselling techniques and model motivational tools that can be practised by the health professional to promote tobacco cessation.

World Health Organization
Regional Office for South-East Asia
World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India
Website: www.searo.who.int

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