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Barriers to tobacco intervention services – A review

[1]Dr. SVSL Aiswarya, Dept. of Public Health Dentistry, PG student, The Oxford Dental College, Rajiv Gandhi University of Health Sciences, Bengaluru, Karnataka, India.

[2]Dr. Shilpashree KB, Dept. of Public Health Dentistry, Professor, The Oxford Dental College, Rajiv Gandhi University of Health Sciences, Bengaluru, Karnataka, India.

[3]Dr. Archana Krishna Murthy, Dept. of Public Health Dentistry, Professor and Head of the Department, The Oxford Dental College, Rajiv Gandhi University of Health Sciences, Bengaluru, Karnataka, India.

[4]Dr. Divya BM, Dept. of Public Health Dentistry, Associate Professor, The Oxford Dental College, Rajiv Gandhi University of Health Sciences, Bengaluru, Karnataka, India.

[5]Dr. Antara Shome, Dept. of Public Health Dentistry, Assistant Professor, The Oxford Dental College, Rajiv Gandhi University of Health Sciences, Bengaluru, Karnataka, India.

Corresponding Author: Dr. Shilpashree KB, Dept. of Public Health Dentistry, Professor, The Oxford Dental College, Rajiv Gandhi University of Health Sciences, Bengaluru, Karnataka, India.

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Abstract

Smoking is known to be a prominent public health problem, which can lead to significant morbidity and mortality but could totally be abolished by preventive measures. This has urged the World Health Organization to initiate the tobacco cessation activities in India. Despite compelling evidence to support smoking cessation intervention, methods such as brief advice, behaviour therapy and nicotine replacement therapy are under-utilized. Smoking cessation may be defined as validated sustained abstinence from cigarettes or any other tobacco products for at least 6 months, but preferably for a year. Understanding the perceived barriers to quitting is important in order to better understand relapse and quitting-related behaviours, to inform appropriate policy, and to facilitate the development of effective tailored smoking cessation interventions. Perceived barriers are associated with personal characteristics and social context including the family and peers, community, and public policy. Hence, this review article discusses the various barriers to tobacco intervention services implementation.

Keywords: Smoking, World Health Organization, Tobacco cessation, Intervention, Cigarettes, Tobacco products, Barriers.

Introduction

Tobacco use is a global epidemic that kills 5.4 million people annually, sadly, more than 80% of those deaths occurs in the developing world. [1] Tobacco use may be defined as any habitual use of the tobacco plant leaf and its products. According to the GATS 2 report every tenth adult in India smokes tobacco and about 11.9% in rural areas, 8.3% in urban areas. Prevalence of smoking among men is 19% and 2% in women.[2] Many health benefits can be achieved through cessation of smoking. Smoking cessation causes favourable changes in the lipid profile and body fat deposition. Smoking cessation reduces or eliminates the risk of passive smoking–induced diseases, especially in children: pneumonia, bronchitis, middle ear infections, and exacerbations of bronchial asthma.[3] A minimal intervention by physicians lasting less than 3 minutes has proven to increase overall tobacco abstinence rates.[4]

Tobacco intervention can be introduced to patients in the dental office when patients seek care for problem-oriented visits (periodontal treatment, extractions, etc. or for cosmetic purposes.[5] Evidence suggests that evidence-based cessation treatments and some high-intensive interventions implemented in a primary care setting can impact cessation among young smokers.[6] Recent research assessing barriers to entering smoking cessation treatment in underserved revealed that low socioeconomic status smokers have distinct perceived barriers to cessation treatment, including little access to information about smoking cessation, stigma attached to using cessation resources, unreliable phone service.[7] To overcome the ill effects of tobacco and to improve the health of public, World Health Organization has introduced the MPOWER package of six evidence-based tobacco control measures that are proven to reduce tobacco use and save lives in 2008. 5 M – Monitor tobacco use and prevention policies, P – Protect people from Tobacco smoke, O – Offer help to quit tobacco use, W– Warn about the dangers of tobacco, E – Enforce bans on tobacco advertising, promotion and sponsorship, R– Raise taxes on tobacco.[8] Evidence-based tobacco cessation treatment is recommended and critical for improving the health of smokers with mental illness.[9] Hence, this overview of barriers for smokers were taken based upon various authors observations.

Barriers to tobacco intervention services are categorized into eight categories

Individual barriers

Relieving tensions and anxieties of life,[10] pleasurable feeling,[10] for achieving greater concentration in studies,[10] continued it for boosting self-confidence,[10] stress at home or working place,[10] lack of recognition / reward,[11] physical addiction,[12] lack of will power,[12] to relieve boredom,[13] unemployment,[13] lack of alternate coping mechanisms,[13] poverty,[13] bullying,[13] distance and cost of travel for availing cessation services,[14] lack of readiness to quit,[15] fear of failure.[16]

Psychological barriers

Less confidence,[12] combatting loneliness,[13] impaired capacity for self-control,[17] lack of intrinsic motivation,[17] insomnia,[18] for relieving anger and frustration.[19]

Cultural barriers

Deeply ingrained cultural habits in rural areas maintains tobacco use,[3] Ceremonial use of tobacco, cultural values of pride, cultural values that promote sharing, kinship and reciprocity, maintenance of cultural identity, racism.[13]

Cognitive barriers

Doubts about the effectiveness of interventions,[1] concerns regarding the expense of pharmacotherapy,[9] affordability of bupropion,[9] opinion that smoking cessation interventions would lead to worsening of psychiatric symptoms,[9] cravings,[12] perception that stopping smoking will harm the body among smokers,[17] preconceived ideas about the intervention or viewing smoking cessation interventions as time-consuming.[20]

Organizational barriers

Very high levels of accessibility of cigarettes and the regular practice of selling cigarettes to those under 18 years of age were identified as at-risk youth,[13] in some studies it showed that people with mental illness and prisoners identified use of cigarettes to reward or punish behaviour by health professionals and other service providers,[13] lack of educational materials,[19] absence of protocols, records,[20] lacks enforcement of tobacco control laws and penalties for violators is the barrier reported in a hospital setting.[21]

Social and community barriers

Presence of other people around them being a smoker, feeling as a sign of maturity or helps one mixing in the different social gathering,[10] presence of smoker in the family or close relative has a very strong motivation for the young boys to start smoking whereas some started by seeing their teachers, social circle and friends, under the motivation of various advertisements and movies shown in the media,[10] social isolation.[13]

Dental student reported barriers

Lack of incentive (no curricular requirements) for dental students,[5] dental students thought that patient should have tobacco related health problem then only tobacco counselling will be effective,[22] students are not able to identify the patient's stage of change,[22] patients are not expecting tobacco cessation counselling from a dental student.[22]

Dentist and physician reported barriers

Lack of sensitization limits the assessment and intervention of tobacco use,[3] health professional's own use of tobacco,[3] inadequate knowledge about quit lines,[5] forgetting to give tobacco intervention counselling,[5] lack of reimbursement,[8] low patient acceptance,[8] perception that patients were not interested in quitting,[9] lack of patient motivation,[11] patient resistance,[19] lack of resources,[19] low confidence in providing the intervention,[20] lack of desire for participation in tobacco cessation activities,[23] lack of time during patient consultations,[24] not aware of the existence of a referral pathway,[25] fear of losing patients if forced for tobacco cessation,[26] lack of training / knowledge.[27]

Discussion

Baig Met al[10] mentioned in their study that 15.3% young smokers those who had made a quit attempt in the past year and those intending to quit within 6 months reported stress at home / work as a barrier to quitting at significantly higher rates in Jeddah, Saudi Arabia. Villanti AC et al[6] stated in their study that 59% US young adult current smokers reported loss of a way to handle stress as barrier. Similar results were shown by Milcarz K et al[28] in their study that 54.5% of them considered stress as barrier and reason stated was smoking is useful for stress relief and in situations like feeling trapped by stressful life circumstances among socially-disadvantaged populations in Poland. In order to reduce this leading perceived barrier, stress management techniques and skills training could be incorporated into an intervention.

Hashim R et al[1] cited that 38% dentists practicing in private sectors in the emirate of Ajman, United Arab Emirates cited patient's resistance as barrier. According

to Prakash P et al,[29] 66% dentists reported patient resistance as barrier due to which they were unable to fully perform "5As" or "5 Rs". Hence, to overcome this barrier, patient education and motivation need to be done in an interesting way according to individual patient level of understanding.

Chen JS et al[30] reported that 21% of smoking individuals residing at a homeless shelter viewed nicotine cravings as barrier. Similar results were found by Joshi V et al[12] that 31.4% of the physicians reported and 28.6% patient-smokers agreed that the key barriers to smoking cessation was craving. Therefore, a key component to a comprehensive tobacco treatment plan and one of the primary treatment modalities directed at reducing cravings and withdrawal symptoms are the evidence-based tobacco treatment medications.

According to Saxena A et al,[26] 84.71% dental students cited fear of losing patients is the most common barrier if counselled for tobacco cessation in Kanpur city. Bhat N et al[31] reported in his study that 35.8% of the dentists of Udaipur city, Rajasthan, India feared that patient would leave the ongoing treatment or before treatment if counselled much for tobacco withdrawal. Therefore, it is highly advisable to incorporate training of the dental students in the smoking cessation techniques within the dental school's curriculum.

According to Dedeke AA et al,[8] 18.5% of dentists in Southwest Nigeria cited lack of reimbursement as barrier. Monson AL et al[32] reported that 75% of dentists stated lack of reimbursement from insurance companies as dentists perceiving barriers.[18] Similar results were found by Kengne Talla P et al[33] in which lack of reimbursement is likely to affect the economic benefit received by dentists to support interventions for quitting.

Panaitescu C et al[24] cited in their qualitative study that lack of training in smoking cessation skills among Romanian family physicians as a barrier. According to Jradi H et al,[4] 66.9% general and family practitioners in primary health care clinics belonging to two major medical centers in Riyadh city, Saudi Arabia cited lack of training as greatest barrier for providing intervention services to their patients. Hence forth, healthcare givers at all levels of the healthcare delivery system must be trained in tobacco dependence treatment. Therefore, making this kind of educational material available might have a positive impact on smoking cessation activities.

According to Rosenthal L et al,[34] 30.9% urban adult daily tobacco smokers cited financial concerns like affordability of nicotine replacement as a barrier in USA. Himelhoch Set al[9] reported that 75% clinicians at community mental health sites in four countries in Maryland cited affordability of nicotine replacement as a barrier in implementation. Therefore, to overcome this barrier, nicotine replacement therapies should be provided at a minimal cost or free of cost.

Skojac CTM et al[14] cited in their study that 45% of the participants reported lack of time and scheduling to be a barrier. According to Blumenthal DS et al,[35] lack of time is the reported barrier to the provision of smoking cessation services by clinicians in underserved communities. This could be because clinicians usually address multiple problems during an office visit, thereby limiting the time available to provide cessation interventions.

Conclusion

In India where there is a predominant influence of sociocultural practices on tobacco use, it becomes the most challenging task for the health care professionals to assist in its cessation. Hence, combined efforts of Government with physicians and at primary health care level measures should be taken. For achieving success in the implementation of tobacco intervention services

systematic training on tobacco and its health hazards, identification and clinical diagnosis of tobacco-related lesions, tailored method for tobacco use cessation and knowledge about referral of cases to the appropriate centres are essential to formulate policies and eliminate disparities. Tobacco cessation training should be directed to the undergraduate and postgraduate students and staff members with an interdisciplinary approach. Tobacco is considered to be one of the cash crops for farmers, so advising them for an alternative crop is one of the majors confront for all the sectors thereby reducing the quantity of tobacco being produced in our country. Hence, government should educate farmers regarding the alternative crop and provide subsidy on seeds.

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