Building Capacity for Tobacco Cessation in India, Indonesia & Turkey: From Formative Research to Clinic & Community-Based Interventions

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Project Quit Tobacco International (QTI)
10 Medical Colleges in 3 Countries

**USA:** University of Arizona
School of Anthropology & College of Medicine

**India:**
- *Kerala State*
  - Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram
  - Academy of Medical Sciences, Pariyaram
  - Amrita School of Medicine, Kochi
  - TD Medical College, Alappuzha
- *Karnataka State*
  - Kasturba Medical College, Mangalore
  - Bangalore Medical College

**Indonesia**
- *Yogyakarta, Central Java*
  - Gadjah Mada University
  - Universitas Muhammadiyah
  - Universitas Islam
- *Sulawesi (South and North)*
  - Hasanuddin University
  - Sam Ratulangi University
Overview

1. Briefly highlight the global burden of tobacco
2. Explain why cessation is our focus
3. Introduce Project QTI assumptions
4. Provide a case study from clinic-based studies on diabetes (India)
5. Describe a community-based intervention (Indonesia)
6. Discuss our evolution to current project in Turkey
Why is tobacco a global health priority?
In 2015, smoking caused more than one in ten deaths worldwide & killed 6 million people

Smoking presently kills more people worldwide than all of the following combined:
- Malaria
- Maternal Mortality
- Major childhood diseases
- Tuberculosis
The global burden of deaths from tobacco has shifted from **high income** to **low and middle income countries** (LMIC)

<table>
<thead>
<tr>
<th></th>
<th>Tobacco deaths 2000</th>
<th>Tobacco deaths 2030</th>
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<tbody>
<tr>
<td>High income</td>
<td>2 million</td>
<td>3 million</td>
</tr>
<tr>
<td>LMIC</td>
<td><strong>2 million</strong></td>
<td><strong>7 million</strong></td>
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By 2030, 7 of every 10 tobacco attributable deaths projected to be in LMIC
Global Tobacco Use

- Worldwide, one in four men—933 million people—are current daily smokers.

- 80% of these smokers live in low and middle income countries (LMIC).

- An estimated 500 million people will die prematurely by their smoking unless they quit.

- In the next decade, tobacco use will surpass infectious diseases to become the leading threat to human health worldwide.
Century-Wide Estimates of Mortality are Staggering

- In the 20th century, smoking caused an estimated 100 million deaths.

- In the 21st century, if current usage patterns persist, smoking will cause approximately 1 billion deaths.
Most estimates are incomplete.

Most calculations are based on smoking alone and do not include the effect of second hand smoke.
- The projections also do not include the use of smokeless tobacco.
- Use in South Asia is highly prevalent and a serious public health problem.
Tobacco Use in India

- Less than 20% of all tobacco is consumed in the form of cigarettes.
- About 40% is consumed in the form of bidi.
- About 40% of overall tobacco consumption is in the form of smokeless tobacco use; in a wide range and variety of products.
Morbidity due to Tobacco Use Matters as Much as Mortality

- People with smoking-related illness are sick for many years.
  - Sick during productive years -> cannot support families
- Their ill health is an economic burden for both their family and the state

- Tobacco is a significant risk factor for many chronic diseases, and increases the chance of serious complications: Diabetes is a prime example
Consider the numerator

- The numerator is larger than just the smoker
- Should include all those in family exposed to SHS, who become ill
- This is several orders of magnitude larger than those who are smokers
- Human cost of tobacco:
  - Direct costs
  - Indirect costs/ carrying capacity
  - Opportunity costs
  - Social and emotional costs
Why India and Indonesia?

**Indonesia**
- Indonesia: prevalence 67% men, 4% women
- Number of smokers growing about 5% per year; country has very young smokers—1/3 of boys (13-15) smoke
- 85% of men smoke cigarettes at home
- Kreteks
- Tobacco: largest source of gov’t revenue after oil, timber, and gas

**India**
- India: smoked & smokeless prevalence 48% men, 20% of women
- About 18% of women use smokeless tobacco (chew); 2% smoke
- An incredibly complex variety of smoked & smokeless products exist in India (including bidis)
Why is Cessation our Focus?

- Tobacco cessation is only means of reducing death toll in shorter term
- Tobacco prevention now will not have substantial effect on mortality until 2040
- Cessation supports all other prevention efforts – seeing people giving up smoking makes others think about not starting
Why Cessation?

- A relatively non-controversial “toe in the door” strategy in countries where tobacco control is in its infancy: gain foothold
- Cannot assume cessation strategies from developed countries will be applicable, so formative research is needed
  - Few LMIC presently have cessation services
- Directly relevant to managing medical conditions, so a means to engage healthcare providers and gain their support:
  - Illness is the most teachable moment
Our approach to cessation applies to place as well as people

- We approach cessation not only on an individual by individual basis
  - But a space by space basis

- Use science to lobby for smoke free environments for women and children
  - Examples: children exposed to second hand smoke at home: Indonesia (85%), China (53%), India (70%)
  - Tobacco control is a women's and children's issue
QTI Assumptions

- Until doctors address tobacco as a serious risk to public health, tobacco use in the general population will not decline.
- Health care providers (HCP) are opinion leaders and role models.
- Doctors must be tobacco control advocates in their daily practice.

For this to happen:

- Health professionals must quit smoking.
- HCP should learn about the systemic harms of tobacco and need to routinely talk to patients about tobacco use.
Why Base QTI Activities in Medical Colleges?

- Early adopters because of roles as teachers and researchers
- Train the next generation of physicians
- Influence practice standards in the medical community
- Are involved / should be involved in community outreach and support
- Faculty often have leadership roles in professional societies, credentialing agencies, government advisory boards or panels
QTI Project Components

Each QTI Medical School

Medical Curriculum
- Modular “lego” Approach
- Knowledge and skills

Cessation Clinic
- Demonstration and Practice Site for Medical Students

Community Intervention
- Medical school outreach Training site
- Research site

Medical School → Nursing
- Pharmacy
- Dental Schools

Example: Diabetes cessation clinic

Examples:
- Smoke free houses,
- Community based Cessation clinics

Experiences Shared

10 Medical Schools
Medical Curriculum: 4 goals

Goal: Adoption and full integration of a QTI Tobacco Cessation Curriculum across all 4 years of medical college

- Illustrate tobacco’s relevance to all subjects covered in medical school
- Easy to use modules for faculty: high turnover of faculty anticipated
- Flexible design: anticipate changes in curriculum in keeping with new models of medical education
- Tailored to needs of each school, and local patterns of tobacco use; build on lessons of experienced local health care providers.
QTI Formative Research

What did we do and what did we learn from formative research?
QTI 1 – Five Core Activities

1. **Baseline data: Perceptions of tobacco harm and patterns of use**
   - Health care providers: Doctors, medical students
   - Patients: general, diabetes and TB
   - General population

2. **Document doctors’ baseline cessation efforts**

3. **Explore how best to raise consciousness about the harm of smoking in the medical community and the community at large**
4. Develop culturally sensitive education materials on tobacco’s relationship to health in general and to specific diseases
5. Develop culturally sensitive approaches to cessation
## Smoking Prevalence among Male Medical Professionals

<table>
<thead>
<tr>
<th>Baseline data</th>
<th>Ever smoker</th>
<th>Current smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>India</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Students</td>
<td>29%</td>
<td>14%</td>
</tr>
<tr>
<td>Doctors</td>
<td>48%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Indonesia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Students</td>
<td>55%</td>
<td>18%</td>
</tr>
<tr>
<td>Doctors</td>
<td>67%</td>
<td>22%</td>
</tr>
</tbody>
</table>

% smokers increases by years in medical school.
Doctors’ perceptions of harmful levels of smoking

- Indonesia: A majority of physicians (80%) believed that smoking up to 10 cigarettes a day was not harmful for health.
- India: 5-6 cigarettes or bidis was viewed as relatively harmless.
Perceptions of risk: general population, patients, and general practitioners

- In both countries, smoking is associated with lung cancer and COPD, but rarely with other diseases such as:
  - Coronary heart disease
  - Peripheral vascular disease
  - Stroke
  - Diabetes
  - TB
Do doctors **routinely** ask patients about their smoking?

- In general practice: most doctors do not ask about smoking
- Between 15-30% of doctors reported doing so
  - This was not confirmed by exit interviews

- Do patients find doctors questions about smoking intrusive?
  - Patient survey: NO

**Busy hospital clinic: 915 patients**
- 57% of men attending had used tobacco in the last 30 days
Patient populations at risk and quit advice

- Do doctors ask or advise patients at greatest risk for tobacco-related complications?

✓ Diabetes and TB patient populations studied as exemplars
  Both diseases significantly affected by smoking
  - Risk factor (both)
  - Relapse (TB)
  - Complications (Diabetes)
Five Lessons Learned:
What People Want to Know

1. Local populations relate to local statistics – not national, regional, or global statistics.
2. Local populations want specific information on how tobacco causes specific health problems, not just general information about harm. They want to imagine how.....
   - Not just that tobacco is bad for people with diabetes, but how tobacco affects blood flow and how poor blood circulation is related to foot ulcers.
3. Visuals that “show how” are appreciated

- People liked before and after photos of diseased organs
- Graphic images okay

(Blackened lungs)

(Atherosclerosis)
4. Culture and Local Biology Matter

- In different cultures the salience of **withdrawal symptoms** differs in keeping with local biology
  - In India, smokers who tried to quit complained of digestive problems, constipation, gaseousness, lethargy (dullness), and throbbing head.
  - In Indonesia, symptoms included: bitterness of mouth; feeling lazy to work; fatigue; being angry; having a headache.

- Quit advice must be culturally sensitive: should index specific symptoms of concern locally.
5. Evocative messages work well in concert with knowledge

Messages, pictures, testimonials that tell a story and pull at one’s heart strings
ibu dan anaknya menunggu menunggu kepada suami/bapak untuk bertemu mereka — suami dalam keadaan mending dan keadaan sakit — buntut2 — untuk kesihatan dia sendiri dan keluarga.
മലയാളം
Clinic-based intervention:

Diabetes clinic in India
Diabetes and Smoking in India

- India has the second largest diabetic population (61 million) and number of tobacco users (275 million) globally.

- Kerala State has the highest diabetes prevalence (21%) in India. Among men, prevalence is 28%.

- Little was known about smoking and cessation practices among patients with diabetes.
Smoking & Diabetes

- Smokers are 30–40% more likely to develop type 2 diabetes than nonsmokers.
- People with diabetes who smoke are more likely than nonsmokers to have trouble with insulin dosing and with controlling their disease.
- Smokers with diabetes have higher risks for serious complications, including:
  - Combined cardiovascular disease risk from smoking and diabetes is nearly 14 times higher than the risk of either smoking or diabetes alone
  - Poor blood flow in the legs and feet leading to infections, ulcers, and possible amputation
  - Retinopathy
  - Peripheral neuropathy (damaged nerves to the arms and legs that causes numbness, pain, weakness, and poor coordination)
Tobacco Use among Diabetes Patients and Doctor’s Quit Advice

India (N=200)

- 44% of diabetes patients currently smoke
- 64% did not associate smoking with risk to diabetes or diabetes complication
- 48% of diabetic patients had not received advice to reduce or quit their tobacco habit
Objectives & Methodology

To find the comparative effectiveness of:

1) strong diabetes specific cessation message delivered by doctors and

2) a diabetes specific cessation counseling by a non-doctor health professional in addition to doctor’s cessation message on quitting
Methodology

- All the diabetes patients (2,490) who attended two peri-urban referral diabetic clinics located in South Kerala were screened for smoking.

  - 224 male diabetic patients (18 & older, mean age 53) who smoked in the last month and gave consent to the study were selected.

  - The patients were randomized into two equal groups.
Smoking Status at 6 months post intervention

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Intervn group 1</th>
<th>Intervn group 2</th>
<th>Unadjusted OR (95% CI)</th>
<th>Adjusted OR* (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=98</td>
<td>N=98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quit rate(^1)</td>
<td>14(12.5)</td>
<td>58(51.8)</td>
<td>7.5(3.8-14.7)</td>
<td>8.6(4.2-17.6)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Harm reduction(^2)</td>
<td>25(25.5)</td>
<td>20(37.0)</td>
<td>1.7(0.8-3.5)</td>
<td>1.7(0.8-3.6)</td>
<td>0.144</td>
</tr>
</tbody>
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*Adjusted for age, education, occupation, presence of any other chronic disease, duration of diabetes and number of sticks per day

1Quit Rate: Point prevalence abstinence of no smoking in the last seven days

2Harm reduction: Reduction of smoking (no of sticks per day) > 50% of baseline
Major findings of Kerala study

- A brief intervention by doctor results in a quit rate of more than 12%.
- If this brief intervention is further supported by culturally sensitive and diabetes-specific cessation counseling sessions by a trained non-doctor health professional, far more patients are likely to quit.
- Our study demonstrated that the odds for quitting was almost 9 times higher for the group that received cessation counseling compared to the group that received a doctor’s quit advise only.
Follow up study: Anthropological team

- Why do some diabetes patients continue to smoke
  - From sensorial to social
  - Cues to smoke
  - Self medication
  - Pleasure
- Does low level smoking last, or does it increase over time
Health Behavior, health practice or both

- By conceiving individual health behavior as discrete, stable, homogeneous and measurable, many other aspects of well being related activities, in particular those relating to sociality, are excluded.
- Reconceptualising what people do in terms of health practices, rather than just health behaviors
  - captures the emergent and contingent properties of people's social activities in particular contexts
- Health behavior more individual and psychological
- Health practices more social context oriented

* Simon Cohn: From Health behaviors to health practices Soc of Hlth and Illness, 36:3, 2014
Community-Based Intervention

Developing Smoke Free Homes in Java, Indonesia
Indonesia: A Tobacco Advertiser’s Paradise

- Little regulations for advertising in the country
- The commonality of tobacco advertising serves to normalize the behavior.
TALK LESS
DO MORE
CLAS
MILD

facebook
jogja
facebooker
The Gathering for Jogja’s facebook maniacs
Jumat 31 July

Hugo’s
CAFÉ

Not Just
Talk Only
Modern Women Associated with Smoking
new SLimZ

MEROKOK DAPAT MENYEBARKAN KANKER,
SERANGAN JANTUNG, IMPOTENSI DAN
GANGGUAN KEHAMILAN DAN JANIN.
Smoking helps you diffuse difficult situations
Nationalism: Kretaks are part of our “national heritage”
Goals of the Smoke Free Homes Initiative

- To make tobacco a woman’s and children’s health issue, beyond the smoker
- To create a movement to restrict smoking inside home to restrict harm to women and children
- To identify relevant steps to allow for replicability and sustainability of this public health movement
- To scale up following identified steps and using educational materials developed
Health Effects of Secondhand Smoke Exposure (SHS)

- Women who have never smoked who live with a smoker have a 90% greater risk of heart disease
- Have twice the risk of dying from lung cancer
- Triggers asthma attacks, bronchitis, pneumonia
- Pregnant women and infants: preterm delivery, low birth weight, poor lung function, recurring respiratory ailments of baby
Situational Analysis

- Initial survey research (n=810) revealed that over 80% of women had a husband who regularly smoked at home.
- 85% of households had no rules regarding smoking.
- Some allowed smoking in one room of the house.
- Rules did not apply to guests—considered impolite to ask guests not to smoke.
Focus Group Findings

- Many women had already asked husband not to smoke in the house but to no avail
- Majority of women disliked smoking but felt powerless to protect themselves and their children
- Smoking seen as an acceptable behavior in Indonesian male culture
- Over 90% of women and 65% of men expressed support for a community wide smoke free homes policy
Formative research findings

- Women and men had general ideas about SHS as harmful; knew little about specific illnesses
- Realized people needed education about specific harms as an important first step
- Why would a man stop smoking inside the house if unaware of the harm he was causing the family?
Presentations to Community Leaders about SHS & Consciousness Raising
Educational sessions for community

- Video contains info on general harms of tobacco and specific harms to women and children-
- SHS – measurement and questions how long in air, how far travel, why smoking room is not enough
- Prevalence data on smoking in the house
- Testimonials by members of communities who are successful
What are community members asked to do?

- Smokers are asked not to smoke inside their homes to protect their families from SHS
- No smoking permitted at community meetings
- No distributions of cigarettes for community work done or at any social events (weddings, funerals)
- Stickers and posters are posted around the community so all are aware of the initiative
Signage makes it clear that it is a smoke free community
Declaration meeting: Social contracts signed
Smoke Free Homes Initiative Receives Media Coverage

- These communities are role models
- One community recognized as the “model village for health” in Indonesia
- Garnered widespread interest in the movement
Changing Social Norms

- Social norms seem to be changing as some smokers noted that they are now ashamed to be seen smoking in or even near their home.

- Men and their wives were proud to talk about quitting after the intervention was introduced.
Moving from self efficacy to collective efficacy

- Following of social norms and adhering to a collective ethic is important in Indonesia
- Developed non-confrontational messages appealing to male responsibility to care for the health of the family
  - An existing and strong cultural value
- Men who quit gained culture capital for self and community
Modeling how to confront when men are resistant to change

- “Smoking is our culture”
- In terms of cultural values, caring for family trumps culture of smoking
- Is your enjoyment more important than well being of household, children?
School-based campaigns are underway developed by student groups letting young men know what young women think of smoking.

QTI is also encouraging young women to get involved in cessation with peers.
Taking the message to primary schools
Engaging nurses in smoking cessation in Turkey

Project QTI Turkey
Tobacco Control in Turkey

- Turkey was among first countries in the world to ratify WHO’s FCTC & is a global leader in this area
- As of 2015, one of only countries in the world to implement all of WHO MPOWER measures (Monitor, Protect, Offer help, Warn, Enforce and Raise Taxes)
- Tobacco use remains a key public health concern—causes at least 100,000 deaths per year.
Smoking Prevalence

- Turkey is the 8th largest consumer of tobacco in the world
- Smoking among men: 41%; Women: 13%
- Among health care providers: 24% of general practitioners, 13% of specialists, 20% of nurses and midwives are regular smokers
- Turks are high level smokers; smoke about 19 cigarettes per day
- Perception around Europe of a heavy smoker is one who “smokes like a Turk”
Politics of Tobacco Control in Turkey

- Turkey’s ruling party, the AKP (Justice & Development Party) -- strongly in favor of tobacco control.
- President Erdogan & Health Minister are both non-smokers united in support of tobacco control.
- The AKP’s high-level interest in tobacco control is not just motivated by public health concerns: politically motivated and tied to:
  - Initially linked to progressive EU policies: Endorsing tobacco control placed Turkey in compliance with EU norms for “high health standards”, for which the country has international recognition
  - More recently, is linked to Conservative Islamic moral identity: Turkish efforts to assume a leadership role in the Middle East
Smoking Cessation in Turkey

- Although a key component of Turkish Health Policy, cessation efforts within the country have not been well documented.
- In 2011, Turkey opened cessation clinics around the country; 27 were located in government hospitals in Istanbul.
- Cessation is only carried out by doctors and is highly medicalized – pharmacotherapy (Varenicline &/or Bupropion) prescribed to nearly all patients who wish to quit.
- Very little behavioral counseling offered in cessation clinics.
- Pharmacotherapy has been purchased at a reduced rate by the Ministry of Health—has created a market presence for Pfizer & GlaxoSmithKline in the country.
- Notably, when medications are available, they’re given freely to patients—distribution has been around the time of elections.
Big Pharma in Turkish Clinics

Cessation clinics only had educational materials supplied from U.S. pharmaceutical companies.

The message on this clock is “You can quit!”

Translations of American posters
Increasing need for cessation services

- Recent national survey results on quitting: 43% of smokers had tried to quit in past year, and 35% had thought about quitting
- The desire to quit is on the rise
- There is a need for more information/education on the harm of tobacco
- At present, people have a general sense that smoking is harmful for health and that it can cause lung cancer
Project Overview

- Overall goal is to extend the reach and depth of smoking cessation training within the Turkish healthcare system.
- Creating a cadre of nurses trained in tobacco cessation who are able to introduce illness-specific as well as general cessation training within their own practice-based communities and sub-specialties.
- Attempting to tailor smoking cessation to Turkish culture
- Developing & providing training for nurses to establish relevance of cessation advice by addressing how smoking has contributed to a patient’s health care problem, and how SHS places others in household at risk
Why Nurses?

- Recent Cochrane Review of 35 trials found nursing interventions to help smokers quit have been effective in US, Europe, Australia, & China.
- Nurses spend more time with patients, are patient educators, involved in health promotion and lifestyle modification.
- When asked about tobacco use & advised to quit by multiple health providers smokers have twice the odds of having successfully quit in past year.
Methods

- Baseline data: Observational data in Istanbul cessation clinic in a large public respiratory hospital to see how clinic functioned; role of doctors and nurses in cessation
- Key informant interviews (n=4) with health professionals involved with training doctors to determine if training had been adapted to Turkish culture
- Interviews with smokers (n=28) to explore attitudes toward quitting & challenges faced when trying to quit
- Reviewed existing nursing curriculum to ascertain whether tobacco use & cessation skills were currently being taught
Trainings of nurses

- Four 2-day training workshops conducted for nurses (n=54) from 5 specialty areas (diabetes, respiratory, cardiology, pediatric, reproductive health)
- Training: systemic harms of tobacco; evidence-based counseling skills; ways of establishing illness/health problem specific relevance of cessation messages; how to respond to common physical, psychological, and social challenges to quitting
- After 2 months, 16 site visits were made to nurse’s workplaces; nurses were debriefed in small group settings on their experience with counseling
- Also observed how pts responded, logistical challenges – time and space
Findings: Project QTI Turkey
Challenges: Doctors & Nurses

- Neither doctors or nurses consider cessation to be part of routine medical practice & as a result, do not pay attention to patient’s smoking status
- Even cardiologists & surgeons have little interest in cessation, viewing it as prevention & not central to their treatment of acute/chronic conditions
- Resulted in limited referral to cessation clinics and lack of advice to quit – even before a surgical procedure
- Cessation in Turkey=pharmacotherapy. Expectation among patients was that they would get drugs, not “just” advice
- Nurses not allowed to prescribe pharmacotherapy
- Nurse’s role was limited to advising patients how to use medication prescribed & discussing side effects
Challenges: Nurses

- High smoking prevalence: 20-45% of nurses are current smokers; 90% of nurses who smoke report initiating smoking in nursing college

- Nurses have been given no prior training in cessation counseling – even in health promotion classes
Impact of health system changes on cessation practice—cessation delivery/services getting worse not better

- In 2010, Turkey shifted to a neo-liberal performance oriented management system with doctors and hospitals revenues tied to volume of curative services provided.
- Doctors dis-incentivized to provide cessation services to patients; as a result, cessation clinics closed or had limited hours of service.
- Overall, decrease in interest in preventive and promotive health.
- All prevention, including smoking cessation viewed as adjunct; and not rewarded.
- Patients have to wait up to 2 months to get first appointment.
Systemic incentives for nurses to smoke

- Nurses are incentivized to smoke as it is one of the few breaks they can take.
- Serves as a time out, when they can take a break and relax, socialize.
- Work long hours, smoking helps keep them awake & alert.
Lack of motivation to engage in cessation

- Little incentive for nurses to participate in free tobacco cessation training—no career advancement or salary increase.
Patient’s response to nurse’s cessation messages

- Patients perceive health care provider smoking to be very high:
  - “Almost all doctors and nurses smoke”
  - “If it’s so harmful, why are they still smoking?”

- General cessation messages—if given—were easily overlooked
Cessation messages challenged

- Turkish smokers commonly questioned scientific evidence about the harm of smoking—were oppositional and dismissive of quit messages.

- Diabetes patients questioned how smoking could be related to their illness.

- Others asked “How can I believe it’s harmful?”—looking at older family members who smoked heavily & were healthy.
Smoking at low levels deemed acceptable by doctors

- Widespread notion among doctors not trained in cessation that low level smoking ("just a few" even among pregnant women) was not harmful for health

- Often seen as beneficial to help calm down patients who had psychological problems

- This undermined cessation messages when provided by nurses
Nurse’s cessation messages not in synch with messages of doctors

- As doctors did not promote cessation, nurse’s advice was not highly valued by patients.
- Patients challenged nurse’s advice, stating that dr had not told them to quit.
Positive experiences of nurses after training

- Increased job satisfaction--helping patient see connection between their illness and their smoking

- Nurses saw this as entry point to patient-centered care—began to talk about patient’s life not just their treatment

- Felt they were making a positive impact on present and future health status of patient
Opportunities for Engaging Nurses

- Turkey has increased number of nursing schools

- Ministry of Health endorsed tobacco curriculum in nursing colleges—can train them in harms of tobacco & cessation counseling

- In line with pro-natalist stance of government, nurses & midwives are incentivized to closely monitor pregnant & postpartum women—can work closely with them over time and help them quit

- Ministry of Health has a new initiative on non communicable diseases where patient education is compulsory for those with chronic illness like diabetes. Presents an opportunity for nurses to offer cessation advice to diabetes patients.
Lessons Learned
Project assumptions challenged

- We assumed Turkey’s proactive national tobacco control policies would result in widespread receptivity to cessation training for nurses & services for patients
- This was not the case
- The importance of counseling patients has not been emphasized in Turkish medical & nursing education
- Several systemic challenges to introducing tobacco cessation in clinical settings were identified
Lessons Learned: Provider Education

- Medical & nursing students must learn to establish relevance of quitting by tying advice to specific health conditions
- Need to practice brief interventions with patients, not just learn skills on line or from lectures
- Health care providers need credible, culturally appropriate educational materials to increase their credibility
Lessons Learned: Emphasize Suffering not Mortality

- Increased chance of mortality is not a powerful motivator to quit smoking in Turkey
- Illness-specific counseling plays up suffering and exacerbation of current illness, and poor response to medication as a means of establishing relevance as a teachable moment
- This approach is being tested in our project
Lessons Learned: Health Administrators

- Health administrators need to buy-in to cessation and recognize that cessation is a cost-effective health intervention.

- Nurses will require training, as well as time and space to participate in routine cessation counseling.

- Continuing education in illness-specific and general tobacco cessation skills for nurses who circulate between sub-specialties will be needed.
Key Lesson Learned

- Health care providers will need to quit—a lesson well documented in global tobacco control
Perspectives that anthropology brings to tobacco control & cessation

- Risk perception; social risk
- Establishing relevance
- Working with self efficacy and collective efficacy
- Ideas about harm reduction & addiction
- Health practices; what is normative in the culture
- Sensitivity to gender
- Social norms and values (advertising uses one set of norms)
- Patient-practitioner communication; behavior change
- Political economic analysis
Thank You!

www.quittobaccointernational.org
Efficacy of Cessation Clinics

- Only one study has evaluated the efficacy of the national cessation program.
- Examined one-year period (2011), & randomly choose 16,500 people who had received free medications (64% Varenicline/Champix; 36% Bupropion/Zyban);
- 30% of Varenicline users and 25% of Bupropion users had quit and had not relapsed at one year.
- Those with hypertension, diabetes and CVD were more likely to have successfully quit.
Publications 2006-13 (N=16)


