A Qualitative Study to Assess the Reasons for Initiation and Continuation of Tobacco Use Among 15 Years and Above in a Selected Village of Ballabgarh.

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

By

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Certificate of Internship Completion for PGDHM

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Priyanka Kardam** working as Research Assistant, AIIMS, has successfully completed her 3 months internship from January 21, 2012 to April 21, 2012 under my guidance while also working as Research Assistant.

She is hard working girl with keen interest in learning. I found her a person who has great concern for health problems in the community and their prevention.

I wish her very best for all her future endeavors.

Puneet Misra

May 18, 2012

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that Dr. Priyanka Kardam , a participant of the Post- Graduate Diploma in Health and Hospital Management has worked under our guidance and supervision. She is submitting this dissertation titled "**A qualitative study, to assess the reasons for initiation and continuation of tobacco use, among 15 years and above, in a selected Village of Ballabgarh.** " in partial fulfillment of the requirements for the award of the Post- Graduate Diploma in Health and Hospital Management.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. Dharmesh Lal
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Certificate of Approval

The following dissertation titled " **A qualitative study to assess the reasons for initiation and continuation of tobacco use among people of age 15 years and above in Chhainsa Village of Ballabgarh.**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

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Abstract

Tobacco use is becoming a serious health problem of people in developing countries. Taking into account various health complications associated with tobacco use, it is very important to understand the factors leading to initiation and its continued use by people. The purpose of this study is to assess the reasons as to why people initiate and continue using tobacco. For the study, 5 Focus Group Discussions and 2 In depth interviews were conducted among tobacco users and various stakeholders in the community like ASHA, Health Worker, ANM, Sarpanch of the village. Study was conducted in Village Chhainsa, which is a field practice area of CRHSP-AIIMS. Tobacco use start at very early age of even 11-12years. Reasons for initiation include seeing the elderly at home, peer pressure, trying for once i.e. Experimental smoking and then develops a habit, to relieve their tension, to seek pleasure and to ease abdominal problems. People also under-estimate the health consequences of tobacco use. It has been socially acceptable among adults and the elderly in the village. Continued tobacco use includes reasons like dependence on tobacco, relieving stress, physical discomfort on quitting. After knowing the reasons for people to initiate and continue smoking, an environment should be created in the community that can help tobacco users to quit. There is need of spreading awareness among the people about ill effects of tobacco use through media, health workers, health care providers and local active NGO's.

***Key words**: Tobacco prevalence, Tobacco use, Initiation of tobacco, continued use of tobacco Smokers, Smoking, Smokeless tobacco.*

Acknowledgement

Apart from the personal effort and steadfastness to work, constant inspiration and encouragement given by a number of individuals served as the driving force that enabled me to submit my dissertation report in the present form.

First of all a special gratitude to **IIHMR**, New Delhi, for giving me the opportunity to work with **Centre for Community Medicine, AIIMS**, New Delhi, for three months dissertation as a part of course curriculum of PGDHHM. It was an immense pleasure for me to work at **CRHSP, Ballabgarh**, which is an Intensive Field Practice Area of CCM, AIIMS and serves as a model for delivery of health care to the villages of India.

No work can be perfect, without the ample guidance. I express my sincere thanks and deepest gratitude to **Dr. Puneet Misra** for his continual guidance, advice and supervision throughout my dissertation.

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A special thanks to the Almighty and above all, I am grateful to my parents and friends for their encouragement and support which made me to finish this work.

Dr Priyanka Kardam

Table of contents

Part-1 Internship Report

Part-2 Dissertation Report

List of Figures

Glossary

Tobacco user: Tobacco user means smokers and users of smokeless tobacco.

Current smokers: current smokers were persons smoking tobacco at the time of study.

Adults: Adults refer to persons of age 15 and above.

Chaupal: A common place in the village.

Abbreviations

AIIMS	**All India Institute of Medical Sciences**
ANM	**Auxillary Nurse and Midwife**
ASHA	**Accredited Social Health Activist**
CCM	**Centre for Community Medicine**
CRHSP	**Comprehensive Rural Health Services Project**
FCTC	**Framework Convention for Tobacco Control**
FGD	**Focus Group Discussion**
GATS	**Global Adult Tobacco Survey**
HW	**Health Worker**
IDI	**In Depth Interviews**
IFPA	**Intensive Field Practice Area**
NFHS	**National Family Health Survey**
PHC	**Primary Health Centre**
WHO	**World Health Organization**

Part 1
Internship Report

1 Organization Profile

1.1 About AIIMS:

The All-India Institute of Medical Sciences was created in 1956, as an autonomous institution,to serve as a nucleus for nurturing excellence in all aspect of health care.

All-India Institute of Medical Sciences was established as an institution of national importance by an Act of Parliament with the objects to develop patterns of teaching in Undergraduate and Post-graduate Medical Education in all its branches so as to demonstrate a high standard of Medical Education in India; to bring together in one place educational facilities of the highest order for the training of personnel in all important branches of health activity; and to attain self-sufficiency in Post-graduate Medical Education.

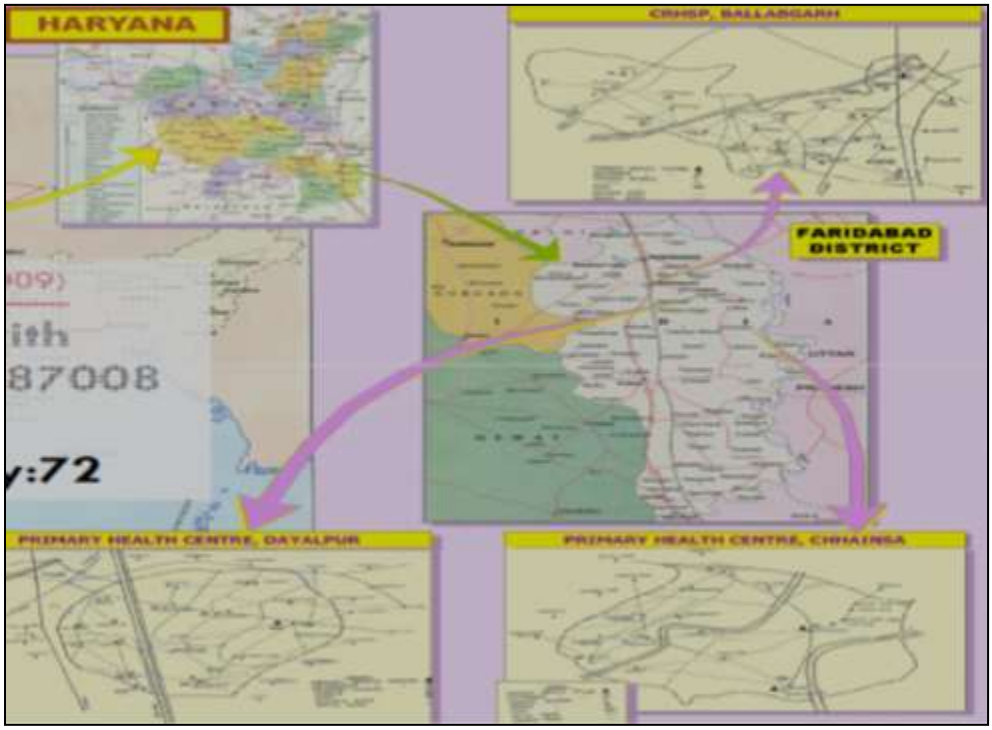
The Institute has comprehensive facilities for teaching, research and patient-care. As provided in the Act, AIIMS conducts teaching programs in medical and para-medical courses both at undergraduate and postgraduate levels and awards its own degrees. Teaching and research are conducted in 42 disciplines. In the field of medical research AIIMS is the lead, having more than 600 research publications by its faculty and researchers in a year.

AIIMS also manages a 60-beded hospital in the Comprehensive Rural Health Centre at Ballabgarh in Haryana and provides health cover to about 2.5 lakh population through the Centre for Community Medicine.

Area of engagement: The area of work is CRHSP, Ballabgarh which runs various research projects at Ballabgarh.

1.2 About CRHSP:

The Comprehensive Rural Health Services Project (CRHSP), Ballabgarh, situated in the state of Haryana in Northern India, was started in 1965 by the All India Institute of Medical Sciences in collaboration with the state government of Haryana. The field practice area of the project comprises of 28 villages catering to a population of 85552, as on 31st December 2008. The primary responsibility of CRHSP Ballabgarh is training of medical and nursing students, as well as delivering health care services patterned on national norms. It serves as a model for delivery of health care to the villages of India. It consists of a subdivisional hospital network of a primary health centres, subcentres and health workers. Its unique feature is a strong element of participation of the community in its own care. The project has demonstrated their major improvement in health care can be achieved with modest resources.



C.R.H.S. Project, Ballabgarh

It provides its services through:

1.a. Community Health Services

1.b. Referral Hospital, Ballabgarh

1.a. Community Health Services

They have an Intensive Field Practice Area (IFPA). This comprises of the two Primary Health Centres - Dayalpur & Chhainsa. Outpatient, domiciliary & referral services are being provided.

1.b. Referral Hospital, Ballabgarh

1. Outpatients

The following outpatient departments are run:

a) General outpatients for adults
b) Child Welfare Centre - for children
c) Ophthalmology outpatients - Daily
d) ENT twice a week
e) Dental outpatients - Daily
f) Obstetrics & Gynaecology OPD - daily
g) Epilepsy Clinic once a week
h) Rehabilitation OPD two days a week
i) Psychiatric OPD once a week
j) ANC Clinic thrice a week
k) Nutrition Rehabilitation clinic once a week
l) Pediatric Surgery OPD cum surgery - once a week
m) NCD clinic – once a week

1.2.1 Health Management System (HMIS) at Ballabgarh:

Health Management System (HMIS) is a computerized management system introduced in the project in 1988. Demographic data, Maternal and Child Health Services data, and data pertaining to various health services provided in the area are stored. CRHSP conducts demographic surveillance on an ongoing basis. Routine data (births, deaths, in-migration, out-migration) is collected on a monthly basis and a yearly census is also conducted in the month of December. The demographic database has been stored electronically since 1991. Every individual in the project area has been assigned a unique identification number that is present in all the files and which is used to link all the databases. The computerised database is updated and revised to accommodate the needs of the users and introduction of new national programmes.

The activities carried out at Ballabgarh are as a result of active collaboration with Indian Council of Medical Research (ICMR, New Delhi and WHO Country Office and South-east Asian Regional Office and WHO, Geneva.

1.3 Reflections from internship at CRHSP, Ballabgarh: An internship is a learning experience

During the entire process of implementation of projects, various phases gave various types of knowledge varying from soft skills, stress handling to technical advancements.

The major learning included designing focus group discussions guide and facilitating a discussion. It led to technical clarifications about focus group discussions. Rapport building and making participants feel comfortable is the key to get the participants into discussion mode. Whereas as a maderator you have to intervene in between if participants are diverting from the issue discussed.

Supervising the workers, assigning work to them and getting it done on time is a challenging task. If not done on time, may further delay the project deadlines. It included managerial skills and I have learned a lot from completing these tasks.

No work is possible without coordination among the team members. Few of the tasks given required everyone's input and working as a team to finish the assigned tasks.

One of the most important lessons I have learned thus far is that flexibility is essential. As I was involved in two projects, shifting focus from one to another was little difficult, but multi tasking is the key here. There are days when you are working on an assignment and something very important comes up and you have to switch gears to focus your attention on that. You must be able to jump on that task and complete it with the best of your ability.

Also, I was open to criticism. Soaked up all the advice and critiques my seniors gave me. The guidance from the seniors helped me in completing the tasks as well as developing the required skills to perform well.

Part-2

Dissertation Report

A qualitative study, to assess the reasons for initiation and continuation of tobacco use, among 15 years and above in a selected Village of Ballabgarh.

1 Background:

1.1 History of tobacco use in India: The history of global tobacco trade is integrally linked with the history of India. Tobacco cultivation has a history of about 8000 years. It was to discover a sea route to this fabled land, reputed for its spices, silk and gems, that Christopher Columbus set sail in 1492. This plant, treasured by the American .Indians. for its presumed medicinal and obvious stimulant properties, was eagerly embraced by the Portuguese. When the Portuguese eventually did land on India's shores, they brought in tobacco. They introduced it initially in the royal courts where it soon found favour. It became a valuable commodity of barter trade, being used by the Portuguese for purchasing Indian textiles. The taste for tobacco, first acquired by the Indian royals, soon spread to the commoners and, in the seventeenth century, tobacco began to take firm roots in India.

It was with the establishment of British colonial rule, however, that the commercial dimensions of India's tobacco production and consumption grew to be greatly magnified. Initially, the British traders imported American tobacco into India to finance the purchase of Indian commodities. in 1776, the British East India Company began growing tobacco in India as a cash crop. In the late nineteenth century, the beedi industry began to grow in India. The oldest beedi manufacturing firm was established around 1887 and by 1930 the beedi industry had spread across the country. The origin of the hookah corresponds to the introduction of tobacco into India. Due to its origin and its patronage by Mughal rulers, hookah became popular in those parts of India where the Mughals had a strong influence. Hookah was popular among men and women of aristocratic and elite classes, especially in north India. As a result, hookah smoking became a part of the culture, and sharing of a hookah became socially acceptable and got associated with brotherhood and a sign of conveying. The first cigarette factory, the Indian Tobacco Company of what is now known as ITC (formerly Imperial Tobacco Company) was established in Monghyr, Bihar, in 1906. In 1912, the first brand Scissors was launched equality. Tobacco, introduced as a product to be smoked, gradually began to be used in several other forms in India. It became an important additive to paan. Paan chewing as a habit has existed in

India and South-East Asia for over 2000 years. In Hindu culture (the predominant religion in India), paan chewing is referred to as one of the eight bhogas (enjoyments) of life. It was also a part of the Mughal culture. Several Mughal rulers were great connoisseurs of paan and employed specialists skilled in preparing paans to suit all occasions. The social acceptance and importance of paan increased further during the Mughal era.

The ill effects of tobacco use on human health were recognized even in the sixteenth century, which led to restrictions on its use even in earlier centuries. It is noteworthy that within twelve years of its introduction in India, Jahangir noticed the ill effects of tobacco and took measures to prohibit its use. In 1617, Jahangir passed orders against tobacco smoking. A draft of the constitution was published in February 1948. According to Article 47 of the Constitution: State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and drugs which are injurious to health. Tobacco cultivation has sustained despite social disapproval because of domestic demand (beedi tobacco) and the international market. India is the world's second largest producer of tobacco and also the second largest consumer of unmanufactured tobacco. It is a major exporter of unmanufactured tobacco. The Tobacco Board, agricultural research institutes located in different parts of India and the tobacco industry, particularly ITC, are facilitating the sustained production of different types of tobacco in the country.

1.2 Various types of tobacco forms used in India:

Smoking and Smokeless forms of tobacco are used in India. Smoking forms include:

Bidis: Bidis are the most popular smoking form of tobacco in India. Beedis are made by rolling a dried, rectangular piece of tendu leaf with 0.15.0.25 g of sundried, flaked tobacco.

Cigarettes: Cigarette smoking is the second most popular smoking form of tobacco used in India after bidis. The prevalence varies greatly among different geographic areas and subgroups such as rural.urban.

Cigars: Cigars are made of air-cured, fermented tobacco, usually in factories, and are generally expensive. Cigar smoking is predominantly an urban practice.

Chuttas: Chuttas are coarsely prepared cheroots. They are usually the products of cottage and small-scale industries, or are made at home.

Reverse chutta smoking: The term .reverse smoking. is used to describe smoking while keeping the glowing end of the tobacco product inside the mouth. Reverse chutta smoking is practised extensively by women in the rural areas of Visakhapatnam and the Srikakulam district of Andhra Pradesh.

Dhumti: Unlike beedis and chuttas, dhumtis are not available from vendors but are prepared by the smokers themselves. Dhumti is a kind of a conical cigar made by rolling tobacco leaf in the leaf of another plant. In a random sample of about 5400 villagers in Goa, 4% were dhumti smokers.

Pipe: Pipe smoking is one of the oldest forms of tobacco use. The different kinds of pipes used for smoking range from the small-stemmed European types made of wood to long-stemmed pipes made from metal or other material.

Hooklis: Hooklis are clay pipes commonly used in western India. Once the pipe is lit, it is smoked intermittently.

Chillum: Chillum smoking is an exclusively male practice; it is limited to the northern states of India, predominantly in rural areas. The chillum is a straight, conical pipe made of clay, 10.14 cm long, held vertically. In a survey of 35,000 individuals in the Mainpuri district of Uttar Pradesh, 28% of the villagers were found to be chillum smokers.

Hookah: The hookah is an Indian water pipe in which the tobacco smoke passes through water before inhalation. In a random sample of 4859 men and 5481 women from the Darbhanga district of Bihar, 2% and 28%, respectively, reported smoking the hookah.5 The reason given for this female predominance is that it is inconvenient for men to carry a hookah, whereas women remain at home most of the time.

More than 100 million people worldwide smoke water pipes daily. Hookah smoking by a large majority is perceived to be a rather innocuous form of smoking tobacco because the smoke gets filtered through water before inhalation. According to study on Kashmiri population, Smokers had a 4.2 times risk of lung cancer compared to non smokers. Hookah smoking is associated with a significantly higher risk for lung cancer in Kashmiri population.

Smokeless forms of tobacco: The term .smokeless tobacco. is used to describe tobacco that is consumed without heating or burning at the time of use. Smokeless tobacco can be used orally or nasally. The oral use of smokeless tobacco is widely prevalent in India; the different methods of consumption include chewing, sucking and applying tobacco preparations to the teeth and gums.

Paan (betel quid) with tobacco: Paan chewing, or betel quid chewing, is often erroneously referred to as .betel nut chewing. Tobacco is the most important ingredient of paan for regular users.

Paan masala: Paan masala is a commercial preparation containing areca nut, slaked lime, catechu and condiments, with or without powdered tobacco.

Mainpuri tobacco: In the Mainpuri district of Uttar Pradesh and nearby areas, this preparation is very popular. It contains mainly tobacco with slaked lime, finely cut areca nut, camphor and cloves. In a study of 35,000 individuals in Mainpuri, 7% of the villagers used this product.

Mawa: This preparation contains thin shavings of areca nut with the addition of some tobacco and slaked lime. Its use is becoming popular in Gujarat, especially among the youth.

Tobacco and slaked lime (*khaini*): Use of a mixture of sun-dried tobacco and slaked lime, known in some areas as khaini, is widespread in Maharashtra and several states of north India.

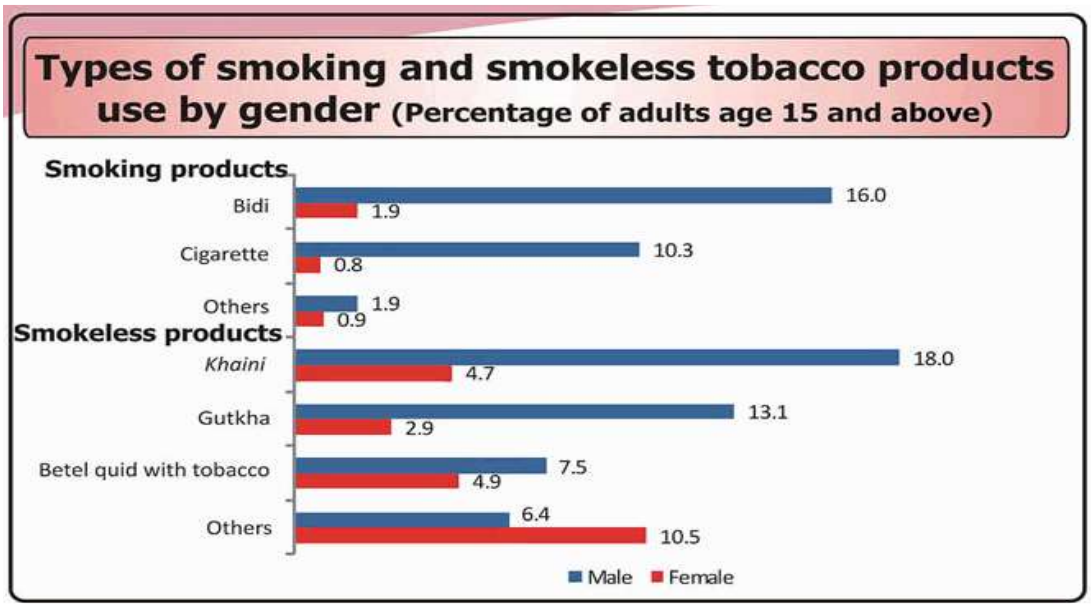
Chewing tobacco: Small pieces of raw or commercially available finely cut tobacco are used for this purpose. Among the 10,000 dental outpatients in Lucknow, Uttar Pradesh, and 57,000 industrial workers in Ahmedabad, Gujarat, 2.1% and 2.6% chewed tobacco alone, respectively.

Lal dantmanjan: Lal dantmanjan is a dentifrice; a red-coloured tooth powder.

Gudhaku: Gudhaku is a paste made of tobacco and molasses. It is available commercially and is carried in a metal container but can be made by the users themselves. It is commonly used in Bihar, Orissa, Uttar Pradesh and Uttaranchal.

Gul: Gul is a pyrolysed tobacco product. It is marketed under different brand names in small
tin cans and used as a dentifrice in the eastern part of India.

Nicotine chewing gum: Nicotine chewing gum containing 2% nicotine (brand name good-kha) has been launched as a help for tobacco cessation. For chewers, it is available in gutka flavour and for smokers, in mint flavour.



Source: GATS India fact sheet 2009-10

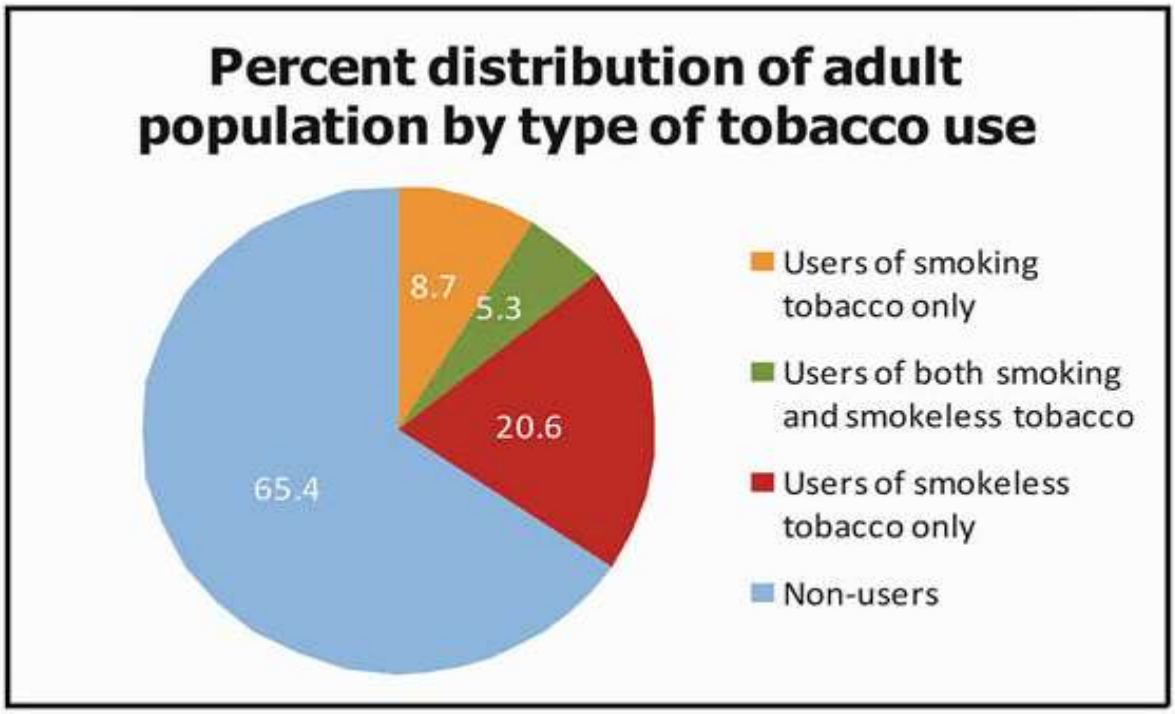
1.3 Prevalence of tobacco use:

Tobacco use is a major health hazard and preventable cause of death. It causes many diseases and impacts nearly every organ of the body including heart diseases, cancers and lung diseases. According to the estimates provided by WHO India will have the fastest rate of rise in deaths attributable to tobacco in the first two decades of the twenty first century.

NFHS-3 which is a household based survey, provides information on the prevalence in the use of tobacco and tobacco products by asking questions to the household head. According to the NFHS-3, prevalence of tobacco among men and women are 57% and 10.8% respectively who use any form of tobacco. Tobacco use is more prevalent among rural population. As per NFHS-3, 35% of rural men smoke cigarettes or bidis compared with 29% of urban men. About 4 out of every 10 men living in rural areas chew tobacco compared to 3 out of 10 in urban men. One in every 10 women in rural areas chews tobacco.

GATS India, is a nationally representative household survey, among population 15 and above. It produces internationally comparable data on tobacco use and tobacco control measures using a standardized methodology. GATS Fact Sheet 2009-10 reports that 34.6% of adults; 47.9% of males and 20.3% of females use tobacco in any form. 38.4% of rural population are current tobacco users. Tobacco user means smokers and users of smokeless tobacco. Average age at initiation of tobacco use was 17.8 years. Five in ten current smokers and users of tobacco planned to quit or at least thought of quitting.

Figure 1: % distribution of adult population by type of tobacco use.



Source: GATS India fact sheet 2009-10

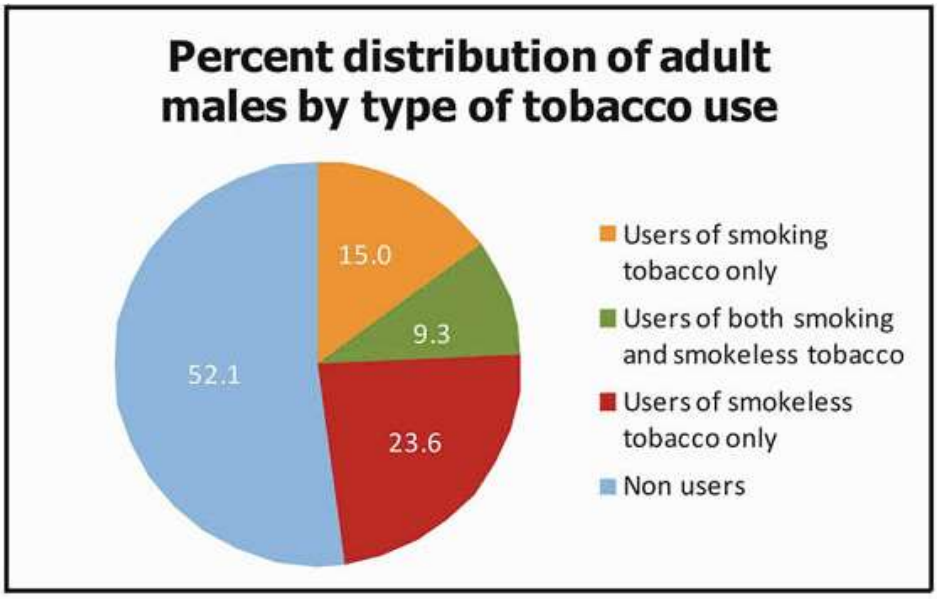


Figure 2: Percantage distribution of adult males by type of tobacco use.

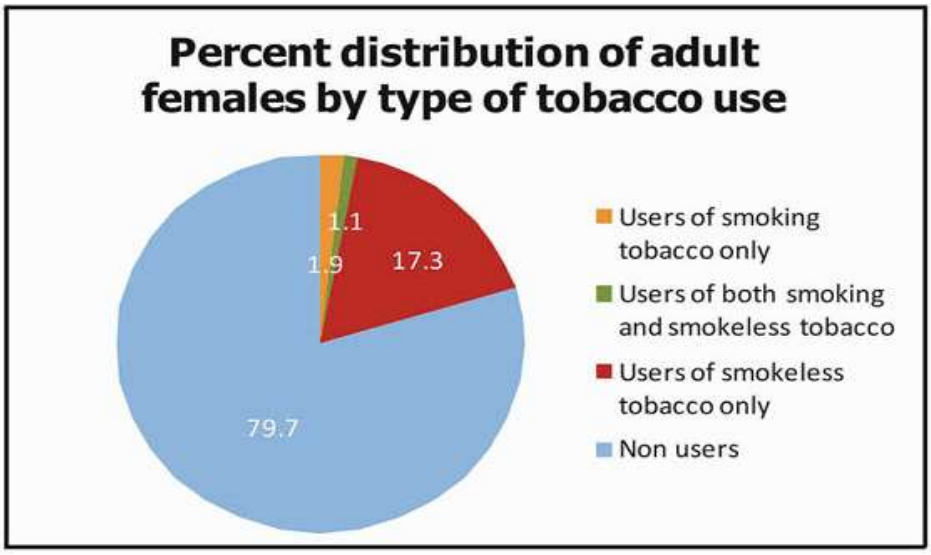


Figure 3: Percentage distribution of adult females by type of tobacco use.

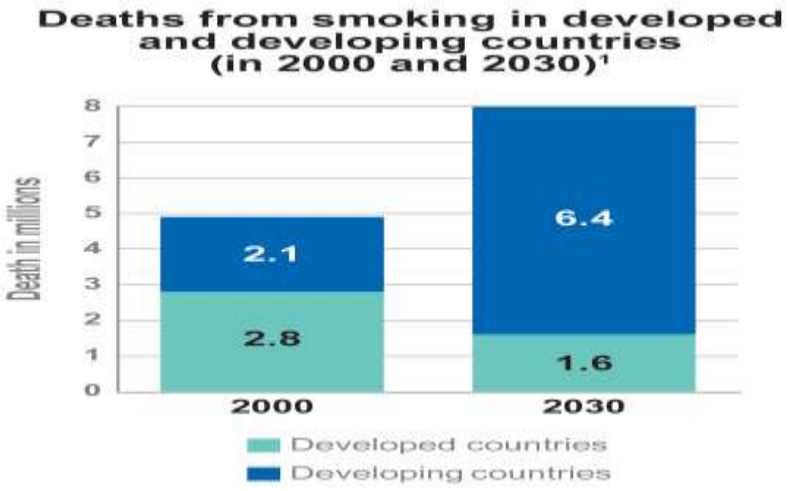
Source: GATS India fact sheet 2009-10

2. A qualitative study, to assess the reasons for initiation and continuation of tobacco use, among 15 years and above in a selected Village of Ballabgarh.

2.1 Introduction:

Tobacco use is a major health hazard in India. It is a major preventable cause of death and disease[1]. According to estimates made by the WHO, currently about 5 million people die prematurely every year in the world due to the use of tobacco, mostly cigarette smoking.[2] Tobacco kills more than 5 million people a year from lung cancer, heart disease and other tobacco-related illnesses. By 2030, the number of deaths will increase to 8 million each year and 80% of those deaths will be in developing countries. Every day, 80,000 to 100,000 young people around the world become addicted to tobacco.[3] If current trends continue, 250 million children and young people alive today will die from tobacco-related diseases.[4]

Figure 4: Deaths from smoking in developed and developing countries (in 2000 and 2030



Source: THE GLOBAL TOBACCO EPIDEMIC, www.tobaccofreecentre.org

As the second most populous country in the world, India's share of the global burden of tobacco-induced disease and death is substantial.[2] Nearly half of cancer among males and one fourth of cancers among females are tobacco related.[1] According to the National Family Health Survey-3, 2005-06, 57% of adult men and 3.1% of adult women used one or more tobacco products.[5] The Global Youth Tobacco Survey 2006 estimated that in India 17.3% of boys and 9.75 % of girls in the age group 13-15 are using a tobacco product.[6] In developing countries like India, tobacco consumption is mainly done in two forms: smoked tobacco products and smokeless tobacco. Taking into account various health complications associated with tobacco use, it is very important to understand the factors leading to initiation and its continued use by people. The present study was done to understand the reasons leading to initiation of tobacco use and what makes people to continue using it.

There are various factors influencing a person's decision to use tobacco, or if that person is a tobacco user, the forces that drive its continued use. Assessed in any manner, tobacco use is one of the most alarming health problems facing the world today.[2] Some common factors that may influence young people to use tobacco include: Peer pressure (having friends, peers using tobacco) or parents who use tobacco, to ease abdominal and dental problem and to seek pleasure were identified as important reasons for initiation of tobacco use.

2.2 Rationale of the study:

Tobacco use is becoming a serious health problem of people in developing countries. Tobacco consumption has been rising among both males and females at an alarming rate in India, WHO warns. According to Global Adult Tobacco survey the prevalence The purpose of this study is to assess the reasons as to why people initiate and continue using tobacco. It is very important to understand the factors leading to initiation and its continued use by people. In spite of the health hazards of tobacco people use tobacco. Hence, there is a need to understand people's perception and beliefs about tobacco use.

2.3 Objective:

- To assess the reasons for initiation and continuation of tobacco use, among 15 years and above in Chhainsa village of Ballabgarh.

2.3.1 Specific Objectives:

- To know the age of initiation of tobacco use.
- To know the forms of tobacco use among the community.
- To know the factors influencing continued tobacco use.
- To know the reasons what prevents them to quit tobacco.

2.4 Review of Literature

The search strategy adopted for review of literature was by:

- Searching journals and articles from PUBMED.
- Accessing Abstract/Full papers
- Using data from large National surveys like NFHS, GATS.
- Google search

Keywords used were: Prevalence of tobacco use, tobacco use in rural population, Reasons for continuation and initiation of tobacco.

Initiation and continuation of Tobacco use: perceptions and beliefs.

The development of tobacco use is influenced by a complex interplay of personal, social, and cultural factors which can vary over time and stage of development. Personal factors include personality type and characteristics that may predispose individuals to risk-taking behavior. Social influences include the behavior and attitudes of the individual's social support network, including friends, family, and peers. Cultural influences constitute the broader environmental context regarding social norms and acceptability in communities, neighbor hoods.[7]

The majority of users start using tobacco before age 18, and some even start as young as 10 years old.[8] According to GATS (2009-10) average age at initiation of tobacco use was 17.8 years.[1] In a study done on street children of Delhi, a total of sixty boys were interviewed. The most common age for initiation of tobacco was between 8 and 10 years with 60.9% of the children smoking and 64.5% consuming a smokeless form of tobacco before 10 years of age. The most common reason for initiation of tobacco was peer pressure (94.1%) followed by curiosity (17.6%) and pressure by relatives (8.8%). The most common reason for continuation of tobacco use was habit (61.8%), pleasure (38.2%), peer pressure (35.3%), for relaxation (23.5%) and liking of the taste (2.9%). Only 32.4% had attempted to stop tobacco use once or more, since starting and 63.6%

among them reported restarting the use of tobacco products, all within a month of leaving. The reasons for restarting included peer pressure (57.1%), not being able to live without it (42.9%), for pleasure and fun (28.6%) and for relaxation (14.3%).[9]

According to a study done at Noida to know the age at initiation and prevalence of tobacco use among school children shows nearly 70 per cent of boys and 80 per cent of girls $\leq$ 15 yr initiated the habit of tobacco before the age of 11 yr.[10]

Factors in the environment that potentially influence initiation and maintenance of smoking by adolescents have been the focus of many investigations since early studies demonstrated the importance of peer and parental smoking as risk factors.[11] The effect of parental smoking on smoking habits of the participants was quite evident among smokers. Peer pressure was the most important risk factor of initiation of smoking habit followed by parental influence.[12] Peer smoking was consistently found to be related to adolescent smoking initiation, maintenance and intentions.[13] Environmental factors that influence initiation and maintenance of tobacco use by adolescents include parental influence, peer tobacco use, and marketing and advertising of tobacco products. In a study of smoker perceptions in the United States, the majority of youth smokers reported giving no thought to how long they would continue to smoke when they began smoking.[14]

Adolescents who began smoking at a younger age were more likely to become regular smokers and less likely to quit smoking.[15] It has been noticed that a huge percentage of kids indulge in smoking by watching their parents and elders.[16] In a 2003 study of students in Alexandria, Egypt, parental and sibling smoking was associated with ever smoking, smoking in the prior 30 days, and susceptibility to smoking. Peer smoking has been shown to predict continued smoking by young people. [17] Heinz AJ et al did a study in USA which examined the influence of negative affect relief expectancies (NAREs) for smoking on smoking behavior and nicotine dependence using longitudinal data from a study on the emotional and social contexts of youth smoking. The results of the study show that NAREs for smoking influenced all smoking outcomes at baseline and predicted increases in smoking behavior and nicotine dependence over time, even after controlling for anxious and depressive symptoms and baseline nicotine dependence. Once smoking

has begun, cessation is difficult and smoking is likely to be a long-term addiction.[18] A number of factors influence the use of tobacco by children and teenagers. Some of these are the family history of tobacco use by elders, peer influence, experimentation, easy access to such products, personality factors, underlying emotional and psychological problems, accompanied risk-taking behaviors, and most importantly, the aggressive marketing strategies of the tobacco industry.[19] The main reasons for starting to use tobacco in various forms include accepted socio cultural norms, beliefs, and use as a medicinal aid.[20] It has been repeatedly demonstrated that stress, measured in a variety of ways, is associated with initiation to smoking and with maintenance of the behavior.[21] However, the belief that smokeless tobacco has a protective effect on teeth and is a pain killer is widely prevalent in many parts of rural India. Use of tobacco products as a dentifrice among adolescents in India has recently been reported, highlighting the continuation of the misconception till date.[22]

According to a report on tobacco control in India says sharing a hookah in daily gatherings, is a common example of fellowship, solidarity and the consultative process. Tobacco consumption is also associated with social status. Now, more and more women are taking tobacco across the world. Women also use tobacco in forms like beedi and hookah in rural Haryana. In the Nindana village in Haryana, for example, women go out in groups to fetch water late in the afternoon. During this time, away from the men and the immediacy of household responsibilities, they settle down for gossip, rest and the commensality and community of the hookah.[2]

A study done at Ballabgarh, Haryana shows the proportion using tobacco was nearly 4% higher in rural men as compared to urban-slum men and 17% higher in rural men as compared to urban men. In rural areas, hookah/pipe/chillum use turned out to be the second most preferred product after bidi, both among men and women. Among smokeless tobacco products, the most commonly used product was *khaini* followed by gutkha, in all three regions.[23]

2.4 Methodology

Study setting: Study was conducted in Village Chhainsa, which is a field practice area of CRHSP-AIIMS. Discussions and interviews were conducted at Chhainsa PHC.

Study design: Qualitative Study

Focus Group Discussions and In depth interviews were conducted among tobacco users and various stakeholders in the community like ASHA, Health Worker, ANM, Sarpanch of the village.

Sampling technique: Purposive sampling

Total of 35 people participated in Focus Group Discussions for the study.

A group of:

10 Male Smokers

5 Female Smokers

5 Male Health Workers

5 ANM

10 ASHA Workers

2 In depth interviews were conducted with the Sarpanch of the village and one Health Worker.

Study Tool: A focus group guide was prepared to facilitate the discussion and a questionnaire was prepared for in depth interviews.

Two Moderators and Two Note takers from CRHSP team who are familiar with the study area and languages, were responsible for data collection. The moderators and note takers were trained before by a senior expertise in qualitative research. FGD's and IDI's were conducted after finalizing the dates and venue and timings. Moderators were responsible for introducing the purpose and procedures of the FGD to the participants. The note takers were responsible for audio taping the discussion and taking notes. The moderators took additional note of any nonverbal gestures and communications in the course of discussions. Each FGD lasted about 30-40 minutes.

2.5 Discussion Analysis: Recorded FGD's and IDI's were transcriped and analysed using Kreguer's Framework Analysis. The advantage of the Krueger approach is that it provides a clear series of steps, which could help first-time researchers to manage the large amount and complex nature of qualitative data much more easily. 'Framework analysis' is used for both individual and focus-group interviews. The five key stages outlined are:

- Familiarization
- Identifying a thematic framework
- Indexing
- Charting
- Mapping and Interpretation

2.6 Observations/Results:

Age of Initiation:

Participants in the focus group discussion were told before about the discussion and discussion proceeded with the help of a guide prepared . the questions were not asked directly. Participants included both smokers and smokeless users of tobacco.

When tobacco users were asked about the age of their initiation, they started it at age of 20-25 years. ASHA and health workers told people start at very early age of even 11-12years. 0ne person in male health worker group told about a community called '***Raisikh'***, in that group tobacco use starts from childhood. One fact revealed here was difference in use of tobacco by age of uneducated and educated class. People in uneducated class start it at age of 10-15, whereas among educated class they take but at later stages, and if they consume tobacco, don't take it in front of their parents because of the fear of parents but in villages no such fear is there.

Types of tobacco forms used in community:

Every type of tobacco is consumed in the community from smoking to smokeless. Young population is more inclined towards cigarette smoking and chewing tobacco whereas discussions with the participants revealed that hookah is preferred by the elderly population of the village. Gutka, bidi, cigarette. hukka and khaini is commonly used. There is a red powder known as ***lal manjan*** used by women is common in the village, as told by one health worker. Bidi is also common among elderly women of the village. Chaupals in the village are places where elderly males gather in evening and take hookah and bidi. There is high social value attached to both smoking bidi and hookah in the rural set up though cigarette smoking and consumption of smokeless tobacco forms is also increasing in the village

Initiation of tobacco use:

They were asked how they got to know and started its use. They responded, no one told them, started using it seeing each other and elders at home. Long and probing discussion was held on as to why they use tobacco or what influences them to use it. One person replied **'*Prachin samay se chalta aa raha hai,bade bujurg peete hai. Jaise- jaise bade peete hain, waise waise chote peete hain'.*** *(*it has been used since long in their families, their elders use to take it, as elders take, children follow them). One more perception regarding smoking hookah, bidi and cigarette among both men and women who use it, say they consume it to get relief of the flatulence. If they don't smoke they feel flatulence in the stomach. Mosltly smokers in the discussion told ' ***gas ban jati hai nahi piye to'subah bidi piye bina pet saaf nahi hota'.(*** If they don't smoke they feel flatulence in the stomach).

During social ceremonies like marriages or other gatherings serving hookah and bidi is a custom which is followed since long. It is considered as a token of respect serving hookah and bidi to the persons who visits the house. If not served it is considered as a disrespect to the persons visiting the house. One persons told that once they visited a house to attend a wedding, there they were not served hukka and bidi. '***hukka nahi puchi humse, hum rishta nahi rakhenge'***. They refused to continue the relation with the family.

Boys in the village start using cigarette out of fun and become habitual. Peer pressure is one factor came into being for the initiation of smoking. ***'Le tu hi le, aree yar le le, kuch nahi hota'.*** This is how they develop the habit of using tobacco and become habitual. People also take this to come out of depression. They say they feel good when take bid or gutka. It gives them a feeling of high.

Children develop this habit because their father tell them to go to shop and buy bidi, tambaku for them. This is how young children become exposed to tobacco. They become inhesitant at later stage of their life to use it.

Continuation of tobacco use:

Inspite of knowing the harmful effects some people continue using it. One elderly person told **-‘** ***itne saal se se pee rahe hain, ab tak kuch nahi hua to ab kya hoga?’***. Health workers and sarpanch also know the harmful effects of tobacco but if they tell about the effects of tobacco to users, they are told ‘***aap hamare ghar mai dakhal andazi mat karo’.*** Another thing revealed in the discussion was consumption of bidi and gutka among the labourers and persons working in the fields is common. They take this to give rest to their body as it gives them a feeling of high and capacity to work further. Tobacco users and other participants told it is difficult for users to quit because they become dependant on it. Even if they want to quit suffer from withdrawal symptoms and start using again.

Sarpanch of the village told there is no anti tobacco law followed in the community. Even a 5 year old child can go and buy cigarette, bidi, and gutka in this village. In cities it is crime to sell tobacco to persons 18 years below, no such law is followed in the village.

Various stakeholders like Sarpanch, ASHA, ANM feel it is thing started by the government, so government should ban it, only then its use in the community can be controlled and stopped.

2.7 Discussion:

During the study it was observed that both smoking and smokeless forms of tobacco use is common among the community people. Both the forms are on a rise among the people.People start using it at early ages. Serving hookah and bidi is a socially acceptable tradition in the village. There is a perception among them that hookah is not harmful for health as the smoke inhaled gets filtered because of the passage of the smoke through water. One more perception regarding smoking hookah, bidi and cigarette among both men and women who use it, say they consume it to get relief of the flatulence. If they don't smoke they feel flatulence in the stomach.

Reasons for initiation include seeing the elderly at home, peer pressure, trying for once i.e. Experimental smoking and then develops a habit, to relieve their tension, to seek pleasure and to ease abdominal problems. Some link smoking with a "positive" social image and bonding with a peer group. People also under-estimate the health consequences of tobacco use. Continued tobacco use includes reasons like dependence on tobacco, relieving stress, physical discomfort on quitting. Tobacco contains 'nicotine' which activates areas of the brain that are involved in producing feelings of pleasure and reward. Recently, scientists discovered that nicotine raises the levels of a neurotransmitter called dopamine in the parts of the brain that produce feelings of pleasure and reward. Researchers now believe that this change in dopamine may play a key role in all addictions. This may help explain why it is so hard for people to stop smoking.

Tobacco use is increasing among young population of the village as there is very low knowledge to the people about Anti- Tobacco laws and they are not followed in the village.

2.8 Conclusion:

Tobacco use among the people of village is increasing. It has been socially acceptable among adults and the elderly in the village. The finding of high use of hookah among elderly population and chewing form of tobacco among adults is a serious concern and therefore needs remedial measures. After knowing the reasons for people to initiate and continue smoking, an environment should be created in the community that can help tobacco users to quit. There is need of spreading awareness among the people about ill effects of tobacco use through media, health workers, health care providers and local active NGO's. Family members and community leader may be powerful agents for influencing people to quit tobacco. Apart from family support, some cessation services should be provided to people who are not able to gather sufficient support from outside. Motivation to quit tobacco should come from within and a person should sustain it.

2.9 Recommendations:

- The primary tool for tobacco control is comprehensive and active awareness of the population about the ill effects of tobacco use, with special emphasis on all aspects of this impact, i.e. social, physical, financial and environmental.
- Public education is an integral part of the efforts to prevent initiation of tobacco use and encourage tobacco cessation. Education, communication and training are most effective when incorporated into a comprehensive tobacco control programme.
- There is one IEC material developed after knowing the beliefs and perceptions of the community which can be distributed and can increase awareness among people (Annexure- 4).

These are some recommendations which came from the community how they want the people who use tobacco in the community to quit.

- Presently the law against tobacco use are not followed in the village, hence awareness about anti- tobacco laws should be done in community.
- Supply and demand concept should be adopted to control its use. Lesser the supply lesser will be the demand in the community
- They want tobacco to be banned by the government only then its use can be stopped among the community and other parts of the world.

Offer help to quit tobacco use:

- **Cessation advice in health care**: Brief advice from primary health-care practitioners increases quit rates.
- **Quit lines**. Cessation advice and counselling can also be provided in the form of free telephone help lines (known as quit lines) .
- **Pharmacological therapy**. Cessation can also include treatment with nicotine replacement therapy (NRT), usually available over the counter, and other drugs that require a prescription. Pharmacological therapy can double or triple quit rates
- Quitting produces immediate and significant health benefits and reduces most of the associated risks within a few years of quitting.

Warn about the dangers of tobacco:

- Proven policies to reduce tobacco use include mandatory health warning labels on tobacco packaging and hard-hitting mass media campaigns that show the harms of tobacco use. Effective warning labels increase smokers' awareness of health risks, and increase the likelihood that smokers will think about cessation and reduce tobacco consumption. Anti-tobacco mass media campaigns can be cost effective compared with other interventions
- Despite the expense required, and can have a greater impact because they reach large populations quickly and efficiently.

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2.11 Annexures

Annexure 1

FGD Guide for FGD's & In-depth interview of Tobacco consumption:

Objective of FGD: To identify reasons for initiation and continuation of tobacco use.

FGDs: (5)

1. 8-10 smokers(Males),
2. 5 smokers(female)
3. Health functionaries: 8-10 ASHA workers
4. Amongst Health functionaries: 5-6 Male ANM's
5. Amongst Health functionaries: 5-6 Female ANM's

In depth interview (2)

1. Sarpanch/panch members of the village (Chhainsa PHC)
2. Health Worker/Aangan Wadi Worker

FGD guide for tobacco project

For tobacco users:

1. At what age do you started using tobacco?
2. From where did you get to know about tobacco containing products?
3. Why do you start using tobacco?
4. What type of tobacco containing products do you usually consume?
5. How do you feel after using tobacco?

6. What is pleasurable about it?

7. Do you know the harmful effects of tobacco use?

8. What your family members/friends think about your tobacco use?

9. Why you still continuing to use it?

10. Have you tried to quit it?

11. What preventing you to quit it?

For other stakeholders: (Health workers, ASHA, Sarpanch, Shop owner, teacher)

1 Is tobacco use common in this community?

2 Why people use tobacco?

3 What influences people to use tobacco?

4 Generally at what age people starts use of tobacco?

5 Which is the most common type of tobacco containing products used in the community?

6 Why people cannot able to quit tobacco ?

7 Is tobacco use is health problem in the community?

8 What can be done to stop tobacco use in the community?

Annexure-2

Page 1 of Pamphlet

Page 2 of Pamphlet

तम्बाकू क्या है ?

तम्बाकू एक कृषि उत्पाद है, जोकि तम्बाकू पौधे की पत्तियों को सुखाकर अलग–अलग रूप से प्रयोग में लाया जाता है।

तम्बाकू सेवन के प्रकार

धूम्रपान: बीड़ी, सिगरेट, हुक्का

सिगरेट – बीड़ी का धुआँ, पीपी गौत का कुआँ

हुक्का नही आदर–सत्कार, कर सकता है जीवन बेकार।

धुआँ रहित : गुटखा, खैनी, जरदा, पान, तम्बाकू वाला मंजन

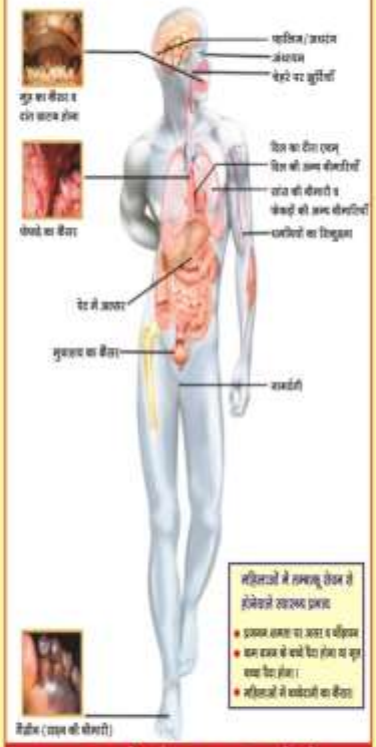
तम्बाकू का मजा मौत की सजा

यहाँ तक की किसी अन्य व्यक्ति के बीड़ी/सिगरेट के धूएँ में सांस लेना भी नुक्सानदायक है, इसे निष्क्रिय धूम्रपान कहते है।

तम्बाकू सेवन के हानिकारक प्रभाव

तम्बाकू लगभग शरीर के हर अंग को हानि पहुँचाता है।

शरीर के विभिन्न हिस्सों के कैंसर



धूम्रपान करने और तम्बाकू खाने से ...

- दिल का दौरा
- सांस की बीमारी
- कैंसर
- खाँसी
- अंधापन
- फालिज/लकवा

इत्यादि की संभावना बढ़ जाती है।

➢ धूम्रपान व तम्बाकू सेवन से दांत खराब हो जाते हैं।

➢ धूम्रपान व तम्बाकू सेवन से त्वचा व बाल रूखे हो जाते हैं, चेहरे पर झुर्रियाँ पड़ जाती हैं।

➢ तम्बाकू पुरुषों में नामर्दगी व महिलाओं में बाँझपन उत्पन्न कर सकता है।

सिगरेट में 4000 से अधिक रसायन पाए जाते हैं व 60 से अधिक रसायन कैंसर का कारण होते हैं।

क्या आप जानते हैं?

➢ तम्बाकू के इस्तेमाल का कोई सुरक्षित रूप नहीं है। सभी रूपों में निकोटिन होता है और लत व स्वास्थ्य समस्याओं को पैदा कर सकता है।

➢ हर साल तम्बाकू सेवन से 8 लाख भारतीय मर जाते हैं।

➢ प्रतिदिन तम्बाकू सेवन से 2200 लोग मर जाते हैं।

➢ भारत में होने वाले 100 में से 40 कैंसर तम्बाकू की वजह से होते हैं।

➢ 95% मुख के कैंसर तम्बाकू का प्रयोग करने वालों में होते हैं।

Annexure-3

Chhainsa PHC

FGD ASHA workers

FGD Male Smokers