January 2004

Barriers to smoking cessation: results of a survey among family practice patients

Waris Qidwai

Aga Khan University, waris.qidwai@aku.edu

Middle East Journal of Family Medicine, 2004; **Vol**. **5** (5)

BARRIERS TO SMOKING CESSATION: RESULTS OF A SURVEY AMONG FAMILY PRACTICE PATIENTS

Dr. Waris Qidwai F.C.P.S (Pak)

Associate Professor
Family Medicine Department
Aga Khan University, Karachi

Correspondence:
Dr. Waris Qidwai
Associate Professor, Family Medicine
The Aga Khan University
Stadium Road, P.O. Box: 3500, Karachi 74800,
Pakistan
Fax: (9221) 493-4294, 493-2095
Telephone: (9221) 48594842/ 4930051Ext. 4842
E-Mail: waris@akunet.org

Abstract

Background and Objectives: Tobacco smoking is a major public health problem. We have studied barriers to smoking cessation among family practice patients.

Methods: It was a questionnaire based survey, conducted at Family Practice Center, Aga Khan University Hospital, Karachi, Pakistan, in July 2003. A trained volunteer administered the questionnaire that included data on demographic profile of the patient and information barriers to smoking cessation. Ethical requirement including the administration of written informed consent and the provision of confidentiality were ensured. SPSS computer software was used for data management.

Results: A total of 100 patients were interviewed, of which 96 (96%) were males. The mean age was 37.4 years. Fifty three (53%) of the respondents had graduate education. Fifty two (52%) respondents wanted to give up smoking while fifty five (55%) had tried to do so in the past. Ninety one (91%) respondents give up smoking during the fasting month of Ramadan. Craving for smoking, fear of inability to cope with stress and an

increase in irritability were reported by seventy four (30%), forty six (19%) and forty two (17%) respondents respectively.

Conclusions: We recommend further research and debate on barriers to smoking cessation.

Key words: Smoking, Smoking Cessation, Tobacco Use Disorder, Tobacco Use Cessation

---

Introduction

Tobacco smoking is spreading in epidemic proportions all over the world (1), being responsible for fifty percent of all avoidable deaths (2). It reduces the life expectancy among smokers, increases overall medical costs and contributes to the loss of productivity during the life span (1). Smoking has been linked with various neurological, cardiovascular, and pulmonary diseases among the smokers as well as non-smokers (1). Passive smoking among children is a significant risk factor for asthma1. Cigarette smoke contains several carcinogens that can lead to lung cancer (1).

The benefits of smoking cessation are unquestionable (3), both in terms of benefit to the health of individuals who stops smoking and reduced health care costs to the health care delivery system.

The efforts aimed at promoting smoking cessation programs have so far been far from successful (4). That is the reason why researchers continue to look at different ways to promote smoking cessation (5,6).

The focus of improving smoking cessation rates has been on advertising (5) to get smokers into the cessation program, improving counseling skills of physicians (6), and nicotine replacement to curb withdrawal symptoms (7). These interventional strategies are based on barriers to smoking cessation programs identified during earlier studies.

Several studies have even looked at barriers to smoking cessation in selected groups such as alcoholics (8) and pregnant women (9). There is now evidence to suggest that smoking cessation program must look at the cultural context that continues to propagate smoking (10). Unless the underlying factors that continue to support smoking are identified and corrected, the success of any smoking cessation program is questionable.

Our hypothesis is that there are barriers to smoking cessation, some of which may be culturally related and that identification of these are mandatory to the success of any smoking cessation program. Given this background, a need was established to identify barriers to smoking cessation among our patients and explore smoker perceptions on how to improve smoking cessation.

Methods

Study Population:

This study was conducted on smokers visiting the family practice center, Aga Khan University hospital, Karachi. Around a 150 family practice patients are seen daily by twelve family physicians at the center. 100 smokers were interviewed. Since we planned a descriptive study and did not intend to subject the data to statistical tests, a sample size based on statistical calculations was not calculated.

Study Design, data collection and management procedure:

The study design was a questionnaire based cross sectional survey. Data collection took place during July 2003. A trained volunteer administered questionnaires to the respondents.

Patients sitting in the waiting area and found to be current smokers were requested to participate in the study. We interviewed patients based on their availability and convenience. A systematic random selection of study subjects was not under taken.

SPSS computer software was used for data management.

Inclusion criteria:

1. Patients visiting the family medicine clinic

2. Smokers

3. Age 18 years and above

4. Those agreeing to participate in the study and sign the consent form

Instrument

A questionnaire was developed to collect information on the demographic profile of the patient along with questions on attempts at smoking cessation, barriers to smoking cessation and factors that can help improve smoking cessation rates.

Data on demographic profile of the patient included age, sex, marital status, education and occupation.

Results

A total of 100 patients were interviewed, among them 96 (96%) were men. The mean age was 37.4 years. Sixty one (61%) respondents were married and fifty three (53%) were

graduates. Forty (40%) of the respondents were in private service and self-employed (Table 1).

Table 2 lists the smoking cessation behavior. Fifty two (52%) respondents wanted to give up smoking while fifty five (55%) had tried to do so in the past. Smoking cessation was attempted at least three times by nineteen (19%) respondents. Age at the first attempt at smoking cessation was between 21 to 40 years among forty two (76%) respondents.

Ninety one (91%) respondents gave up smoking during the fasting month of Ramadan. Craving for smoking, habit of smoking and enjoyment derived from smoking were quoted as reasons for not continuing with smoking cessation after Ramadan, among thirty one (31%), thirty (30%) and twenty seven (27%) respondents respectively (Table 3)

Table 4 lists the perceived smoking cessation barrier among the smokers. Craving for smoking, fears of inability to cope with stress and an increase in irritability were reported by seventy four (30%), forty six (19%) and forty two (17%) respondents respectively.

TABLE 1
DEMOGRAPHIC PROFILE OF THE PATIENTS
(n=100)

PARAMETER	NUMBER (%)
SEX: **Males** Females	 **94(94)** 06(06)
Mean Age in years (SD)*	37.4(15.54)
MARITAL STATUS: **Married** Single	 **61(61)** 39(39)
EDUCATIONAL STATUS: **Grade X and below** Grade XII **Diploma** Graduate **Post-graduate**	 **05(05)** 23(23) **02(02)** 53(53) **17(17)**
OCCUPATION: **Private service** Government service **Self Employed** Unemployed **Student** Housewife	 **20(20)** 17(17) **20(20)** 15(15) **24(24)** 04(04)

*Standard Deviation

TABLE 2
SMOKING CESSATION BEHAVIOR
(n=100)

Smoking Cessation	Number (%)
Want to stop smoking? **Yes** No **Not sure**	 **52(52)** 10(10) **38(38)**
Ever tried to stop smoking? **Yes** No	 **55(55)** 45(45)
Number of attempts at smoking cessation? **None** One **Two** Three **More than three**	 **45(45)** 10(10) **15(15)** 11(11) **19(19)**
Age at first smoking cessation attempt (in years)? **<20** 21-30 **31-40** 41-50 **>51**	(# of respondents=55) **07(12.7)** 24(43.6) **18(32.7)** 04(7.3) **02(3.7)**

TABLE 3
SMOKING CESSATION DURING RAMADAN*
(n=100)

Question	Number (%)
Stop smoking during Ramadan?	
Yes	**91(91)**
No	09(09)
Why cant quit smoking completely if one can during Ramadan?	
Craving for smoking	**31(31)**
Due to the habit of smoking	30(30)
Due to enjoyment from smoking	**27(27)**
Fear of god during Ramadan	04(04)
Don't know	**08(08)**

* Ramadan is the holy month of fasting for the Muslims

TABLE 4
BARRIERS TO SMOKING CESSATION
(n=100)

Barrier	Number (%)*
Craving for smoking	**74(30.1)**
Fear of inability to cope with stress	46(18.7)
Fear that irritability will increase	**42(17.1)**
Fear of loss of companions who smoke	26(10.6)
Peer pressure	**22(8.9)**
Fear that depression will ensue	14(5.7)
Fear of failure at quitting	**07(2.8)**
Fear of losing enjoyment	07(2.8)
Negative influence of advertisements	**05(2.0)**
Lack of family support	02(0.8)
Fear of weight gain	**01(0.4)**

*** number of responses=246**

Table 5 lists the perceived advantages of smoking cessation among the smokers. Better health of the smokers, better health of the family members and monetary savings were reported by ninety three (41%), fifty (22%) and fifty (22%) respondents respectively.

TABLE 5
ADVANTAGES OF SMOKING CESSATION
(n=100)

Advantages	Number (%)*
Better personal health	**93(40.6)**
Better health of family members	50(21.8)
Monetary saving	**50(21.8)**
Improved breathing	33(14.4)
Improved social life	**01(0.4)**
No advantage	02(0.9)

*** number of responses=229**

Table 6 lists factors that the smokers believe can convince them to stop smoking. Realization of the benefits of smoking, seeing a smoker ill due to smoking and better health were reported by 68 (37%), forty seven (26%) and twenty five (14%) respondents respectively.

TABLE 6
FACTORS THAT CAN CONVINCE A SMOKER TO STOP SMOKING
(n=100)

Factors	Number (%)*
Realization of the benefits of not smoking	**68(37.4)**
Seeing a person ill due to smoking	47(25.8)
Better health	**25(13.7)**
Better breath, taste and smell	18(9.9)
Monetary saving	**13(7.1)**
None	11(6.0)

*** number of responses=182**

Fifty three (53%) smokers showed their willingness to initiate smoking cessation on their own while thirty five (35%) of the smokers agreed to join a smoking cessation program. Fifty nine (59%) smokers showed their willingness to give up smoking if provided with nicotine replacement. Eighty four (84%) smokers were not convinced that health department and media were playing an adequate role in discouraging smoking in the country.

DISCUSSION

This study documents the failed attempts and perceived barriers to smoking cessation. Since we have interviewed a limited number of patients, and without using systematic random method for patient selection, generalization of the study results cannot be recommended. The majority of the respondents were men (96 percent) and with graduate education (53 percent), making generalization of the results to the rest of the population difficult. The overwhelming proportion of men in the study is due to the low prevalence of smoking among Pakistani women11. Since we interviewed patients visiting a teaching hospital, this again introduces a bias in the study. Despite these inherent weaknesses in the design and conduct of the study, we have documented the barriers to smoking cessation among the study population.

It will improve our understanding of the management of smoking cessation programs. It is for this reason that such survey should be part of family practice facilities, in order to improve the success rates of smoking cessation among the patients.

It is reassuring to note that fifty (52%) smokers wanted to stop smoking while an overwhelming fifty five (55%) had tried to do so in the past. This finding is in keeping with earlier reports from the region (12).

Three attempts at smoking cessation among nineteen (19%) smokers testifies to the seriousness of the smoker's intent to give up this habit. Such failed attempts at smoking cessation are widely reported in literature (13,14).

It is again interesting to note that forty two (76 percent) smokers attempted smoking cessation in the 21 to 40 years age group. Those beyond this age are less likely to attempt smoking cessation. Such information is useful for those who want to target age groups that will be well motivated to quit the habit.

Ninety one (91%) respondents gave up smoking during the fasting month of Ramadan. This is in keeping with the earlier reports of reduced smoking during this period (15,16). It is perhaps the strong spiritual drive that helps an individual to stop smoking during Ramadan but only to resume the practice once the drive has gone. It is indeed an opportunity to help these individuals give up smoking all together, taking help from the spiritual drive.

It is not surprising to note that it's the craving for smoking, habit of smoking and enjoyment derived from smoking that causes the habit to take its roots again. It happens because the spiritual drive is no longer there. Our finding that main barriers to smoking cessation are nicotine withdrawal related is again in keeping with the earlier reports (17,18). Craving for smoking, fear of inability to cope with stress and an increase in irritability are some of the symptoms reported by respondents which are due to nicotine withdrawal. The strategy to provide nicotine replacement is already in place (19) and is mandatory for the success of any smoking cessation program.

The perceived advantages of smoking cessation among the smokers include better health for themselves and their families along with monetary savings. Such information can be used to encourage smokers to quit the habit and should be part of all smoking cessation programs. Similarly, factors that the smokers believe can convince them to stop smoking such as realization of the benefits of smoking, seeing a smoker ill due to smoking and better health, can again be used to motivate smokers to stop smoking.

It is to be noted with interest that more smokers are willing to start smoking cessation on their own rather than join any program. There is a need to further study the reasons for such a preference. Are smokers reluctant to take direct help from others in quitting this addiction or are there deficiencies in the smoking cessation program.

We intend to share the information obtained from this survey with our colleagues and will use it in order to help smokers quit this habit and live a healthier and good quality life.

CONCLUSION

Smoking cessation is the key to good health. A better understanding of the factors that continue to propagate smoking will help us achieve better success at smoking cessation among patients.

We must incorporate strategies to counter the barriers to smoking cessation in our programs. Education of those who run smoking cessation programs, with regard to the concerns of smokers who want to give up smoking is mandatory, if we want to curb smoking among our communities.

We recommend further research and debate on the important issue of barriers to smoking cessation.

REFERENCES:

1. Das SK. Harmful health effects of cigarette smoking. Mol Cell Biochem. 2003; 253(1-2): 159-65

2. Gohlke H. Lifestyle modification-is it worth it? Herz. 2004; 29(1): 139-44

3. Girgis ST, Ward JE. A financial case to enable state health jurisdictions to invest in tobacco control. Med J Aust. 200317; 179(10): 539-42

4. Vaszar LT, Sarinas PS, Lillington GA. Achieving tobacco cessation: current status, current problems, future possibilities. Respiration. 2002; 69(5): 381-4

5. McDonald PW. A low-cost, practical method for increasing smokers' interest in smoking cessation programs. Can J Public Health. 2004; 95(1): 50-3

6. Kaplan CP, Perez-Stable EJ, Fuentes-Afflick E, Gildengorin V, Millstein S, Juarez-Reyes M. Smoking cessation counseling with young patients: the practices of family physicians and pediatricians. Arch Pediatr Adolesc Med. 2004; 158(1): 83-90

7. Le Houezec J, Sawe U. Smoking reduction and temporary abstinence: new approaches for smoking cessation. J Mal Vasc. 2003; 28(5): 293-300

8. Asher MK, Martin RA, Rohsenow DJ, MacKinnon SV, Traficante R, Monti PM. Perceived barriers to quitting smoking among alcohol dependent patients in treatment. J Subst Abuse Treat. 2003; 24(2): 169-74

9. Tod AM. Barriers to smoking cessation in pregnancy: a qualitative study. Br J Community Nurs. 2003; 8(2): 56-64

10. Lawlor DA, Frankel S, Shaw M, Ebrahim S, Smith GD. Smoking and ill health: does lay epidemiology explain the failure of smoking cessation programs among deprived populations? Am J Public Health. 2003; 93(2): 266-70

11. Bush J, White M, Kai J, Rankin J, Bhopal R. Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study. BMJ. 2003; 326(7396): 962

12. Maher R, Devji S. Prevalence of smoking among Karachi population. J Pak Med Assoc. 2002; 52(6): 250-3

13. Grimshaw G, Stanton A, Blackburn C, Andrews K, Grimshaw C, Vinogradova Y, et al. Patterns of smoking, quit attempts and services for a cohort of 15- to 19- year-olds. Child Care Health Dev. 2003; 29(6): 457-64

14. Nerin I, Crucelaegui A, Mas A, Guillen D. Profile of smokers who seek treatment at a smoking cessation clinic. Arch Bronconeumol. 2003; 39(7): 298-302

15. Afifi ZE. Daily practices, study performance and health during the Ramadan fast. J R Soc Health. 1997; 117(4): 231-5

16. Kadri N, Tilane A, El Batal M, Taltit Y, Tahiri SM, Moussaoui D. Irritability during the month of Ramadan. Psychosom Med. 2000; 62(2): 280-5

17. Le Houezec J, Sawe U. Smoking reduction and temporary abstinence: new approaches for smoking cessation. J Mal Vasc. 2003; 28(5): 293-300

18. Haustein KO. What can we do in secondary prevention of cigarette smoking? J Cardiovasc Risk. 2003; 10(6): 476-85

19. Schneider NG, Olmstead RE, Nides M, Mody FV, Otte-Colquette P, Doan K, et al. Comparative testing of 5 nicotine systems: initial use and preferences. Am J Health Behav. 2004; 28(1): 72-86