

Health System Facilitators and Barriers to Delivery of Selected Tobacco Cessation Interventions at Healthcare Facilities in Kenya and India – a Qualitative Study

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Introduction



- More than **7,000** chemicals in tobacco smoke,
- **500** metals
- **70** carcinogens

- U.S. Department of Health and Human Services. [The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014](#). Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
- U.S. Department of Health and Human Services. [How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General](#). Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

Point to note

- **Tobacco kills more people annually** – more than AIDS, alcohol, car accidents, illegal drugs, murders and suicides **combined!!**

• www.tobaccofreekids.org

Introduction

- Tobacco dependence is recognized as a **mental and behavioural disorder** in the International Classification of Disease of the World Health Organization (WHO) (ICD-10) (2015) and in the Diagnostic and Statistical Manual of Mental Disorders of the American Association of Psychiatry (DSM-V) (2013).

Introduction

The likelihood that a person who smokes may have a mental disorder is **twice** that of a person who does not have one (Brown, 2004).

Introduction

- The World Health Organization (2011) estimates that **more than 28% of all deaths in Kenya** are attributable to non-communicable diseases (NCDs) and **55%** of all deaths from cancers of the trachea, bronchitis and lung cancers **are attributable to tobacco use.**
- In Kenya, 69 per 100,000 deaths for individuals aged 30 and above result from tobacco use.

Burden of Tobacco use in Kenya

- **Tobacco Use among the Adult Population**
- The Stepwise Survey for NCD risk 2015 revealed that 13.3% of Kenyans age 18 -69 years use tobacco (23.0% of men 4.1% of women). **Nearly one in ten Kenyans smoke tobacco** while 3.6% use smokeless tobacco. Daily tobacco smokers constitute 8.3%.
- Approximately 2.5 million adults in Kenya (11.6% of the adult population) currently use tobacco. Of great concern is that **one in five men (19.1%)** use tobacco (GATS, 2014).

Tobacco Use among the Youth

- According to the Global Youth Tobacco Survey conducted in 2013 among youth aged 13-15 year, 9.9% were currently using tobacco products.
- Boys comprised of **12.8%** while the girls comprised **6.7%**.
- Overall, **7.0%** of the youth smoked cigarettes while 3.9% used smokeless tobacco.
- The same study revealed that **24.7%** of the students were exposed to second-hand tobacco smoke (SHS) at home and **44.5%** in public places.

Among Health professional students'

- Among health professional students' the survey showed that:
 - **9.8%** medical students,
 - **47.8%** dental students,
 - **60.5%** for pharmacy students and
 - **34.9%** for nursing students currently smoked cigarettes.

Effects of tobacco use and smokeless tobacco

- **Tobacco use** can cause cancer almost anywhere in the body. Cardiovascular diseases and lung disorders, stroke, cataract, reproductive problems etc. The risk of developing diabetes is **30–40%** higher for active smokers than nonsmokers
- The **use of smokeless tobacco** is associated with cancers of oral cavity, esophagus, stomach, pancreas & throat.



Effects of tobacco use: Pregnant women

- **Tobacco use by pregnant women** leads to low birth weight of babies, pregnancy complications, premature deliveries, stillbirths and birth defects



Effects of tobacco use: SHS to children

- It increases the risk of serious respiratory problems in children, such as severity of asthma attacks and lower respiratory tract infections, and increases the risk of middle ear infections.

Effects of tobacco use on mental health

- Individuals with a mental illness are more likely to have a chronic disease and **to have a shorter life expectancy** (Lawrence et al, 2001).
- Tobacco-related illnesses including cancer, heart disease, and lung disease **are among the most common causes of death among the mentally ill.** Individuals with serious mental illness and substance abuse treated in the public health system die a **startling 25 years earlier** than those without mental illness (Lancet, 2013).

Effects of tobacco use on mental health

- People with schizophrenia **have life expectancy 20% shorter** than the general population, (Hennekens et al, 2005) a 10-fold increase in risk of dying from respiratory disease and two-thirds will die of cardiovascular disease.
- **Half of all long-term smokers will die of a smoking related illness** (Joukamaa et al, 2001).
- Long-time tobacco use has been shown to trigger and exacerbate mental illness. It also results in poorer treatment outcomes and increased hospital admissions compared to the general populations as there are **higher suicide rates** related to it. (Aguilar et al, 2005).

Tobacco and NCDs

- Non communicable diseases (NCDs), for which tobacco is a risk factor, currently **account for more than 27% of the mortality in the country** and approximately **50% of the public-hospital admissions** are due to NCDs.

Mental health professionals and cessation services

- 2014 BMJ systematic review and meta-analysis noted that ‘there is consistent evidence that stopping smoking is associated with **Improvements in:**
- **depression**
- **Anxiety**
- **Stress**
- **Psychological quality of life**
- **and positive affect compared with continuing to smoke.**

Health professionals and cessation services

- **Hospitals**, in particular, have been recognised as a key setting for initiating the delivery of tobacco cessation care (Prochaska, 2013).
- However, as is the case in general medical settings, (Henrikus et al, 2005) evidence from **psychiatric settings** suggests that **without post-discharge support tobacco use is likely to return to pre-admission levels within 2 weeks**
- There are several types of smoking cessation interventions with varying levels of effectiveness.

The following table gives a summary of effectiveness of selected smoking cessation interventions (abstinence for at least six months)

Intervention source vs comparator group	Odds ratio (95% CI)	Increased chances of quitting successfully
Physician brief advice vs no advice	1.66 (1.42-1.94)	66%
Nursing intervention vs usual care	1.28 (1.18-1.38)	28%
Nicotine replacement therapy (NRT) vs placebo or non-NRT	1.58 (1.50 -1.66)	58%
Bupropion vs placebo	1.94 (1.72 – 2.19)	94%
Varenicline vs placebo	2.33 (1.95-2.80)	133%
Clonidine vs placebo	1.63 (1.22- 2.18)	63%
Nortriptyline vs placebo	2.34 (1.61 – 3.41)	134%

Rationale of the study

- There is **currently a gap between the evidence base available and the implementation of the evidence.**
- Although brief tobacco cessation interventions are widely recommended in medical settings such interventions have rarely been implemented or studied in mental health settings in Kenya. In fact, few mental health clinicians ask patients about tobacco use status or advise them to quit.

Objectives

- The main objective of the study was:
- **To understand the facilitators and barriers to delivery of selected tobacco cessation interventions by healthcare providers in healthcare facilities in Kenya and India**
- **For this presentation, we shall focus on Kenya**

Study design

- A qualitative approach utilizing semi-structured interviews was chosen in order to ensure that the beliefs, perceptions, attitudes, and contexts were adequately captured by our study.

Study sites

- Two study sites from Kenya were selected. The two sites in Kenya were Nairobi County (Capital city and parts of Kiambu) and Western region in Nyanza County.

Method

- Qualitative in-depth interviews of patients, HCPs, programme managers and policy makers were conducted between February and May 2017
- Purposive and snowball sampling techniques were used to recruit participants.
- Interviews were conducted by trained researchers in English and local language using semi-structured interview guides (tailored to the type of participant) and were audio-recorded and transcribed.
- Data were analysed using NVivo version 10. Content analysis was conducted to generate themes and subthemes.

Results

- Out of total 55 participants in Kenya, 19 patients, 25 HCPs, and 11 policy makers and programme managers were recruited.

Results: Facilitators to provision of cessation services

- Positive attitude of HCPs
- Their good rapport with the patients

Barriers to provision of cessation services

- Lack of availability of **trained manpower** on tobacco cessation interventions (Most clinicians were not familiar with cessation medications)
- Lack of appropriate facilities for counselling,
- Lack of funding,
- Lack of access to cessation facilities
- Lack of **availability of cessation medicines** and their high cost
- Lack of coordination among staff

Barriers..

- Poor referral and follow up system
- **Lack of awareness among the general population and HCPs regarding cessation interventions and non-uniform screening for tobacco use at health facilities were also reported.**
- **Use of tobacco by some HCPs themselves**
- It was perceived that **government gives less importance** to the National Tobacco Control Program (Policy makers have not prioritized cessation support)

Conclusion

- There is an urgent need to address the health system level barriers in Kenya

**Thank you for
listening.**

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