



## BARRIERS TO TREATMENT SEEKING AMONG FEMALE SMOKERS IN RURAL COMMUNITY IN NORTH INDIA ; A QUALITATIVE STUDY

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### Abstract

**Introduction:** According to the Global adult tobacco survey 2016, 14.2% of females used tobacco in India. The use was prevalent in urban and rural areas alike. Studies suggest that females from rural areas are less likely to receive suggestions from primary health workers to quit smoking as well as make fewer cessation attempts. A number of physical, social, and personal barriers have been hypothesised for the poor treatment seeking in female smokers.

**Method:** A Qualitative study was conducted on female smokers from three different villages of Haryana in North India to explore the barriers associated with treatment seeking for smoking cessation. One to one interview was done with 13 females and responses were analysed using theoretical thematic analysis.

**Results:** the sample consisted of middle age females with mild to moderate tobacco dependence. Most of them initiated tobacco as it helped relieve gastritis. Except the older females, others would smoke in privacy. Majority had never made a quit attempt and were unsure about future attempts. The barrier themes reported were craving, poor knowledge about quitting tobacco, distance and poor trust on health services.

**Conclusions:** There exist significant cultural related barriers which prevent female smokers in rural region of north India from availing tobacco cessation services.

Tobacco use disorders are the most common substance use disorders across the globe. Recent GATS India 2016-17, reported the prevalence of tobacco use disorders to be 28.6% which although is a 6% reduction in tobacco use disorders as compared to previous survey, it still continues to be a public health concern (1). Another discerning fact tobacco use disorders is higher prevalence in women as compared to other substance abusers. The above mention survey reported the gender wise prevalence to be 42.4% in males and in 14.2% females.

It should be noted that the pattern of tobacco use in females is slightly distinct from males. Most of the females use smokeless form of tobacco and bidi, as compared to cigarettes due to various reasons including availability and economic constraints (2). Also the prevalence of tobacco use in females is more common in rural background as compared to urban females. The GATS survey reported that females as compared to males had made less number of cessation attempts, and were also less interested in making future attempts. They were less influenced with the various warning labels and fewer had received suggestions from primary health workers to quit smoking as compared to their male counterparts (3). Thus females are less likely to receive suggestions to quit smoking, and are less willing to do so. Hospital studies also reflect that the majority of females seek treatment for substances other than tobacco (4,5). Since these studies are few and only from tertiary centres, they are much likely to be biased and are expected to represent very serious substance abusers. But results from various tobacco cessation clinics also suggest that female smokers form a very small part of the treatment seeking group, which is much lower than their share in the prevalence of such disorders (6).

Western literature has suggested a number of significant barriers in treatment seeking for female substance use disorders (7). Among these perhaps most strongest is the presence of stigma accompanied by a lack of gender focus in the substance abuse treatment delivery models, and negative attitudes toward women drug users. Others include Systemic Barriers, Physical or structural barriers, Social cultural and personal barriers. In India, there is still a lack of research-based information on all aspects of women's substance use and related problems, including pattern and prevalence, physiological and psychosocial effects and consequences, characteristics of women with substance use problems, and their treatment experiences (8). Our study aims to fill the gap in the literature regarding the barriers in treatment faced by the rural female tobacco users. In addition to this we also plan to carry out a focussed group study in order to better understand these barriers as there has been no previous study addressing this problem.

## **Methods**

While conducting Mental Health awareness camps in rural areas of district Rohtak, Haryana we reached out to female smokers in 3 different villages. These interviews were facilitated by lay health workers (anganwadi workers), who guided the team to the confirmed female smokers in their region. A total of 13 female smokers in 3 different villages of Rohtak district in Haryana, North India were interviewed to explore various factors related with smoking initiation and barriers for tobacco smoking cessation. The participants after due consent were assessed using a semi-qualitative interview which had questions regarding their current tobacco use, factors related with initiation and continuation of smoking, attitude of family members, and perceived barrier towards seeking help to quit smoking. The study was approved by the local ethical committee. The quantitative responses were expressed in frequencies and percentages. For qualitative responses generic approach was undertaken, with coding and theme development guided by the content of the data. All responses were carefully examined for qualitative analysis. Key statements were extracted, and meanings were formulated based on the significant statements. These formulated meanings were then categorized, clustered, and organized into themes and subthemes, capturing shared experiences among all participants and achieving consensus among the investigators.

## Results

The Age of the participants ranged from 45-70 years, 11 out of 13 were illiterate, all belonged to low socio-economic background and stayed at home, performing household chores and farm related activities. Eleven participants reported smoking daily, with total duration of smoking ranging between 15-50 years. All participants smoked bidi, while 7 of them additionally smoked hookah. Apart from two females, none of the participants smoked more than 5 bidis/day. All the participants had low to moderate dependence on Fagerstrom test for nicotine dependence. The usual time of smoking would be morning and evening, when females would assemble in the outskirts of the village or one of the farmlands. A number of perceived beneficial effects of smoking were reported, mainly to stay active in the morning as well as to keep company. Female smokers were also aware of certain harmful effects related with smoking including cancer, Cardiovascular and respiratory complications.

The predominant source of obtaining bidi was either asking children in house to bring it or stealthily picking from spouse. While the older ladies smoked bidis in open, individually or in groups and would not be usually objected as they commanded respect from other family members, younger females preferred to smoke in hiding and were often criticized if they were found smoking. Very often, they would be pointed out that smoking is meant for males and females should refrain from it. Younger members in family would object more often as compared to older ones.

### Reason for initiation

Eight of the twelve participants initiated smoking to relieve stomach related discomfort after childbirth, while 4 others started following persistent non-specific pain abdomen and the remaining one initiated under peer pressure. All participants reported initiating smoking after being advised by local registered medical practitioner (RMP's). The most recurring theme for initiation was as recounted by the oldest participant

“ after my first childbirth, I suffered from severe bodyache for which I was prescribed certain diet by a local practitioner. Following that diet I developed gastritis and uneasiness in stomach, and when I reported this to him he advised to smoke a bidi once in a while. Following this I became regular”.

### Reasons and Barriers in quitting

Females smokers reported two important barriers in quitting smoking. One theme was related to craving, as one participant stated, “ if I do not smoke for few days, there is irritation and restlessness, and I have to go out and smoke to control it. Meeting with other ladies also doesn't help, as they advise that it's alright to smoke once in a while”. The other barrier were positive outcome expectancy, for eg. “ smoking is good for it gives me energy to do all the household work and also keeps my gastritis in control”. Except for two, none had made any attempt to quit smoking in the past. One of these two was advised by a doctor to quit as she had developed hoarseness of voice while other decided to quit by herself. Others didn't think that smoking could be stopped and had no ideas about ways of doing so.

Barriers in seeking help to quit A number of themes were reported regarding the barriers to quit smoking, a) traveling to medical facility and waiting, b) Dissatisfaction with existing health systems and limited solutions from General practitioners and c) limited knowledge about facilities for tobacco cessation.

## Discussion

Our qualitative survey surfaced certain interesting factors among rural female smokers. Majority started smoking after being advised by a local medical practitioner to manage non-specific abdominal pain. These females despite being in contact with health services rarely received advice to quit smoking. Furthermore, despite having a close proximity to primary health service centre, majority of the female smokers considered traveling to medical facilities as a significant barrier as well as showed distrust in such services for seeking treatment for smoking.

It's likely that similar barriers exist for female smokers from rural areas in India (8). For this group, utilising lay health workers to deliver brief intervention may be much more useful rather than referral to treatment at health facilities (9). Utilising lay health workers would present a culturally sensitive

and appropriate approach which would also prove to be much more economically viable option in order to manage such a large and hard to reach population.

Further, there seems to be a poor knowledge regarding the harmful use of tobacco as most attribute to using it to overcome some mild health related problems. These individuals, despite being in contact with health services for various issues had never been properly advised to consider quitting tobacco and seek help, echoing the findings from the GATS study (10-12).

Availability and accessibility of treatment services also remains a significant barrier in promoting tobacco cessation. There is limited availability of health professionals actively engaging in tobacco cessation and in places where they do there is lack of support in terms of availability of medicines and non-pharmacological interventions (9).

Based on these findings, there is an urgent need to target women in rural communities using local resources. Further, any contact with the treatment settings should be taken as an opportunity to spread awareness about harmful effects of tobacco and facilitate tobacco cessation. Recent initiative taken by the government of India to have regular tobacco cessation services at all government medical colleges is a much welcome step. but this should be seen as the start rather than the end goal as tobacco cessation services must be part of health case services at all levels.

Our study presents some interesting findings but these must be looked at in view of study limitations. The sample was small and only represented Three villages of state of Haryana and hence cannot be generalised broadly. Further, as these interviews were conducted as part of routine mental health awareness, they may suffer from some bias.

#### Conclusion

There exist significant cultural related barriers which prevent female smokers in rural region of north India from availing tobacco cessation services. Despite availing health services for multiple reasons there seems to be paucity of information regarding tobacco harms and ways to quit it among these older females.

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