

Strategies for Tobacco Cessation Counseling by Dental Personnel

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ABSTRACT

Tobacco is one of the greatest challenges in public health, ravaging countries and regions. Tobacco thrives everywhere despite social (and some religious) disapproval and causes a wide range of conditions effecting all the body organs. It is also identified as major risk factors for many oral disorders comprising from simple staining of teeth to deadly oral cancer. The dental practice is a potential location for partaking in tobacco cessation measures accessing to large population. The advice delivered through dental practice is as effective as support provided by other primary care professionals. Dental personnel has a unique opportunity in providing tobacco control activities by recognizing the early abnormal change in routine clinical examination via repeated oral check-up as part of their provision of ongoing oral healthcare. The dentist and dental practices have a critical role to play in encouraging and supporting tobacco cessation. This article aimed to review the literature on history, types, and impact of tobacco use, strategies for Tobacco Cessation Counseling at dental office and community level by dental personnel.

Keywords: Counseling, Dental office, Dental personnel, Smoking, Strategies, Tobacco

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INTRODUCTION

Tobacco is the major cause of death during one's productive years of their life. The flexibility in the ways of consuming tobacco made it prevalent across the world and facilitated its use and suitability in various sociocultural backgrounds around the globe. Majority of deaths happen as a result of an addiction developed in youth. The overall untimely deaths produced by tobacco during the last century has been projected about 100 million.¹ Globally, tobacco as a risk factor causes 4.1% of the total burden of disability (WHO, 2002c). In the 21st century, it is anticipated that tobacco will be the chief cause for one billion deaths worldwide, with three-quarters of these deaths occurring in low-income countries.² Tobacco use is a disease of addiction and a behavior choice, its control is both a public health concern and an issue of international law.³

India's tobacco issue is further difficult than any other country in the world, with significant affliction of tobacco-associated disease and death. India holds a very distinct place on the world tobacco map. India being the second most populous country in the world, its share of

the overall problem of tobacco-related disease and death is extensive. The intricate interplay of economic comforts and public health obligations develops principally important in the Indian context being the second-largest producer and consumer of tobacco in the world. These make a greater necessity to study the tobacco control program.¹

The World Oral Health Report 2003 points out that "All health providers must be involved (in treatment of tobacco dependence), including oral health professionals who, in many countries, reach a large proportion of the healthy population."⁴ The definite requisite to prevent tobacco addiction and its affliction on the health, the economics, the social, and environment of a nation that aims for its accelerated development, could be the reason for the medical, oral health professional, and auxiliaries to intervene by providing cessation counseling¹ as no single profession can access all tobacco users.⁵

It is therefore very important that members of the dental team to become involved in tobacco cessation activities within their practices. This literature review (PubMed and Google search) focuses on the history, types, and

impact of tobacco use, strategies for Tobacco Cessation Counseling (TCC) at dental office and community level by dental personnel.

HISTORICAL BACKGROUND

Tobacco was discovered along with the discovery of the New World in 1492 by Christopher Columbus.¹ The study of tobacco effects (John Hill) was reported and the snuff users were warned for risk of nasal cancers in England during 1761. The first link between smoking and lung cancer was informed by Ochsner, USA in 1939. The United States Surgeon General's Report of 1964 warned about the association of smoking with lung cancer in men. It was in Victoria, Australia during 1987, the use of tobacco tax came into existence for the 1st time to establish a health foundation countering tobacco usage among the population.⁶

TOBACCO

Tobacco belongs to the genus *Nicotiana rustica*, a mild-flavored, fast-burning species, was originally raised in Virginia. While modern commercial varieties of tobacco have descended directly from *Nicotiana tabacum*.¹ Both the smokeless and the smoked form of tobacco consist close to 4000 odd chemical constituents and many of them have a carcinogenic potential.⁷ Nicotine is one among these, with cotinine and nicotine-N oxide as its chief metabolites. Nicotine that absorb through the oral mucosa and skin enters the bloodstream and reaches the brain in 10-19 s and acts through specialized cell receptors located in the brain and other organs producing wide range of physiological effects.⁸

FORMS OF TOBACCO PRODUCTS

Tobacco are used in various ways smoked form as cigarettes, bidis and kreteks (clove cigarettes) and cigars; pipes as water pipes (hookahs, bhangs, narghiles, shishas), chillum, and hookli and oral preparations/non-combusted "oral" or "smokeless" tobacco products for chewing and holding in the mouth or placing in the nose. Four major forms of smokeless tobacco are chewing tobacco, snuff, Swedish snus and gutkha. The other forms of smokeless tobacco products common in India and South-East Asia are khaini, mainpuri tobacco, mawa, mishri/masheri, paan, zarda, pan masala, gudakhu.^{1,9}

EFFECTS OF TOBACCO

The health-related effects of smoking tobacco (cigarettes and bidis), smokeless forms of tobacco, and other forms of tobacco ranges from general ill health conditions such

as tuberculosis, cardiovascular diseases, peripheral vascular disease, respiratory diseases, cancers, and diabetes. Diseases of the oral cavity include leukoplakia, oral submucous fibrosis, preleukoplakia, leukoedema, smoker's palate, palatal erythema, central papillary atrophy of the tongue, erythroplakia, oral lichen planus, periodontal diseases, dental caries, tooth loss, and loss of jaw bone.⁸

OTHER TYPE OF SMOKING AND ITS EFFECTS

Reverse smoking is a type of smoking keeping the glowing end of the tobacco product inside the mouth. Reverse smoking causes palatal patches which have been reported to show a malignant change and associated with cancer of the base of the tongue. Reverse smoking is found in Colombia, Panama, Venezuela, Jamaica, and some islands of South Caribbean, the Pygmy negritos of Bataan peninsula (Philippines), Sardinia, and India.^{1,10}

PASSIVE SMOKING (SECOND AND THIRD HAND SMOKING)

Indirect forms of exposure to tobacco smoke are variously referred to as passive smoking, involuntary smoking, environmental tobacco smoke (ETS) or tobacco smoke pollution. Second-hand tobacco smoke is the combination of smoke emitted from the burning end of a cigarette or other tobacco products and the passive inhalation of tobacco smoke when another person is smoking. Second-hand smoke has 4000 different chemicals, at least 250 are known to be harmful and 50 of which are known to cause cancer. It has 2 times nicotine and tar and 5 times the carbon monoxide than the smoke that smokers inhale. Various effects produced to its exposure are in infants, sudden death; in pregnant women, low birth weight infants and in adults, serious cardiovascular and respiratory diseases.¹¹

THIRD HAND SMOKE

Third-hand smoke applies to the tobacco smoke by products that stick to the smoker's hair and clothing or to household fabrics even after the second-hand smoke has cleared. The residue also cleaves to walls and ceilings and is absorbed in vehicle interiors, and other items. This invisible toxic brew consists of gases and particulate matter, including carcinogens and heavy metals such as arsenic, lead, and cyanide. Young children are particularly susceptible as they breathe near, crawl on, play on, touch, and lick contaminated surfaces.^{8,12}

DIAGNOSIS OF TOBACCO HABIT AND ADDICTION LEVEL

Evidence of tobacco use in an individual could be established by general and clinical oral examination followed by assessing the tobacco addiction level with the help of Fagerstrom Test for Nicotine Dependence (FTND). Investigations such as lung function test and cotinine test are conducted to measure the exposure of tobacco in active users and nonusers who were exposed to passive smoke. The FTND, past efforts to quit and patient choices are the important factors to consider while providing interventions.^{8,13}

GENERAL PHYSICAL EXAMINATION

The odor of tobacco on the individual, the nicotine staining of fingers/nails and facial hair, and the cigarette/bidi burn marks on the clothes may provide evidence of the tobacco use. The clubbing of the fingers may also provide early evidence of a complication like a bronchial carcinoma, and cyanosis may indicate associated respiratory failure. Peripheral edema and a raised jugular venous pulse/pressure may indicate congestive cardiac failure and/or chronic cor pulmonale as a complication of chronic obstructive pulmonary disease. The extremities, including the peripheral pulses, must be examined for evidence of any peripheral vascular disease.⁸

ORAL EXAMINATION

The routine examination of the oral cavity provides an opportunity for the dental personnel to observe discolored teeth, gingival recession, dental erosion,¹⁴ dental caries, periodontitis, delayed wound healing¹⁵ smoker's palate, and white or red or speckled lesions.¹⁶

FTND

- For smoked tobacco user (6-item questionnaire), a score of 6 or greater (maximum score of 10) indicates a high level of nicotine dependence.
- For smokeless tobacco user (9-item questionnaire), a score of 9 or greater are interpreted as indicating a high degree of dependence, with greater difficulty in quitting, and possibly the need for higher doses of medication.¹³

INVESTIGATION

A simple and an inexpensive instrument such as breath CO monitor that can measure carbon monoxide in the exhaled air, high levels of carbon monoxide (above 7 ppm), can be used to indicate a recent heavy smoking.⁸

LUNG FUNCTION TEST

The spirometry helps to evaluate age-appropriate lung function, provide an opinion to the patient about his/her current status and also helps to monitor improvement in their lung function after tobacco cessation.⁸

COTININE TEST

A cotinine test can be used as an index for ETS exposure/passive smoking and as a marker for active smoking. The estimated half-life of cotinine in plasma is about 15-20 h while, the half-life of nicotine is only 0.5-3 h.^{8,17}

COUNSELING

The approach in helping patients quit tobacco and guiding them toward habit cessation by any health professional is termed as counseling. The tobacco user's self-image and socialization behavior should be assessed based on the stages of behavioral changes theory to accommodate the new self-awareness of a smoke-free person rather than expecting an immediate, radical change in that individual. The clinician must also address the patient's fear about the withdrawal symptoms.¹⁸

The three components of effective counseling and behavioral therapies are:

- Practical counseling includes identification of events, internal states, or activities that increase the risk of smoking or relapse, and practice coping of problem solving skills. Providing basic information about smoking and successful quitting.
- Intra-treatment social support by encouraging the patient in the quit attempt, communicating the patient with care and concern, and encourage the patient to talk about quitting process.
- Extra-treatment social support by training patient in support solicitation from family, friends, and coworkers; prompting support seeking and clinician arranging outside support.¹⁹

RATIONALE FOR TOBACCO CESSATION COUNSELING (TCC) BY DENTAL PERSONNEL

The commitment of the dental team (includes dentists, dental hygienists, and practice assistants), plays a major role in the primary or the secondary prevention of tobacco addiction, and is important to achieve success in helping patient quit tobacco.²⁰ Approximately, 63,000-190,000 smokers would stop smoking in a year if all dentists routinely offered smoking cessation advice as mentioned by Daly *et al.*²¹

Evidence show that dental practice has been identified as a potential location for smoking cessation activities. Dentists and their team members have access to a large proportion of the smoking population²² and have many opportunities to reduce the prevalence of tobacco use.²³

Dental treatment often necessitates multiple visits, providing a mechanism for initiation, reinforcement, and support of tobacco cessation activities²⁴ by the same individual.²³ The very early effects of tobacco use manifested in the mouth can be used as a tool to educate the patient without any other aid.²² Dental patients are particularly receptive, teachable moment,²⁵ to health messages at periodic check-ups, and oral effects of tobacco use provide visible evidence and a strong motivation for tobacco users to quit.^{16,26}

Involving dental personnel takes holistic approach in number of ways: As role models by not smoking; in primary care prevention and cancer detection in their practices;²⁷ in counseling patients not to smoke; in referring patients to smoking cessation services;¹⁶ in speaking out publicly; and lobbying for comprehensive public policies to control tobacco use. Thus, the involvements of oral health professionals in tobacco use cessation help contribute to wider tobacco control strategies.²⁸

STRATEGIES FOR TCC AT INDIVIDUAL LEVEL IN DENTAL OFFICE

In providing tobacco cessation in dental office, routine screening for tobacco use followed by identification itself increases the rates of dental personnel intervention.⁸ Dentist who recognizes a patient as a tobacco user has a duty to inform the patient of the options available to them.¹⁶ Effective identification of tobacco use status not only opened the door for successful interventions, but it guided dental personnel to identify appropriate interventions based on patient’s tobacco use status and willingness to quit. The strategies are summarized in Figure 1.¹⁹

Patients, who have not used tobacco in any form, should be complimented and encouraged never to begin. As for tobacco users, a quick assessment should be made of each patients’ current habit and aspire them to quit tobacco use. Patients who use tobacco should be advised of the effects of tobacco on general health and on oral health and educate them regarding the oral health that has improved following tobacco cessation explicitly with pictures.¹⁸ Simple, tailored questioning, advice, and follow-up support are all required to help patients successfully stop tobacco.²⁹

Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and also the effectiveness increases with treatment intensity.⁸ Strong dose-response relationship is also seen between the intensity of tobacco dependence counseling and its effectiveness.¹⁹ Different levels of addiction are treated differently. Clinical and epidemiological studies have indicated high success rate in more intense therapies and that mild smokers may not need such intensive therapies. Treatment options according to the level of addiction for a smoker are given in Table 1.¹⁸

BRIEF BEHAVIORAL INTERVENTIONS

Brief intervention of 3-4 min can move patients through various stages of change.¹⁸ Interventions as brief as 3 min can increase cessation rates significantly.¹⁹ A brief intervention using available resources on the various effects of tobacco use (e.g., tooth discoloration), was effective in educating tobacco users who were not

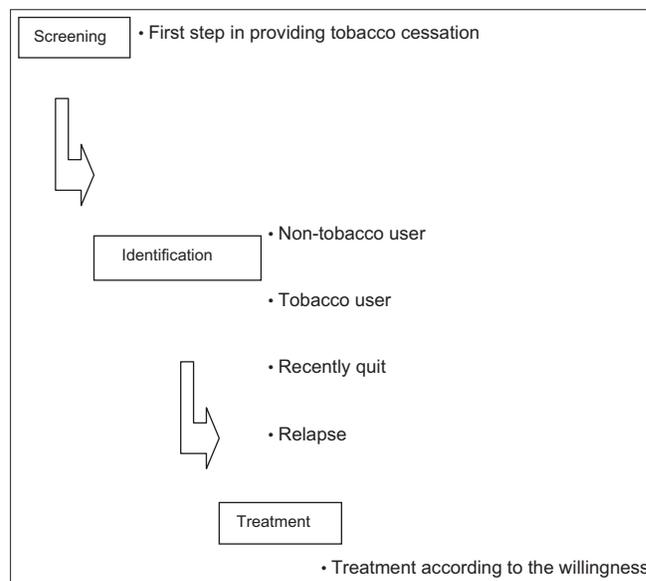


Figure 1: Strategies for Tobacco Cessation Counseling

Table 1: Tobacco user addiction level and treatment option (smoke tobacco)

Level of addiction	Number of cigarette per day	Treatment
Mild	1-5	Brief behavioral intervention
Moderate	Up to 10	Brief behavioral intervention +NRT* +Adjunctive pharmacotherapy
Severe	Up to 20 or more	Brief behavioral intervention +NRT* +Adjunctive pharmacotherapy +Intensive behavioral change

*NRT: Nicotine replacement therapy

prepared to quit. Method of utilizing visually seen effects for education is distinctive to the dental setting that can function independently of medical facilities as a health resource in providing intervention for tobacco users.³⁰

Brief advice against smoking as defined by the Cochrane Tobacco Addiction Group as “verbal instructions to stop smoking with or without the added information about the harmful effects of smoking,” has been shown to increase the rates of smoking cessation in a general population.³¹

Brief interventions can be used with 3 types of patients:

1. Current tobacco users now willing to make a quit attempt;
2. Current tobacco users unwilling to make a quit attempt at this time; and
3. Former tobacco users who have recently quit.¹⁹

CURRENT TOBACCO USERS NOW WILLING TO MAKE A QUIT ATTEMPT

A very popular approach to tobacco cessation intervention is the 5 As Model (Table 2) for helping patients who are willing to quit. The strategies are designed to be brief, requiring 3 min or less of direct clinician time.²⁶ The 5 major steps (the “5 As”) to intervention in the primary care setting are: Ask, advise, assess, assist, and arrange. It is important for the dental care provider to practice the 5 As.^{19,26}

Tobacco use prevention and cessation counseling are based on what is known as the 6 As approach, which is similar to the 5 As used internationally. The 6 As approach includes asking patient’s tobacco use at least once in a year, assess and account for nicotine dependence and willingness to quit, advise patients to quit, assist in quitting, and arrange for follow up.²³

In recent years, this has been condensed to Assist, or an ABC Model: Ask provide Brief advice Cessation support.⁸

Table 2: 5 As model for helping patients quit using tobacco

Strategy	Action
Ask	Ask all patients about tobacco use at every visit and record their status
Advise	Advise in a clear, strong and personalized manner every tobacco users to stop using tobacco and non-tobacco users to remain tobacco-free
Assess	Ask if tobacco user is willing to quit within the next 30 days
Assist	Help all tobacco users to stop based on their willingness to quit with a quit plan
Arrange	Schedule follow-up contact, either in person or by telephone

PHARMACOTHERAPY

Pharmacotherapy should be part of the tobacco intervention program as it can increase success rate up to 30%.¹⁸ Nicotine replacement therapies increase the rate of long term quitting by 50-70%.⁸ Some of the nicotine replacement therapy (NRT) used in smoking cessation are nicotine patch, nicotine gum and nasal spray inhaler and nicotine inhaler. Medication which is prescribed when NRT fail or given in combination with NRT are bupropion, varenicline, nortriptyline, clonidine, methoxsalen, and rimonabant. Some of the pharmacotherapies given in tobacco control intervention are given in Table 3.^{8,13}

INTENSIVE BEHAVIOURAL CHANGE

The dental personnel should limit themselves to brief interventions or counseling sessions. Intensive behavioral interventions are required for heavy tobacco users, who have co-morbidities like clinical depression and advanced social and emotional conflicts. Heavy tobacco users need referral to family practice clinic dealing with addiction issues or are treated as well by clinical psychologists or psychiatrists.¹⁸

INTENSIVE CLINICAL INTERVENTIONS

Intensive tobacco-dependence treatment is more potent than brief treatment. Any trained clinician who has the resources to provide intensive interventions can provide intensive tobacco dependence treatment. Intensive interventions (requiring multiple visits for longer periods of time and provided by more than one clinician) are appropriate for any tobacco user willing to participate but their effectiveness and cost effectiveness is not limited to a subpopulation of tobacco users (e.g., heavily dependent smokers). In addition, patients, even those who are not ready to quit, have reported increased satisfaction with their overall health care as tobacco-counseling intensity increases.¹⁹

CURRENT TOBACCO USERS UNWILLING TO MAKE A QUIT ATTEMPT AT THIS TIME

For patients who are not ready to make a quit attempt, dental personnel should briefly motivate to quit. Patients may be unwilling to quit due to inadequate information about the harmful effects of tobacco, lack of financial resources, fears or concerns about quitting, dispirit from previous relapse. The components of motivational intervention built around the “5 Rs”: Relevance, risks, rewards, roadblocks, and repetition as shown in Table 4.²⁶ Clinicians’ empathy, patient autonomy (e.g. in choosing options), avoiding arguments, and supporting

Table 3: Pharmacotherapies use for tobacco cessation

Pharmacotherapy	Considerations	Adverse effects	Dosage	Duration
Bupropion hydrochloride	Pregnancy, heart disease and history of seizure and eating disorders	Insomnia, dry mouth, and seizures	150 mg every morning for 3 days, then 150 mg twice daily (begin treatment 1-2 weeks pre-quit)	7-12 weeks maintenance upto 6 months
Nicotine gum	Pregnancy and heart disease	Mouth irritation, sore jaw muscles, dyspepsia, nausea, and hiccups	1-24 cigarettes/day: 2 mg gum (up to 24 pieces/day) ≥25 cigarettes/day: 4 mg gum (up to 24 pieces/day)	Up to 12 weeks
Nicotine inhaler	Pregnancy and heart disease	Local irritation of mouth and throat	6-16 cartridges/day	Up to 6 months
Nicotine lozenge		Nausea/Heartburn	Time to 1 st cigarette >30 min: 2 mg lozenge Time to 1 st cigarette ≤30 min: 4 mg lozenge Between 4 and 20 lozenges/day	Up to 12 weeks
Nicotine nasal spray		Nasal irritation	8-40 doses/day	3-6 months
Nicotine patch	Pregnancy and Heart disease	Local skin reaction Insomnia	Ex. 21 mg/24 h 14 mg/24 h 7 mg/24 h Ex. 15 mg/16 h	4 weeks then 2 weeks then 2 weeks 8 weeks
Varenicline	Significant kidney disease Patients on dialysis	Nausea/Trouble sleeping Abnormal or vivid/strange dreams Depressed mood and other psychiatric symptoms	0.5 mg/day for 3 days, increased to 0.5 mg twice/day for 4 days, and then increased to 1 mg twice daily Then, 1 mg twice/day (Begin treatment 1 week pre-quit)	3-6 months
Nortriptyline		Arrhythmias, light-headedness, constipation, blurring of vision, dry mouth, urinary retention, sleepiness, and hand tremors	75-100 mg/day	12 weeks

Table 4: 5 Rs model for patients not willing to quit tobacco use

Strategy	Action
Relevance	Encourage the patient to indicate why quitting is personally relevant, being as specific as possible
Risk	Ask the patient to identify potential negative consequences of tobacco use and suggest and highlight those that seem most relevant to the patient
Rewards	Ask the patient to identify the potential rewards of stopping tobacco use
Roadblocks	Ask the patient to identify barriers to quitting and note elements of treatment
Repetition	Repeat motivational intervention every time

the patient's self-efficacy (e.g., by recognizing previous successes in efforts to change behavior) of quitting, and assisting the patient make motivational intervention more successful.¹⁹

FORMER TOBACCO USERS WHO HAVE RECENTLY QUIT

Dental personnel should provide brief relapse prevention treatment for recent quitters because of the chronic relapsing nature of tobacco dependence. Relapse prevention interventions are especially essential soon after quitting and can be provided through scheduled clinic visits, telephone calls, or any time the dental personnel come across an ex-tobacco user. A systematic, institutionalized mechanism to recognize recent quitters and communicate them is needed to deliver relapse prevention messages effectively. They should reinforce

recent quitters, reexamine the benefits of quitting, and help the patients in understanding any persisting problems arising from quitting.¹⁹

Relapse prevention interventions can be divided into 2 categories:³²

1. Minimal practice for all quitters: These interventions should be part of every encounter with a patient who has recently quit.
2. Prescriptive interventions for patients with problems continuing abstinence: Prescriptive interventions, these are tailored based on information obtained about problems the patient has faced in maintaining abstinence.

RELAPSE COUNSELLING

Very few tobacco users accomplish permanent abstinence in an initial quit attempt; most of them continue in tobacco use for many years and classically cycle through several periods of relapse and remission. It is important that dental personnel be aware that relapse is common and that it reveals the chronic nature of dependence, not their own or their patients' failure.²⁰ Following are the several steps include in relapse counselling:⁸

- Understanding that relapses are possible and do not imply a personal failure
- Knowing about the situations that can lead to using tobacco again and handling them differently
- Dealing with urges or cravings

- Learn how to handle tensions, irritation and low moods
- Develop a healthy lifestyle and a healthy outlook
- Increasing support to prevent relapse
- Handling a lapse or a relapse.

METHODS OF QUITTING

Different methods suit different people in quitting tobacco habit. The options are:

Tapering off S-L-O-W-L-Y

Dental personnel can assist the patient willing to quit by setting a quit date 1-2 weeks, from the date the patient begin to taper off. This is followed by progressive reduction that is by cutting down one or more cigarettes/ beedis/ packet.³³

Cold Turkey (Stopping all at once)

Smokers who smoke <10 cigarettes per day, have a relatively low level of nicotine dependence as per the FTND (score lower than 6 out of the possible 10 points), and individuals who don't require the "extra help" are the best candidates for this method for whom an NRT or Bupropion could be provided. Individual who are determined to quit even if they smoke more than 10 cigarettes per day, having a high score on the FTND, can also attempt the cold turkey method. Pharmacologic therapy can be initiated in failure of long-term tobacco abstinence.¹³

WITHDRAWAL SYMPTOMS

The unpleasant symptoms that occur when a person suddenly stops use of any psychoactive drug are known as withdrawal symptoms. The common symptoms of withdrawal are: Depressed mood, craving, insomnia, irritation, poor concentration, restlessness, and increased appetite. Withdrawal symptoms are most severe during the 1st week and last 2-4 weeks after stopping tobacco. However, the urge to use or "craving," an important symptom of withdrawal, may last a few months and is an important cause for restarting tobacco use.⁸

STRATEGIES FOR TCC AT COMMUNITY LEVEL

The local dental associations can be involved in tobacco control coalition, which performs to organize and enable the community in supporting the nonuse of tobacco. Some of the activities that could be included are community-based programs comprising educating the health risks of environmental tobacco smoke, developing smoke-free public places, and encouraging policies and

programs that help tobacco control interventions.²⁶ The dentist's contribution in tobacco use cessation at a community level are as follows:²⁹

- As a role model by abstaining from tobacco or by quitting successfully
- Conducting periodic individual or group meetings about the significance of tobacco use cessation
- Developing and executing tobacco cessation intervention models in schools
- Exhibiting educational material during the outreach programs or at the urban and rural health centers
- Writing a column in newspaper or magazines about the benefits of various tobacco control policies or other aspects of addiction
- Spreading health awareness linking with NGOs, involving in talk shows, bringing into publicity about the tobacco use cessation success stories thereby helping to understand the community about tobacco use,
- Encouraging the farmers to produce an alternative cash crop and in co-ordination with horticulture department.

Besides giving health education to the public on the detrimental effects of tobacco using pamphlets, role play, mass media, etc. dental personnel can also help in the following:²⁹

- Referring the tobacco users to counseling centers and arrange for follow-up
- Recognizing and extending support to quit tobacco among the high-risk groups such as young adults and pregnant women
- Assisting in monitoring the action against all forms of tobacco use at a local level and also endorsing an implementation of these policies through community participation
- Periodic surveillance and carrying out research for initiating newer methods for tobacco control.

BARRIERS FOR THE TOBACCO CESSATION COUNSELING AND CURRENT SCENARIO IN INDIA

Despite the ever increasing burdens of tobacco, there are several factors which impede dental personnel from participating in counseling their patients here in India. The tobacco use among dental personnel and also the lack of awareness of the need to counsel their patients are one of the major reasons for not performing tobacco cessation activities. Doubting their own efforts/skills of counseling may be due to lack of formal training in providing TCC limit their capabilities. Lack of confidence and concern, prioritizing other dental treatments over counseling considering TCC as time-consuming, fear of losing the patient, uneasy talking to their patients, and

Table 5: Some of the organizations working at the community level in India

Name of the organization	Portfolio of the organization	Actions of the organization
Indian Dental Association (IDA) ³⁹	Non-profit, charitable organization of dentists	Advocacy for a close participation of the dental team in a dynamic role in Tobacco Intervention Initiative
Advocacy Forum for Tobacco Control (AFTC) ⁴⁰	Public health experts, health professionals, research scientists, and officers from Indian NGOs	Advocacy, awareness and research related to tobacco control at national and regional levels
Voluntary Health Association of India ⁴¹	Federation of 27 State Voluntary Health Associations, linking together more than 4500 health and development institutions	Toward implementation of strong graphic health warnings, advocacy on bidi issues, tax increase across all tobacco products, seeking high level commitment from policymakers, comprehensive implementation of COTPA at state-level, creating smoke-free settings, supporting the gutka ban, and media advocacy on tobacco control
Salaam Bombay Foundation ⁴²	Schools students, trained, and called Super army	To increase awareness about the harms of tobacco and ensuring stronger implementation of the Indian tobacco control law
Hriday-Shan ⁴³	Organization of public health professionals, social scientists and lawyers	To create awareness and advocate strategies to advance tobacco control in India and contribute to the global tobacco control movement

no remunerations for such kinds of acts are some of the other factors.^{25,34-36}

Lately, there have been many tobacco cessation clinics set up in dental institutions in various departments across the country, but they are not recognized and accredited. Dental Council of India has established guidelines for initiating tobacco cessation clinics. The Indian Dental Association has launched 115 Tobacco Intervention Initiative centers across 16 states in India 2012.³⁷ The Public Health Foundation of India has offered Health Promotion and Tobacco Control aided by Bill and Melinda Gates Foundation 1 year Post Graduate Diploma in Health Promotion and 3-month Certificate Course since 2011.³⁸

In India, around 70 organizations/NGOs are working in the field of tobacco control. Some of the organizations working at the community level in India are given in Table 5.

CONCLUSION

Tobacco is a major and foremost cause of preventable death in the world. It is important that all health providers including dental personnel must involve in combating today's tobacco war as no single health care professional can access all tobacco users. Dental team can play a vital role in various forms, at the dental office and at the community level, in decreasing the burdens inflicted by tobacco consumption.

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