

Developing Information, Education and Communication (IEC) Strategies for Tobacco Cessation and HIV Prevention in Urban Slums of Jodhpur City

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ABSTRACT

Introduction: The coexistence of tobacco use with low level of awareness regarding HIV/AIDS doubles the disease burden among the slum population. There is need to focus on HIV and tobacco related health education strategies in urban slum population.

Methods: The study was conducted for period of 6 months during (2018-2019) among slum population of Jodhpur city. Data was collected using sampling strategy from 1200 subjects on patterns of tobacco use, the risks involved in utilizing tobacco, knowledge and awareness regarding HIV/AIDS. Further, based on needs, IEC strategy for HIV prevention and tobacco control in slum population was developed and implemented.

Results: A total of 1200 subjects were surveyed, out of which 583 were males and 617 were females (age 15-90 years). Around 65.7 % (n=789) of study population consuming tobacco in one or more forms. Gutka (n=354), Bidi (n= 81) and cigarette (n=93) usage were higher in males than females. About 58% (n=697) has heard about HIV/AIDS and only 17.5% (n=211) have knowledge that the HIV and AIDS are different. Based on health education needs IEC was developed. Folk media like *nukkad-natak* were used to increase awareness regarding misconception. Special focus group discussions were held for males and females. Printed materials like posters along with pamphlets were distributed and Individual counseling sessions were also conducted.

Conclusion: This study provided an IEC framework for sensitizing urban slum population for tobacco cessation and HIV/AIDS prevention considering their health education needs. This IEC strategy further can be scaled up to other slums of Rajasthan state.

Keywords: Information, Education and communication (IEC) strategies, tobacco cessation, HIV prevention, Jodhpur urban slums.

INTRODUCTION

Rapid and unplanned urbanization in India could be due to migration of rural population in urban cities in search of suitable jobs. This leads to formation of slums that are comparatively poor and vulnerable. [1] Majority of slum dwellers lived in inhuman conditions and unhygienic

environments that deprived of basic facilities (like adequate infrastructure, proper drinking water, and sanitation). [2] Urbanization causes a double burden of disease in developing countries due to rapid expansion of non- communicable diseases and their risk factors along with infectious diseases and under nutrition. [3]

In India, tobacco related mortality is estimated to be 1.3 million and higher incidence of oral cancer accounted (almost half of all oral cancer cases worldwide). The estimated number of tobacco consumers (age 15 or above) in India is 266.8 million. [4] Studies reported that low socioeconomic groups have higher tobacco consumption and low quitting rates. [5,6] It is challenging to curb tobacco usage in urban slum population because of their socioeconomic conditions like low literacy level and occupation. [7]

It was reported that low level of knowledge about HIV/AIDS among slum dwellers and they are more at risk of HIV infection. [8] As per National AIDS control organization (NACO) 2017, 21.40 lakh people living with HIV (PLHIV) in India. About 87.58 thousand people were reported as newly HIV infected while 69.11 thousand deaths due to AIDS-related causes. [9,10] Various studies conducted in India reported that in slums people are unaware about their HIV status and there is low level of awareness. [9, 11]

Globally, tobacco and HIV/AIDS are major causes of deaths and indicated the association between tobacco consumption and increased risk of HIV infection. [12] A number of studies from different parts of India have independently highlighted the prevalence of tobacco use, knowledge gap regarding HIV/AIDS transmission and prevention among slum dwellers. [13-16] The coexistence of tobacco use with low level of awareness regarding HIV/AIDS doubles the disease burden among the slum population. [17] There is need to focus on HIV and tobacco related health education strategies in urban slum population. Therefore, study is conducted to develop IEC strategies for tobacco cessation and HIV prevention in urban slums of Jodhpur city.

METHODS

The study was conducted in the time period of 6 months during (2018-2019) among slum population of Jodhpur city. In the first phase, a cross sectional baseline

survey was conducted in eight different localities of the city, selected based on master plan 2001-2013 of town planning department of Jodhpur. Baseline data was collected using sampling strategy from 1200 subjects on patterns of tobacco use, the risks involved in utilizing tobacco, knowledge and awareness regarding HIV/AIDS.

In the second phase, the collected data were entered in Microsoft excel and statistical analysis was done. Baseline data and extensive literature search was used to identify health promotion needs in context to HIV and tobacco usage in urban slum population of Jodhpur city. Further, based on needs, IEC strategy for HIV prevention and tobacco control in slum population was developed and implemented.

RESULTS

A total of 1200 subjects were surveyed, out of which 583 were males and 617 were females between ages of 15 and 90 years. The socio-demographic profile of study population shown in table no 1.

Table 1: Socio-Demographic profile of study population

Demographic variables	N=1200	Percentage (%)
1.Age in years		
15-30	578	48.16
30- 45	415	34.58
46 and above	207	17.25
2.Gender		
Males	583	48.58
Females	617	51.42
3.Educational qualification		
Illiterate	442	36.84
Primary	186	15.5
Secondary and above	572	47.67
4.Marital status		
Unmarried	910	75.84
Married	243	20.25
Divorced	15	1.25
Widow	32	2.7
5.Income		
Below 10,000	395	32.92
In between 10000-20000	415	34.59
Above 20000	390	32.5

Pattern of tobacco use and knowledge for oral cancer

Around 65.7 % (n=789) of study population consuming tobacco in one or more forms, out of which 58.5 % (n= 462/789) were males and 41.45% (n=327/789) were females. Majority of

study population were consuming gutka (n=576), followed by zarda users (n=279), bidi users (n=107), and cigarette users (n=100). Gutka (n=354), Bidi (n= 81) and cigarette (n=93) usage were higher in males than females whereas zarda (n=151) was more prevalent in females. Areca nut (n=163) was found to be mostly consumed by females as compared to males. Details for patterns of tobacco usage in urban slums were shown in table no.2. About 31 % (n= 383) of the tobacco consumers have willingness to quit tobacco and 41.4 % (n=327) have consulted doctor or dentist to quit tobacco.

In study population, about 56% (n=677) of the population has heard about oral cancer. 63% (n=761) of the population had misconception that oral cancer is matter of luck and only 33% (n=397) of population think that prevention of oral cancer can be possible. The younger population of age group 15-30 years has heard more about oral cancer in comparison to older population (> 31 years) but majority of participants who had misconception about oral cancer belonged to younger age groups. Details for knowledge in context to oral cancer in urban slum population shown in table no. 2.

Table 2: Frequencies for tobacco usage pattern, oral cancer and HIV/AIDS awareness to selected socio-demographic characteristics

Variable	Gender		Age (years)			Education		
	Male N (%)	Female N (%)	15-30 N (%)	31-45 N (%)	46 and above N (%)	Illiterate N (%)	Primary N (%)	Secondary and above N (%)
1. Tobacco usage pattern								
Bidi users	81 (75.7)	26 (24.3)	31 (28.9)	45 (42.2)	31 (28.9)	45 (42.0)	18 (16.8)	44 (41.2)
Cigarette users	93 (93)	7 (7)	55 (55)	29 (29)	16 (16)	44 (44)	13 (13)	43 (43)
Gutka users	354 (61.45)	222 (38.55)	243 (42.1)	233 (40.4)	100 (17.3)	251 (44.6)	95 (16.4)	230 (39)
Zarda users	128 (45.8)	151 (54.2)	89 (31.9)	125 (44.8)	65 (23.3)	113 (40.6)	55 (19.7)	111 (39.7)
Pan- masala users	119 (48.2)	128 (51.8)	107 (43.4)	103 (41.6)	38 (15.0)	100 (40.2)	38 (15.3)	109 (44.5)
Areca nut users	23 (12.4)	163 (87.6)	77 (41.4)	80 (43.0)	29 (15.6)	83 (44.6)	30 (16.2)	73 (39.2)
2. Knowledge about oral cancer								
Heard about oral cancer.	316 (46.6)	361 (53.4)	391 (57.7)	191 (28.3)	95 (14.0)	221 (32.6)	97 (14.3)	359 (53.0)
Oral cancer is matter of luck.	379 (49.8)	382 (50.2)	356 (46.7)	264 (34.7)	141 (18.6)	277 (36.4)	119 (15.6)	365 (47.9)
Oral cancer can be prevented.	193 (48.6)	204 (51.4)	183 (46.0)	141 (35.6)	73 (18.4)	148 (37.3)	56 (14.1)	193 (48.6)
3. HIV/AIDS awareness								
Ever heard about HIV/AIDS	366 (52.5)	331 (47.5)	333 (47.8)	236 (33.8)	128 (18.4)	272 (39)	100 (14.3)	325 (46.6)
Awareness for prevention of HIV	205 (57.9)	149 (42.1)	81 (22.9)	102 (28.8)	171 (48.3)	105 (29.7)	62 (17.5)	187 (52.8)
Treatment is available for HIV/AIDS	442 (43.8)	567 (56.2)	475 (47.1)	355 (35.1)	179 (17.8)	395 (39.2)	155 (15.4)	459 (45.4)

Perception regarding HIV/AIDS

About 58% (n=697) has heard about HIV/AIDS and only 17.5% (n=211) have knowledge that the HIV and AIDS are different. Only 17.8% (n=214) of the study population have undergone HIV testing. About 84% of study population has misconception that HIV/AIDS can be prevented by eating healthy food. Males (n= 362) were more aware about preventive measures of HIV/AIDS as compared to females. Around 56 % (n= 567) reported that treatment is available for HIV/AIDS which was higher in comparison to males

(n= 442). The younger population of age group 15-45 years has lower knowledge level for preventive measures of HIV/AIDS in comparison to older population (> 45 years).

Development and implementation of Information, Education and Communication (IEC) strategies

Overall consumption of tobacco and misconception of oral cancer was found to be high in survey population. So, there was need of making them aware about harmful effects of consumption of tobacco. For this,

mass approach and group approach were used like mass media, folk, media, community gatherings, banners, posters and discussions. Special focus group discussions (FGDs) were held for males with focus on harmful effects of tobacco and ways to quit tobacco.

Misconceptions regarding HIV/AIDS were high and people believe that cure for HIV is available. Folk media like *nukkad natak* were used to increase awareness regarding misconception. Females had low awareness about HIV/AIDS. So, special focus group discussions (FGDs) were conducted to increase awareness about HIV/AIDS in females were conducted. For younger population, printed materials like posters along with pamphlets were distributed to make them aware about preventive measures. Individual counseling sessions were also conducted.

DISCUSSION

In this study, we try to develop IEC strategy for urban slum population of Jodhpur city. Based on our framework which was developed from extensive literature search, we carried out our study in the following steps: planning, preparation, implementation and feedback. Similar framework is also proposed by World health organization (WHO) for development of IEC strategies in context to HIV/ AIDS prevention. [18] In planning phase, we planned our study after extensive literature search and developing linkages with the community. In preparatory phase, we did situational analysis by conducting baseline survey for identifying health education needs in context to tobacco usage, oral cancer and HIV/ AIDS. Based on baseline data and philosophy of IEC development, we develop customized IEC approach which included interpersonal group and mass approach and did the implementation of IEC in the surveyed population. For interpersonal approach, personal contact and home visits were done for sensitization. Interpersonal approach along with mass

media were considered as effective form of communication interventions for HIV/AIDS prevention and researchers also revealed that sensitive issues like sexual behaviour could be effectively addressed by interpersonal approach. [19] Lectures, demonstrations and discussions were done to implement group approach. Printed materials, posters and folk media including songs and dramas were conducted to sensitize masses. After the implementation, a quick feedback was taken from the community representation about IEC strategy. We received a positive feedback from community members and they appreciated our efforts made.

CONCLUSION

This study provided an IEC framework for sensitizing urban slum population for tobacco cessation and HIV/AIDS prevention considering their health education needs. This IEC strategy further can be scaled up to other slums of Rajasthan state.

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