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Training Lay Interventionists to Support Tobacco Cessation among Teachers in India

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Abstract

Despite the rapidly increasing burden of tobacco-related morbidity and mortality in low- and middle-income countries, tobacco control initiatives - especially cessation - receive little emphasis. This is true despite low-cost methods that have potential for widespread dissemination. The purpose of this paper is to provide a case study example of how lay interventionists may be trained and supported to facilitate tobacco use cessation, based on the successful *Tobacco Free Teachers—Tobacco Free Society* program (TFT-TFS) implemented in Bihar, India. This school-based program included multiple components, with lay interventionists having a crucial role. The lay interventionists included health educators and lead teachers, both of whom were selected based on formative research, underwent extensive training and received continuing support. We emphasized encouraging and supporting teachers to quit tobacco use and engaging both tobacco users and nonusers to create a supportive environment for cessation. We also stressed that neither the health educators nor lead teachers were being trained as counselors or as cessation experts. We focused on the importance of respecting teachers as individuals and identifying locally relevant methods of cessation. Although we cannot isolate the precise contribution of the lay interventionists to the successful TFT-TFS intervention, the abstinence findings in favor of the intervention at follow up

are highly encouraging. Teachers have been neglected as lay interventionists for tobacco cessation despite the fact that they tend to be highly respected and credible. The approach used for TFT-TFS could be disseminable in multiple low- and middle-income country contexts through train-the-trainer programs targeted to teachers.

Introduction

The burden of tobacco-related morbidity and mortality is increasing in low- and middle-income countries. If present trends continue, there will be 1 billion tobacco-related deaths globally in the 21st century (Peto and Lopez 2001, World Health Organization 2011). India faces particular challenges due to the multiple forms of tobacco in widespread use and the limited resources available for tobacco control (International Institute for Population Sciences 2010). There were an estimated one million deaths in 2010 from tobacco-related causes in India, with increases projected in the future (Jha et al. 2008).

Tobacco use cessation is the central means of substantially reducing the tobacco death toll in the relatively near term (Jha and Peto 2014, Jha et al. 2013, Pirie et al. 2013).

Unfortunately, tobacco use cessation has received relatively low priority in India, and little assistance is available to help dependent tobacco users to quit. The World Health Organization and Ministry of Health in India established a few cessation clinics in major metropolitan areas; however, the potential reach of these clinics is grossly inadequate to the scope of the problem (Varghese et al. 2012). In addition, although brief advice from health professionals has proven effective in increasing quitting (Fiore et al. 2008), such advice is not routinely available, especially in contexts where time allocated to individual patient consultations is extremely limited (Thankappan, Pradeepkumar, and Nichter 2009). In addition, nicotine replacement therapy (NRT) and similar pharmacological supports can cost well over \$100 for a six-week course of treatment and therefore are generally cost prohibitive in low-income countries including India (National Cancer Institute 2007).

Effective cessation methods are needed that can be implemented at low cost and widely disseminated in resource-limited settings such as India. Several successful studies have demonstrated the potential promise of training lay individuals to provide support to dependent tobacco users who wish to quit (Lando 1987, Anantha et al. 1995, Gupta et al. 1986). Lay interventionists may provide sustained support at very low cost provided they are trained adequately.

Such an approach was applied in a recently completed cluster randomized controlled trial in India. The Bihar School Teachers Study (BSTS) tested a school-based intervention designed to promote tobacco control among teachers in the Indian state of Bihar, one of the highest tobacco-using states in India. Teachers can be important role models both in abstaining from tobacco and encouraging others to abstain. This study, conducted in 72 rural and urban schools, found significant improvements in tobacco use cessation among teachers using lay interventionists to support tobacco use cessation. The purpose of this paper is to provide a case study example of how lay interventionists, including health educators and lead teachers,

may be trained and supported to facilitate tobacco use cessation, thereby potentially increasing the accessibility of tobacco use cessation interventions for low-resources settings.

Methods

Study Overview

The BSTS was designed to assess the extent to which a comprehensive school-based tobacco control intervention – known as the *Tobacco-Free Teachers, Tobacco Free Society (TFT-TFS)* program -- resulted in tobacco use cessation among teachers and implementation of school tobacco control policies. The specific aims were to:

1. Assess the extent to which a comprehensive tobacco control intervention results in increased cessation of tobacco use among teachers in Bihar schools.
2. Assess the extent to which a comprehensive tobacco control intervention results in changes in school tobacco control policies.

The TFT-TFS program was tested in a cluster randomized trial in which 72 government schools with grades 8–10 in the Indian state of Bihar were randomly assigned to intervention or delayed intervention control conditions. (Nagler et al. 2013) The 36 intervention schools received the intervention in two waves across two academic years in 2009–2010 and 2010–2011. As shown in Figure 1, the delayed intervention control schools received an abbreviated intervention after the completion of the final data collection. Cessation was measured at baseline, immediate post-intervention and 6-months post intervention using a self-reported teachers' survey; policy adoption was also assessed at these three time points using the teachers' survey and an observation checklist (Sorensen et al. 2013). This study was a collaboration among the Healis-Sekhsaria Institute for Public Health (Healis) in Mumbai and Patna, India, and the Dana-Farber Cancer Institute (DFCI) and the Harvard T.H Chan School of Public Health (HSPH) in the United States, and was approved by the Indian Council of Medical Research and the Healis and the HSPH Institutional Review Boards. Immediately post-intervention, the 30-day quit rate was 50% in the intervention group compared to 15% in the control; nine months after the completion of the intervention, the adjusted 6-month quit rate was 19% in the intervention group and 7% in the control (Sorensen et al. 2013).

Intervention Methods

Figure 2 presents the framework of the TFT-TFS program, which included educational components delivered by health educators and lead teachers, and support for implementing tobacco-free policies. The program was conducted over seven months (September to March). The intervention objectives, also presented in Figure 2, focused on increasing knowledge of the health risks of tobacco and increasing motivation to quit, while also aiming to build a supportive environment for quitting.

TFT-TFS program contained six program components: (1) a notice board (to display materials); (2) a suggestion box (for the health educator and lead teacher to receive feedback and questions from teachers); (3) six posters (one per theme); (4) a calendar (displaying the monthly theme); (5) self-help quit booklets (a step-by-step guide to quitting tobacco use,

available for each teacher); and (6) discussion on six program topics. With the principal's permission, the tobacco use policy statement was painted on the school's walls in large, bold writing, as is common practice for posting messages in Indian schools. The discussions were conducted twice per month at each school and were centred on six topics or themes: (1) teachers as role models for tobacco control; (2) health effects of tobacco; (3) motivations to quit tobacco; (4) skills to quit tobacco; (5) dealing with withdrawal symptoms; and (6) maintaining abstinence from tobacco. The first session of each month was facilitated at the school by the health educator and the second session was facilitated by the lead teacher approximately two weeks later. These sessions were usually conducted during lunch-breaks (to avoid interference with teaching schedules) and engaged both tobacco users as well as non-users. Twelve sessions were offered to each school. All TFT-TFS program materials were in Hindi, the local language in Bihar, and activities were detailed in standardized protocols (Nagler et al. 2015, Pawar et al. 2015)

Lay interventionists played two central roles in the delivery of this intervention. First, health educators, who visited the intervention schools monthly, played a leadership role in intervention delivery. Second, one teacher in each intervention school was designated by the principal as the 'lead teacher,' who was responsible for working with the health educator to implement the program in their school. The selection of the lead teacher was based on the guidelines evolved by the research team. Health educators and lead teachers were trained to facilitate tobacco use cessation among teachers and the development of a school environment supportive of tobacco control.

Evaluation Methods

Formative research—We conducted focus groups with teachers and principals, including four in January 2008, and six in June 2008, to inform intervention development overall and particularly the roles of the lay interventionists in the program. Each group had a mix of male and female teachers as well as users and non-users of tobacco. All focus groups lasted between 60–90 minutes and were guided by scripts based on stated research objectives. Staff members were trained to moderate the focus groups and were assisted by trained note takers who took careful, systematic notes during each discussion. All focus groups were audio-recorded, conducted in Hindi, and translated into English immediately afterwards. The transcribed focus group data were analyzed using a two-stage coding process: Level 1 structural coding and Level 2 thematic coding. Structural coding followed the structure of the focus group guide, in which the response to every question received a structural code. Thematic coding was based on themes that arose from the structural coding, and was applied in a second pass analysis. These methods were enhanced by the use of N'Vivo software (QSR International).

Process evaluation—We trained health educators to track the delivery of the intervention on process tracking forms. The forms were checked for completeness after each session by the study team and included information on: (1) time spent by each health educator and lead teacher conducting the session with the teachers (in hours; excluding time spent on logistics); (2) number of school teachers participating in each session; (3) number of school personnel present on the school roster; (4) whether or not specific topics were discussed as per the

protocol; (5) types of materials used in each session; and (6) questions posed by teachers along with responses given by health educators or lead teachers. The health educators recorded information about each health education session on the respective form at the end of the day. Based on the recorded data, we developed three process indicators: fidelity, dose and reach. Using the participating schools as the unit of analysis, descriptive statistics for each indicator were calculated. All analyses were carried out using Statistical Package for Social Sciences (*S.P.S.S. version 13.0*) software (Pawar et al. 2015).

Post-intervention focus groups with school personnel—In July 2012, one year after the intervention, we conducted five focus group discussions: one group with principals (n=4) and four groups with teachers (n=35) to assess their overall reactions to the TFT-TFS program and obtain specific feedback about each intervention component. The same data collection and analysis methodology was followed as described above under ‘Formative research.’

Results

Formative research results: Defining the roles of the lay interventionist in the TFT-TFS Program

Defining the roles that lay interventionists would play in this intervention was drawn from our formative research and understanding of the local context (Pischke et al. 2013, Nagler et al. 2013). This formative research not only underscored the important role of lead teachers as lay interventionists embedded within the school to provide continuity in support for tobacco control, but also informed our intervention design. Findings from this research also provided a foundation for core overarching principles that guided the definition of these roles and the plans for training the health educators and lead teachers. Among these principles were *inclusion*, that is, the importance of including both tobacco non-users as well as users as part of the intervention; and *engagement*, that is engaging teachers in discussion, rather than lecture, as a means to support teachers and to find ways to embed support into natural conversations between teachers. We further drew on principles of adult learning, including *respect*, that is, understanding that like other adult learners, teachers must feel heard, honored and respected as individuals; *immediacy*, that is the importance of communicating ways that new knowledge, skills and attitudes can be applied immediately; and *experience*, recognizing that adults learn best when their learning is directly related to their own life experience (Vella 1995, 2008, 2002).

Formative research results: Developing messages delivered by lay interventionist in the TFT-TFS Program

The formative research further informed the design of the messages to be delivered by the lay interventionists. We identified a need to dispel myths about the benefits of tobacco use (i.e. chewing tobacco is good for teeth and gums, it gives energy to the body, it perks you up) that were prevalent in Bihar (and other parts of India)(Gilljam 2002) and developed messages to counter these myths. For example, teachers were asked to put a peppermint in their mouth instead of tobacco to give them energy and not harm their teeth and gums. Our formative research also pointed to perceptions of the quitting process that needed to be

addressed in intervention messages. For example, we balanced messages about willpower, perceived as central to successful quitting, with skill-building around coping strategies, and underscored that relapse is a normal part of the quitting process. A unique aspect of the TFT-TFS program was the simplification of standard, theoretical approaches to the stages of quitting (Prochaska and DiClemente 1983) into three distinct phases, including: (1) preparation to quit; (2) actual quitting; and (3) maintenance. Table 1 provides details of each phase along with key messages as steps to take. The training aimed to build an understanding of the need for health educators and lead teachers to tailor their support to the phase of quitting; it also made clear that quitting is not a linear process and may require multiple attempts. Of note, NRT was not included as part of the intervention due to significant cost barriers in this context (Kishore et al. 2010) thus further underscoring the importance of social support and skill building in the cessation process.

Process evaluation results: Intervention delivery

We monitored program implementation with the process evaluation system. As reported previously, the intervention was delivered with high fidelity to the protocol. All twelve discussion sessions were delivered in 33 out of 36 schools. Thirty-one schools implemented all six program-components and in 29 schools, 100% teachers reported exposure to all program messages. In 18 schools, 95% of the teachers participated in one or more sessions. The tobacco policy was painted on the wall in all schools (Pawar et al. 2015). We also used the process evaluation system to track training and support provided to the health educators and lead teachers.

Intervention delivery via Health Educators: The health educators provided overall leadership for school-based interventions—Six male staff members from the Bihar office of Healix who were college graduates with some community work experience, were trained to serve as the project health educators. We restricted the training to men because the job often involved traveling to schools at odd hours and in isolated areas, which could be unsafe for women. The primary roles of the health educators were to (1) deliver the intervention; (2) train and support lead teachers; (3) provide cessation support and information for teachers; and (4) document their interactions with teachers and principals as part of the intervention delivery process.

Training—Before the TFT-TFS intervention began, in June 2009, the Healix Mumbai office organized a four-day training for the health educators in Patna, the capital of Bihar, with a cessation expert serving as a lead trainer. This training addressed key components related to tobacco control in India, communication skills appropriate for different groups, the role of teachers in tobacco control, as well as the dynamics of tobacco addiction and the strategies to support quitting. Along with learning how to implement the various program components in the schools, the health educators reviewed factors that promote adult learning and how they applied to tobacco use cessation, as described above. We used these principles as a foundation to train the health educators to communicate with teachers in a respectful way, and in particular, not to stigmatize tobacco users. For example, the health educators were trained to empathize and develop a good rapport with teachers, which allowed them to relate the cessation support provided to teachers' lives and personal experiences. At the same time,

they were trained to encourage non-users to play a supportive role and extend help to fellow teachers who were trying to quit tobacco use.

To make the training more interactive and relevant, we included an experiential learning exercise in which health educators were asked to select a personal health behavior they might want to change, as a way of exploring how participants might initiate the process of behavior change. We used the stories of actual quitters in Bihar to localize methods employed to quit or coping strategies used to increase the chance of long-term success of staying quit. Stories focused on local examples, for example, of a quitter who was motivated to quit when a doctor told him he looked old for his age (tobacco is known to cause wrinkles) and may face premature death as a result of his tobacco use; a user who was motivated to quit when a relative who was a smokeless tobacco user was hospitalized for mouth cancer; and a grandfather who was influenced to quit by his grandson's avoidance behavior towards him, since the grandfather had a foul smell from chewing tobacco. A common theme in many stories was that successful quitters maintained their determination to quit through a daily routine, typically including yoga or other physical exercises, maintaining a healthy diet, and addressing withdrawal symptoms through activities such as playing with children, gardening, and participating in religious rituals. Some found it helpful to chew common spices and herbs found in Indian kitchens (e.g., fennel leaves, peppercorn, and cloves). The health educators encouraged teachers to utilize these locally-relevant resources as possible alternatives to stay tobacco-free.

Guided by the adult learning principles described above, a fundamental feature of the training included opportunities for health educators to practice assessing a range of examples of phases of readiness to quit, and tailoring their support accordingly. To achieve this, health educators watched the cessation expert model how to counsel and support someone in each of the phases of quitting by utilizing program materials, such as posters, the compilation of quitting tips and the quit booklet. The health educators then role played a counseling session between the health educator and a teacher who was trying to quit tobacco but would give in when he saw his friend chewing *paan* (a mixture of betel leaf with areca nut and sometimes also with tobacco) or was offered it during a wedding or traditional function. The health educator would show the teacher the section of the quit booklet, which talked about triggers and then engage the teacher in a conversation about how to deal with triggers while quitting. We also created structured feedback sessions where the health educator practiced and observers commented on strengths of the counseling or support provided and possible areas for improvement.

At the conclusion of the health educator training, the trainers solicited their ideas for improvements to the training and identified additional content areas. Their ideas and suggestions - which included an emphasis on further role plays and interactive sessions between the trainers and the health educators - were incorporated into a refresher training..

Ongoing support—Mid-way through the intervention, we reconvened the health educators for a two-day refresher training. The training agenda comprised a review of the intervention themes, sharing of experiences and shared problem solving, and practice in presenting intervention sessions and providing support for tobacco use cessation. Rather

than addressing new material, this refresher built on their initial training. Along with reviewing the principles of cessation, the majority of the time was spent practicing how to support teachers and other school personnel in the different phases of quitting. Throughout the refresher training, role play was a crucial platform to develop skills and clarify subtle differences in the support provided, based on a teacher's readiness to quit tobacco use. In addition, the refresher training emphasized the importance of supporting and guiding those interested in quitting, rather than focusing on how many people actually quit.

In addition to the refresher training, continuous support and supervision were provided to the health educators to ensure effective implementation of the TFT-TFS program in intervention schools. A regular schedule for phone communication between health educators in Patna and Healis investigators in Mumbai was established. On a fortnightly basis, the Healis team talked to each health educator by phone in order to get information on his experience visiting the schools, using a structured de-briefing form.

Intervention delivery via Lead teachers—Lead teachers functioned as lay interventionists embedded within the schools. In each intervention school, the health educator worked with the school principal to designate a teacher as a lead teacher. Criteria for selecting lead teachers included: the lead teacher be a non-user of tobacco, have strong communication and leadership skills, be empathetic and respected by peers, and have a good rapport with fellow teachers. The main role of the lead teacher was to serve as a resource for teachers interested in quitting. For example, if a teacher wanted to know how to decide when to quit, the lead teacher would indicate where in the quit booklet this issue was addressed. Additionally, the lead teachers' roles included serving as a liaison between the health educator and teachers; encouraging teachers to participate in program activities; facilitating discussions about tobacco; and working with other teachers and the school principal on their school's tobacco control policy.

Training—We organized a two-day training in Patna for the lead teachers in the intervention schools at the beginning of the school year for each intervention wave. Trainers included the health educators and Healis staff members. Including the health educators as trainers was designed to solidify their knowledge of the content and skills related to cessation as well as to foster a relationship with the lead teachers. Along with instruction on how to implement the different program components, a key area of their training focused on skills to facilitate discussions with teachers and other school personnel interested in quitting tobacco, including how to ask open-ended questions, use active listening, brainstorm solutions and be supportive of a person's desire to quit, quit attempts and efforts to remain tobacco-free. Cessation content included strategies to talk to their peers about quitting, such as telling a fellow teacher who wanted to use tobacco to divert his mind by getting up from his seat, taking a walk, drinking a glass of water or talking to a student. Content also covered understanding addiction, the three phases of quitting and relapse, and how to identify and support someone in each phase of quitting with the help of all the program materials. Given the low rate of cessation in India (i.e. only 3% of the population reported as 'former users' in the 2010 Global Adult Tobacco Survey) (International Institute for Population Sciences

2010), relying on local suggestions for coping strategies was vital to enhancing teachers' self-efficacy to quit.

The training focused on developing the lead teachers' skills to help teachers identify practical and feasible strategies to quit that would work for them. Throughout the training, we stressed that the training was not intended to make the lead teachers experts in cessation counseling, but rather aimed to provide basic skills to support others in quitting with the help and support of the health educator. To accomplish this, the training provided simplified strategies that lead teachers could employ if a teacher asked about support for cessation: (1) talk with the teacher to determine stage of readiness to quit, using the three phases described above; (2) refer the teacher to the health educator for advice and resolving any questions, queries, or concerns; and (3) follow-up with additional resources, such as directing them to specific sections of the TFT-TFS quit booklet and providing them with encouragement from the success stories of others who have quit.

Ongoing support—Mid-way through the intervention, we also hosted a one-day meeting of lead teachers and their respective school principals. Like the health educator refresher session, the purpose of this gathering was for lead teachers to share and learn from each other's experiences in implementing the program and helping teachers in their quit attempts. Success stories of those who had faced challenges and how they overcame them were highlighted. The training also included project staff listening to the lead teachers' experiences to determine if any mid-course modifications were required. We also provided ongoing support of the lead teachers: the health educators checked in with the lead teacher on each visit to the school, had regular scheduled calls, and were available at any other time by phone.

Post intervention focus groups

The teachers and principals also discussed how the program created a support system for them inside the schools, mainly through the efforts of the lead teachers and health educators. The discussions led by the health educators and lead teachers were viewed as the most important part of the program. They helped create a safe space for open dialogue about tobacco, which in turn motivated people to quit. School personnel expressed that the atmosphere of open discussions - where they were given the chance to talk freely - made them feel that they were important and the program was truly driven by them. This made the teachers very receptive to the program.

Both teachers and principals reported the strategies, activities and information provided in the TFT-TFS program created an atmosphere where they started to believe more deeply that tobacco use was truly harmful to their health. School personnel respected the lead teachers and appreciated they were available to support teachers in the absence of the health educators. The teachers viewed the health educators as very knowledgeable and had confidence in the information provided by them, particularly the facts about the harmful effects of tobacco. They also reported that they particularly valued several aspects of the health educators approach, including their respect, shared cultural values, responsiveness to teachers' questions, and their empathy.

Discussion

The TFT-TFS intervention was shown to be efficacious in promoting tobacco use cessation among school teachers in the Indian state of Bihar (Sorensen et al. 2013). A core element of this intervention was the inclusion of lay interventionists to deliver the intervention and support cessation among teachers. The overall success of the intervention suggests that the model presented here may hold promise for the participation of lay interventionists in other low-resource settings. We were able to incorporate extensive cessation training within the context of a comprehensive intervention intended to change social norms around tobacco use and to encourage and empower teachers as lead change agents and role models for tobacco use abstinence.

We assumed no special tobacco use cessation background or knowledge on the part of the health educators and lead teachers. A central theme throughout the training was that the health educators and lead teachers worked together as a team to support cessation among teachers. The lead teachers were trained to respond to the needs of the teachers by supporting them with materials and resources rather than approaching them to ask them to quit the use of tobacco. Considerable emphasis was placed upon facilitating discussions with teachers and other staff who might be interested in quitting and providing support for quit attempts. The training of health educators was more intensive than that of the lead teachers because the health educators had the dual role of both supporting cessation attempts and advising lead teachers in encouraging others. The training was not intended to make the lay interventionists experts in cessation counseling, but rather aimed to provide basic skills to support others in quitting. For both health educators and lead teachers the training was highly participatory and interactive. A fundamental goal was to empower both health educators and lead teachers to engage others around the issue of tobacco use and to encourage abstinence.

A limitation is that we cannot isolate the contribution of the lay interventionists, mainly because the study was not designed for this purpose. Because this is a multi-component intervention that was delivered with a high degree of fidelity by the health educators and lead teachers, we cannot separate their unique role in supporting cessation among the teachers. Nevertheless, the overall success of the Bihar School Teachers' Study in promoting cessation among teachers is highly encouraging. The 30-day quit rates in the intervention and control schools were dramatically different and both the 30-day and 6-month outcomes were statistically significant. Although we did not collect cost data, tobacco use cessation has been identified as the gold standard of intervention cost effectiveness (Fiore et al. 2008). Costs can be substantially reduced through use of lay facilitators as opposed to masters or doctoral level professionals. Lando (1987) delivered a multisession group cessation program at very low cost through the use of volunteer lay interventionists and donated facilities (Lando 1987). In addition, although we did not assess the impact of this program on students, these findings suggest that the program prompted further attention to tobacco control in these schools, created visible indicators of supportive policies, such as wall paintings and posters, and may have had spillover effects within the classroom and the broader community.

We viewed teachers as especially important role models in both abstaining from tobacco and in encouraging others to abstain. The cessation skills and supportive strategies that we taught to both health educators and lead teachers could be conveyed to lay individuals with brief training that could readily be incorporated into workshops. The training of the health educators and lead teachers is consistent with an approach that emphasizes the role of lay interventionists (Glenton et al. 2013). This approach could be readily disseminable through train-the-trainer programs targeted to teachers, who have been a neglected resource for tobacco cessation. More generally, lay interventionists could be a fundamental asset in limited resource environments such as those that typically exist in low- and middle-income country settings.

In conclusion, enlisting lay individuals who receive basic skills training in delivering cessation interventions can substantially augment the reach and impact of health professional cessation services. Behavioral counseling and social support are effective both in increasing success of individual quit attempts and in promoting norms that encourage tobacco abstinence (Balaji et al. 2012). By training and empowering lay facilitators it may be possible to expand the current reach of effective cessation services in low resource settings. This approach will, as part of comprehensive tobacco control initiatives, contribute substantially to reducing tobacco use and thereby to consequent reductions in tobacco-attributable morbidity and mortality. Given the demonstrated efficacy of delivering the intervention through lay interventionists, the approach used has considerable promise for successful application to other low-resource settings.

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Figure 1.
Bihar School Teachers Study (BSTS) schema

Figure 2.
Tobacco Free Teachers/Tobacco Free Society Intervention Overview

Table 1

Three phases of quitting as operationalized in the *Tobacco Free Teachers, Tobacco Free Society* intervention program

PHASE/Key Messages	PREPARATION TO QUIT	ACTUAL QUITTING	MAINTENANCE
	<p>Reinforce: Remind teachers that they play a very important role on shaping the minds of the young. Their students imitate them and internalize what they see them doing. Also remind teachers that they play a key role as community leaders.</p> <p>Recapitulate: Review all the harms associated with tobacco including health, economic, morbidity and mortality. Remind them how tobacco affects the whole family. It eats up a considerable amount of family resources.</p> <p>Interact: With people interested in quitting and address their doubts.</p> <p>Emphasize the immediate benefits of quitting.</p>	<p>Congratulate: the teacher or staff member for deciding to quit tobacco.</p> <p>Verify: Confirm that the teacher is ready to quit.</p> <p>Review: the contents of <i>Quit: Your Pocket-Size Guide to Quitting Tobacco</i> booklet + <i>Actual Quitting Tips</i> handout with the teacher.</p> <p>Discuss: Talk with the teacher about: <u>How to set a quit date</u></p> <ul style="list-style-type: none"> • Could be an important date such as an anniversary, birthday or holy day <p><u>How to prepare to quit</u></p> <ul style="list-style-type: none"> • Tell family and friends about intention to quit • Start doing exercise and deep breathing • Identify a ritual the night before quitting • Get rid of all tobacco products in the house <p><u>What to do when withdrawal symptoms set in</u></p> <ul style="list-style-type: none"> • Take a walk • Drink water • Practice yoga or other exercise • Splash cool water on your face • Chew seeds, such as fennel or cloves <p>Emphasize: Conclude by reviewing the benefits of quitting</p>	<p>Remind: teachers that quitting is a process and a major part of the process is staying quit over the long-term. For some, maintenance can be the hardest phase.</p> <p>Review: Teachers need to continually remind themselves of their reasons for quitting to remain tobacco-free.</p> <p>Provide: Tips to teachers for staying tobacco-free, such as:</p> <ul style="list-style-type: none"> • Take one day at a time • Learn to say 'no' to tobacco and reward yourself for small successes • Do things you enjoy that do not involve tobacco • Listen to music • Read books • Buy fruits with the money saved and distribute it as you like • Keeping away from tobacco each day gets you closer to your goals <p>Encourage: Teachers to solicit the support and advice from others who have quit</p>

Cutting across all phases was the possibility of **relapse**, which was discussed throughout the different training sessions along with ways to deal with it.