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Prevalence of Cigarette Smoking and Nicotine Dependence Among Physicians and Employees and Their Attitude Towards Smoke Free Workplace

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Abstract: *This study aimed to evaluate cigarette smoking and nicotine dependence among physicians and employees and their attitudes towards smoke free workplace in Port-said City. A cross-sectional survey design was used in this study during the period from June 2013 until August 2013. This study was conducted at the hospitals, private clinic and the different public health sectors in Port-said City. Sample size was 1086. Study subjects were employees and physicians. It includes 550 employees (420 males &130 females) and 536 physicians (332 males & 204 females). World Health Organization's smoke free workplace questionnaire was the tool used in this study. Fagerstrom test for nicotine dependence was used to assess the degree of nicotine dependence among smokers. The cut off point was taken at 6 on10 point scale. The result of the study shows that 35.7 % of the employees were smokers but only 23.13% of the physicians were having the habit of smoking. The majority of the samples were worked in shared office; 76.4% of employees, while 51% of the physicians so they were subjected to fumes of others, or they were affecting others. The percentage of the current smokers of employees, about 40.8% used to smoke their first cigarettes within the 5 minutes after waking up, while 18.5% among physicians. Around 28.6% of employees and 18.5% of physicians smoked even if they were ill. About 51% of employees and 37.1% of physicians can smoke 11to20 cigarettes per/day. The mean score of Fagerstrom test of smokers who want to quit was 4.9 and 2.1standard deviation while for those who would not want to quit was 6.4and 2.2 of standard deviation. There was a relationship between being smokers who would quit or not and their total score in nicotine dependence test, (P<0.0001). Total ban of smoking in public places was chosen by the majority of participants, but nicotine dependence may play as an obstacle to achieve this objective. Smoking cessation programs should consider a dependence treatment program.*

Key words*: Nicotine dependence, Tobacco, attitudes, beliefs, smoking, smoke free workplaces, cigarettes smoking,*

I. Introduction

Smoking represents a critical international issue for public health policymakers and strategists. According to the World Health Organization, tobacco is the second major cause of death and the fourth most common risk factor for diseases worldwide. If the current trends continue, by 2020 it will have cause around 10 million deaths each year, with approximately 650 million fatalities overall. There are more than 4,000 different compounds in tobacco smoke. More than 40 of the chemicals in tobacco are known to cause cancer [1]. Nicotine is the drug in tobacco that makes smoking a powerful addiction. Experts rank nicotine ahead of alcohol, cocaine and heroin with regard to the severity of dependence resulting from its use. Tobacco dependence is also recognized as a disease in the World Health Organization's International Classification of Diseases (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV). In developed countries a large proportion of smokers want to stop smoking and many try to stop, but the corresponding proportions in developing countries are low. Quit rates are also low in many developing countries. Smokers who try to quit often find it difficult because of the addictive properties of nicotine [2]. Smoking harms the health of smokers and those around them. Smokers are at far higher risks of strokes, heart attacks and other cardiovascular diseases; cancers of lungs, mouth, larynx, bladder, pancreas, kidneys and stomach; emphysema, bronchitis, and tuberculosis.These diseases cause serious illness, disability and premature death. Tobacco causes 4 million deaths worldwide each year, and the numbers are raising fast [3-5].

Tobacco smoke also harms non-smokers exposed to so-called second hand smoke or, Environmental Tobacco Smoke (ETS). In addition, to smell and irritation to eyes, ETS exposure increases the risk of lung cancer, cardio-vascular and respiratory diseases[6]. In USA alone, each year ETS kills an estimated 35,000 to 65,000 adult nonsmokers from lung cancer. This is a small fraction of global deaths from ETS. ETS exposure is common in workplaces. In 1996, an estimated 130 million adult non-smokers in China were exposed to

workplace ETS. In the UK in 1999, more than 3 million non-smokers were continuously or frequently exposed to tobacco smoke at work. In France, where there are laws restricting smoking in public spaces, 40% of employees are still exposed to ETS. ETS can interact with chemicals and radiation in workplaces to produce an additive or multiplicative effect and increase significantly the risk of many occupational diseases[2, 6].

As per the report of Ministry of Health and Population (MOHP, 1999), over 13 million Egyptians, or one in every five, are smokers. An alarming number of students, teachers and physicians regularly smoke. Tobacco cigarette consumption increased from 26 million in 1977 to an estimated 57 billion in 1998 consistent with the tobacco epidemic experience in other countries. Although tobacco cultivation is prohibited in Egypt, yet around 39 billion cigarettes are produced every year. The percentage of smokers is increasing by 8% yearly[7-8]. Physicians are highly respected in their communities. They act as role models in issues related to health, and people turn to them for advice and consultation. For this reason, they are very important in advancing any tobacco control policies. Data from this survey will help to find out whether there will be a possibility to achieve the goal of World Health Organization towards smoke-free workplace or not.

I.1 Statement of the Problem

Prevalence of cigarette smoking and Nicotine Dependence among Physicians and Employees and Their Attitude towards Smoke free workplace in Port – said City, Egypt

I.2. Aim of the study

This study aimed to evaluate cigarette smoking and nicotine dependence among physicians and employees and their attitudes towards smoke free workplace in Port-said city, Egypt.

Objectives of the study:

1. Determine the prevalence of cigarette smoking among physicians and employees.
2. Determine the prevalence of nicotine dependence among physicians and employees.
3. Identify the attitudes of physicians and employees towards smoke free workplace in Port-said city, Egypt.
4. Recognize the relationship of nicotine dependence to willingness of cigarette smoking cessation.

II. Materials and Methods

II. 1. Research Methodology

Research Approach: Quantitative Research Approach
Research Design: A cross-sectional survey design was used in this study.
Setting: This study was conducted at the Hospitals, Private clinic and the different Public health sectors in Port-said city, Egypt.

II.2. Sample

Population: Employees and Physicians
Sample Size: 1086
Sampling Techniques: Purposive Sampling
Samples: The subjects of the present study were selected by a purposive sampling technique. Sample size was 1086, out of those 550 employees (420 males & 130 females) and 536 physicians (332 males &204 females). They were at their workplaces at the time of data collection.
Inclusion criteria were including in this study: (a) Gender (males &females), (b) physicians and employees of health sectors (private & public) (c) willing to participate in the study.
Exclusion criteria includes (a) The person with consequences of smoking.

II.3. Research Tools for data collection

The necessary information was collected by using a questionnaire sheets (WHO Smoke free workplace survey). Questionnaire sheets used to assess the current smoking pattern of physicians and employees, their attitudes towards smoking in workplaces and their desire of assistance with cessation of smoking. Fagerstrom test for nicotine dependence (Heatherton TF, et al 1991) was used. This test scale was used to evaluate the strength of the nicotine dependence on graded scale. The score ranged from zero which means no nicotine dependence and 10 which means complete dependence on nicotine. The cutoff point is taken at 6, below 6 means low degree of dependence on nicotine and above 6 means high degree of dependence and difficult to quit smoking. In this surveys, work place means any place in which employees, contractors, volunteers, or other persons perform duties of employment or work and include private offices, common areas, and any area, which they generally use during the course of their employment or work.

II.4. Preparatory phase:

It include reviewing of literature and research results related to cigarette smoking, nicotine dependence among physicians, employees, using books , articles and magazines to evaluate the study tools for data collection.

II.5. Pilot study:

Pilot study was carried out on10% of total sample and it was excluded from the study subject to test the feasibility, applicability and the clarity of the questionnaire and to estimate the length of time needed to fill the sheet. As a result of the pilot study, the necessary modification in the tools was done and the final form was developed.

II.6. Implementation phase:

Data collection period for this study was from June 2013 to August 2013, the researchers collect the data during the morning from 9A.M. to 11A.M, three days/week, at the hospitals, private clinic and the different public health sectors in port-said city. The physicians& employees filled the questionnaires alone except few from employees who were illiterate and worked as coffee makers and on janitorial services the items of the questionnaire were read to them within 45-60minutes wherein the aim of the study were explained to them to obtain their cooperation for data collection.

II.7. Ethical consideration

At the initial interview, all subject were informed about the nature, purpose and benefits of the study and that their participations were voluntary. They were individually interviewed to evaluate cigarette smoking and nicotine dependence among physicians, employees and their attitudes towards smoking free workplace in port-said city. The time allotted to fill the questionnaire sheet was 45minutes for each participant. Also, all the information was kept confidentially.

II.8. Limitation of the study:

The scope of the study was limited as it was restricted to those men and women who voluntarily agreed to participate.

II.9. Validity and reliability:

Validity: questionnaire sheet was revised by nursing experts. Alpha reliability it is equal (0.87).

III. Figures and Tables

Analysis of data

The data collected were coded, analyzed and tabulated to evaluate cigarette smoking and nicotine dependence among physicians, employees and their attitudes towards smoke free workplace in port-said city. Descriptive statistics as frequency and percentage were calculated using SPSS. Chi square test was used and p values less than $P \leq 0.05$ were considered as statistically significant.

Table I. Frequency Distribution of Subjects Based on Gender and Habits of Smoking

Gender	Employees						Physicians					
	Currently smoking		Ex-&Non Smoker		Total		Current smoking		Ex- &Non smoker		Total	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Males	196	35.64	224	40.72	420	76.4	111	20.71	221	41.23	332	61.9
Females	0	0	130	23.64	130	23.6	13	2.42	191	35.63	204	38.1
Total	196	35.64	354	64.36	550	100	124	23.13	412	76.87	536	100

Table I shows that the study subjects were 1086, which includes 550 employees and 536 Physicians, out of 550 employees 76.4% were males and 23.6% were females. Regarding 536 physicians, 61.9% of them were males and 38.1% of them were females. According to smoking status the samples were grouped in to two i.e. (a) Current smoker, (b) Ex or Nonsmokers. About 35.64% of the employees were Smokers but among the physicians 23.13% of them were having the habit of smoking.

Figure 1: Frequency distribution of current smokers among employees and physicians.

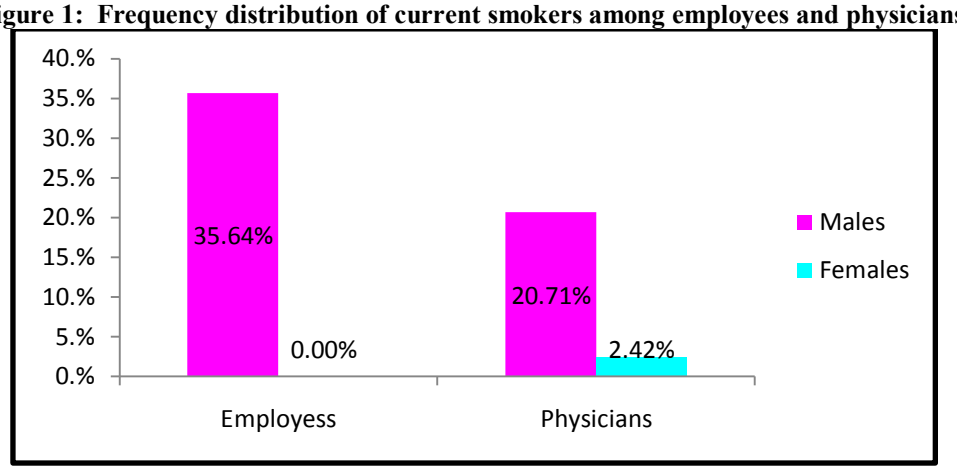

Figure 1 display that 35.64% of the employees are smokers and 20.71% of the physicians were smokers, but 2.42% of the female doctors were also smokers.

Table 2: Distribution of employees and physicians according to the status of work place.

	Employee		Physician	
Work Place	Frequency	%	Frequency	%
Single Office	60	10.9	124	23.1
Shared Office	420	76.4	277	51.7
Public Office	70	12.7	83	15.5
Others	--	--	52	9.7
$\chi^2 = 103.7$	**Significant at 0.05**			
Bothered because of smoking in their workplace				
Yes	350	63.6	420	78.4
No	200	36.4	116	21.6
$\chi^2 = 28.1$	**Significant at 0.05**			
Moved because of smoking in their workplace				
A lot	150	27.3	99	18.5
Sometimes	150	27.3	142	26.5
Never	250	45.4	295	55.0
$\chi^2 = 14.2$	**Significant at 0.05**			

Table 2 illustrates that the samples where exposed to fumes of others or they were the source of fumes that affects others. About 76.4% of employees and 51.7% of physicians were have shared work place; 63.6% of employees and 78.4% of physicians were bothered by smoking in their working places and they moved from the work place because of smoking; while 45.4% of employees and 55% of physicians never moved because of smoking.

Table 3: Smoker's behaviors in work place

	Employee		*Physician*	
	Frequency	%	*Frequency*	%
If they Smoke at work				
Yes	196	100.0	90	72.6
No	---	----	34	27.4
If smoking is restricted				
Smoke less	100	51	69	55.6
Stop Smoking	3	1.5	26	21
No change	93	47.5	29	23.4
If smoking is restricted; it would be				
Very easy	50	25.6	20	16.1
Easy	53	27	44	35.5
Difficult	53	27	47	37.9
Very difficult	40	20.4	13	10.5
If there is a program to give up smoking at work;				

would you join it?				
Yes	150	76.53	93	75
No	46	23.47	31	25

Table 3 shows the distribution of smoker's behavior in the work place, All most all employees are smoking at work place (100%) but 72.6% of the physicians were smoked in their own work place. About half of the employees (51%) and more than half (55.6%) of the physicians will smokeless if restriction to smoking is present in their working place, while only 1.5% of employees and 21% of physician stop smoking in case of any restriction. On the contrary, around 20.4% of employees and 10.5% of physicians found it very difficult if restriction to smoking will take place. More than two thirds in both employees (76.53%) and physicians (75%) smokers would join a smoking cessation program when conducted at work.

Table 4: The attitude of physicians and employees towards smoking in workplace according to their smoking status.

Items	**Employee**						**Physician**					
	Current smoking		**Ex- &Non smoker**		**Total**		**Current smoking**		**Ex- &Non smoker**		**Total**	
	Frequency	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*
Not allowed	12	2.7	200	94.3	212	38.5	44	12.8	299	87.2	343	64.0
Allowed in rest period	100	50.0	100	50.0	200	36.4	51	35.4	93	64.6	144	26.9
Allowed if most agree	19	44.2	24	55.8	43	7.8	6	46.2	7	53.8	13	2.4
Allowed if all agree	20	40.0	30	60.0	50	9.1	18	66.7	9	33.3	27	5.0
Allowed any where	45	100.0	-----	100.0	45	8.2	5	55.6	4	44.4	9	1.7
Total	196	35.6	354	64.4	550	100.0	124	23.1	412	76.9	536	100.0

Table 4 shows that the attitude of employees and physicians towards smoking in workplace according to their smoking status; the sample was divided into current smokers, ex and nonsmokers; majority of the physicians, 64% chosen not to allow smoking in workplace, while 38.5% of employees. In connection with the timing or condition that smoking is allowed, most of the samples agreed to have it during rest period, among employees (36.4%) responded yes and 26.9% among physicians.

Table 5: The attitude of physicians and employees towards restriction of smoking in some public places.

Places	**Employee**								**Physician**							
	Total banning		**Separate area**		**Smoking at certain time**		**No restriction**		**Total banning**		**Separate area**		**Smoking at certain time**		**No restriction**	
	Frequency	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*
Toilet	325	59.1	40	7.3	15	2.7	5	0.9	249	46.5	30	5.6	12	2.2	0	0
Restaurant	250	45.5	110	20.0	20	3.6	20	3.6	262	48.9	103	19.2	11	2.1	24	4.5
Cafeteria	200	36.36	150	27.4	30	5.5	35	6.4	194	36.2	133	24.8	28	5.2	45	8.4
Sport area	350	63.64	50	9.1	10	1.8	10	1.8	343	64.0	33	6.2	13	2.4	11	2.1
Lifts	324	58.9	20	3.6	9	1.6	7	1.3	82	71.3	9	1.7	7	1.3	2	0.4
Corridors	250	45.5	40	4.3	30	5.5	70	12.7	247	46.1	39	7.3	27	5.0	87	16.2

Table 5 shows the opinion of the participants about restriction of smoking in public places; as it has been observed that total banning in sports area is chosen by majority of employees (63.64%), while among the physicians (71.3%) in lifts. The least restricted public areas identified by the samples were the toilet, 0.9% employees and 0% from the physician responded "no restriction".

Table 6: Demonstrates tendency to quit smoking against gender.

Items	***Employee (n= 196)***				***Physician (n= 124)***			
	Males		***Females***		***Males***		***Females***	
	Frequency	*%*	*Frequency*	*%*	*Frequency*	*%*	*Frequency*	*%*
Want to quit	121	61.7	-------	-------	85	76.6	7	53.8
Do not want to quit	75	38.3	-------	--------	26	23.4	6	46.2
Total	196	100.0	0	0	111	100.0	13	100.0

Table 6 displays that there is a higher tendency of the smokers to quit. There has been a strong willingness to quit smoking which includes 61.7% male employees (no female samples among employees who are currently smoking) and 76.6% among male physicians and 53.8% for female physicians.

Table 7. Fagerstrom Test for Nicotine Dependence.

Question	**Answer**	***Employee***		***Physician***	
		Frequency	*%*	*Frequency*	*%*
How soon after you wake up do smoke first cigarette	Within 5 minutes	80	40.8	23	18.5
	6 - 30 minutes	40	20.4	41	33.1
	31 - 60 minutes	54	27.6	28	22.6
	61 + minutes	22	11.2	32	25.8
Do you find it difficult to refrain from smoking in places where it is forbidden?	Yes	110	56.1	10	8.4
	No	96	43.9	114	91.9
Which cigarette would you hate most to give up?	First in the Morning	119	60.7	78	62.9
	All others	77	39.3	46	37.1
How many cigarettes per day do you smoke?	10 or less	30	15.3	46	37.1
	11 - 20	100	51	46	37.1
	21 - 30	43	21.9	18	14.6
	31 or more	23	11.7	14	11.2
Do you smoke more frequently during the first hours? After waking than during the rest of the day	Yes	110	56.1	50	40.3
	No	86	43.9	76	59.7
Do you smoke if you are ill that you are in bed most of the day?	Yes	56	28.6	23	18.5
	No	140	71.4	101	81.5

Table 7 shows the responses of the samples on the Fagerstrom test for Nicotine Dependence. The result showed that 40.8% of employees and 18.5% of physicians smoked their first cigarette within the 5 minutes after waking up. Around 51% of employees and 37.1% of physician can consume between 11 to 20 cigarettes per day. About 28.6% employees and 18.5% physicians were smoking still even if the samples were ill.

Table8: Nicotine dependence level, using Fagerstrom test.

Nicotine dependence level	***Employee (n= 196)***				***Physician (n= 124)***			
	Want to quit		***Do not want to quit***		***Want to quit***		***Do not want to quit***	
	Frequency	***%***	***Frequency***	***%***	***Frequency***	***%***	***Frequency***	***%***
Less than 6	86	71.1	22	29.3	60	65.2	1	3.1
6 and more	35	28.9	53	70.7	32	34.8	31	96.9
Total	121	100.0	75	100.0	92	100.0	32	100.0
X^2	**70.3**				**significant**			**0.05**

Table 8 shows that result of Fagerstrom test for Nicotine dependence. Among the samples 71.1% employees and 65.2% most of them scored less than 6 out of 10 which means low level of nicotine dependence and having the highest possibility of quitting from smoking. On the other hand the willingness to quit is very low among the samples classified as high nicotine dependence 28.9% for employees and 34.8% for physicians.

IV. Discussion

Demand of tobacco is continuously on the rise despite rigorous efforts in prohibiting its use and controlling its production. According to the report of WHO (2010), currents smokers all over the world is about 1 billion [1]. This study was able to find out the prevalence of smoking which was 29.47% of the total population of 1,086 employees and physicians of the private and public health sectors in Port Side City, Egypt. The record of WHO Report on the Global Tobacco Epidemic, 2013, identified that there is a total of 3.7% among the youth who are currently cigarette users, while 24.4% were currently tobacco smokers among adults[2]. Reports also relate smoking among male population but nowadays female population is also having the habit of smoking. According to Hitchman S. & Fong, G (2011), as to the frequency of smoking, male smokes approximately five times as much as female but its proportion is different from each country. The ratio of male to female in high income countries like United States, Canada and etc. women smokes almost the same rate with men. On the other hand, the middle to low income countries records shows that there is a lower smoking prevalence rate to women [11], which is also true with this study that among the samples identified there is a higher ratio for male smokers which is 35.64% from male employees while 0% female employees and 20.71% smokers among the male physicians while 2.42% from female physicians. With this result it has been observed that there is a higher prevalence of smoking among employees compared to physicians, but female smokers were noted among physicians (2.42%). According to Amos, O'Keefe, &Nerin, the pattern of smoking among females is ascending which has been associated with social factors, economic resources and a symbol of freedom which the tobacco industry's marketing of cigarettes was emphasizing [12-14].

The public health policy makers were exhausting their efforts to promote smoke free workplaces. Globally mortality rate related to tobacco was projected approximately 12% of all deaths among adults aged 30 years and over [15]. In United States smoking kills one in every five deaths each year, thereby classified as the leading preventable cause of death [16]. There was a great impact noted of smoke free workplaces on motivating the smokers to totally stop or lessen their chances of smoking (Fichtenberg, C., 2002), which projects 3.8% reduction on the prevalence of smoking and the number was also reduced on cigars smoked per day i.e. about 3.1%. In line with the results of our study, majority of the samples shared offices, 76.4% among employees and 51.7% among physicians, which indicates that if somebody smokes there is a large chance of being exposed to their fumes causing passive smokers to increase. Most of the samples were also bothered if there will be somebody smoking in their workplace with a 63.6% among employees and 78.4% among physician. Although most of them will not transfer from their workplaces just because of smoking taking into consideration that they value their job rather than their exposure to smoke. Among the samples, 100% of the employees admitted that they were smoking at work, while 72.6% of the physicians were smokers, with this result high prevalence of smoking at work has been observed. The relationship of restriction as to the frequency of smoking was noted wherein among the employees 51% will lessen their frequency of smoking while 55.6% among physicians. Majority from the 1,086 samples would not allow smoking in their workplaces 38.5% of the employees and 64% of the physicians. In this result it reflects that if restriction in smoking to workplaces will be implemented there will be a great decline as to the consumption of cigarettes per day among smokers and protects the non-smokers from passive smoking.

The WHO, explained about the tobacco – free public places which means that all indoor workplaces and indoor public places should be 100% smoke – free, thereby designating areas for smokers will break this standard and it is against the WHO Framework Convention on Tobacco Control guidelines. Furthermore, designating smoking areas is totally prohibited indoors [17]. From the results of this study, majority from the respondents agreed total banning of smoking in any sports areas, 63.64% of employees and 64% of physicians. Although there was a high prevalence of no restriction should be implanted along the corridors, 12.7% among employees and 16.2% among physicians. This result described the willingness of the respondents to observe smoke free workplaces but on the other hand open spaces such as corridors was determined to be a good venue for smoking.

The second leading cause of death worldwide was due to nicotine addiction [18]. Dependence on nicotine is characterized by both the persistence of a drug-taking behavior and the emergence of withdrawal symptoms upon the abrupt cessation of nicotine administration [19-20]. The result of Fagerstrom test to assess the level of

nicotine dependence among the sample who are currently smoking, it shows that there is greater percentage of those who scored less than 6 (low level of nicotine dependence) with a total of 52.8% and 47.2% scored a scale of 6 & more (high level of nicotine dependence). Nicotine is the major chemical component that is responsible for addiction in tobacco products [30-33]. Addiction depends on the amount of nicotine delivered, its way of delivery, rate of absorption whether its desired dose of concentration has been attained [34-35].

The findings of the study of Ashton &Streem, 2012, were that fully 70% of smokers report wanting to quit, and 46% attempt to quit each year. Only 5% to 7% of them were abstinent from smoking for an entire year after quitting. Several factors appear to affect rates of abstinence in different groups. Women have less success with quitting smoking and higher rates of relapse. Patients with higher levels of nicotine dependence (as evidenced by higher FTND scores) and those with a history of depression also have lower abstinence rates. African Americans and Chinese Americans have lower smoking cessation numbers than European Americans [36]. The present study shows that among the employees with low level of dependence express willingness to quit smoking with 71.1% and 65.2% among the physicians. On the other hand those sample who have been categorized to have a high level of dependence to nicotine reported of unwillingness to smoking cessation which includes 70.7% among employees and 96.9% among physicians. There is an indirect proportional relationship between motivations to quit as to the level of nicotine dependence. This explains that the higher the level of nicotine dependence the lesser the person is motivated to stop smoking, and vise verse. The result of the study shows that the relationship between the levels of nicotine dependence to smoking cessation is significant.

V. Recommendation

Every person has the right to a clean, healthy and smoke free environment.

1. The local government must apply restrictions to smoking in places where large numbers of persons are likely to congregate within close proximity to one another.
2. A place of lodging, bar or restaurant may designate guest rooms where smoking is allowed if those room are physically detached or if these are separately ventilated, employers shall not require nonsmoking employees to work in smoking area.
3. Protect people from involuntary exposure to tobacco smoke by establishing smoke-free public places. Tobacco dependence treatment program should be offered as a part of Smoking cessation programs.
4. Ensure adequate institution support for tobacco control capacity building, applied research, routine surveillance and program.
5. It is Necessary to apply current laws which prohibit advertisement on TV, Radio, and bans smoking on public transportation, in health care facilities, cinemas, theaters and public offices.
6. The media can assist by disseminating the message of quitting smoking to the whole population in Egypt.
7. The researchers recommend that the factors identified in this study should be taken into consideration in antismoking programmers to make them more effective and better able to influence the attitude and behaviors of smokers.
8. The community health nurse and the psychiatric nurse must be shared with oriented educational programmers in treating nicotine addiction, the creation and support of hospital-based smoking cessation centers and the continuous monitoring of compliance to existing legislations should be central to efforts that reinforce the viability of a smoke-free health care system. Further research into the factors that modify both personnel smoking habits and the health professionals' beliefs on tobacco related issues is warranted.
9. The community health nurse and the psychiatric nurse can support local communities by identifying tobacco – related problems, advocating for and assisting in planning and implementation of strategies to correct the problems, and facilitating social and structural change that supports long –term success. A community must accept ownership and feel empowered to intervene.

VI. Conclusion

Tobacco use is becoming epidemic to any part of the world. Its effects are becoming more obvious especially on its negative impact to health. Intensive measures have been made by the authorities and every 31st of May the World No Tobacco campaign has been celebrated with the advocacy of encouraging all countries to raise the tax for tobacco, but this seems to be somewhat not enough to motivate persons who already developed addiction to nicotine. Health care professionals and employees to health care sectors are not being excluded from this epidemic. In connection there for we must look into a more detailed and individual approach to scrutinize the reasons for nicotine dependence and the best possible approach to decrease chances of initiating and continued use of tobacco. While health professionals play a major role in tobacco control, tobacco

consumption in this group is often high. The role and image of the health professionals are essential in promoting tobacco-free lifestyles and cultures. So we must assess the degree of nicotine dependence to design the suitable program for smokers who want to quit.

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