QUIT SMOKING CLINIC ATTENDEES AND THEIR INTENTIONS TO QUIT SMOKING: A HEALTH BELIEF PERSPECTIVE

By

OOI SWEE YAW

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ABSTRACT

QUIT SMOKING CLINIC ATTENDEES AND THEIR INTENTIONS TO QUIT SMOKING: A HEALTH BELIEF PERSPECTIVE

OOI SWEE YAW

The Malaysian government has committed itself to reduce uptake in smoking and increase smoking cessation using a multiple approaches. One of the most significant media campaign undertaken by the government is the anti-smoking "Tak Nak!" campaign. This aggressive campaign based on fear provocation in the mainstream media and on-pack cigarette advertising is to drive smokers to seek for help in the Quit Smoking Clinics established nationwide. This research aimed at testing the Health Belief Model (HBM) to identify important variables that will have an influence on intentions to quit smoking. A total of three Quit Smoking Clinics in Kuala Lumpur city area were selected based on size of attendees and viability. From these three clinics a total of 133 respondents were selected using a purposive sampling approach. Correlations test between the independent HBM variables namely perceived susceptibility, perceived benefits, perceived barriers, cues to action, general health orientation, self-efficacy, perceived severity and quit intentions (dependent variable) showed that perceived susceptibility, cues to action and self-efficacy were positively and significantly correlated to the quit

intentions. Based on the research outcome, quitting intention can be enhanced by emphasizing on anti-smoking fear campaign to signal the attendees to stop smoking because they will be highly susceptible to the danger. The research also shows that self-efficacy needs to be emphasized where the attendees should be trained to instill self-confidence in order to stop smoking. Besides, the research also shows that the there are no other barriers from quitting smoking such as transportation, time and others.

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APPROVAL SHEET

This dissertation entitled "**QUIT SMOKING CLINIC ATTENDEES AND THEIR INTENTIONS TO QUIT SMOKING: A HEALTH BELIEF PERSPECTIVE"** was prepared by OOI SWEE YAW and submitted as partial fulfilment of the requirements for the degree of Master of Communication at University Tunku Abdul Rahman.

Approved by:

_____

(Associate Prof. Thinavan Periyayya) Date: ……

Supervisor

Department of Media

Faculty of Creative Industries

University Tunku Abdul Rahman

_____

(Ms Cynthia Lau Pui-Shan) Date: ……

Co-supervisor

Department of Mass Communication

Faculty of Creative Industries

University Tunku Abdul Rahman

FACULTY OF CREATIVE INDUSTRIES

UNIVERSITY TUNKU ABDUL RAHMAN

Date: 21st June 2019

SUBMISSION OF DISSERTATION

It is hereby certified that **OOI SWEE YAW** (ID No: **12UJM00011**) has completed this dissertation entitle **"QUIT SMOKING CLINIC ATTENDEES AND THEIR INTENTION TO QUIT SMOKING: A HEALTH BELIEF PERSPECTIVE"** under supervision of Mr. Thinavan Periyayya (Supervisor) from the Department of Media, Faculty of Creative Industries, and Ms. Cynthia Lau Pui-Shan (Co-Supervisor) from the Department of Mass Communication, Faculty of Creative Industries.

I understand that the University will upload softcopy of my dissertation in pdf format into UTAR Institutional Repository, which may be made accessible to UTAR community and public.

Yours truly,

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(OOI SWEE YAW)

DECLARATION

I, OOI SWEE YAW hereby declare that the dissertation is based on my original work except for quotations and citations, which have been duly acknowledged. I also declare that it has not been previously or concurrently submitted for any other degree at UTAR or other institutions.

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(OOI SWEE YAW)

Date: 21st June 2019

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CHAPTER 1

INTRODUCTION

1.1 Background of the Study

It is well established that tobacco consumption is a formidable global public health challenge. The ASEAN Tobacco Control Report (Southeast Asia Tobacco Control Alliance, 2015) shows that approximately 26.6% or equivalent to 121 million of ASEAN adults are current smokers. Over the past decades, ASEAN region is losing one live for every five tobacco related illness (Southeast Asia Tobacco Control Alliance, 2015).

In 2013, 23.1% (43.9% of male and 1% of female) of Malaysian adults were current smoker of tobacco. The report shows that 30.9% and 5.3% of boys and girls aged between 13-15 year-old respectively were current smoker (Southeast Asia Tobacco Control Alliance, 2015). On other hand, a recent study in Malaysia (2015) shows that 20.5% of all current tobacco smokers were daily smokers (38.8% of men, 1.1% of women) (Institute for Public Health, 2015).

Most teenage smokers are of the view that smoking does not have major ill effects on their bodies, but research found that smokers had a wrong perception until they reached middle age (Milam, 2000). Several tobacco related diseases such as lung cancer, other cancers, heart disease and stroke do not occur immediately but after several years of tobacco consumption. Based on medical

reports, there are several immediate health effects on the body when the smokers attempt their first puff, such as: rapid effects on brain such as increase stress, alters brain chemistry; effect on gastrointestinal system such as peptic ulcer disease and halitosis; effects on immune system such as otitis media and sinusitis and other immediate health effects (Tobacco Free Kids, 2013).

The WHO Framework Convention on Tobacco Control (FCTC) became the world's first international public health treaty when the 56th World Health Assembly first adopted it on 21st May 2003 (Institute for Public Health, 2012). The FCTC came into force on 27th February 2005 and primarily "provides legal dimensions for international health cooperation and sets high standard for compliance" (World Health Organization, 2003, p. 36). Among the measures, the treaty required countries to restrict tobacco advertising, promotional and sponsorship, protect people from exposure to tobacco smoke and other actions which against tobacco consumption (World Health Organization, 2003).

Among the ASEAN countries, Brunei Darulssalam, Myanmar, Singapore, Vietnam and Thailand were the first 6 countries to ratify FCTC. Several Tobacco Control laws were implemented, except Cambodia is in the midst of drafting the National Tobacco Control Law (Southeast Asia Tobacco Control Alliance, 2015). Malaysia government has ratified the Framework Convention on Tobacco Control (FCTC) in September 2005 to impellent more stringent tobacco policies (International Tobacco Control, 2011).

Malaysia government's initiative in curbing the tobacco threat began in the 1970s. In 1983, the Malaysia Ministry of Health (MOH) collaborated with the

Malaysia Medical Association to launch the first major anti-tobacco effort - a nationwide "No Smoking Day" campaign (Malaysia Council for Tobacco Control, 2005). Several efforts have been undertaken throughout the past decades in order to reduce the statistics on tobacco-related disease and death.

In order to achieve above-mentioned efforts, Malaysia implemented a national tobacco control policy based on the requirements of World Health Organisation's Framework Convention on Tobacco Control. The action taken were tax increment, establishing smoke-free zone in order to protect non-smokers from exposure to second-hand smoke, ban tobacco advertising, promotion and sponsorship, introduce effective tobacco smoking warning such as pictorial warning on cigarette pack, limitation on descriptor words such as "light" and "mild" and last but not lease, preventing tobacco industry interference (Southeast Asia Tobacco Control Alliance, 2015).

1.2 "Tak Nak!" Campaign Phase 1

One of the most aggressive, nation-wide anti-smoking campaign launched by the Government of Malaysia is the "Tak Nak!" Campaign in February 2004 by the former Prime Minister Dato' Seri Abdullah Ahmad Badawi (Tan, 2010). The objective of this nationwide anti-smoking campaign was to reduce the trends of smoking that would ultimately decrease smoking related incidence(Foong et al., 2005). The campaign was designed to aim at discouraging adolescents and women from starting smoking, encourage the smokers to quit the smoking habit, and encourage friends and families to support in smoking cessation like quit smoking (Foong et al., 2005). "Tak Nak!" As the largest government funded anti-smoking

campaign successfully created the awareness either on smokers or non-smokers (Foong et al., 2005). Not to forget, one of the primary goals of the campaign is to increase the number of current smokers to quit smoking (Zain, 2007). The entire media campaign was primarily based on health-threatening messages to invoke fear in both the smokers and non-smokers.

Generally, fear appeal posits the risk of using and not using specific product, service or idea (Williams, 2012). Many communication experts explain fear appeals in similar elaboration. Perloff (2008) says that fear appeal is persuasive communication that ultimately change human attitudes by using scary message such as implying negative consequences if the person does not attempt the recommended action. Fear also acts as mechanism to protect human from threatening situation (Williams, 2012). A prominent scholar in this field defined fear appeals as "persuasive message that arouse fear by depicting a personally relevant and significant threat, followed by a description of feasible recommendation for deterring the threat" (Witte, 1992, 1994, as cited in Williams, 2012, p. 2).

Williams (2012) says that fear appeal rely on a threat to an individual which motivates the person toward action. There are three main concepts that construct the dear appeal: perceived efficacy, fear and threat (Williams, 2012). Witte and Allen (2000) have concluded that fear appeals are most effective when they contain both high levels of efficacy and high levels of threat. Both scholars recommend that the fear message needs to contain a meaningful threat or important problem and particularly directed actions that an individual can take to reduce the threat (Williams, 2012). Additionally, there are three aspects that

contribute to success in fear appeal implementation. First, the advertisement must be designed to motivate changes in individual behaviour; second, it must reach the appropriate target audience; third, use sustained communication efforts to bring change (Abernethy & Wicks, 1998).

A research conducted on a national anti-smoking campaign in Malaysia - "Tak Nak!" showed that the campaign was successfully in creating awareness, establishing a sense of susceptibility and severity, two important ingredients in a fear-based approach to modify smoking behaviour (Foong et al., 2005). The finding of the research showed that the horror series of "Tak Nak!" campaign was readily recalled. The statistic showed that the awareness of horror messages advertised on television was high among respondents who were aware the campaign (Foong et al., 2005). Average 80% of the respondents recalled seeing most of the fear base advertisement on television such as "Blood clot in the brain", "Tar in Lungs of smokers", "Rotting lung", and "Lung cancer"(Foong et al., 2005).

1.3 "Tak Nak!" Campaign Phase 2

The "Tak Nak!" Anti-smoking campaign initially emphasised the negative consequences of smoking, and recipients of this message were encouraged to say NO to smoking in order to avoid the ill consequences of smoking. Subsequently in October 2009, in the second phase of the campaign, a new series of very gory print advertisement with highly emotional TV advertising which encouraged people to seek for help using the info line given: 03-88834400. The first wave of the "Tak Nak!" media campaign was successful in establishing a sense fear and a

high level of awareness of smoke g messages. The second phase was primarily to continue emphasising the fear, at the same time persuade smokers to take affirmative action on the quit line at least as initial behaviour to find out information about the quit smoking clinic through the info line number before seriously taking the action to register as a quit smoking clinic participants.

One study on quit smoking clinics showed that, there are more than 300 clinics and 32 hospitals within the Ministry of Health Malaysia, which provide smoking quitting services (Institute for Public Health, 2012). The services include counselling service and pharmacotherapy advice. Ministry of Health Malaysia also established the tobacco "Quitline" in order to provide further accessibility and penetration to cessation assistance for smokers who intended to quit smoking (Institute for Public Health, 2012). The quit smoking clinics across the nation provide a cessation platform to the smokers.

Previous research done on quit smoking clinic provides good understanding of the quit participants perception as well as their view about methodology used in the clinic and general clinical condition (Lee, Hassali, & Shafie, 2012). Another study which examined the association between initial perceived risks and benefits of quitting smoking suggested that there is no association between the baseline perception of the benefits of cessation prior to the therapy with quit results (Yasin, Masilamani, Moy, Koh, & Zaki, 2012). Another study identified the smokers' characteristics and also the factor leading them to the quit clinics in Malaysia (Wee, Shahab, Bulgiba, & West, 2011). Abd Aziz and colleagues suggested that "information on the characteristics of smokers attending the quit smoking clinics and predictors of smoking cessation among

clinic attendants would help in improving the effectiveness and efficiency of these clinics (Abdul Aziz, Aljunid, Wan Puteh, & M Zain, 2006). However, most of the research done on quit smoking clinic participants in Malaysia provides empirical insights but are not theoretically driven.

This study intends to study other variables beyond the quit clinic factors that may have an impact on the quit smoking behaviour, specifically variables identified in the Health Belief Model. Becker (1974) developed Health Belief Model (HBM) from the work of Rosenstock (1966) (Corcoran, 2007). The Health Belief Model consists of the following variables namely cues to action, perceived susceptibility, perceived severity, perceived benefits, perceived barriers and self-efficacy. Essentially the theory states that an individual will appraise the seriousness of the issue and weigh it against the benefits and barriers to take the recommended action in order to attain a change in attitude and behaviour that is beneficial. In the context of quit clinic attendees, the interplay of these variables will determine the quitting intentions.

1.4 Problem Statement

This far Malaysian research on quit smoking clinic attendees is scarce and published research are largely descriptive and not founded on any health communication theories. Much of the focus has been on demographics and quit clinic conditions. This research therefore will explore personal variables identified in the Health Belief Model (HBM) that determines impact on quitting behaviour of registered quit smoking clinic attendees. Previous research done on quit smoking clinic provides good understanding of the quit participants perception as

well as their view about the methodology used in the clinics and general clinical condition (Lee, Hassali, & Shafie, 2012). Another study on examined the association between initial perceived risks and benefits of quitting smoking suggests that there are no association between the baseline perception of the benefits of cessation prior the therapy with quit results (Yasin, Masilamani, Moy, Koh, & Zaki, 2012). However, most of the research done in quit smoking clinic participants in Malaysia provides empirical insights but without theoretical backing. This study tends to use the variables proposed in the Health Belief Model which are beyond quit clinic environment factors studied in past research factors. This far the HBM has not been tested in the context of quit smoking behaviour in Malaysia.

1.5 Research Objective

The research will focus on quit smoking clinic attendees who have taken the affirmative action to change their behaviour. Their success or failure in their attempt to modify their smoking behaviour is dependent on personal factors according to Health Belief Model. As such, this study will evaluate quitting intentions in the context of several variables identified in the Health Belief Model, which is subjected to an overall evaluate process based on barriers and benefits.

1.6 Research Questions

The research questions pertaining to the Health Belief Model variables and quit clinic attendees' intention to quit smoking are as follow:

Q1: Is there a relation between perceived threat and intention to quit smoking?

Q2: Is there a relation between barriers and benefits and quitting intention?

1.7 Research Methodology

This study uses quantitative methodology. According to Kumar (2011), "quantitative study designs are specific, well structured, have been tested for their validity and reliability, and can be explicit defined and recognised". This study intends to measure the relationship between independent variables from Health Belief Model on the dependent variable (quit intention), as such quantitative methods is most appropriate. The quantitative approach that will be used in this research will enable appraisal of the relationship between identified independent variables and dependent variable.

Since this study is criteria base, the sample selection approach will use non-probability sampling design or purposive sampling for population sampling. Non-probability sampling is a sampling procedure that does not follow the guidelines of mathematical calculation (Wimmer & Dominick, 2011). Due to several concerns on sampling procedures such as cost and time constraint, the utilisation of non-probability sampling is usually satisfactory (Wimmer & Dominick, 2011) and may meet the need temporarily. Additionally, this study is to study the relationship between the independent variables (Health Belief Model's constructs) and dependent variable (quit intention), thus, as what Wimmer and Dominick (2011) suggest, when the study is "not designed to generalise the results to the population but rather to investigate variable relationships", non-probability is suitable or appropriate for this situation. Among

the types of non-probability sampling, purposive sampling will be utilised in this study.

1.8 Significance of Study

This study will fill in the gap in our understanding of quit smoking clinic attendees and their quit smoking intention. Besides that, this study will provide valuable information grounded on health communication theory. This study will also help authorities concerned to formulate effective quit Strategies that take into account both the personal variables and clinical factors.

1.9 Structure of Dissertation

This dissertation is comprised of five chapters. Chapter 1 outlines the motivation, problem statement, research objective, and significance of the study and definition of terms. Chapter 2 reviews the literature and theoretical perspective relevant to Health Communication, application of fear elements in Health Communication and the constructs of Health Belief Model. The research questions that will be tested in the study will be introduced in relation to the literature review and are summarised at the end of the chapter through a proposed conceptual framework that ties the questions to key concepts. Chapter 3 describes the research methods employed for data collection. It also provides insight into the recruitment process of the study. Chapter 4 presents various test carried out to measure the questions and the results obtained, the analysis of the study, which is introduced in relation to the research questions will brief discussions on the

general implication of the findings. Chapter 5 briefly summaries key finding and outlines the contribution of the study.

1.10 Definition of Terms

1) WHO FCTC - Refers to World Health Organisation Framework Convention on Tobacco Control, is a global effort to reduce tobacco demand and supply through a variety of agreements. The core demands of WHO FCTC are mainly to reduce the consumption and demand for tobacco, such as Article 6 for pricing and taxation control, Article 8 protection from exposure to tobacco smoke, tobacco advertising and promotion under Article 13, packaging and labelling of tobacco products under Article 14 and others endorsed by World Health Organisation (World Health Organization, 2005).

2) Health Belief Model - Several core perceptions such as perceived susceptibility, perceived benefits, perceived barriers, perceived severity, cues to action and self-efficacy serve as the main constructs of the model that allows us to explain the person health behaviour by adapting either each perception individually or any combination (Hayden, 2009). Health Belief Model suggests that an individual behaviour is determined by threat perception and the threat can be resolved by evaluation of self-behaviour (Ng, Kankanhali, & Xu, 2009). In other words, Health Belief Model focuses on the evaluation of an individuals' health behaviour through the examination of their perceptions and attitudes towards negative outcomes of certain actions (Burke, 2013).

2.1 Perceived Susceptibility - An individual's assessment of his or her chances of getting disease.

2.2 Perceived Benefits - An individual's conclusion as to whether the new behaviour is better than what he or she is ready doing.

2.3 Perceived Barriers - An individual's opinion as to what will stop him or her from adopting the new behaviour.

2.4 Perceived Severity - An individual's judgment as to severity of the disease.

2.5 Cues to Action - Those factors that will start a person on the way changing behaviour.

2.6 Self-efficacy - Personal belief in one's own ability to do something.

3) Health Promotion Campaign - An activity aims at informing target audience most likely about the prevention of disease and ill though health information, preventive programs, and access to medical care in order to change their behaviour (Reference.MD, 2012)

4) Fear Appeal - Fear appeal using scare perspective in persuasive communication in order to change their attitudes and behaviours by implying negative consequences if positive recommendation to avoid the threat is not complied with (Perloff, 2008).

5) Smoking cessation services - A services that include the counselling and pharmacotherapy for quitting smoking (Institute for Public Health, 2012).

6) Smoker - Person who inhales and exhales tobacco smoke or something similar to tobacco for at least one day in the last 30 days (Reference.MD, 2012), (Lim et al., 2009).

7) Non-smoker - Never smoked (Lim et al., 2009).

8) Former smoker - Stopped smoking for at least 6 months (Lim et al., 2009).

CHAPTER 2

LITERATURE REVIEW

2.1 Health Communication

Communication refers to the exchange of information, serves as an instrument for behavioural change intervention, and reflects human as a member of community. The essential of elements of the communication process consists of four components: channel, source, message and receiver. As an instrument for behavioural change, through communication, it is necessarily to think which channel is a proper medium to deliver the message, to whim or which specific target audience the message should reach, and what us the response of the received towards the predesigned message in order to evaluate the message impact (Rimal & Lapinski, 2009).

Health Communication can be defined as an approach to improve individual or public health (Schiavo, 2007). Alternatively, Health Communication can be defined as "approach to reach different audiences and share health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers, and the public to champion introduce, adopt, or sustain a behaviour, practice, or policy that will ultimately improve health outcomes" (Schiavo, 2007, p. 7).

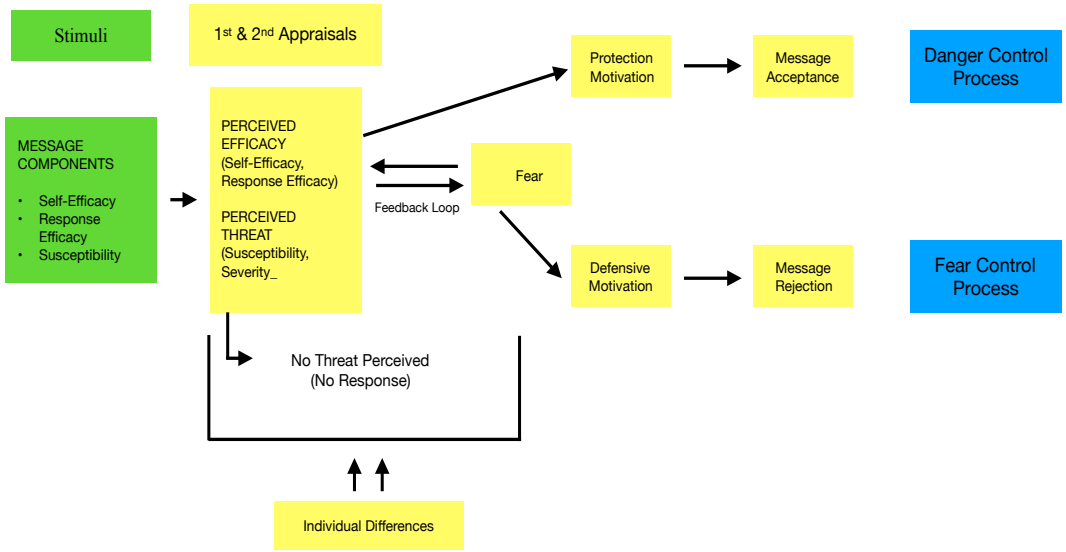
In recent decades, Health Communication has become an important strategy in promoting public health. Health Communication practitioners recognize the importance of health threats prevention could play a significant role in the improvement of health. In 2010, Health Communication was set as United States America's Healthy People Objective in order to illustrate its growing importance (Rimal & Lapinski, 2009).

Rimal and Lapinski (2009) stated that Health Communication is important in public health because of the intervention efforts. Health Communication can be divided into several aspects, which are disease prevention, health care policy, health promotion, as well as to enhance the quality of life and health of individuals (Healthy People, 2009). According to Health Communication expert, Health Communication can serves as a medium to bring the most valuable information to individuals and provides health related information about health issues, apparently, it can develops and presents high quality information to target audience and collaborates the decision making process in modern health care efforts (Kreps, 2001). In the context of Malaysia, a fear base anti smoking campaign namely "Tak Nak!" was launched at 2004. This campaign provides a cue to the smokers on the danger of smoking and encouraging them to quit smoking.

The Extended Parallel Process Model (EPPM) is the most recent fear appeal theory that explains the effectiveness of fear model (Witte, 1992, 1994, 1998; Witte & Allen, 2000). The EPPM model is the combination of early fear model which focused on how a human perceived the threat (emotion) in terms of perceived severity and perceived susceptibility, and the latter theories which

considered as cognitive processing of the recommended action to avoid the severe health problems. This model is essentially a message-processing model, which is using the fear messages to process at both emotional and cognitive level. “Tak Nak!” campaign using wording and pictorial as a tool to deliver the fear message, this attempt as a cue to warn the public about the negative outcome of cigarette smoking. When an individual read the message from the campaign, they are not only focused on how to cope with fear awakens, but they also thought on how to overcome the threat.

Diagram 2.1 Extended Parallel Process Model



Source: Witte (1992)

“Tak Nak!” anti smoking campaign using scare elements to change as an effort for behavioural intervention. This media campaign was evaluated one year after the launch by Clearing House and Research Network for Tobacco Control, National Poison Centre of Malaysia and University Science Malaysia and the results shown the campaign was having high levels of exposure amongst adult and

adolescent smokers and non-smokers, majority of the respondents were able to recalled the horror messages from the campaign (Foong et al. 2005).

The study on quit smoking has been done previously. Abd Aziz et al (2006) study mainly focused on effectiveness of clinic or clinical factors and clinic personnel factors. Study on clinic's attendees' in Malaysia is limited, most studies are focus on adolescents and factors relevant with smoking initiation (Wee, Chan, & Nantha, 2016). Wee and colleagues (2016) say that there is lacking on examining smoking in adults and special group such as the quit smoking clinic attendees. Additionally, previous research did not use a comprehensive model co conduct the study such as Yasin and colleagues (2012) are using perceived risk and benefit in their study, which is only one of the variables in this study. This study on quit smoking clinic attendees is based on the Heath Belief Model and is expected to contribute data and information on the Malaysian initiative to make smokers attend quit smoking clinics.

2.2 Health Belief Model (HBM)

Becker (1974) developed Health Belief Model (HBM) from the work of Rosenstock (1966) (Corcoran, 2007). Initially, there were four core perceptions which served as the main constructs of the model, which is Becker (1974) developed Health Belief Model (HBM) from the work of Rosenstock (1966) (Corcoran, 2007). Initially, there were four core perceptions, which served as the main constructs of the model, which is perceived susceptibility, perceived severity, perceived benefits and perceived barriers. One can explain a person's health behaviour by adapting either each perception individually or any

combination. Apart of that, more recently the Health Belief Model has been expended to include motivating factors, self-efficacy, and cues to action (Hayden, 2009)

Table 2.1 The Health Belief Model Constructs

Health Belief Model Constructs Chart	
Perceived Susceptibility	An individual's assessment of his or her chances of getting disease.
Perceived Benefits	An individual's conclusion as to whether the new behaviour is better than what he or she is already doing.
Perceived Barriers	An individual's opinion as to what will stop him or her from adopting the new behaviour.
Perceived Severity	AN individual's judgement as to the severity of the disease.
Modifying Variables	An individual's personal factor that affect whether the new behaviour is adopted.
Cues to Action	Those factors that will start a person on the way to changing behaviour.
Self-efficacy	Personal belief in one's own ability to do something

Source: Hayden (2009)

The Health Belief Model identified two considerations when it comes to individual's decision making to adopt a certain behaviour (particularly healthcare behaviour) in response to threat and illness (Ng, Kankanhali, & Xu, 2009). First consideration is perception towards the illness threat and second consideration is evaluation of behaviour to against the threat. The first consideration depends on two beliefs, perceived susceptibility and perceived severity. While the second

consideration depends on assessing the perceived benefits and perceived barriers (Conner & Norman, 2005).

Within the context of the Health Belief Model, perceived susceptibility refers to the "subjective risks of contracting a condition" (Rosenstock, 1966). Different individuals have varied perceptions of perceived susceptibility. Perceived susceptibility examines the likelihood of the health threat leading them to negative health outcome, whereas the greater the individual's perceived the risk, the person will have a greater likelihood to do something on decreasing the risk (Hayden, 2009). Perceived severity refers to the personal belief towards the seriousness or severity of the contrasting illness (Hayden, 2009). Clinical consequences is not the only concern on perceived seriousness, but is already extended to the implications on the individual's job and family (Rosenstock, 1966). As Rosenstock (1966) mentions, the perception of consequences of negative health condition is also subjective. Based on this, it can be hypothesised that:

H1 - There is a positive correlation between perceived susceptibility and intention to quit smoking.

Based on the Health Belief Model, perceived severity is believed to moderate the effects of the other determinants. Ng and colleagues suggest "the expectancy-value theory that the desirability of behaviour is based on the summed products of the expectancy and value of outcomes" (Ng et al., 2009). They argue that perceived severity can be regarded as value in Vroom (1964)'s expectancy theory of motivation (Ng et al., 2009). Vroom says an interaction between

expectancy and value can be defined as a motivation, which refers to the valence to the individuals of the outcomes (Vroom, 1964). The main objective of smoking cessation is to avoid negative outcomes, and hence the valence of the behaviour is the perceived seriousness and consequences of negative outcomes. Perceived severity is a strong motivating factor and can affect the dependent variable that is quit intention. Based on this, it can be hypothesised that:

H2 - There is a positive correlation between perceived severity and intention to quit smoking

In the Health Belief Model, the second consideration depends on assessing the perceived benefits and perceived barriers, in other word, the combination of perceived benefits and perceived barriers providing a pathway to action (Witte, Meyer, & Martell, 2001). Perceived benefits can be defined as the evaluation of the advantages gained from undertaking an action. In other word, what are the benefits if the individual make the change? Meanwhile perceived barriers refer to the reasons that individual cannot change the behaviour? Rosenstock (1996) says that low readiness and negative aspects are viewed as high, perceived barriers are constructed, put it in other word, when the barriers outweigh any benefits of the information, the individuals probably would not perform the recommended action (Witte et al., 2001). Based on this, it can be hypothesised that:

H3 - There is a positive correlation between perceived benefits and intention to quit smoking

H4 - There is a negative correlation between perceived barriers and intention to quit smoking.

In addition to the original beliefs or perception, Health Belief Model suggests that cue to action also influenced the behavioural change (Hayden, 2009). Rosenstock (1966) argues that healthcare action does not take place if "some instigating event occurred to set the process in motion (Ng et al., 2009). This scenario is means cue to action. Cue to action can be anything that prompts an individual to think about or intentionally to act on the healthcare action. Health Belief Model introduces two cues, which are internal and external cues. Internal cues such internal perception of health symptoms like cough might trigger the smokers to have lung check up. External cues such as television public service announcement about quit smoking, magazine article about smoking causes lung cancer and the conversation among friends about negative effects of smoking. Individuals may be in an action if the level of susceptibility and severity are increase from above-mentioned cues (Witte et al., 2001). Based on this, it can be hypothesised that:

H5 - There is a positive correlation between cue to action and intention to quit smoking.

In the Health Belief Model, General Health Orientation can be defined as "the individual's predisposition or habit concerning health seeking behaviour in general" (Walker & Thomas, 1982). General Health Orientation is about the individual's general response tendency (Ng et al., 2009). Ng and colleagues (2009) argue that General Health Orientation is not related to foreseeing named

health consciousness. Similar construct also proposes in another study named Health Consciousness. Jayanti and Burns (1998) define health consciousness define health consciousness as "the degree to which health concerns are integrated into a person's daily activities" (Jayanti & Burns, 1998). Prior research has shown that the individual is more likely to engage in health care preventing activity if the individual is more health conscious (Jayanti & Burns, 1998; Rosenstock, 1966). In the quite smoking context, this refer to an attendees predisposition and interest concerning quit intention. Based on this, it can be hypothesised that:

H6 - There is a positive correlation between general health orientation and intention to quit smoking.

Initially, self-efficacy as a variable was not included in the original Health belief Model; the concept of self-efficacy originates from the Social Cognitive Theory or commonly known as Social Learning Theory (Ng et al., 2009). The focus of this theory is perceived self-efficacy (Witte et al., 2001). Social Cognitive Theory was developed by Albert Bandura in 1977 and it can be defined as "people's belief that they can exert control over their motivation and behaviour and over their social environment" (Bandura, 1989). Generally, self-efficacy is referring to an individual's self-confidence on his or her ability to do something (Hayden, 2009; Witte et al., 2001). As in fear appeals, perceived self-efficacy is what you believe about your capability to perform a health orientation behavioural change or action, in another words, it refers how an individual perceived the self-effectiveness towards certain action taken (Witte et al., 2001). Self-efficacy was added to the Health Belief Model in 1988 (Rosenstock, Strecher, & Becker, 1988). Based on this, it can be hypothesized that:

H7 - There is a positive correlation between self-efficacy and intention to quit smoking.

As explained earlier, one of the primary strategy of “Tak Nak!” campaign is to provide information on smoking cessation services (Quit Smoking Clinic, Quit Smoking Infoline) throughout the nation., “Tak Nak!” campaign acted as a cue to action role. The campaign in particular trigger the smokers take action on the quit line at least as initial behaviour to find out information about the Quit Smoking Clinic through the infoline number before seriously taking the action to register as a Quit Smoking Clinic participants.

2.3 Quit Smoking Clinic

One study shows that, there are more than 300 clinics and 32 hospitals within the Ministry of Health facilities that provide smoking quitting services (Institute for Public Health, 2012). The services are including counselling service and pharmacotherapy advice. Ministry of Health also establishes the tobacco “Infoline and Quitline” in order to provide further accessibility and penetration to cessation assistance for smokers who intended to quit smoking (Institute for Public Health, 2012). The quit smoking clinics across the nation are providing a cessation platform to the smokers.

Previous research done on quit smoking clinic provides good understanding of the quit participants perception as well as their view about the methodology used in the clinics and general clinical condition (Lee, Hassali, &

Shafie, 2012). Another study on examined the association between initial perceived risks and benefits of quitting smoking suggests that there are no association between the baseline perception of the benefits of cessation prior the therapy with quit results (Yasin, Masilamani, Moy, Koh, & Zaki, 2012). However, most of the research done in quit smoking clinic participants in Malaysia provides empirical insights but without theoretical backing. This study tends to use the other variables beyond the clinic factors that will have an impact on the quit smoking behaviour and further explained by Health Belief Model.

2.4 Conceptual Model

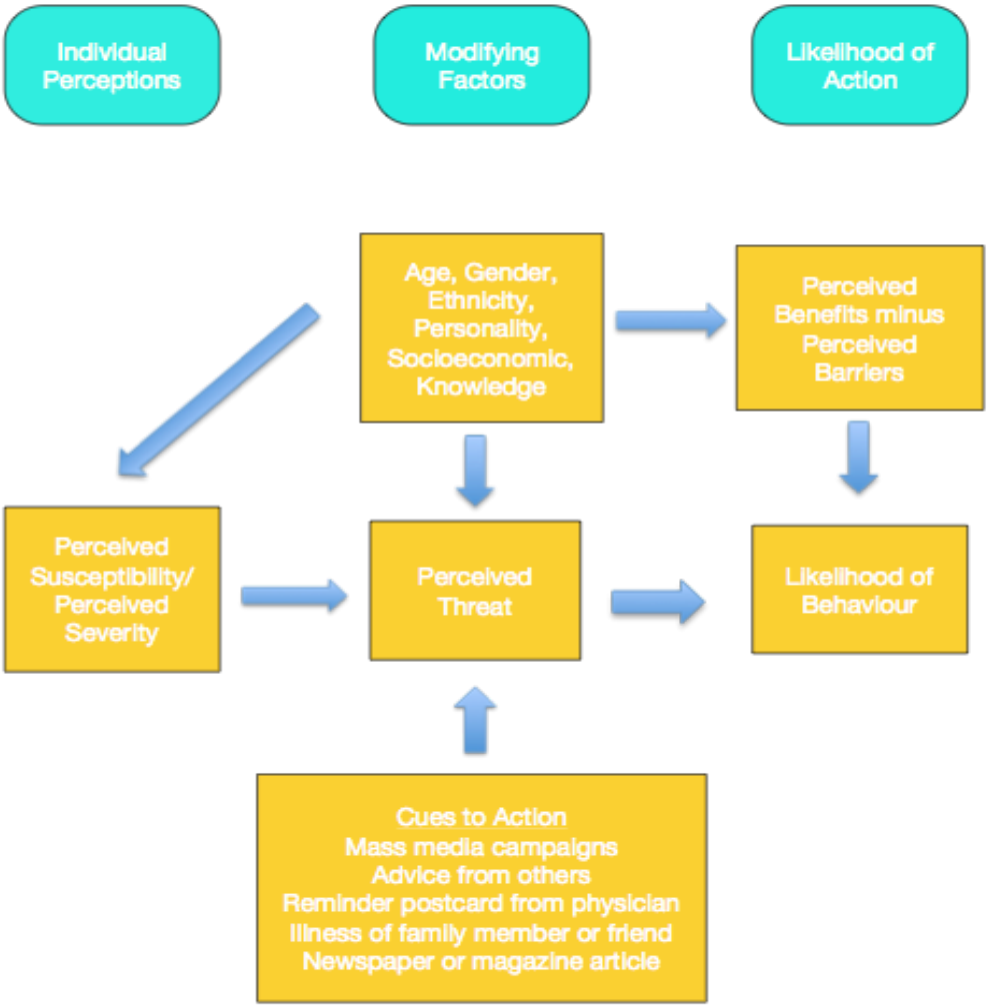
HBM has been tested on previous research. One study on HBM in motivating for tobacco cessation suggests that HBM was an effective model in motivating to enrol on tobacco cessation programme (Renuka & Pushpanjali, 2014). Tobacco is considered as one of the most important risk factor for personal health. Many initiatives have been taken at micro and macro levels to control the tobacco used, both national and international level. As such, according to Renuka and colleague (2014), health education is one possible method for intervention strategies. Added by Renuka and colleague (2014), health intervention should be theoretical driven in order to achieve most effective outcome. The results of their study concluded that HBM was useful model in testing the quit intention on tobacco cessation programme.

HBM was chosen for this study has been proof through Renuka and colleague (2014)'s research. The questionnaires were distributed by healthcare provider to the attendees, it is applicable for interpersonal approaches. Secondly, HBM is a good model for addressing behaviours that raise health concerns.

Thirdly, HBM is a popular model to apply in issues focusing on attendees and health care provider. Last but not least, HBM addresses the relationship between a person's belief and behaviour. This also indicates that the model has verified and tested, no new variable has been added. As such, for this research, we continue to use same variable, however, one extra independent variable has been added which is general health orientation.

As a popular expectancy-value model used in healthcare, Health Belief Model is an ideal theory to imply the preventive heath behaviour for quit smoking clinic attendees. The Health Belief Model is comprehensive in including a number of constructs such as perceived susceptibility, perceived severity, perceived barriers, perceived benefits, cue to action, self-efficacy and general health orientation. This study will tests the preventive health behaviour by using the Health Belief Model's constructs as variables. The diagram below shows the original Health Belief Model:

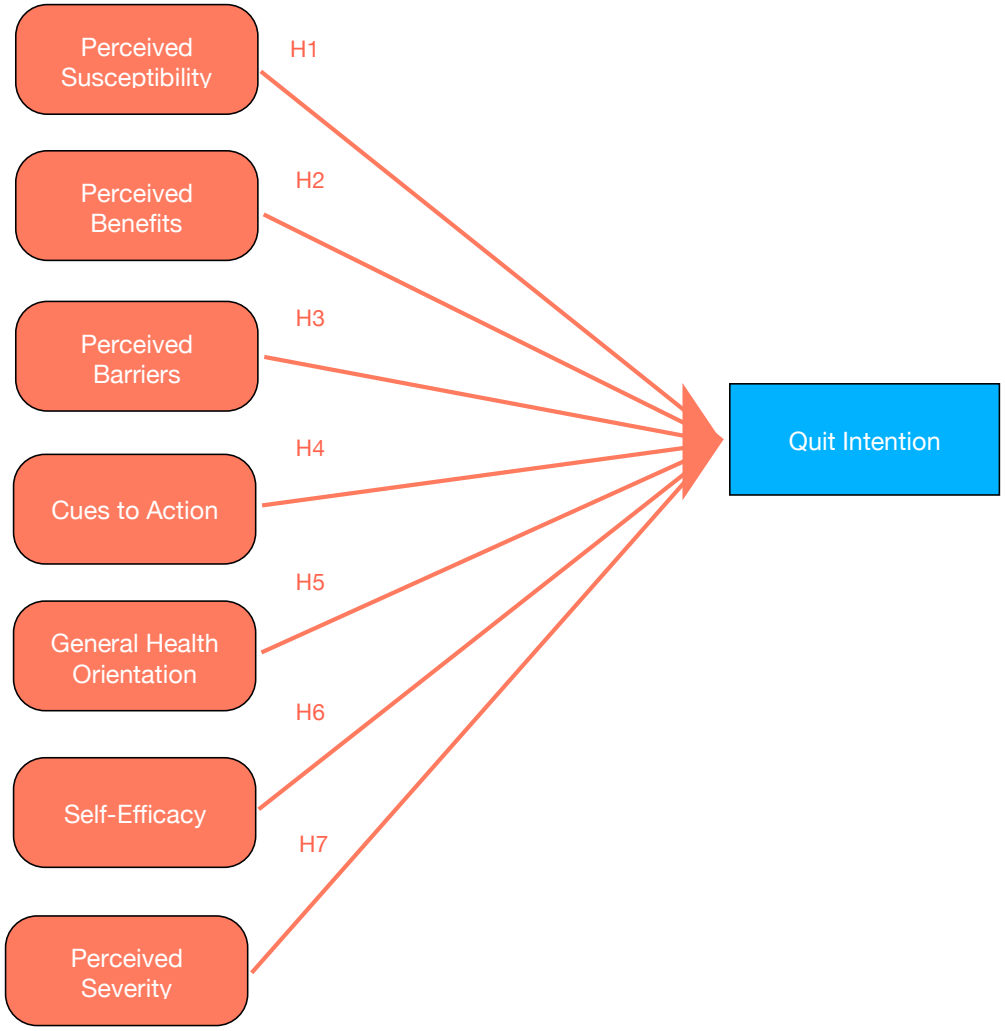
Diagram 2.2 Original Health Belief Model



Source: Stretcher & Rosenstock (1997) as cited in Hayden, (2009, p. 34)

Based on the above diagram, the dependent variable and independent variable are stated as below:

Diagram 2.3 Conceptual Framework



Independent Variable Dependent Variable

Modify from: Ng, Kankanhalli & Xu (2008)

In this research the independent variables correlations with the dependent variable will be evaluated as shown in the diagram. In summary, the following are the research Questions and Hypotheses:

RQ: What are the factors that triggered smokers to attend quit smoking clinics?

H1: There is a positive correlation between perceived susceptibility and intention to quit smoking.

H2 - There is a positive correlation between perceived severity and intention to quit smoking.

H3 - There is a positive correlation between perceived benefits and intention to quit smoking

H4 - There is a negative correlation between perceived barriers and intention to quit smoking.

H5 - There is a positive correlation between cue to action and intention to quit smoking.

H6 - There is a positive correlation between general health orientation and intention to quit smoking.

H7 - There is a positive correlation between self-efficacy and intention to quit smoking.

CHAPTER 3

METHODOLOGY

3.1 Research Methodology

This chapter provides an understanding of the research procedures, the questionnaire design and measurement, the statistical technique, and the methods that were used in the study on quitting intention of quit smoking clinics attendees' based on the using Health Belief Model and to predict quit intention. Therefore, the research objectives for this study are as follow:

1) To establish the relationship between perceived threat and intention to quit smoking.
2) To establish relationship between barriers and benefits and quitting intention.

This study uses quantitative methodology as an appropriate approach to study the above research objectives. According to Kumar (2011), "quantitative study designs are specific, well structure, have been tested for their validity and reliability, and can be explicitly defined and recognised". This study intends to measure the relationship of independent variables from the Health Belief Model on the dependent variable, which is quit intention, as such, quantitative method is most appropriate. Recent Health Belied Model studies show that construct validity and reliability was not clearly established (Ng, Kankanhali, & Xu, 2009), this is because these studies used the qualitative approach which is less specific and

precise (Kumar, 2011). According to Malhator (2001), the quantitative approach is able to general results of a sample's behaviour, and since this current study seeks to determine the relationship between the independent and dependent variables on the issue of quitting smoking, it is the most suitable approach to use. It can also help to determine the factors that play a prominent role in the quit intention behaviour of the respondents.

3.2 Sampling

This study is based on purposive sampling and is a non-probability design for population sampling. The purposive sampling also known as judgmental sampling, is extremely useful when conducting the research to describe phenomenon or develop something which is not fully discovered (Kumar, 2011). According to Wimmer and Dominic (2011), " a purposive sample is a sample deliberately chosen to be the representation of a population, and it also includes subjects to elements selected for specific characteristics or qualities, eliminating those who fail to meet these criteria". As such, the selection of the sample of this study is criteria-based instead of being mathematically guided. Purposive sampling is appropriate for this study because specific criteria must be met in the selection of samples. One of the criteria for the sampling is the smoker who attends the quit smoking clinic. In order to predict the healthcare behaviour (quit intention), the sample will be chosen amongst those who are in early midst of the treatment. Smokers who attend the quit smoking clinics will be provided free nicotine replacement therapy (NRT) during quit smoking session and the follow-up sessions will be scheduled. Average each smoker is expected to quit smoking on sixth month. The sample for this research is those who are in early midst of the

treatment, meaning that the sample will be those who must attended at least one month but not more than 2 months of quit smoking clinic.

By using the purposive sampling approach, those who do not meet the research criteria, which will be explained later, will not be selected. Wimmer and Donmminick (2011) say the criterion for purposive sampling is chosen with the knowledge that the sampling is not representative of the population study.

3.3 Sample Size Determination

This study will adapt the sample size calculation from Israel (1992), which is combination of levels precision, confidence and variability. According to Israel (1992), there are four approaches in deciding an appropriate sample size for a given research such as: using a censes for small population, imitating a sample size of similar studies, using publishing table, and applying formulas to calculate a sample size. In this study on smoking cessation, an appropriate sample size was determined using a published table provided by Israel (1992). A total number of three Quit Smoking Clinic's were selected from the KL city area were selected based on size of attendees and viability. Throughout the quit smoking clinics located at KL city area, only three of the selected clinic's health care providers were fully cooperated. Some of the clinics did not fulfil the requirement as the attendee number was too low.

The total number of registered attendees in all three clinics who qualified to be selected was 230. Out of this 30 were used for pilot-test as such were discounted from 230 and leaving behind 210. According to Israel (1992), if the

size of population is 210, an appropriate sample size should be estimated 134 to achieve the precision rate of ± 5% as per Table 3.1. The precision rate selected for this study is ± 5% as this is regarded as sufficiently accurate.

Table 3.1 showing the sample size for ±5%, ±7% and ±10% Precision Levels, where Confidence Level is 95% and P=.5. (Israel, 1992).

Table 3.1 Sample Size for Precision

Size of Population	Sample Size (n) for Precision (e) of:		
	±5%	±7%	±10%
100	81	67	51
125	96	78	56
150	110	86	61
175	122	94	64
200	134	101	67
225	144	107	70
250	154	112	72
275	163	117	74

Source: Israel (1992)

3.4 Questionnaire Distribution Procedures

A total number of 133 questionnaires were distributed by three selected quit smoking clinic health care provider. Prior to the distribution of the questionnaire, a written consent was obtained from the director of Jabatan

Kesihatan Wilayah Persekutuan Kuala Lumpur (JKWPKL) (Refer Appendix A) and the director of National Medical Research Register (NMRR) so that the public quit smoking clinic attendees can be used(Refer Appendix B). A total six healthcare providers from 3 clinics were recruited to assist in the distribution of the questionnaires. The healthcare provider was informed that respondents who fulfilled the following two criteria were eligible to participate in the study and the criteria are as follows:

a) Attending the quit smoking for the first time and never before.
b) He or she must have attended at least 1-2 months of the quit smoking programme.

The respondents were required to answer the questions without any guidance from either healthcare provider or the researcher. The selected respondent, however were informed by the healthcare provider of the purpose of the study and upon their consent given the questionnaire was given to the respondent.

3.5 Questionnaire Design and Measurement

A structured questionnaire was developed to study the relationship between the independent and dependent variable and the respondents quit behaviours among attendees of quit smoking clinics located in the city of Kuala Lumpur. The questionnaire was in English Language and Bahasa Malaysia, Chinese translation (Refer Appendix C). The pilot test was carried out to test the validity and reliability of the questionnaire. The cover letter of the questionnaire

indicated clearly that all information obtained from the respondents would be kept strictly private and confidential.

The first part of the questionnaire consists of six basic demographic items such as gender, age, race, marital status, ethnicity, education level and income. This is essentially to generate descriptive data of all respondents. The second part of the questionnaire consists of four items that will provide the smoking history of the respondents. The questions include who introduced them smoking, followed by number of years they have been smoking; cigarettes per day and have they attended quit smoking clinic previously. These questions were adapted from Wee and colleagues (2011). The section on history of smoking will provide important descriptive data that can be used to draw inferences on quitting behaviours. The third part of the questionnaire consists of 26 questions pertaining to the independent and dependent variables, which is the focus of this research. The items for this section were adapted from the research done by Ng and colleagues (2008). The variables and items are listed below:

Table 3.2 Independent Variables

Construct	Item	Source
General Health Orientation (GHC)	GHC1: I worry that there are harmful chemicals in cigarettes. *(Saya bimbang bahawa terdapat bahan-bahan kimia berbahaya dalam rokok.)* GHC2: I am concerned about my smoking behaviour. *(Saya mengambil berat tentang perilaku merokok saya.)* GHC3: I read more health-related articles that I did 3 years ago. *(Saya membaca lebin banyak artikel berkaitan dengan kesihatan berbanding dengan tiga tahun yang lepas.)* GHC4: I am interested in information about my health. *(Saya berminat dengan maklumat mengenai kesihatan saya.)* GHC5: I am concerned about my health all the time.	Ng et al., 2009

Construct	Item	Source
	(Saya mengambil berat tentang kesihatan saya sepanjang masa.) GHC6: I am concerned about my health issues and take preventive action. *(Saya mengambil berat perihal kesihatan saya dan mengambil tindakan lindungan diri dari kesan buruk.)*	
Cue to Action (CtA)	CtA1: I am aware about the existing of anti-smoking campaign such as "Tak Nak!" *(Saya sedar dengan kempen anti merokok seperti "Tak Nak!")* CtA2: The message from anti-smoking campaign such as "Tak Nak!" Campaign trigger my quit cigarette smoking intention. *(Mesej yang disampaikan oleh kempen anti merokok seperti "Tak Nak!" Akan mencetuskan niat saya untuk berhenti merokok.)* CtA3: My friends and family constantly remind	Ng et al., 2009

Construct	Item	Source
	me not to smoke. *(Rakan-rakan dan ahli keluarga saya sentiasa mengingatkan saya supaya berhenti merokok.)* CtA4: I want to have healthier life such as breath easier when exercise. *(Saya ingin mempunyai gaya hidup yang lebih sihat seperti dapat bernafas dengan lebih selesa ketika melakukan senaman.)* CtA5: Bad symptoms on my body condition trigger my quit smoking intention. *(Simptom yang berbahaya terhadap badan saya akan mencetuskan niat saya untuk berhenti merokok.)*	
Perceived Severity (PSv)	PSv1: Cigarette smoking illness is a serious threat. *(Penyakit yang berkaitan dengan merokok merupakan ancaman yang series.)* PSv2: Cigarette smoking illness is harnmful *(Penyakit yang berkaitan dengan merokok merupakan ancaman yang berbahaya.)* PSv3: Cigarette smoking illness is a severe threat.	Ng et al., 2009

Construct	Item	Source
	(Penyakit yang berkaitan dengan merokok merupakan ancaman yang teruk.)	
Perceived Susceptibility (PSc)	PSc1: I am at risk for cigarette smoking illness. *(Saya berisiko tinggi untuk menghadapi penyakit yang berkaitan dengan merokok.)* PSc2: It it possible that I will experience cigarette-smoking illness. *(Saya berkemungkinan akan menghadapi penyakit yang berkaitan dengan merokok.)* PSc3: I am susceptible to getting cigarette-smoking illness. *(Saya Mudah terdedah untuk menghadapi penyakit yang berkaitan dengan merokok.)*	Ng et al., 2009
Perceived Benefits (PBn)	PBn1: Quit cigarette smoking will help me to lower my chances of developing heart problems. *(Saya boleh mengurangkan risiko untuck menghadapi penyakit jauntung apabila saya berhenti merokok.)*	Ng et al., 2009

Construct	Item	Source
	PBn2: Quit cigarette smoking will help me to save money. *(Saya boleh menjimat duit apabila saya berhenti merokok.)* PBn3: Quit cigarette smoking will help me gain respect of my friends. *(Saya akan dihormati oleh rakan-rakan saya apabila saya berhenti merokok.)*	
Perceived Barriers (PBr)	PBr1: I don't have accessible transportation to Quit Smoking Clinic. *(Saya todas mempunyai pengakutan yang bleh diakses ke klinik berhenti merokok.)* PBr2: I have to take off from my job or other commitments to attend quit smoking clinic. *(Saya dikehendaki mengambil cute untuck menghadiri klinik berhenti merokok.)* PBr3: I will miss the taste of cigarettes. *(Saya akan rindui rasa rokok.)* PBr4: The treatment is time-consuming.	Ng et al., 2009

Construct	Item	Source
	(Rawatan akan mengambil masa yang lama.)	
Self-Efficacy (SE)	SE1: I am able to quit cigarette smoking. *(Saya mami untuk berhenti merokok.)* SE2: It is easy for me to quit smoking. *(Ianya mudah untuk berhenti merokok.)* SE3: I am confident to attempt quit cigarette smoking. *(Saya yakin saya boleh berhenti merokok.)*	Ng et al., 2009

Source: Ng et al.(2009, p. 817)

The measurement items employed in this research are anchored on a 7-point Likert scale, which is strongly disagree, somewhat disagree, disagree, neutral, agree, somewhat agree and strong agree. The questions were in English and Bahasa Malaysia/national language and Chinese to allow for language preference, which will ensure the respondent understand the questions in the preferred language and provide an accurate response. Thirty research respondents

were recruited from the same research sample frame, and these twenty respondents were not included in the final research findings. According to Bruin (2006), a reliability coefficient of 0.70 or higher is considered as acceptable in social science Table 3.3 shows the reliability:

Table 3.3 Reliability Statistics

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.824	.895	30

Based on the table 3.3 the Cronbach's Alpha is .824 which is an acceptable level of reliability.

3.6 Data Analysis Procedure

The research hypotheses and data obtained from the 133 respondents in this study was analysed by using Statical Package for Social Science (SPSS) for Mac version 23. According to Howitt and Cramer (2010), SPSS is a computer application that provides statistical analysis of data, and it allows for in-depth data access and preparation, analytical reporting, graphics, and modelling. Prvan et al. (2002) further indicated that SPSS will carry out almost all statical analysis required at a professional level, and it is particularly good for the analysis of questionnaire data.

CHAPTER 4

FINDING

This chapter will be focused on describing the descriptive data obtained using SPSS version 23 for Mac. The Pearson correlation statistical analysis will also be presented to determine the strength of the independent variables with the dependent variable.

4.1 Demographic Findings

A total of 133 QSC attendees completed the survey document. The gender statistics showed that a total of 93.2% of the respondents were male attendees and 6.8% were female attendees. In term of ethnicity, 73.7% of Quit Smoking Attendees were Malay, followed by 18% Chinese and 6.8% Indians. More than 53.4% of the QSC attendees have a smoking history of more than 10 years. In terms of education 61.7% of the attendees possessed secondary education and 5.3% primary education. The largest average number of cigarette consumed is between 15-20 sticks per day, and this makes up 40% of the QSC attendees. A total of 72.2% of the attendees have attempted to quit smoking at least once and 27.8% were attempting for the first time. According to the data, 58.6% of the attendees were influenced by their friends, family 4.5%, and self-motivated to smoke 36.8%. A total of 72% of them were 40 years and above in age.

4.2 Hypothesis Testing Model

The HBM independent variables were tested against dependent variable that is intention to quit smoking using SPSS version 23 for Mac. The Pearson correlation statistical test was used to analyze the strength of the relationship between the independent variables and dependent variable. Based conceptual model, the following hypothesis were tested. The research hypothesis are shown below:

Table 4.1 Mean, standard deviation and Pearson Correlation matrix for continuous variable (n = 133)

	Mean	SD	GHC	CtA	PSv	PSc	PBn	PBr	SE	BI
1. GHC	5.9236	1.26822	-							
2. CtA	5.6481	.91126	.459**	-						
3. PSv	6.2707	.96762	.469**	.634**	-					
4. PSc	5.8170	1.19375	.296**	.354**	.496**	-				
5. PBn	6.0526	.87890	.328**	.472**	.574**	.446**	-			
6. PBr	3.5902	1.48137	.138	.095	-.009	-.002	.065	-		
7. SE	5.2932	1.11844	.286**	.372**	.297**	.202*	.256**	.214*	-	
8. BI	5.5113	1.38081	-.066	.216*	.119	.174*	.070	.098	.332**	-

GHC: General Health Orientation; CtA: Cue to Action; PSv: Perceived Severity; PSc: Perceived Susceptibility; PBn: Perceived Benefits; PBr: Perceived Barrier; SE: Self Efficacy; BI: Behavioural Intention

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

H1 - There is a positive correlation between perceived susceptibility and intention to quit smoking.

Perceived susceptibility is referring to a person perception towards a chance of getting certain condition. In this study, the questionnaire is referred to whether the attendees believe that he is potentially to be suffered from illness if they continue smoking. With reference to table 4.1, the correlations statistic indicates that there is a significant and positive

relationship between perceived susceptibility and intention to quit smoking. As such, hypothesis 1 is accepted.

H2 - There is a positive correlation between perceived severity and intention to quit smoking.

Perceived severity refer to a person's opinion on how severe the condition will be when he or she adapted into certain action. Tobacco consumption may cause several severe diseases such as cancel. However, the respondents from this study had refused to perceive them as a threat. With reference table 4.1, the correlation statistic indicates there is no significant correlation between perceived benefits and intention to quit smoking. Therefore Hypothesis 2 is rejected.

H3 - There is a positive correlation between perceived benefits and intention to quit smoking.

Perceived benefit is referred to a person's belief on the effectiveness on reduce the harmful impact when certain action has been taken. With reference table 4.1, the correlation statistic indicates there is no significant correlation between perceived benefits and intention to quit smoking. The level of perceived benefits from the quit smoking clinic attendees are not high, therefore, Hypothesis 3 is rejected.

H4 - There is a positive correlation between perceived barriers and intention to quit smoking.

Perceived barrier is an opposition of perceived benefit. When the barriers outweigh any benefits of the information, the attendees probably would not perform the recommended action. Table 4.1 shows that there is no significant correlation between perceived barriers and intention to quit smoking. Therefore, Hypothesis 4 is rejected.

H5 - There is a positive correlation between cue to action and intention to quit smoking.

According to Health Belief Model, cue to action is referring to an event, people or things that trigger a person to change their behaviour. There are two cues, which are internal and external cues. Internal cue can be prescribed as a person internal perception of health symptoms. External cue such as the physicians showing the leaflet about the bad impact of smoking may trigger a person's level of susceptibility towards smoking. With reference table 4.1, the correlations statistic indicates there is significant and positive relationship with Cue to Action and intention to quit smoking. As such, hypothesis 5 is accepted.

H6 - There is a positive correlation between general health orientation and intention to quit smoking.

In this study, general health orientation is additional construct added into Health Belief Model. In the quite smoking context, this refers to

attendees' predisposition and interest concerning quit intention. Table 4.1 shows that there is no significant correlation between General Health Orientation and intention to quit smoking. Therefore Hypothesis 6 is rejected. The table shows that the Pearson Correlation is strong.

H7 - There is a positive correlation between self-efficacy and intention to quit smoking.

Self-efficacy is a person's belief on himself or herself have ability or determination to do some suggested action. This study showing the quit smoking attendees portraying positive determination on quit intention. With reference to table 4.1, the correlations statistic indicates there is significant and positive relationship with self-efficacy and intention to quit smoking. As such, hypothesis 7 is accepted.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 Discussion

This chapter discusses the statistical results of the finding. The discussion also gives clear picture on conclusion related to the objective of the research. The limitation will be discussed and the recommendation will be made for future research.

Based on the demographic data, male dominance (93.2%) is evident in the smoking prevalence Malaysia. This finding supports the 2017 WHO Report on The Global Tobacco Epidemic where 72% of current smokers are male and 5.3% are female smokers. Similarly a recent review on smoking research in Malaysia also confirmed that the male category dominated the smoking prevalence (Wee , Chan and Yogarabindranath, 2016). The male dominance in smoking is a global trend. In terms of ethnicity, in this study, 73.7% of the QSC respondents were from the Malay community. This finding was similar to a recent cross sectional study of 15,639 Malaysians showed 55.9% were Malay smokers (Lim, Mohd Ghazali et al. 2013). Similarly the National Health and Morbidity Survey 2015 based on a sample of 21,000 respondents, the Malays made up 24.6% of the total

smokers followed by Indians at 19.7% and Chinese at 15.4%. The dominance of the Malay community in smoking prevalence is unclear although recent research point towards socio-economic interests where the tobacco industry has been viewed as supporting Malay economic development, however, this view is being challenged in recent times (Barraclough and Morrow 2017).

The findings also showed that the average consumption per day is 15 sticks and this is supported by the National Health and Morbidity Survey 2015, whereas 15 sticks per day was the average consumption of smokers aged 15 years and above. An average of 15 sticks per day leans towards heavy smoking. It can be concluded that majority of the respondents of the survey are heavy smokers.

Most of Quit Smoking Clinic's attendees have a smoking history above 10 years and this indicates that the Quit Smoking Clinics are relevant to smokers with a long history. There is a link between lower education levels and smoking uptake as per demographic data, which is also supported in earlier research (Lim, Mohd Ghazali et al. 2013). Based on the average smoking per day, it can be inferred that most of the Quit Smoking Clinic's attendees are heavy smoker. Generally most of the attendees were influenced by friends to smoke. This finding is supported by earlier research. Lim et al. found that smoking was relevant to those who have a friend who smokes and poor academic performance (Lim, Amal et al. 2006).

The Pearson correlation test between the independent and dependent variables resulted in three independent variables, which had significant positive relationship with the dependent variable. The three independent variables are

perceived susceptibility, cue to action and self-efficacy. The additional independent variable which was added to the original model that is General Health Orientation did not have a significant relationship with the dependent variable that is intention to quit. This can be attributed to the argument that the QSC attendees are smokers and hence are not orientated to healthy lifestyle. They are attending the QSC to try and achieve smoking cessation. This does not mean that General Health Orientation as an additional variable should be discounted in the study of factors that can motivate smoking cessation. If the QSC attendees are also given education on healthy living and its broad benefits it could feature as a strong factor to make people quit smoking. Broad healthy lifestyle and education which can include avoidance of all types of behaviours that can harm health such as indulgence in alcohol, drugs and others can actually foster behaviour positive behaviour which also includes smoking cessation.

Perceived susceptibility correlated significantly with intentions to quit. The fear of the risk of contracting the tobacco-related diseases is a strong motivator for smoking cessation. According to Witte, Meyer and Martel (2001) fear appeals can motivate people to affirmative action towards healthy behaviour such as giving up smoking. In comparison perceived severity was not significantly correlated although it is about fear provocation. In the context of the QSC respondents they may not have considered severity as a major threat since they are not suffering from any of tobacco related diseases as yet it is the fear of suffering such diseases in the future (perceived susceptibility) which motivates them towards intention to quit smoking. The likelihood of acquiring or susceptible to the dangerous tobacco diseases was found to be more significantly related to quitting intention in this research.

Cues to action or what triggers a smoker to develop quitting intentions was also positively correlated and this largely due to the aggressive fear based anti-smoking campaign using both the mainstream media and on-pack cigarette as a medium motivated the respondents to register in QSC's. Fear appeals work successfully because it created lasting awareness, established a sense of susceptibility and severity (South Asia Tobacco Control Alliance,2012). This is also supported by a research undertaken by Mahoney (2010), which showed that 97% of Australians can recall the anti-smoking campaign and 98% believed in the message. This implies that the Malaysian government's efforts to continuously communicate about the dangers of smoking and encouragement to attend the QSC in the mainstream media is effective and has encouraged many to seek for help through the QSC. Although the number may not big but it has the potential of snowballing into large numbers with continued anti-smoking campaign.

Self-efficacy is another factor that was positively correlated with intentions to smoke. Several researches on smoking in Malaysia have emphasized the importance of this factor. Self-efficacy is closely associated with quitting intentions because both local and overseas research findings showed that those who attempted several times to quit by attending the QSC were successful in quitting smoking. Research done by Sui, Gan and Nurdiyana(2016) on smoking cessation concluded that successful QSC participants are those who commit to longer duration of follow-up, higher frequency of follow-up, fewer number of cigarettes per day and had lower nicotine dependence. Similarly in another research self-efficacy was cited as predictive of both making a quit attempt and remaining abstinent (Wee,Chan and Yogarabindranath, 2016).

5.2 Conclusion

Based on the three variables which had positive, significant correlations with intentions to quit it can be said that the QSC clinic administrators should continue emphasizing the possibility of suffering serious tobacco related diseases or risk of suffering ill consequences is very real since the research shows strong correlations between susceptibility and intentions to quit. In all their counselling sessions this should be emphasized. The Malaysian government should continue the fear campaign because it acts a as a cue to those who have yet to seek help from a QSC and those who are already a registered QSC participant it will motivate them to be disciplined to continue attending the QSC counselling sessions. Since self-efficacy is an important factor in the quitting process the QSC should provide all possible skills to ensure they know how to stop the cravings, peer pressure to return to smoking, urge to smoke seeing other smoke and others. According to research failure to quit is because of the lack of skills to overcome the withdrawl symptoms, peer pressure and inconsistent attendance at the QSC's. The QSC's must work towards enhancing their self-efficacy to overcome all the external and personal pressures to return to smoking (Wee,Chan and Yogarabindranath, 2016).

In summary this research has identified the three personal factors amongst the QSC participants that needs to be emphasized in order for these participants who have newly joined the QSC to quit smoking at the end of the six-month

period and remaining abstinent. The HBM model in this research was found to be useful in identifying variables that needs to be prioritized and actioned upon to enable more participants to attend quitting success.

5.3 Limitation and Recommendation

One of the main limitations of this survey is that the findings are not generalizable since the sample was drawn from three clinics only. Due to limited time and resources only three QSC's were selected. It is recommended that future research consider selection of samples from more clinics across the nation so that the findings can be generalized. A longitudinal research is recommended to observe the final outcome of the participants after six months of the QSC counselling and therapy sessions. This research is at the early stage of the quitting process and the actual outcome is not known and it would be pertinent to collect data on those who successfully quit after the six-month period and those who failed to quit. Future research can also take into consideration intervening variables that can influence quitting behaviour. Another limitation from this study is the findings are very weak and research post-mortem found that there was another research the attendees were involved and this could have resukted in the attendees being impatient and rushed through the questionnaire. It is recommended that future research should ensure the selected respondents are not involved in other research at the same time or in the same day. In this research only one additional independent variable was added to the HBM model that is General Health Orientation.

REFERENCES

Abdul Aziz, S., Aljunid, S. M., Wan Puteh, S. E., & M Zain, Z. (2006). *A Study on the Effectiveness of the Quit Smoking: Clinics in West Malaysia - Are we Ready?* Paper presented at the Malaysia Conference on Tobacco Control 2006, Kuala Lumpur.

Abernethy, A. M., & Wicks, J. L. (1998). Television Station Acceptance of AIDS Prevention PSAs and Condom Advertisements. *Journal of Advertising Research, 38*(5), 53-62.

Bandura, A. (1977). Self-efficacy: Toward a Unifying Theory of Behavioral Change. *Psychological Review, 84*(2), 191-215.

Bandura, A. (1989). Human Agency in Social Cognitive Theory. *American Psychologist, 44*(9), 1175.

Barraclough, S., & Morrow, M. (2017). Tobacco and the Malays: Ethnicity, Health, and the Political Economy of Tobacco in Malaysia. *Ethnicity & Health, 22*(2), 130-144.

Bruin, J. (2008). Newtest: Command to Compute New Test. *UCLA: Academic Technology Services*.

Burke, E. (2013). Professional e-portfolio of Evan Burke. from http://www.personal.psu.edu/eab5160/blogs/the_professional_e-portfolio_of_evan_burke/The%20Health%20Belief%20Model.pdf

Conner, M., & Norman, P. (2005). Perdicting Health Behavior: A Social Cognition Approach *Predicting Health Behavior*: Open University Press.

Corcoran, N. (2007). *Communicating Health: Strategies for Health Promotion*. London: SAGE.

Foong, K., Omar, M., Lajis, R., Awang, R., Tan, Y. L., & Check Yoon Yong. (2005). Evaluation of the National Anti-Smoking Campaign in Malaysia - Tak Nak Media Campaign (C. a. R. N. f. T. Control, Trans.). Penang: National Poison Centre of Malaysia.

Hayden, J. (2009). *Introduction to Health Behavior Theory*. Sudbury: Jones and Bartlett.

Howitt, D., & Cramer, D. (2010). *Introduction to Research Methods in Psychology* (3rd ed.). London.

Institute for Public Health, I. (2012). Report of the Global Adult Tobacco Survey (GATS) Malaysia. Kuala Lumpur: Institute for Public Health (IPH).

Institute for Public Health, I. (2015). National Health and Morbidity Survey 2015 - Report on Smoking Status Among Malaysian Adults. Kuala Lumpur: Institute for Public Health, National Institute of Health, Ministry of Health.

International Tobacco Control, I. (2011). The International Tobacco Control Policy Evaluation Project. 2012, from http://www.itcproject.org/countries/Malaysia

Israel, G. D. (1992). Sampling the Evidence of Extension Program Impact *Progam Evaluation and Organizational Development*: University of Florida.

Jayanti, R. K., & Burns, A. C. (1998). The Antecedents of Preventive Health Care Behavior: An Empirical Study. *Academy of Marketing Science Journal, 26*(1), 6-15.

Kreps, G. L. (2001). Office of Disease Prevention and Health Promotion. *Communication Yearbook, 24*, 231-253.

Kumar, R. (2011). *Research Methodology: A step-by step guide for beginner*. London: SAGE.

Lee, M. L., Hassali, M. A., & Shafie, A. A. (2012). A Qualitative Exploration of the Reasons for the Discontinuation of Smoking Cessation Treatment among Quit Smoking Clinics' Defaulters and Health Care Providers in Malaysia. *Research in Social & Administrative Pharmacy*, 1-14.

Lim, K. H., Amal, N. M., Hanjeet, K., Mashod, M. Y., Wan Rozita, W. M., Sumarni, M. G., & Hadzrik, N. O. (2006). Prevelance and Factors Related to Smoking Among Secondary School Students in Kota Tinggi District, Johor, Malaysia. *Tropical Biomedicine, 23*(1), 75-84.

Lim, K. H., Mohd Ghazali, S., Kee, C. C., Lim, K. K., CHan, Y. Y., Teh, H. C., . . . Salleh, S. (2013). Epidemiology of Smoking among Malaysian Adult Males: Prevalence and Associated Factors. *BMC Public Health, 13*(1).

Lim, K. H., Sumarni, M. G., Amal, N. M., Hanjeet, K., Wan Rozita, W. M., & Norhaminah, A. (2009). Tobacco Use, Knowledge and Attitude among Malaysians Age 18 and Above. *Tropical Biomedicine, 26*(1), 92-99.

Mahoney, J. (2010). Strategic Communication and Anti-smoking Campaign. *Public Communication Review*, 33-48.

Malaysia Council for Tobacco Control, M. (2005). Malaysia Council for Tobacco Control. Retrieved 21 July 2014, 2014, from http://www.mctc.org.my/conferences/.../9_plenary1_rosnah_mod_full.pdf

Milam, J. (2000). Perceived Invulnerability and Cigarette Smoking among Adolescent *Additive Behaviors, 25*(1), 71-80.

Ng, B.-Y., Kankanhali, A., & Xu, Y. C. (2009). Studying Users' Computer Security Behavior: A Health Belief Perspective. *Decision Support Systems, 46*, 815-825.

People, H. (2009). Health Communication. *Healthy People.* Retrieved May, 2014, from http://www.healthypeople.gov/document/HTML/Volume1/11HealthCom.htm

Perloff, R. M. (2008). *The Dynamic of Persuasion: Communication and Attitudes in the 21st Century*. New Jersey: Lawrence Erlbaum Assoc.

Prvan, T., Reid, A., & Petocz, P. (2002). Teaching Statistics *Statistical laboratories using Minitab, SPSS and Excel: A practical comparison.* (Vol. 24, pp. 68-75).

Reference.MD. (2012). Reference.MD. Retrieved 26th November, 2013, from http://www.reference.md/files/D006/mD006293.html

Renuka, P., & Pushpanjali, K. (2014). Effectiveness of Health Belief Model in Motivating for Tobacco Cessation and to Improving Knowledge, Attitude and Behavior of Tobacco Users. *Cancer and Oncology Research, 2*(4), 43-50.

Rimal, R. N., & Lapinski, M. K. (2009). Why Health Communication is Important in Public Health *Bull World Health Organ* (Vol. 87, pp. 247-248). Baltimore.

Rosenstock, I. M. (1966). Why People Use Health Services. *Memorial Fund Quarterly, 44*(3), 94-127.

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social Learning Theory and the Health Belief Model. *Health Education Quarterly, 15*(2), 175-183.

Schiavo, R. (2007). *Health Communication: From Theory to Practice*. San Francisco: Jossey-Bass.

Southeast Asia Tobacco Control Alliance, S. (2015). The ASEAN Tobacco Control Report. Jakarta: Southeast Asia Tobacco Control Alliance.

Stretcher, V., & Rosenstock, I. M. (1997). The Health Belief Model. In K. Glanz, F. M. Lewis & B. K. Rinner (Eds.), *Health Behavior and Health Education: Theory, Research and Practice*. San Francisco: Jossey-Bass.

Tan, Y. L. (2010). Implementing Pictorial Health Warnings in Malaysia: Challenges and Lessons Learned (K. a. Information, Trans.). Bangkok: Southeast Asia Tobcco Control Alliance.

Tobacco Free Kids, T. (2013). Smoking's Immediate Effects On The Body. *Campaign For Tobacco-Free Kids.* Retrieved July, 2013, from http://www.tobaccofreekids.org/research/factsheets/pdf/0264.pdf

Vroom, V. H. (1964). *Work and Motivation*. New York: Wiley.

Walker, L. R., & Thomas, K. W. (1982). Beyond Expectancy Theory: An Integrative Motivational Model from Health Care. *Academy of Management Review, 7*(2), 187-194.

Wee, L. H., Chan, M. H. C., & Nantha, Y. S. (2016). A Review of Smoking Research In Malaysia. *Medical Journal Malaysia, 71*.

Wee, L. H., Shahab, L., Bulgiba, A., & West, R. (2011). Stop Smoking Clinics in Malaysia: Characteristics of Attendees and Predictors of Success. *Addictive Behaviors, 36*, 400-403.

WHO, W. H. O. (2017). WHO Report on the Global Tobacco Epedemic, 2017: World Health Organization, WHO.

Williams, K. C. (2012). Improving Fear Appeal Ethics. *Journal of Academic and Business Ethics, 5*.

Wimmer, R. D., & Dominick, J. R. (2011). *Mass Media Research: An Introduction* (9th ed.). Wadsworth: Cengage Learning.

Witte, K. (1992). Putting the fear Back into Fear Appeals: The Extended Parallel Process Model. *Communication Monographs, 59*(4), 329-349.

Witte, K. (1994). Fear Control and Danger Control: A Test of the Extended Parallel Process model (EPPM). *Communication Monographs, 61*(2), 113-134.

Witte, K., & Allen, M. (2000). A Meta Analysis of Fear Appeals: Implications for Effective Public Health Campaigns. *Health Education Behavior, 27*(5), 591-615.

Witte, K., Berkowitz, J., Cameron, K., & McKeon, J. K. (1998). Preventing the spread of genital Warts: Using fear appeals to promote self-protective behaviors. *Health Education Behavior, 25*, 571-585.

Witte, K., Meyer, G., & Martell, D. (2001). *Effective Health Risk Messages: A Step-by-Step Guide*. Thousand Oaks: SAGE.

World Health Organization, W. (2003). *WHO Framework Convention on Tobacco.* Paper presented at the WHO Framework Convention on Tobacco, Geneva.

World Health Organization, W. (2005). *WHO Framework Convention on Tobacco Control.* Paper presented at the World Health Organization, Geneva.

Yamane, T. (1967). *Statistics: An Introductory Analysis* (2nd ed.): Harper and Row.

Yasin, S. M., Masilamani, R., Moy, F. M., Koh, D., & Zaki, R. A. (2012). Can Initial Perceptions about Quitting Predict Smoking Cessation among Malaysian Smokers? *Southeast Asian Journal Trop Med Public Health, 43*(2), 501-509.

Zain, Z. (2007). *Malaysian Smoking Cessation Programme & Smoke-Free Air Laws.* Paper presented at the International Union Against Tuberculosis & Lung Disease Asia Pacific Region 1st Asia Pacific Regional Conference, Kuala Lumpur.

APPENDIX A

Versi 2.0 Tarikh: 15 Feb

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.

Dokumen ini adalah untuk penghantaraan atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikkan. Borang ini dikeluarkan sebagai gantian dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbaskan dokumen ini dan hantar atas talian.

Unique Research ID : *[Nombor Pendaftaran]*	17669
Research Title : *[Tajuk]*	APPLYING HEALTH BELIEF MODEL TO QUIT SMOKING CLINIC ATTENDEES' QUIT INTENTION
Protocol Number if available : *[Nombor Protokol jika ada]*	

Investigator agreement ***[Persetujuan penyelidik]***

I have understood the above titled proposed research and I agree to participate in the research as an investigator.

Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik.

Name of Investigator : *[Nama Penyelidik]*	OOI SWEE YAW
IC number : *[Nombor KP]*	830117025387
Site Institution : *[Institusi]*	Klinik Kesihatan Jinjang
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	
Date : *[Tarikh]*	24 SEP 2013

Head of Department Agreement ***[Persetujuan Ketua Jabatan]***

I agree to allow the above named investigator to conduct or to participate in the above titled research.

Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head : *[Nama Ketua]*	Inthirani
Name of Department and Institution *[Jabatan dan Institusi]*	DR. INTHIRANI A/P M. SIVARAJAH Pegawai Penyelaras Gred UD54 Pejabat Kesihatan Kepong No. Daftar: 043462
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	DR. UMMI KALTHOM BT SHAMSUDIN No. Pendaftaran Penuh MPM: 31233 Timbalan Pengarah Kesihatan (Kesihatan Awam) Jabatan Kesihatan Wilayah Persekutuan Kuala Lumpur & Putrajaya
Date : *[Tarikh]*	

Institutional approval ***[Pengesahan Institusi]***

This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details.

[Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.

Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director : *[Nama Pengarah]*	
Name of Institution *[Institusi]*	Dr. BALACHANDRAN A/L SATIAMURTI A.M.N, P.K.C. MBBS (DACCA), M.MED (O&M) SINGAPORE, (MPM:24646 Pengarah Kesihatan Negeri Jabatan Kesihatan Wilayah Persekutuan Kuala Lumpur & Putrajaya
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	
Date : *[Tarikh]*	

Versi 2.0 Tarikh: 15 Feb

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.

Dokumen ini adalah untuk penghantaraan atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikkan. Borang ini dikeluarkan sebagai gantian dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbaskan dokumen ini dan hantar atas talian.

Unique Research ID : *[Nombor Pendaftaran]*	17669
Research Title : *[Tajuk]*	APPLYING HEALTH BELIEF MODEL TO QUIT SMOKING CLINIC ATTENDEES' QUIT INTENTION
Protocol Number if available : *[Nombor Protokol jika ada]*	

Investigator agreement ***[Persetujuan penyelidik]***

I have understood the above titled proposed research and I agree to participate in the research as an investigator.

Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik.

Name of Investigator : *[Nama Penyelidik]*	OOI SWEE YAW
IC number : *[Nombor KP]*	830117025387
Site Institution : *[Institusi]*	Klinik Kesihatan Tanglin
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	[signature]
Date : *[Tarikh]*	24 SEP 2012

Head of Department Agreement ***[Persetujuan Ketua Jabatan]***

I agree to allow the above named investigator to conduct or to participate in the above titled research.

Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head : *[Nama Ketua]*	
Name of Department and Institution *[Jabatan dan Institusi]*	
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	[signature] DR. NORALIZA BT. NOORDIN MERICAN Pegawai Perubatan UD54 MMC: 32864 [stamp: PEJABAT KESIHATAN LEMBAH PANTAI, JLN. CENDERASARI 50590 KL LUMPUR]
Date : *[Tarikh]*	

DR. UMMI KALTHOM BT. SHAMSUDIN
No. Pendaftaran Penuh MPM: 31233
Pakar Perubatan Kesihatan (Kesihatan Awam)
Jabatan Kesihatan Wilayah Persekutuan
Kuala Lumpur & Putrajaya

Institutional approval ***[Pengesahan Institusi]***

This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details.

[Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.

Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director : *[Nama Pengarah]*	
Name of Institution *[Institusi]*	
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	[signature] Dr. BALACHANDRAN A/L SATIAMURTI A.M.N, P.K.C MBBS (DACCA), M.MED (O.M) SINGAPORE, (MPM:24646) Pengarah Kesihatan Negeri Jabatan Kesihatan Wilayah Persekutuan Kuala Lumpur & Putrajaya
Date : *[Tarikh]*	

APPENDIX B

JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
(Medical Research & Ethics Committee)
KEMENTERIAN KESIHATAN MALAYSIA
d/a Institut Pengurusan Kesihatan
Jalan Rumah Sakit, Bangsar
59000 Kuala Lumpur

Tel. : 03 2282 9082/03 2282 9085
03 2287 4032/03 2282 0491
Faks : 03 2287 4030

Ruj. Kami : ( ) KKM/NIHSEC/800-2/2/2 Jld3.P13-1009
Tarikh : 6 November 2013

Ooi Swee Yaw
Klinik Kesihatan Tanglin

Tuan,

NMRR-13-954-17669
APPLYING HEALTH BELIEF MODEL TO QUIT SMOKING CLINIC ATTENDEES' QUIT INTENTION

Lokasi Projek : **1) Klinik Kesihatan Tanglin**
2) Klinik Kesihatan Pantai
3) Klinik Kesihatan Kampung Pandan
4) Klinik Jinjang
5) Klinik Berhenti Merokok, IJN

Dengan hormatnya perkara di atas adalah dirujuk.

2. Jawatankuasa Etika & Penyelidikan Perubatan (JEPP), Kementerian Kesihatan Malaysia (KKM) mengambil maklum bahawa projek tersebut adalah untuk memenuhi keperluan akademik Program Sarjana Komunikasi, Universiti Tunku Abdul Rahman (UniTAR).

3. Sehubungan dengan ini, dimaklumkan bahawa pihak JEPP KKM tiada halangan, dari segi etika, ke atas pelaksanaan projek tersebut. JEPP mengambil maklum bahawa kajian ini tidak melibatkan sebarang intervensi dan hanya menggunakan borang soal selidik sahaja untuk mengumpul data kajian. Segala rekod dan data adalah SULIT dan hanya digunakan untuk tujuan kajian dan semua isu serta prosedur mengenai *data confidentiality* mesti dipatuhi. Kebenaran daripada Pengarah Kesihatan Negeri di mana kajian akan dijalankan mesti diperolehi terlebih dahulu sebelum kajian dijalankan. Tuan perlu akur dan mematuhi keputusan tersebut.

4. Adalah dimaklumkan bahawa kelulusan ini adalah sah sehingga 6 November 2014. Tuan perlu menghantar *'Continuing Review Form'* (Lampiran 1) selewat-lewatnya 2 bulan sebelum tamat tempoh kelulusan ini bagi memperbaharui kelulusan etika. Pihak Tuan juga perlu mengemukakan laporan tamat kajian dan juga laporan mengenai "*All adverse events, both serious and unexpected*" kepada Jawatankuasa Etika & Penyelidikan Perubatan, KKM.

Sekian terima kasih.

BERKHIDMAT UNTUK NEGARA

Saya yang menurut perintah,

(DATO' DR CHANG KIAN MENG)
Pengerusi
Jawatankuasa Etika & Penyelidikan Perubatan
Kementerian Kesihatan Malaysia

APPENDIX C

Dear Participant,

I am a Master of Communication student in University Tunku Abdul Rahman, Petaling Jaya and I am conducting a research **exploring the quit intention of the quit smoking clinic's attendees**. Findings of this study will also hopefully provide a better understanding of individual factors that impacts quit intention. You will be required to complete a set of questionnaire, which consists of basic demographic questions, smoking history, and questions pertaining to the Health Belief Model. This process should only take approximately fifteen to twenty minutes of your time.

Data gathered from the questionnaire administrated will remain private and confidential and will only be used for the purpose of this research. You may decline to answer any question and you have the right to withdraw from participation at any time. **Your identity will not be revealed and will be kept in strict confidentially.**

Your kind participation is highly appreciated. Should you have any further enquiries regarding my study, please do not hesitate to contact me, OOI SWEE YAW, WAYNE at my email address of **syooi.wayne@gmail.com.**
Thank you.

Sincerely,

OOI Swee Yaw, Wayne

Para peserta,

*Saya seorang pelajar Sarjana Komunikasi di Universiti Tunku Abdul Rahman, Petaling Jaya dan saya ingin menjalankan penyelidikan mengenai '**niat berhenti merokok di kalangan hadirin Klinik Berhenti Merokok**. Objektif kajian ini adalah untuk menilai niat berhenti merokok oleh para hadirin Klinik Berhenti Merokok dengan menggunakan **Model Kepercayaan Kesihatan (Health Belief Model)**. Hasil daripada kajian diharapkan dapat memberi pemahaman yang lebih baik mengenai faktor-faktor individu yang memberi kesan atas niat untuk berhenti merokok.*

Anda akan diminta untuk melengkapkan satu set soal selidik yang terdiri daripada soalan-soalan asas demografi , sejarah merokok, dan soalan-soalan yang berkaitan dengan Model Kepercayaan Kesihatan. Proses ini hanya akan mengambil masa kira-kira lima belas atau dua puluh minit.

*Data yang dikumpul dari soal selidik akan dirahsiakan dan hanya akan digunakan untuk tujuan kajian ini. Penyertaan anda dalam kajian ini adalah secara sukarela. Anda juga berhak untuk menarik diri daripada kajian ini pada bila-bila masa **. Identiti anda akan dirahsiakan dan tidak akan didedahkan.***

Penyertaan anda adalah amat dihargai. Sekiranya anda mempunyai sebarang pertanyaan lanjut mengenai kajian ini, sila hubungi saya , OOI SWEE YAW , Wayne di alamat e-mel saya syooi.wayne @ gmail.com.

Yang benar,

OOI Swee Yaw, Wayne

親愛的參與者們，

我是馬來西亞拉曼大學傳播學碩士研究生。感謝您撥空填寫這一份問卷。本問卷目的是在“探討戒菸診所出席者的戒菸意向”。問卷採匿名的方式，而且您在問卷中所提供的資訊，僅作為學術研究之用，不會提供其他單位，敬請安心填寫。 您的意見對我們非常重要，衷心期盼您依自己的實際感受填答。
感謝您的熱情支持與協助！如有任何疑問，請聯絡以下電郵。
敬祝　平安快樂，萬事如意！

黃綏耀，Wayne 上

PART 1: Demographic Information *(Informasi Demografi)* 第一部分：人口統計數據

Direction: Please ☑ the relevant demographic information as required. *(Sila tanda ☑ di mana yang berpatutan)* 請在相關的人口統計數據上☑。

1. What is your gender? *(Jantina anda?)* 請問您的性別？

□ Male *(Lelaki)* 男　　□ Female *(Perempuan)* 女

2. What is your age? *(Umur anda?)* 請問您的年齡？

□ Below 25 *(Berumur 25 tahun dan ke bawah)* 未滿 25 歲

□ 26-35 *(Berumur dari 26 hingga 35 tahun)* 26-35 歲

□ 36-45 *(Berumur dari 36 hingga 45 tahun)* 36-45 歲

□ 46 and above *(Berumur 46 tahun dan ke atas)* 46 歲以上

3. What is your race? *(Kaum anda?)*請問您的種族？

□ Malay *(Melayu)*巫裔　　□ Chinese *(Cina)*華裔

□ Indian *(India)*印裔　　□ Others *(Lain-lain)*其它:_____

4. What is your marital status? *(Status perkahwinan?)*請問您的婚姻狀況？

□ Single *(Bujang)*單身　　□ Married *(Sudah berkahwin)*已婚

□ Widowed *(Janda)*喪偶　　□ Divorced *(Sudah bercerai)*離異

5. What are the highest degree or level of school you have completed? *(Tahap pendidikan tertinggi?)* 請問您的教育背景?

□ Primary school *(Sekolah rendah)*小學　　□Secondary school *(Sekolah menengah)* 中學

□ Undergraduate *(Mahasiswa)* 學士　　□ Postgraduate *(Lepasan ijazah)* 研究生

6. What is your estimate household income? *(Anggaran jumlah pendapatan isi rumah sebulan?)* 請問您的家庭收入估計是多少？

□ Less than RM3000 *(Kurang daripada RM3000)* 未滿 RM3000

□ RM3000 – RM4000 *(Dari RM3000 hingga RM4000)*

□ RM4001 – RM5000 *(Dari RM3001 hingga RM5000)*

□ More than RM5000 *(Lebih daripada RM5000)* 超過 RM5000

PART 2: Smoking History *(Sejarah Merokok)* 第二部分：抽菸經歷

Direction: Please ☑ the most relevant information as required. *(Sila tanda ☑ di mana yang paling berpatutan)* 請在相關的人口統計數據上☑。

7. Who introduced you to smoking cigarette? *(Siapa yang memperkenalkan anda untuk merokok?)* 請問是誰介紹你抽香菸？

☐ From friends *(Daripada kawan-kawan)* 朋友

☐ From family *(Daripada ahli keluarga)* 家庭成員

☐ Self purchased *(Membeli diri sendiri)* 自行購買

8. How many years you been a cigarette smoker? *(Sudah berapa lama anda mula merokok?)* 請問您接觸香菸已經有多少年的時間了？

☐ Less than 1 year *(Tidak melebihi satu tahun)* 少過一年

☐ 1-5 years *(Setahun hingga 5 tahun)* 1-5 年

☐ 5-10 years *(5 tahun hingga 10 tahun)* 5-10 年

☐ More than 10 years *(Lebih daripada 10 tahun)* 超過 10 年

9. How many number of cigarettes you smoke per day? *(Berapa batang rokok anda menghisap sehari?)* 請問您每天抽食香菸的數量是多少？

☐ Less than 10 *(Kurang daripada 10 batang)* 少於 10 支

☐ 10-15 *(10 hingga 15 batang)* 10 – 15 支

☐ 15-20 *(15 hingga 20 batang)* 15-20 支

☐ More than 20 *(Lebih daripada 20 batang)* 超過 20 支

10. Previous quit attempt? *(Pernahkah anda cuba berhenti merokok?)* 請問您之前有嘗試過戒菸嗎？

☐ Yes *(Ya)* 有　　☐ No *(Tidak)* 沒有

PART 3: List of questions to evaluate cigarette smoking quit intention. You are required to rate on a scale 1 to 7. (1. Strongly disagree, 2. Disagree, 3. Somewhat disagree, 4. Neutral, 5. Somewhat agree, 6. Agree, 7. Strongly agree).
(Senarai soalan-soalan untuk menilai perilaku berhenti merokok. Anda diminta menilai mengikut skala 1 hingga 7. [1. Langsung tidak bersetuju, 2. Tidak setuju, 3. Tidak begitu bersetuju, 4. Neutral, 5. Agak bersetuju, 6. Bersetuju, 7. Sungguh bersetuju]

第三部分：以下問題將評估您的戒菸意向。請您詳閱題目內容，並請把與您意見最相符的答案圈上。對於以下評估程度共有 1.非常不同意， 2.不同意， 3.有點不同意， 4.無意見，5.有點同意，6.同意，7.非常同意等七種程度，請就您滿意的程度圈選（單選）。

Direction: Please indicate to what extent you agree or disagree with the statements listed below by placing a circling the appropriate answer. *(Sila jawab soalan-soalan berikut dengan membulatkan jawapan yang anda rasa berpatutan.)*

PART 3A: GHC

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	I worry that there are harmful chemicals in cigarettes. *(Saya bimbang bahawa terdapat bahan-bahan kimia berbahaya dala rokok.)* 我擔心香菸中含有有害化學物質。	1	2	3	4	5	6	7
2.	I am concerned about my smoking behavior. *(Saya mengambil berat tentang perilaku merokok saya.)* 我在意我的吸菸行為。	1	2	3	4	5	6	7
3.	I read more health-related articles than I did 3 years ago. *(Saya membaca lebih banyak artikel berkaitan dengan kesihatan berbanding dengan tiga tahun yang lepas.)* 比起三年前，我讀了更多與健康相關的文章。	1	2	3	4	5	6	7
4.	I am interested in information about my health. *(Saya berminat dengan maklumat mengenai kesihatan saya.)* 我對於有關我健康的信息感興趣。	1	2	3	4	5	6	7
5.	I am concerned about my health all the time. *(Saya mengambil berat tentang kesihatan saya sepanjang masa.)* 我時刻在意我的健康。	1	2	3	4	5	6	7

6.	I am concerned about my health issues and take preventive action. *(Saya mengambil berat perihal kesihatan saya dan mengambil tindakan lindungan diri dari kesan buruk.)* 我關心我的健康問題並且採取預防措施。	1	2	3	4	5	6	7

PART 3B: CtA

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	I am aware about the existing of anti-smoking campaign such as "Tak Nak!" *(Saya sedar dengan kempen anti merokok seperti "Yak Nak!)* 我意識到反吸菸運動像是"Tak Nak!"的存在。	1	2	3	4	5	6	7
2.	The message from anti-smoking campaign such as "Tak Nak!" campaign trigger my quit cigarette smoking intention *(Mesej yang disampaikan oleh kempen anti merokok seperti "Tak Nak!" akan mencetuskan niat saya untuk berhenti merokok)* 反吸菸運動的信息像是""Tak Nak!"的信息引發我戒菸的意向。	1	2	3	4	5	6	7
3.	My friends and family constantly remind me not to smoke. *(Rakan-rakan dan ahli keluarga saya sentiasa mengingatkan saya supaya berhenti merokok)* 我的朋友和家人經常提醒我不抽菸。	1	2	3	4	5	6	7
4.	I want to have healthier life such as breath easier when exercise. *(Saya ingin mempunyai gaya hidup yang lebih sihat seperti dapat bernafas dengan lebih selesa ketika melakukan*	1	2	3	4	5	6	7

	senaman) 我要有更加健康的生活，就加運動時可以呼吸暢通 。							
5.	Bad symptoms on my body condition trigger my quit smoking intention. *(Simptom yang berbahaya terhadap badan saya akan mencetustan niat saya untuk berhenti merokok)* 吸菸引起的不好症狀會引發我想要戒菸的意圖。	1	2	3	4	5	6	7

PART 3C: PSv

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	Cigarette smoking illness is a serious threat. *(Penyakit yang berkaitan dengan merokok merupakan ancaman yang serius)* 吸菸引發的疾病是一種嚴重的威脅。	1	2	3	4	5	6	7
2.	Cigarette smoking illness is harmful. *(Penyakit yang berkaitan dengan merokok merupakan ancaman yang berbahaya)* 吸菸病症是有害的。	1	2	3	4	5	6	7
3.	Cigarette smoking illness is a severe threat. *(Penyakit yang berkaitan dengan merokok merupakan ancaman yang teruk)* 吸菸引發的疾病是一種嚴厲的威脅。	1	2	3	4	5	6	7

PART 3D: PSc

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	I am at risk for cigarette smoking illnesses. *(Saya berisiko tinggi untuk menghadapi penyakit yang berkaitan dengan merokok.)* 我有吸菸引發疾病的風險。	1	2	3	4	5	6	7
2.	It is possible that I will experience cigarette-smoking illnesses. *(Saya berkemungkinan akan menghadapi penyakit yang berkaitan dengan merokok)* 我有吸菸引發疾病的可能性。	1	2	3	4	5	6	7
3.	I am susceptible to getting cigarette smoking illnesses. *(Saya mudah terdedah untuk menghadapi penyakit yang berkaitan dengan merokok)* 我很容易得到吸菸引發的疾病。	1	2	3	4	5	6	7

PART 3E: PBn

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	Quit cigarette smoking will help me to lower my chances of developing heart problems. *(Saya boleh mengurangkan risiko untuk menghadapi penyakit jantung apabila saya berhenti merokok)* 戒菸將會幫助我降低患上心臟相關疾病的機率。	1	2	3	4	5	6	7

2.	Quit cigarette smoking will help me to save money. *(Saya boleh menjimat duit apabila saya berhenti merokok)* 戒菸將會幫我省錢。	1	2	3	4	5	6	7
3.	Quit cigarette smoking will help me to gain respect of my friends. *(Saya akan dihormati oleh rakan-rakan saya apanila saya berhenti merokok)* 戒菸將幫助我贏得朋友們的尊敬。	1	2	3	4	5	6	7

PART 3F: PBr

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	I don't have accessible transportation to Quit Smoking Clinic. *(Saya tidak mempunyai pengakutan yang boleh diakses ke klinik berhenti merokok)* 我沒有便利的交通方式到達戒菸診所。	1	2	3	4	5	6	7
2.	I Have to take time off from my job or other commitments to attend quit smoking clinic. *(Saya dikehendaki mengambil cuti untuk menghadiri klinik berhenti merokok)* 我必須從我的工作或其他責任中抽出時間來參加戒菸診所療程。	1	2	3	4	5	6	7
3.	I will miss the taste of cigarettes. *(Saya akan rindui rasa rokok)* 我會懷念香菸的味道。	1	2	3	4	5	6	7
4.	The treatment is time-consuming. *(Rawatan akan mengambil masa yang lama)* 療程是非常耗時的。	1	2	3	4	5	6	7

PART 3G: SE

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	I am able to quit cigarette smoking. *(Saya mampu untuk berhenti merokok)* 我有能力放棄吸菸。	1	2	3	4	5	6	7
2.	It is easy for me to quit smoking *(Ianya mudah untuk berhenti merokok)* 停止抽菸對我來說是容易的。	1	2	3	4	5	6	7
3.	I am confident to attempt quit cigarette smoking. *(Saya yakin saya boleh berhenti merokok)* 我有信心嘗試戒菸。	1	2	3	4	5	6	7

PART 3H: BI

		Strongly Disagree *(Langsung Tidak bersetuju)* 非常不同意	Disagree *(Tidak Setuju)* 不同意	Somewhat Disagree *(Tidak Begitu Setuju)* 有點不同意	Neutral *(Neutral)* 無意見	Somewhat Agree *(Agak Bersetuju)* 有點同意	Agree *(Bersetuju)* 同意	Strongly Agree *(Sungguh Bersetuju)* 非常同意
1.	I intend to quit smoking during the next 3-4 months time. *(Saya berhasrat untuk berhenti merokok dalam masa 3-4 bulan)* 我打算在未來的 3-4 個月期間戒菸。	1	2	3	4	5	6	7
2.	I expect to quit smoking during the next 3-4 months time. *(Saya dijangka akan berhenti merokok dalam masa 3-4 bulan)* 我期望在未來的 3-4 個月時間期間戒菸。	1	2	3	4	5	6	7
3.	I will try to quit smoking during the next 3-4 months time. *(Saya akan cuba berhenti merokok dalam masa 3-4 bulan)* 在未來 3-4 個月的時間裡，我會嘗試戒菸。	1	2	3	4	5	6	7

-END- TAMAT -完