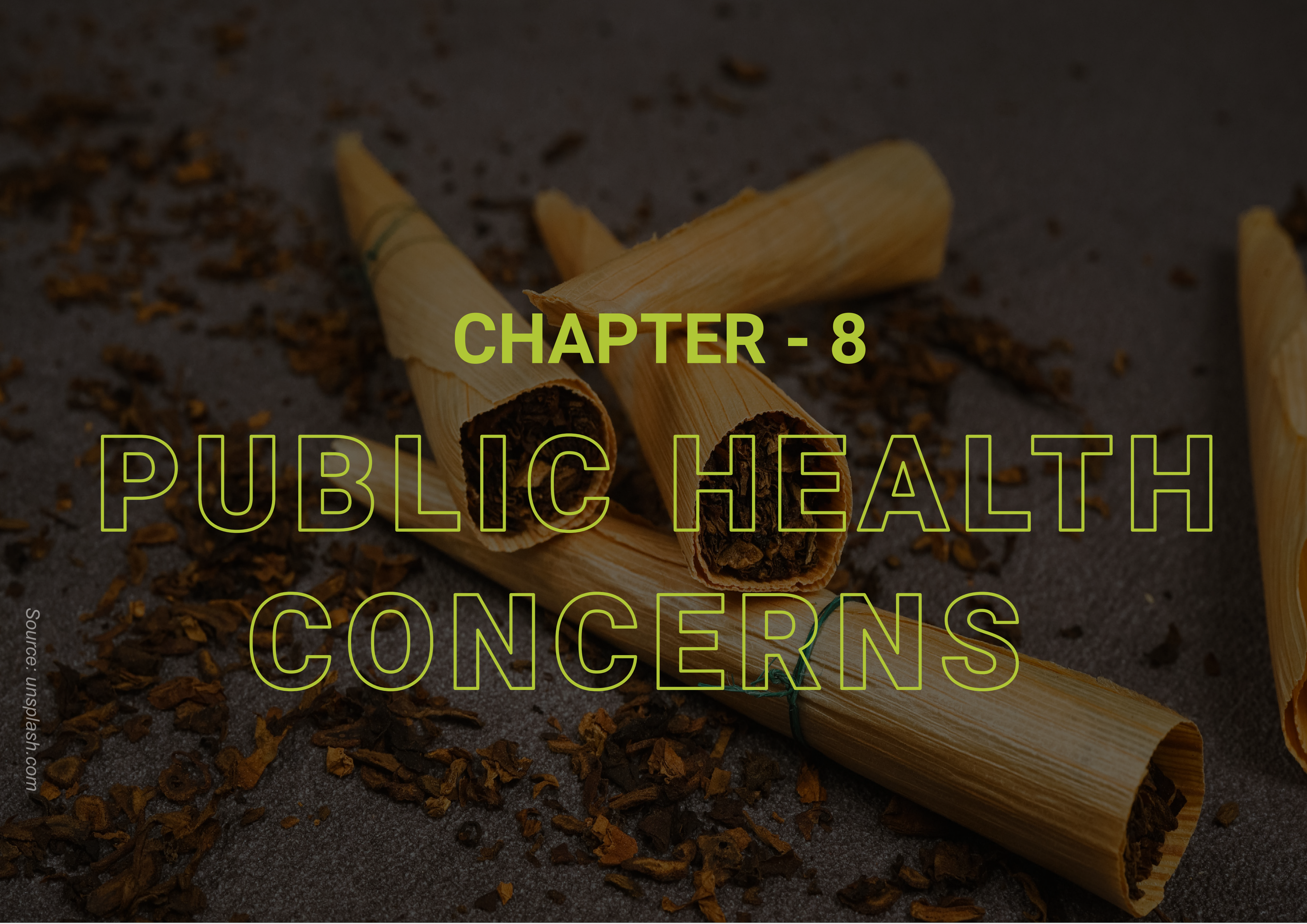

CHAPTER - 8

PUBLIC HEALTH CONCERNS

Source: unsplash.com

8.1. Literature Review

According to the National Centre for Biotechnology Information (NCBI), public health is concerned with disease prevention and control at the population level, through organised efforts and informed choices of society, organisations, public and private communities, and individuals (Lakshminarayanan, 2011)[98]. However, the role of the government is crucial in addressing these challenges and achieving health equity. These include alcohol and tobacco consumption, addiction and rehabilitation, HIV, TB, malaria, eating disorders and obesity, teenage pregnancies and unwanted abortions, air pollution, etc. While India has made a significant transition both in terms of its economy and healthcare in better life expectancy, and decreased infant and maternal mortality rates, it continues to suffer from the triple burden of diseases, including infectious/communicable diseases, non-communicable/lifestyle diseases, and the emergence of new microbes causing pandemics and epidemics (Narain, 2016)[99]. Tobacco consumption, for instance, is the most easily preventable risk factor for premature death in the world, and yet, in developing countries like India, the consumption of cigarettes continues to increase. Owing to its easy accessibility, availability and affordability, tobacco is one of the biggest public health threats both in India and globally. Thus, this chapter aims to cover misinformation around tobacco consumptions under public health concerns, given the extent of social, environmental, and economic costs.

Tobacco Consumption

Tobacco contains over 4,000 chemicals including carcinogenic compounds and 400 other toxins. India is the second largest consumer of tobacco in the world, after China, with 266.8 million adults consuming different tobacco products (Desk, n.d.)[100]. The prevalence of tobacco use among males is 42.4% and that among females is 14.2%, according to the Global Adults Tobacco Survey 2016-17 (WHO)[101]. The survey also presented that about 55% of the current smokers in India are planning to quit, while 48.8% of smokers have been medically advised to quit smoking. According to a report by the Ministry of Health and Family Welfare, the total economic costs attributable to tobacco usage-related diseases in India in 2011 for people aged 35-69 was Rs 1,04,500 crore (around USD 22.4 billion) (PHFI)[102]. India is home to roughly 11.2% of the smokers in the world and 1.35 million people in the country die every year due to tobacco-related illnesses, while 27% of the cancer cases in India are due to tobacco usage. In the context of the environment too, the millions of cigarette butts dumped in the world's beaches leach lots of toxic chemicals into the oceans. Therefore, given the intent and the necessity for tobacco cessation, tackling misinformation becomes quintessential in addressing this public health problem.

8.2. Common Myths and Misconceptions

MYTH: 01 **Nicotine is the only harmful substance in cigarettes.**

FACT: While nicotine is the addictive substance, cigarettes have thousands of chemicals including lead, arsenic, ammonia, radioactive elements, etc., and at least 70 of them are carcinogenic.

MYTH: 02 **Smoking relieves stress.**

FACT: While smokers justify the act of smoking as relieving stress, in reality, it increases tension and anxiety in the body, while nicotine creates a sense of relaxation and this perceived relaxation in turn creates a sense of craving.

MYTH: 03 **Rolling your own tobacco is more natural than factory-made.**

FACT: No matter how 'natural' the rolling is, tobacco is harmful in all forms and has thousands of chemicals and gases.

MYTH: 04 **Quitting after years of smoking is futile as the smoker's systems are permanently damaged.**

FACT: Multiple studies have shown the positive effects of quitting smoking including the repair of lungs, reduced levels of carbon monoxide, normalised blood pressure, and reduced risk of heart diseases and other tobacco-related diseases.

MYTH: 05 **E-cigarettes, hookah, and cigars are safer alternatives.**

FACT: It is a myth that there is no nicotine (a highly addictive substance) in hookah or e-cigarettes. These are equally harmful. In fact, the coal used in hookah releases a higher amount of carbon monoxide than traditional cigarettes.

MYTH: 06 | **A lot of smokers live into old age and so, smoking is perhaps not that harmful.**

FACT: Most people buying into this argument are not informed of the risks and probability of tobacco-related diseases and cancers. Only quitting smoking can improve life expectancy and quality of life.

MYTH: 07 | **Social smokers are not at the risk of addiction.**

FACT: Owing to the addictive nature of nicotine, according to American Cancer Society, anyone who starts smoking can become addicted to nicotine and have a tough time quitting it.

MYTH: 08 | **Chewing tobacco is safer than smoking tobacco since there is no inhalation of smoke.**

FACT: Chewing tobacco is as harmful as smoking given that chewing likely develops oral cancers on the tongue, cheek, lips and gums.

MYTH: 09 | **Cutting back on cigarettes is good enough, if not quitting.**

FACT: Often, it is not the number of cigarettes but taking more puffs or inhaling the tobacco more deeply and harder to over-compensate that is the issue. This also gives them a false sense of security and further delays cessation.

MYTH: 10 | **Medications do not aid in quitting smoking/one should wait for the 'right time' to quit.**

FACT: Several medications can lower nicotine withdrawal and thereby help overcome addiction. Medication paired with therapy and will power will aid the withdrawal process.

MYTH: 11 | **Menthol cigarettes are harmless.**

FACT: Menthol cigarettes have added flavours in addition to the same nicotine and the flavour can, in fact, make it more addictive than traditional cigarettes.

MYTH: 12 | **Non-smokers are safe from lung and other cancers**

FACT: From air pollution to second-hand smoking, non-smokers are also exposed to/at risk of lung cancer through inhaling carcinogens.

8.3. Case Study- Tradition vs Science among Hookah Users in Rajasthan

About the Cigarettes and Other Tobacco Products Act

The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA), 2003 is applicable to all products containing tobacco in any form, i.e., cigarettes, cigars, bidis, gutka, pan masala (containing tobacco), mavva, khaini, snuff, etc., across the country. The recent amendment to the Act in 2018 prohibits any person from 'owning or opening and running on behalf of someone else, a hookah parlour at any place in the state, including at eating houses'. The rationale behind the amendment was both safety concerns of hookah parlours and to discourage youngsters (minors and college students) from consuming hookah that contains tobacco.

A new University of California, Los Angeles study finally busted the myth that smoking hookah is safer than smoking a cigarette (Mary Rezk-Hanna, 2018)[103]. It finds that smoking hookah for 30 minutes has a similar probability of developing cardiovascular risk factors (stiffening of arteries) as smoking a cigarette and, therefore, concludes that hookah is hazardous. In fact, flavoured hookah does have tobacco as against the usual belief that is not a tobacco product. The coal that is used is also harmful to the user.

> *Traditionally, hookah consumption is a deep-rooted cultural norm and a social event in most of the rural areas, so much so that it is an everyday gathering after work in the fields (gram chaupals), weddings, and all social gatherings including funerals.* ***(Times Of India)***

However, the COTPA amendment is a challenge to the cultural norms followed in the villages of Rajasthan. Traditionally, hookah consumption is a deep-rooted cultural norm and a social event in most of the rural areas, so much so that it is an everyday gathering after work in the fields (gram chaupals), weddings, and all social gatherings including funerals. This has made it difficult for health authorities to implement the amended COTPA in the rural areas, where the elders especially refuse to comply with the ban. Unlike in the urban setting, hookah in these villages is not recreational but a part of social norms that binds people together. The villagers explain that unlike in the urban areas, they make their hookah with jaggery and tobacco and believe it to be safe, if not less harmful, than the chemical hookah and liquor. However, there is enough evidence that tobacco is harmful in any form and the goodness of jaggery does not overcompensate for the harmful chemicals in the tobacco. Health officials and activists continue to disseminate awareness both about the law and the harmful impact of tobacco that will disrupt their social fabric at the community and individual levels. Therefore, consumption of tobacco in any form including hookah in unhealthy and is a grave public health concern for which appropriate laws are in place.

8.4. Experts Speak

DR PREETI KUMAR

She is Vice President, Public Health System Support at the Public Health Foundation of India. She is an ophthalmologist and a public health specialist, working in the area of health systems, in the domain of infectious diseases She has over 25 years experience of working with the Government of Uttar Pradesh, Ministry of Health, Government of India, World Health Organization (WHO) and the Global Fund to fight AIDS, Tuberculosis and Malaria.

DR SONU GOEL

He is working as Professor in the Department of Community Medicine and School of Public Health, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh with over 18 years of experience in the field of public health. He has written over 140 papers, authored 35 chapters, produced 12 films on national health programmes, and edited many books on public health. He is also Vice-Chair of Tobacco Control section of International Union against TB and Lung Diseases.

01 What are some of the biggest challenges in public health concerns (HIV, TB, alcohol and tobacco consumption, addiction, eating disorders, etc.) and how should these challenges be dealt with?

Dr Kumar:

1. The lack of a universal healthcare approach results in siloed investments in planning, financing, and implementation of all disease prevention and control programmes.

2. The health system response is reactive rather than anticipatory or proactive: the priorities are still infectious diseases, while the Global Burden of Diseases study clearly demonstrates the higher impact of noncommunicable diseases on morbidity and mortality across the country.

3. Priorities and investments continue to be influenced by global agendas, where infectious diseases in LMIC (low- and middle-income countries) have a large potential impact globally rather than nationally. Similarly, the effect of global strategies on national strategies. An example of HIV: despite the prevention programme of HIV in India demonstrating great success, funding is increasingly diverted to testing and treatment, while time-tested strategies on prevention are not a priority.

4. Structural investments in the public health system strengthening continue to be limited, with the public and private sectors siloed: public systems continue to focus on emergency and priorities while the entire spectrum of healthcare provision lies in the private sector.

02 What are some of the biggest challenges in tobacco control? And how should we deal with these challenges?

Dr Goel:

Tobacco is one of the problems where we have excellent laws, not only globally, but also in our country, and most people are aware of these laws. However, the challenge arises in the proper implementation of these laws. Although we know that smoking in public is an offence, people continue to do so without any consequences like fines. Bystanders do not report these smokers either. Number two, the tobacco industry, which is the organisation, or the people who are involved in the tobacco trade, from production to consumption, usually try and find loopholes in the law, delay or dilute the implementation through lobbying. That is why the tobacco industry is the biggest challenge for tobacco control advocacy in the country. Although we must abide by the WHO's 5.3 framework convention on tobacco control, like every other country in the world, we still have several challenges. The third issue is the question of banning tobacco. The problem with this is that it is not just the decision of the Health Ministry; 13 ministries are involved in tobacco control, right from the agriculture ministry, to taxation, to customs, to education, to excise and taxation, finance ministry, and so on. Therefore, we must advocate and appeal to each of these ministries for tobacco control as the health ministry is just a minuscule stakeholder in tobacco control.

03 Behavioural change is one of the toughest things to achieve, especially with something like addiction. How do we address this public health concern?

Dr Goel: I think tobacco or smoking is a graver addiction than something like heroin. According to statistics, 5% of the people, say 5 in 100 people, quit smoking without any intervention; with counselling, about 15-20% people quit smoking. Further, using pharmacotherapy (medication) along with counselling, they don't go beyond 25-30%. Therefore, despite the best of the counselling, we may not be achieving the target of 100% people quitting smoking or tobacco use. So, that means that that stopping initiation is more important than cessation. And again, that means that we need to focus more on school children and the youth, so that they don't initiate smoking till they reach 25 years, after which there is very little chance of initiation. Second is to focus on sustainable cessation techniques, like the simple ABC technique which includes: A - ask about tobacco use whenever we see them in the clinics, whether it is cardiology, or neurology, or any other clinical discipline. We always ask the question whether s/he is/ was a tobacco user. Then B - brief advice: we give them brief, tailored advice based on their condition. This is followed by C - counselling to quit tobacco and suggest them psychiatric OPDs to ensure they get all the support they need.

Dr Kumar: Behavioural Change Communication (BCC) is a continuous, unceasing process. Unfortunately, BCC is largely programme-driven and one of the first to be axed in prioritisation of budget exercises. Therefore, advocacy for BCC budgets is essential. However, embedding communication in implementation science research is needed to build a case for its importance and potential for creating an impact. BCC strategies rarely undergo a scientific development process. There is a need to understand context, use mixed method approaches to broaden our understanding of population behaviour, and use the huge amounts of data generated for informing strategies and demonstrating impact.

04 Unlike liquor, tobacco products have easier and wider accessibility and availability in public spaces. Given the extensive sale of tobacco products, what kind of interventions must be adopted to educate people, especially the youth?

Dr Goel: There are a few things that are in the pipeline with the Government of India, for example, to increase the age limit for purchasing tobacco from the current 18 years. At present, any person who is 18 years and above can buy it from tobacco shops, but we are propagating that the age should be extended to 21 or 25 years (on lines with alcohol), preferably, which will thereby decrease accessibility. We are also propagating tobacco vendor licensing, another concept on the lines of alcohol license. We have exclusive alcohol shops, but we don't have specific tobacco shops. Instead, there are tobacco vendors in every nook and corner. Some states like West Bengal, Uttar Pradesh, Uttarakhand, Himachal Pradesh have introduced this tobacco vendor licensing and have allotted tenders only to a few shops. And for example, they have selected an area, like within 500 metres or one kilometre, there shall only be one shop, and that one shop should abide by all the guidelines. Besides propagating for a ban, we need to realise that spreading continuous awareness is the most sustainable and effective way to reduce tobacco use.

05

We have all seen advertisements in the theatres, such as the famous Mukesh ad, and the graphic illustrations on cigarette boxes with a disclaimer that smoking kills or causes cancer and yet, people don't take it seriously. Has the visual communication been effective? What other effective methods should be adopted to educate the public better?

Dr Goel: About the graphic images on the cigarette packs, I must compliment the Government of India, because initially, the graphic covered only 20% of the package and was not that strict. But now, 85% of both sides have the graphic material. So, that means whenever a person opens the pack, he repeatedly sees that body. And various technical literature has shown that it has caused a reduction in tobacco use when they repeatedly see the graphic body, and this is a kind of education for the smokers. Theatre advertisements have also proven to be effective. However, it is imperative to look for innovative techniques to especially appeal to the youth. As per the latest global adult tobacco survey, the mean age for smoking is 19 years as opposed to 18 years, five years ago. This is important because studies show that if the age limit is increased to at least 24 years, there is only 5-10% chance that the person will pick up smoking thereafter. We should use social media for innovative IEC (information, education, and communication) to reach out to the youth. While tobacco companies continue to promote catchy headlines on the safety of 'organic' cigarettes, thereby downplaying the harm on the public health, especially with addiction, efforts must be channelised to inform, engage with, and continuously spread the awareness on tobacco consumption in terms of cardio and neurological problems, and oral and lung cancers it causes.

06

What has been the impact of COVID-19 on public health in India?

Dr Kumar: COVID-19 has brought health emergencies to public attention. It has increased a political prioritisation of funding for strengthening extremely neglected public health areas, such as surveillance, outbreak response, and management. Within the health system, it has highlighted the need for strengthening primary healthcare and the lack of continuity between primary healthcare and hospital-based care. On the upside, COVID-19 has been a field laboratory for scale-up of technology/ICT in improving access to services through different models, for surveillance, testing, diagnosis, and care and treatment. It has also highlighted the need for strengthening community engagement. Last, it has shown the need for strengthening the public sector on healthcare delivery, to reduce the financial burden on households in pandemics.

8.5. Conclusion

Given the significant prevalence of misinformation on vaccines, public health is no exception in the percolation of misinformation. Under the spotlight of tobacco consumption, there is significant misinformation in terms of not providing warnings on mass media such as YouTube, Facebook, and Twitter on tobacco products. The other major stakeholder involved in misinformation is the tobacco industry that has, time and again, misled the public through explicit denial that there is no causal relationship between smoking and cancers or addiction. With catchy taglines and advertisements, the public has been led to believe that the 'organic/herbal' nature of some of the tobacco products and e-cigarettes is sustainable. Other misinformation includes non-filtered cigarettes being more harmful or e-cigarettes not having an impact on children; and hookah or menthol cigarettes being a 'healthier' option. Both misleading and non-factual claims made in the media by pro-tobacco stakeholders must be actively debunked given how incorrect beliefs continue to persist. Misinformation, especially in the context of addiction of tobacco products, can easily manipulate and mislead the public of all age groups into undermining the dangers of tobacco in the coming years. This, in turn, implies that misinformation is a major threat to public health, especially to the vulnerable who are in the grip of addiction. Such false/undermining messages on social media will only further the damage. Addiction is a grave public health concern that requires hours of therapy, will power, support (physical, mental and financial), rehab in some cases, and many other things. Although the first step is to retract and provide corrective statements, their recall value is limited in the minds of the public (Joseph N. Cappella, 2016)[104]. Also, misinformation and disinformation percolate faster than corrective statements do. Therefore, once the corrective statements are in place, it becomes imperative to address the root cause of the problem—fighting the addiction and helping the public to overcome the same. Both the state and national governments must work on anti-tobacco campaigns including providing necessary infrastructure in primary healthcare centres, IEC material propagated by healthcare workers and local stakeholders, and proper implementation of COTPA. Effective strategies must be in place to handle the burden of addiction by consulting the relevant stakeholders to address this grave public health concern.