Review Article

Strategic Initiatives to Improve Tobacco Cessation Delivery in India

Rakesh Gupta, Mira B. Aghi[1], Arpit Gupta[2], Garima Bhatt[3], Sonu Goel[4]

Department of Deaddiction, Santokba Durlabhji Memorial Hospital and President, Rajasthan Cancer Foundation, Jaipur, Rajasthan, [1]Behavioural Scientist and Communication Expert, Healis Sekhsaria Institute of Public Health, Navi Mumbai, Maharasthtra, [2]Oral Health Sciences Center, Postgraduate Institute of Medical Education and Research, Chandigarh, [3]Department of Community Medicine, School of Public Health, Postgraduate Institute of Medical Education and Research, Chandigarh, [4]Department of Community Medicine, and Director, Resource Center for Tobacco Control, School of Public Health, Postgraduate Institute of Medical Education and Research, Chandigarh, India

Abstract

Background: Globally, India is recognized for providing comprehensive coverage of tobacco cessation through the infrastructure and resources over the last two decades. Nevertheless, its current tobacco burden is worrying due to an increase in ~2 million initiators and 5.87% tobacco related deaths annually. **Objective:** It was to identify and describe challenges and barriers in tobacco cessation delivery that exist at various levels of health care as well as at the level of tobacco users, their care givers and communities in which they live. **Method:** Besides authors' first-hand collective experience in the tobacco control for over 80 years and ~35 years in tobacco cessation and reviewed references, the stakeholders communications during various events along with telephonic or in-person with some of them were assimilated to comprehend an overall understanding of the issue. **Results:** The challenges and barriers are primarily due to low priority assigned by the relevant functionaries, the inadequacy of resources, poor engagement of health-and insurance-sectors and healthcare workers, a low intent to quit by its users, suboptimal and discontinuous enforcement of the Cigarette and Other Tobacco Products Act of 2003 (COTPA), and indifference of the non-users. **Conclusion:** The countrywide strategic initiatives required "as a package" should include political and bureaucratic commitment, mass communication on benefits of quitting, licensed current users quitting through a timeline, use of systems approach in tobacco cessation delivery, implementation, and enforcement of vendor licensing and the proposed amendments in COTPA. Their perceived benefits will become a win-win situation for all stakeholders engaged in tobacco cessation delivery.

Keywords: Barriers, benefits, cessation, challenges, health, India, strategic initiatives, tobacco

Introduction

Thirty-one percent population of the world now has some form of coverage for the delivery of tobacco cessation.[1] Globally, the hope is that tobacco cessation through collective adoption on "O" (Offer to quit) of WHO MPOWER[2] and WHO FCTC Article 14[3,4] will duly assist in advancing tobacco control toward an Endgame for tobacco, preventing premature loss of lives and achieving development envisioned under sustainable development goals.[5] India, among 26 out of 195 countries,[4,5] launched its cessation efforts w.e.f. year 2001 through tobacco cessation clinics (TCCs) project by some apex tertiary care institutions of the country.[6] These have been extended since then to: (1) a network of over 500 TCCs under the National Tobacco Control Program (NTCP)[7]; (2) National Quitline[8] along with its 3 regional subsidiaries; (3) mCessation[9]—a mobile telephone message-driven program; (4) Deaddiction services under psychiatry departments/units of the government medical colleges; (5) TCCs run under Tobacco Intervention Initiative of the Indian Dental Association[10] and a few institutes of national eminence (NIMHANS, MAIDS, etc.), some private hospitals, and corporate health facilities. The National Oral Health Program envisions establishing TCCs in ~ 300 dental institutes.[11]

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Address for correspondence: Dr. Rakesh Gupta, B-113, 10 B Scheme, Gopalpura Bypass, Jaipur, Rajasthan - 302018, India.
E-mail: rakesh.gupta.acs@gmail.com

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Still, the burden of tobacco in India is ever increasing due to a dismally low and relatively stagnant rate of quitting[12] and an increase in its population by ~1% annually[13] and ~2 million children getting initiated into tobacco use every year[14] along with an average increase in tobacco-attributed deaths by 5.87%.[15,16] Thus, exploring existing challenges and barriers to the delivery of tobacco cessation and laying down strategies that will facilitate the desired change with a resultant increase in the quit rate emerged as the objective of this review.

The Challenges and Barriers

These are the following challenges at all levels of healthcare and among all its stakeholders:

At center

Besides an inability to prioritize tobacco cessation due to a perennial shortage of dedicated human resources, interruptions in fund allocation precipitate existing inadequacy further. Also, policies do not exist for compelling: (1) private health sector to deliver cessation services at all levels and (2) medical insurance agencies to reimburse the cost of tobacco dependence treatment.

In states

The tobacco cessation efforts diluted under NTCP have lost priority following its convergence with other national health programs under the National Health Mission such as National Program for Cardiovascular Diseases, Cancer and Stroke (NPCDCS), Revised National Tuberculosis Control Program (RNTCP), National Tuberculosis Eradication Program (NTEP), etc.[17,18] Also, multi-tasking officials of the State and Tobacco Control Cell (STCC) cannot invest their efforts optimally and as per the needs. By the time they get oriented to priorities in tobacco control to take initiatives, they are off to another department and post. Added to all this is that the State tobacco control cells are short-staffed and do not get sufficient funds and in time.

Both at center and in states

The most prominent challenge at the Center and the State levels is suboptimal participation of bureaucracy. Or else, mass communication campaigns to highlight the benefits of quitting could be there, so also the TCCs in every health facility, adequate resources for national and regional quitlines and/or mCessation, and the government health insurance schemes to motivate and reimburse quitting. The major barrier is the lack of political will. These also lack in the engagement of decision-making multi-sectoral stakeholders who delay or defer timely acceptance of experts' opinion. In addition, besides the inability of civil societies to access the information necessary to strengthen awareness and advocacy campaigns, there are gaps in the implementation of the policy and strategic initiatives at both levels. These have failed to establish a "Systems Approach"[19] in all their health facilities to "Screen, Treat and Follow-up" all tobacco using patients, set accountability of the non-participating healthcare workers to either treat or refer tobacco users for cessation, and to establish coding for tobacco-using patients as per International Classification of Diseases- 11 (ICD-11) norms.[20] The surveillance that could inform on actual quit rates both at the national and the state level is suboptimal as it depends primarily on the timely actions at lower levels. The support of the government to tobacco cultivation and export through Tobacco Board[21] and informal bidi- and smokeless tobacco- sectors are in direct conflict with the health of the people. These are the hurdles these governments have to earn revenue that is about 18% of the total spending and that too on a few select tobacco-related illnesses.[22]

At districts

As yet, there are no case studies to highlight best practices in tobacco cessation delivery at this level due to the following challenges: (1) ill-equipped TCC set-ups that lack visibility and easy access, (2) non-engagement of the healthcare workers, specifically the doctors[23] in their making referrals to the neighboring TCC,[7] national quitline[8] or mCessation,[9] (3) not following-up proactively those treated, (4) inadequate reporting on quit rates by some districts, and (5) inability to engage the earned media, local NGOs and the non-users or those not directly associated with tobacco cessation.

Users, caregivers, and communities

Tobacco users suffer a high addiction rate and have low intent to quit[12] due to a lack of promotion and motivation to quit, besides a carefree and indifferent attitude to a healthy life. There is a glaring knowledge gap in delivering information on the benefits of quitting in addition to easy access and affordability of a variety of tobacco products available everywhere. Exposure to the surrogate advertisement and non-users indifference and resultant lack of concern and non-participation worsens the situation.

Tobacco industry[24]

Although there is no direct evidence of tobacco industry interference about cessation, promoting the initiation of youth into tobacco use through surrogate advertisements and dubious marketing tactics certainly affects it indirectly. Some experts wonder why there is a delay in the Cigarette and Other Tobacco Products Act of 2003 (COTPA) amendments.[25] Tobacco industry lending help to establish health facilities sound odd, to say the least, if not simply preposterous.[26] That it thrives despite its products killing half its users legally, raises doubts of its political patronage and bureaucratic acceptance since the government which committed "not to be in the business" is investing heavily into companies that have shares in the tobacco industry.

The strategies

These are some strategies that may help improve the outcomes favorably:

1. Generate political and bureaucratic will for an outcome and quality-oriented tobacco cessation delivery to all tobacco users with ease of access and preferably at "no-cost." Engage everyone through a message, which

is "Tobacco use is A Disease and, thus, Every Tobacco User is A Patient."

2. Begin specific awareness drives on "Benefits of Quitting" through sustained funding for "Mass Communication" besides mandating the IEC sections in the Medical and Health Directorates of the States to develop effective strategies to outreach extensively and even to the remotest parts. Besides reaching out to all the doctors working in the medical, health, and wellness facilities, the States should also engage the nurses, counselors, social and ancillary medical workers, ASHAs, Anganwadi workers, and all media platforms including over-the-top platforms (the OTTs).
3. Motivation to quit tobacco to all current users through all means possible and within a timeline and supporting the successful quitters not to relapse should be undertaken countrywide and expeditiously. Those unable to quit in the given timeline should be explicitly supported through their families, educational institutions, and organizations to which they are affiliated. Their incentives (affiliations, regular raises in the salary and perks, etc.) may be held back until they quit successfully.
4. Mandatory licensing for tobacco users: Under this scheme, those seeking to purchase tobacco products shall be issued a "smart card" with a purchase limit that can be renewed annually. Financial incentives may be provided to those users who wish to discard the card permanently. The new tobacco users should be referred to the nearest TCC to provide knowledge and awareness regarding tobacco use and its implications on health and financial costs.[22]
5. Restrictions on tobacco sale: Vendor licensing should be made mandatory. In addition, the number, location, and working hours of tobacco retailers should be regulated. The cost of licenses should be high**,** along with an even higher cost of violating licensure provisions.
6. Introduce Systems Approach[17] in all medical and health facilities: Screen, Treat, and Follow-up plus (1) "high visibility" of the TCCs set up in the premises and the displays that inform the tobacco users optimally on the benefits of quitting and how to reach out to the TCC therein; and (2) introduce coding for tobacco use and nicotine addiction (ICD-11) in tobacco using patients seeking management for other ailments.[18] Capacity building of all doctors, nurses, and counselors should be targeted to cover and empower all along with the setting of their accountability for failing to deliver tobacco cessation or a documented referral to a cessation service as "not an option." Making health facility premises tobacco-free will enhance the motivation and commitment of the tobacco-using patients to quit successfully.
7. The amendments to COTPA[23] are a much-awaited step. Their approval of both houses of the parliament will not only improve enforcement and compliance but will also hopefully motivate a higher number of tobacco users to quit, as these will: (1) increase the age of minors from 18 years to 21 years, (2) increase the distance of tobacco vending retailers from 100 yards to 100 meters (3) eliminate the "designated smoking areas" and their unauthorized presence in the workplaces, (4) abolish surrogate advertisements, and (5) stop the sale of loose tobacco products that initiate smoking among the adolescents and youth.

The benefits

The implementation of the above strategies can result in a win-win situation for all stakeholders:

1. There will be lesser spending on the management of tobacco-related illnesses versus earning revenue by taxing tobacco products[20] and preventing loss of productivity on account of premature loss of lives of its citizens. The expected gains for the governments in the Center, States and the Union Territories appear huge in all this.
2. Engagement of the larger and "more preferred" private health sector in delivery of tobacco cessation service besides improving the quit rate, will help the country reduce the burden of tobacco-related illnesses and deaths significantly.[21] Given that many tobacco using patients attend every health facility in the country, the overall benefits including net profit to the private health management will also be substantial and mutual.
3. Empowerment of patients to eliminate a major risk factor,[27] especially those suffering from tobacco-related non-communicable diseases (NCDs) or tuberculosis. Not only this, but such a scenario will also assist healthcare workers in managing the illnesses better and with lesser complications and recurrence/relapse.
4. It will also result in benefits to the tobacco-using *patients and their families* on account of (a) minimizing the cost of treatment, (b) gaining what would otherwise be a premature loss of 6 to 10 years of life along with productivity[28] plus (c) eliminating daily spending on tobacco products.

Conclusion

Tobacco cessation delivery is a win-win business case if it eliminates existing challenges and barriers by the strategic initiatives "through a timeline" in the form of mass communication on benefits of quitting, proactive political and bureaucratic support, multi-sectoral engagement of all stakeholders, sustained adequacy of the necessary resources that strengthen existing cessation services, health workers engagement along with coding for tobacco use and nicotine addiction, engagement of communities and the private health and medical insurance sectors, and as "a package." Besides India, it can benefit other low- and middle-income countries to be tobacco-free by year 2030.

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Conflicts of interest

There are no conflicts of interest.

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