Prevention of Tobacco Use and the Mass Media

Dr. H. Elizabeth Department of Social Work
Mizoram University
Tanhril, Aizawl -796 004

Abstract:

Media has a great impact on human health behavior and played a key role in the historical trends in tobacco use. Worldwide, media are involved in subsequent efforts on health promotion including control of tobacco use and cessation. It is becoming among the most powerful socializing agents in shaping collective perceptions of "normative" and "normal," and of "cool" and "uncool," . So, the roles and functions of media have grown complex over time, reflecting the post-industrial world's growth and complexity as well as its paradoxes and contradictions.

Several research studies including the Surgeon General report (2004), report of the National Cancer Institute (NCI) and the systematic review of the literature on the impact of mass media campaigns, published (2012) had confirmed and emphasize the significance of psychological mechanisms to tobacco use promotion or tobacco control that depends on the theory of attitude and behavior. Therefore, it is significant to understanding the importance of media interventions in promoting cessation, motivation to quit or increasing the chance of success on any given attempt.

The Study was conducted in 2012 among 350 women tobacco users in Aizawl district, Mizora, India to examine the awareness level on the health consequences of tobacco use by using structured interview schedules. The study examines the pattern of tobacco use including the socializing agents on opinion-attitudes, beliefs, knowledge, and behavior which are operating at the individual level to larger society, awareness level on tobacco use. The major findings of the study reveal the connection of the above variables to mass media campaign and the relevance of tobacco control communication in the prevention of tobacco Use.

Key words: addiction, tobacco use, mass media, eHealth, tobacco control communication.

Introduction

The growth of mass media has been critical to the rapid expansion of tobacco use in the 20th century and subsequently smoking and the use of tobacco has paralleled the growth of tobacco control efforts. Several modern research frameworks advance the study of tobacco use and the media at individual, organizational, and societal levels, and the knowledge and evidence base in this area continues to expand. The relationship between media and tobacco use is explored as a multilevel issue, ranging from consumer-oriented advertising and promotion to stakeholder-level marketing aimed toward retailers and policymakers among others. Hence, media communications play a key role in shaping attitudes toward tobacco, and current evidence shows that tobacco-related media exposure affects both tobacco use and prevention [1].

The use of tobacco by the general public is almost pandemic. Globally, 4.9 million deaths a year are attributed to tobacco-related diseases (World Health Organization, 2005). If tobacco use continues unchecked, this rate is projected to rise to 10 million deaths annually by 2020. To help stem this alarming increase in tobacco-related mortality, governments should help reduce the number of young smokers because most smokers initiate tobacco use in their youth. One way to reduce the number of young smokers is to help youth make a commitment to not smoking [2]. The World Bank has reported that nearly 82,000-99,000 children and adolescents all over the world begin smoking every day [3]. The

Global Youth Tobacco Survey reports from 131 countries shows that 9% of 13- to 15-year-old students around the world currently smoke cigarettes (Warren et al., 2006).

Mass media provide effective tools for convincing youth not to smoke, because they can communicate prevention messages directly to young people and influence their knowledge, attitudes, and behaviors (Hopkins et al., 2001). By using mass media as part of a comprehensive tobacco control program, several countries have been successful in reaching and influencing youth with messages that encourage a commitment to not smoking. WHO reports note that mass media have played an important role in effective tobacco control programs when they were supported by other components of these programs, such as a mix of environmental and policy changes, educational programs, cessation treatment programs, and grassroots activism (U.S. Department of Health and Human Services, 2000; CDC, 1999; Hopkins et al., 2001; Institute of Medicine, 2000; WHO, 2001). These youth-targeted tobacco use prevention campaigns were able to influence youth, effectively reducing uptake through strong media campaigns supported by community- and school-based programs, youth access policy enforcement and, in some cases, smoking cessation promotion. The media campaigns built awareness and delivered the message that youth needed to seriously consider not smoking, while the other tobacco control program elements provided additional incentives not to smoke, such as excise taxes that increased the cost of smoking, clean indoor air policies in schools and restaurants, and regulations that prohibited the sale of tobacco products to youth.

One of the challenges in developing effective anti-tobacco messages is achieving awareness and behavior change in youth who are most susceptible to smoking initiation (based on the number of friends and family members who smoke and the youths' attitudes toward tobacco and tobacco companies), including older youth.

II. Approach of media on tobacco Use

The perspective to understanding of the role of mass communications in tobacco control requires a multilevel approach including the individual level, organizational level and societal level by and large. At the individual level, one must examine how individual-level factors such as knowledge, beliefs, and attitudes Influence and are influenced by tobacco related media messages and the channels in which the messages occur. At the organizational level, attention needs to be focused on the structure of mass media organizations and the practices of media practitioners lead to the production of media messages in the form of advertising, news, and entertainment; the attempts of tobacco industry and tobacco control to influence the news and entertainment media; and the role of regulation and public policy in influencing tobacco communications. Finally, at the population level, it is important to consider the larger cultural environment that is shaped by the interplay of the tobacco industry, mass media, tobacco control researchers, advocates, and policymakers.

Many of the social science research are assessing the causality in determining the relationship between mass communications and tobacco-related outcomes. Establishing causality is more challenging in the case of mass communications, the complex nature of communication effects, and the limitations of research designs [4].

The National Cancer Institute's Tobacco Control Monograph 19 is one of the most comprehensive distillations of the scientific literature on media communications in tobacco promotion and tobacco control. The work has explored the psychosocial dimensions on tobacco use and media among the youth and found that many of the tobacco advertisement target the psychological needs of adolescents, such as popularity, peer acceptance, and positive self-image [5]. Moreover, advertising creates the perception that smoking will satisfy these needs and adolescents who believe that smoking can satisfy

their psychological needs or whose desired image of themselves is similar to their image of smokers are more likely to smoke cigarettes. Majority of cross-sectional studies had found the highly association between exposure to cigarette advertising and adolescent smoking behavior. The total weight of evidence from multiple types of studies, conducted by investigators from different disciplines, using data from many countries, demonstrates a causal relationship between tobacco advertising and Promotion and increased tobacco use, as manifested by increased smoking initiation and increased per capita tobacco consumption in the population.

Tobacco Use & India

India is the second most populous country in the world. India is the third largest producer and consumer of tobacco in the world. The country has a long history of tobacco use. And the use of tobacco has unfortunately been well recognized among the adolescents. Tobacco addiction of a large number of adults has been initiated during the adolescence [6-7].Human beings have been using tobacco since 600 A.D. [8]. It was introduced in Europe by Columbus and was introduced in India by the Portuguese [9]. Earlier, tobacco was generally smoked using different types of pipes or as cigars or was consumed orally (smokeless tobacco).

In connection to the patterns of tobacco use, it is practice in various forms in smoke and smokeless form. Tobacco is smoked in the forms of beedis and cigarettes or by using devices like hooka, hookli, chhutta, dhumti, or chillum [10, 11]. Tobacco is used in a number of smokeless forms in India, which include betel quid chewing, mishri, khaini, gutka, snuff, and as an ingredient of pan masala [12, 13]. According to the most recent Government of India's National Sample Survey data, there are 184 million tobacco consumers in India. About 40% of them use smokeless tobacco, 20% consume cigarettes, and another 40% smoke *beedis.* Smokeless tobacco use includes *pan* masala and chewing of tobacco in different forms. Tobacco is also smoked using indigenous devices like *hooka, chhutta or dhumti* in different parts of the country [14].

The extent of tobacco use by the different population in India reveals that the adolescents typically become addicted to nicotine while still being teenagers. Usual interval between the first cigarette consumption and daily smoking is 1-2 year(s). More than half of the adolescent smokers try to quit smoking every year with fewer than 20% being able to quit for a month. The majority of adolescent smokers report withdrawal symptoms when they try to quit [15]. The prevalence of smoking has been found to vary from 6.9 to 22.5% among the male school and college students. Among the girls, the prevalence is considerably low varying from 0-2.3%. More than 40% of children had started the habit between 10-15 years of age [16, 17].

Hence, understanding of the underlying social determinants provides an insight on the significance of media intervention in the prevention of tobacco use. Several factors influence the use of tobacco by children and teenagers including the family background information on tobacco use by elders, peer influence, experimentation, easy access touch products, personality factors, underlying emotional and psychological problems, accompanied risk-taking behaviors, and most importantly, the aggressive marketing strategies of the tobacco industry. Tobacco use by parents or an elder sibling increases the likelihood that a child begins smoking [18, 19].

The adolescence has been characterized as a period in which youths begin to favor the norms of their peers over the norms of their parents, it is not surprising that we found peer norms be an important predictor of current use of smokeless tobacco. These unspoken norms may be conceptualized as one of the benefits or costs of using smokeless tobacco by the adolescent boy [20-22]. The anti-tobacco interventions of the Tobacco Control Program include school programmes and media campaigns aimed

at adolescents, in addition to other programmes involving local lead agencies, medical care programmes, and the competitive grants programme.

The primary prevention programmes should target elementary school age children before they develop a regular pattern of use. These prevention efforts should stress the negative effects associated with smokeless tobacco use and emphasize the maintenance of present health and physical competence [23]. Tobacco related prevention programmes geared towards adolescents should address these youth oriented advertisement themes to prevent adolescents from trying smokeless tobacco. Some messages about social approval of not smoking or disapproval of smoking, as well as refusal-skills messages, emphasize that instead of increasing the popularity of youth, smoking has just the opposite effect. Other ads address ways to respond to peer pressure to smoke [24]. Interventions for older children might best be implemented with peers in school, and with athletic and youth groups. Advertising and promotion of smokeless tobacco products must be considered in any prevention programme, because the tobacco industry attributes much of the increase in smokeless tobacco consumption to marketing and advertising strategies [25].

The Study

A study was conducted in 2012-2013 among 350 women tobacco users in Aizawl District, Mizoram. Quantitative data was gathered through structured interview schedule. The study examines the level of awareness of the respondents on tobacco use and assessed the psychosocial factors that determined to initiation of tobacco use and smoking. These determinants are important to consider by providing an insight on the relevance of media interventions in the prevention of tobacco use in Mizoram.

Tobacco Use Practices: Tobacco use is prevalent all over the world and becoming one of the preventable causes of death. Several literature and studies have shown the change in the trend of tobacco use by women from *smoke forms* to *smokeless forms*. While, smoke form of tobacco use is still higher in developed countries it is declining in the less economically developed countries. However, the use of smokeless forms of tobacco is drastically increased among women from the less developed countries.

The data on the pattern of tobacco use by women shows the presence of geographical variation (rural-urban) on forms of tobacco use by women. It is noticed that the use of smoke forms of tobacco by women is much higher in the rural areas is 16.2% as compared to 8.9% in the urban communities. The types of smoke forms of tobacco used by the respondents include *cigarrete*, *zozial*, Bidi and pipe tobacco. While, the other smoke forms of tobacco are not in practice by the respondents of the study.

Table 1: Tobacco Use Practices

Sl.no	Form of Tobacco	Locality				Total	
		Rural		Urban			
		Mean	S.D	Mean	S.D	Mean	S.D
1	Smoke Form	1.5 (16.2)	4.0	1.4 (8.9)	5.4	1.4 (10.4)	5.0
2	Smokeless Form	7.8 (83.8)	8.8	14.2 (91.1)	12.2	12.3 (89.6)	

Source: Computed ***Figures in parentheses are percentages***

Hence, the mean value for using smoke forms of tobacco is 10.4. While, the use of smokeless tobacco is largely prevalent in both rural and urban communities and the practice is observed to be more among urban respondents as compared to rural respondents. Majority (89.6%) of the respondents are using smokeless tobacco like paan (betel quit with tobacco), paan with zarda, *sahdah*, khaini, *tuibur* and other gutkha products. However, the other smokeless forms of tobacco like *mishri, snus*, Manipuri tobacco, *Mawa, gul, bajjar, gudhaku* are contemporary in other parts but not practiced in the study area.

Determinants of Tobacco Use: Use of tobacco, alcohol, and illicit drug are a public behavioural as well as health problem and it is observed that in some populations' tobacco and alcohol remain commonly usage and illicit drug consumption that is still frequent in adolescent. The associations of family environment and individual factors with tobacco use, alcohol and illicit drug use in adolescents was studied by Bruno Challier, Nearkasen Chau, Rosemay Prdine, Marie Choquet and Bernard Legras in 1999.

Social Factors: The determining social factors on tobacco use by the respondents is assessed by using 14 items such as the social environment like the peer group taking tobacco, experimentation, easy availability of tobacco in the environment, enhancement of social interaction and social network. It enquires about tobacco use within the house like use of tobacco by siblings, use of tobacco by parents, lack of parent-child communication on tobacco and absence of awareness on harmful consequences of tobacco.

The social determinants to tobacco use are shown in table 2 and are responsible for respondents taking tobacco. The social factors are assessed through 14 items and the mean for those reasons ranges from a maximum of 3.1 to a minimum of 2.2 as shown in the table, these reasons are more or less similar for both rural and urban respondents were not much difference is found. Among the reasons given by the respondents, *peer taking tobacco* is the greatest temptation to use tobacco both by the respondents belonging to the urban and rural communities. This is followed by the *easy accessibility of tobacco* in the surrounding environment. This reflects that the mechanism of prohibition of selling of tobacco to minors needs much more attention.

Table 2: Social Determinants

Sl.no	Factor	Locality				Total	
		Rural		Urban			
		n = 105		n = 245		N =350	
		Mean	S.D	Mean	S.D	Mean	S.D
1	Peers taking tobacco	3.0	0.6	3	0.7	3	0.7
2	Easy availability of tobacco in the environments	2.8	0.5	3	0.7	3	0.7
3	Experimentation	2.9	0.5	3	0.6	3	0.6
4	Enhancing social interaction	2.8	0.5	3	0.8	3	0.7
5	Due to siblings using tobacco at home	2.7	0.5	3	0.6	3	0.6
6	Due to parents using tobacco at home	2.8	0.6	3	0.7	3	0.7

7	**Lack of parental communication and control**	**2.8**	**0.6**	**2**	**0.6**	**3**	**0.6**
8	**Absence of awareness on harmful consequences of tobacco**	**2.9**	**0.6**	**2**	**0.6**	**3**	**0.6**
9	**Personal involvement in preparation of *tuibur***	**2.8**	**0.6**	**2**	**0.7**	**3**	**0.7**
10	**Personal involvement in preparation of pipe tobacco**	**2.8**	**0.6**	**2**	**0.7**	**2**	**0.7**
11	**Personal involvement in preparation of *zozial***	**2.8**	**0.6**	**2**	**0.7**	**2**	**0.7**
12	**Personal involvement in selling *of zozial* and cigarettes**	**2.8**	**0.6**	**2**	**0.6**	**2**	**0.6**
13	**Receiving compliments from shopkeepers**	**2.3**	**0.5**	**2**	**0.6**	**2**	**0.6**
14	**Media and advertisement**	**2.3**	**0.5**	**2**	**0.6**	**2**	**0.6**

Source: Computed

The other factors includes experimentation of tobacco use where the respondent's had develop curiosity to experience on how an individual will physically and psychologically act while using tobacco, the respondents started using it as the group members are using and offered to them. Initially, it is used to enhance social interaction. The study has also found that *the use of tobacco by both the parent, either of the parents and siblings at home is also responsible for the respondent's continuation of tobacco use.* In this case, the availability of tobacco products within the house, *limited exercise of control and lack of rigid disapproval of tobacco use by parents are the responsible factors*. While, on the other hand, the respondents are from different economic backgrounds pursuing different nature of work. This includes the personal involvement in the preparation and selling of tobacco products and is a valid determining factor for the respondents tobacco use. In addition to this, another common reason for using tobacco, especially by the minors and youngsters, is that receiving compliments from the shop keepers such as giving of *pan-masala or tiranga* instead of Re 1 or Rs 2 as change. These newly introduced sachet of tobacco products are commercially meant to attract the minor and is less expensive which is affordable by them with their pocket money. The other relevant issue of tobacco products gaining popularity is the media and advertisement. Further, advertisements of the new tobacco products targeted the minor and the youngster especially and influenced them strongly and reveal the weaknesses of the value system. It is partly important to notice that there is *only little parent–child communication* on inculcation of anti-tobacco attitudes and lack of orientation on the harmful health consequences of tobacco use. Many of the respondents has justify that *they did not receive communication or teaching from their parents not to indulge in tobacco.*

Awareness Level: The Government of India has made a mandatory intervention to control and minimize the use of tobacco and regulates tobacco products at an optimum level in India. The COTPA 2003 focuses on ensuring public health including the backward population. A study on the awareness level of the respondents on the availability of tobacco cessation clinics (TCC) in the area is conducted among the women of Mizoram state where the rate of consumption of smokeless tobacco by women is highest all over the countries. And it crosses beyond the national average reflected in the National Family Health Survey -III.

a) Tobacco Cessation Clinic (TCC) - Tobacco cessation services address the needs of tobacco users to give-up the tobacco using habit. It aims to reduce the rate of tobacco consumption in the country through behavioural change intervention. It is established in par with the FCTC and with the initiatives of the National Tobacco Control Cells, GoI and the WHO as part of tobacco control in India. At the initial stage in 2002, the WHO has supported the setting up of 12 TCCs in different settings like in cancer treatment centres, psychiatric centres, and medical colleges and also in the reputed non-governmental organizations. The trained personnel included the clinical psychologists and medical social workers, who developed a manual on TCC and concentrated mainly on *behavioural change counselling (BCC).*The initial goal of psychosocial intervention is to increase motivation to initiate a quit attempt and help the patient quit for a short period. However, the main goal of tobacco cessation is sustained abstinence, change of life style and improves the quality of life (Callum C., 1998).

Table 3: Tobacco Cessation Clinic (TCC)

Sl.No	Aware of TCC	Locality		Total
		Rural	Urban	
		n = 105	n = 245	N =350
1	No	102 (97.1)	223 (91.0)	325 (92.9)
2	Yes	3 (2.9)	22 (9.0)	25 (7.1)

Source: Computed ***Figures in parentheses are percentages***

Table 3 shows the awareness on the existence of tobacco cessation clinic (TCC) in civil hospital, Aizawl. Contrary to the extensiveness of the intervention that has taken place by the TCC, 92.9 % of the respondents had never heard the presence of TCC in Aizawl civil hospital. Among them, 97% of the respondents are from rural areas and another 91% respondents from the urban communities. The respondents did not have knowledge of the free services provided by the central government that is designed to curb their tobacco using habits and to protect them from further ill -health due to tobacco use. The data has shown that 9% of urban respondents and 2.9 % of rural respondents alone have known of the existence of tobacco cessation clinic at Aizawl hospital through their friends and mainly from schools. The above data highlighted the importance of creating more awareness on the existence of TCC at Aizawl hospital and to have greater implications, the public should also be aware of TCC programmes and services.

b) Attempt to Quit- The public health concern of tobacco use by women is to ensure their health rights and promote the general well-being of the population and in particular the women's reproductive health by mobilizing the users to attempt to quit tobacco use. Therefore, all the tobacco users are the target of the TCC. The trained personnel of TCC have provided behavioural counselling and administer pharmacotherapy with bupropion. Contrary to the core aim of TCC, 66.9% of the respondents did not ever attempt to quit tobacco use and the remaining 31.1% of the respondents aim to change their behaviour of using tobacco for various reasons including physical health concern, found to be expensive-spending amount regularly, unhygienic, feel bored of continuing using tobacco, spirituality and also due to family request.

Table 4: Reasons Attribute to Quit Tobacco Use

Sl.no	Reasons for attempt	Locality		Total
		Rural	Urban	
		n = 105	n = 245	N =350
1.	Not Attempted	56 (53.3)	178 (72.7)	234 (66.9)
2.	Physical Health Concerns	36 (34.3)	49 (20.0)	85 (24.3)
3.	Costly	6 (5.7)	7 (2.9)	13 (3.7)
4.	Unhygienic	1 (1.0)	8 (3.3)	9 (2.6)
5.	Bored	3 (2.9)	3 (1.2)	6 (1.7)
6.	Spiritual	1 (1.0)	0 (0.0)	1 (0.3)
7.	Family's Request	2 (1.9)	0 (0.0)	2 (0.6)

Source: Computed ***Figures in parentheses are percentages***

The above Table 4 on the assessment of reasons for attempting to quit using tobacco has shown that two-thirds of the total respondents including the rural and urban respondents have not made an attempt to quit. So far, those respondents had not yet recognized that they had experienced major health problems and complaints due to using of tobacco. The remaining 30 % of the total respondents have attempted to quit using tobacco for various reasons and less than a quarter (24 %) of the respondents *interested to stop further use* after knowing the health consequences that can happen due to tobacco use. The other 3.7% of the respondents has attempted to quit tobacco due *to it being expensive*. While, 2.6 % of the respondents, mainly the minors, had found that using tobacco is *orally unhygienic, disrupts whitening of teeth, and causes unpolished teeth*. Regular using of tobacco after developing dependency is also sometimes *found boring and irritating* by the users. Like many other parts of the country, only a few respondents (2%) attempted to quit tobacco due to a family request, health sake and also due to *spiritual commitment*, thinking that involvement and active participation in the church no longer suited consumption of tobacco.

Further, it is observed that there are some respondents who would like to quit tobacco use but due to lack of knowledge, many of the respondents are less motivated to do so and they did not seek any professional help. It is also known that the respondents believed that coming out of addiction is possible only through spiritual support.

c) Seek Help for Tobacco Cessation- The agency where the respondents sought help to quit tobacco is also important because once the physical or psychological or both dependencies have developed it is not easy achieve abstinence by self-initiation. In fact, the FCTC -WHO knew the situation better and therefore establish TCC with a set of professionals and other requirements.

Table 5: Agency

Sl.no	Agency	Locality		Total
		Rural	Urban	
		n = 105	n = 245	N =350
1	No response	87 (82.9)	179 (73.1)	266 (76.0)
2	Self	18 (17.1)	65 (26.5)	83 (23.7)
3	Primary Health Centre (PHC)	0 (0.0)	1 (0.4)	1 (0.3)

Source: Computed Figures in parentheses are percentages

Out of the entire respondents only 31.1% of the respondents had attempted to quit using tobacco and among them 7.1 % of the respondents did not mention the place where they have sought help for quitting tobacco. So, the Table 29 shows the place where the respondents seek help to enable them to quit tobacco and that two-thirds of the respondents did *not ever attempt to quit* tobacco use and therefore they did not seek any professional assistance. However, less than a quarter (23.7%) had attempted to *quit it by themselves* in their own way such as keeping themselves away from tobacco products, not receiving tobacco offered to them and also through spiritual campaign for quitting tobacco products. Only 1 % of the respondents visited primary health centres in seeking help to stop using tobacco.

d) Prohibition of Smoking in Public Place - The health consequences of exposure to smoking is entirely preventable tobacco related mortality. The smoking bans and restrictions are policies and regulations that ban the consumption of tobacco product, smoking in public places, where the general public has access like public transports, shopping malls, hospitals, restaurants, hotels, educational institutions, government offices, waiting lounges and others. The illegal smoking at the stipulated restricted area is punishable and is under the purview of legislation. This aspect tries to protect and to promote the public health by preventing exposure to second hand smoke. Table 6 on prohibition of smoking in public places explores the legal awareness level of the respondents. It shows that majority of the respondents (82.9%) knew that smoking in public places is prohibited against 17.1% who do not have such awareness. The contradictory statement is that the respondents have high level of awareness on prohibition of smoking at public places but the incidences of second hand smoke (SHS) is much higher in the state of Mizoram as compared to other states of India.

Table 6: Prohibition of Smoking in Public Places

Sl.No	Aware of the prohibition	Locality		Total
		Rural	Urban	
		n = 105	n = 245	N =350
1	No	11 (10.5)	49 (20.0)	60 (17.1)
2	Yes	94 (89.5)	196 (80.0)	290 (82.9)

Source: Computed ***Figures in parentheses are percentages***

Therefore, it may be assumed that due to the lower access of places for smoking, many of the smokers smoke inside the house. Despite the fact, smoking in public place is prevalent in Mizoram.

I. Relevance of Public Education Campaigns

The evidence that public education campaigns are effective at reducing tobacco use is solid and extensive. The relevance of media interventions has outline in 'The Role of the Media in Promoting and Reducing Tobacco Use' [26] as follows:-

a) The Surgeon General's report on Preventing Tobacco Use Among Youth and Young Adults, concluded that adequately funded anti-tobacco media campaigns reduce tobacco use among youth, and that there is a dose-response relationship between exposure to antismoking media messages and reduced youth smoking, i.e., the greater the exposure the less likely youth are to smoke (HHS, Preventing Tobacco Use among Youth and Young Adults, A Report of the Surgeon General, 2012http://www.cdc.gov/Features/YouthTobaccoUse/).

b) A comprehensive report released by the National Cancer Institute (NCI) 2008, on The Role of the Media in Promoting and Reducing Tobacco Use, concluded that anti-tobacco media campaigns are effective in reducing smoking among youth and adults. Particularly, advertisements that evoke strong emotions have the most impact on viewers, and youth also react positively to anti-tobacco advertisements aimed at adults. (National Cancer Institute, The Role of the Media in Promoting and Reducing Tobacco Use, Smoking and Tobacco Control Monograph No. 19, NIH Pub. No. 07-6242, June 2008).

c) A systematic review of the literature on the impact of mass media campaigns, published in 2012, concluded that these campaigns can promote quitting among adults and reduces adult smoking rates. Messages to portray the negative health consequences of smoking were found to be most effective at generating increased knowledge, positive beliefs, and quitting behaviour. Television was found to be the most effective communication channel in which to reach and influence adult smokers (Durkin, S., et. al., "Mass media campaigns to promote smoking cessation among adults: an integrative review," Tobacco Control 21, 127-138, 2012)

d) The CDC's Best Practices for Comprehensive Tobacco Control Programs concluded that public education (counter-marketing) campaigns are an integral part of efforts to both prevent initiation of

tobacco use and to encourage tobacco cessation.(Centres for Disease Control and Prevention (CDC), Best Practices for Comprehensive Tobacco Control Programs– 2007. Atlanta, GA: U.S. Department of Health and Human Services, October 2007,)

e) The American Journal of Public Health, 2012 found that greater exposure to state sponsored anti-tobacco advertisements was associated with less smoking and with current smokers' intention to quit, even when controlling for potential confounding state tobacco control policies (Emery, S, et. al., "The Effects of Smoking-Related Television Advertising on Smoking and Intentions to Quit Among Adults in the United States: 1999-2007," American Journal of Public Health Vol. 102, No. 4,April 2012.).

f) The Health Education Research, 2006 found that increased exposure to state sponsored anti-tobacco media campaigns increases smoking cessation rates, even after controlling for other factors that may affect smoking cessation (Hyland, A, et al., "Anti-tobacco Television Advertising and Indicators of Smoking Cessation in Adults: A Cohort Study," Health Education Research 21(3):348-54, June 1, 2006.

Conclusion and suggestion

The effects of media are complex and multidimensional. At a micro level, media influence may be such as on individual cognitions, affect, and behavior, or influencing social policies, social movements, and social factors. Unlike the epidemiological studies in many other fields of research it is not always easy to establish a direct causal link between media messages and behavior. It could have short-term effects such as the impact of a short burst of advertising on consumer attitudes and behaviors and long-term effects that are stable and sustained, such as on social norms and values; Moreover, the effects may alter norms or opinions, such as changing norms regarding tobacco use, while others may stabilize and reinforce existing norms on smoking. So, it is clear that media influence may range from effects on individual cognitions or attitudes to direct behaviour. Further, it is significant to understand the integration effort as the effects of media as on antecedents to behavior such as beliefs, norms, and intentions.

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