

Concurrent Sessions 1  
The 1<sup>st</sup> Asian American Health Conference  
University of Medicine and Dentistry at New Jersey

**Oral Health**

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Introductory Statements

- I'm neither a dentist nor an oncologist; I am a public health professional.
- I believe in the prevention model, patient and community empowerment, and cultural sensitivity.
- The cultural influences on South Asian oral health disparities is a model example that encompasses these principles.
- I want to begin with the caveat that this is not a SAPHA sponsored presentation; it is based on a literature review and analysis of a study conducted by the School of Public Health at UC Berkeley.

Oral Health

- The purpose of this presentation is not to detail the biomedical or clinical etiology (progressive stages) of oral diseases is not as important to me as preventing them in the first place.
- Why is this important? Oral cancer accounts for 30% of all South Asian cancers; there are 80,000 new cases of oral cancer every year.
- Notably missing are studies of South Asian cancer prevalence in the United States; only rates found were in California.
- However, studies in England find South Asian men have an 1.44 Incidence Rate Ratio of oral cancer, 1.95 for South Asian women.
- When there was a press release about a potential oral cancer epidemic in Queens County (New York), it seemed obvious why it was happening.
- However, if you're not of South Asian descent, this understanding may not be so readily apparent.
- This is where the role of the model minority myth (ascribed to South Asians and other Asian subgroups), cultural translation, and sensitivity come into play.

Common behavioral characteristics

- There are common tobacco-related products used by South Asians.
- Some oral health related statistics: 98% of Indians with oral cancer (in India) smoke bidis; the odds of developing oral squamous carcinoma (potentially lethal form of oral cancer) are 17 times higher in Pakistanis who used *paan masala*;

another study found Pakistanis who used *paan masala* with *zarda* were 8.4 times more likely to develop oral cancer.

- What are these weird terms? I'll tell you in a bit.
- A study conducted by my mentor, Dr. Susan Ivey, who does research in cardiovascular health of immigrant populations, was called Cardiovascular Health of Asian Indians (CHAI)-- yes, one of the 19 different studies or programs with the "CHAI" acronym found nationally and globally.
- The CHAI study focused on the Sikh population in Yuba City, CA; this community of one of the oldest South Asian ones in the country.
- The study asked about a whole scope of cardiovascular risks and found a variety of answers.
- For females, 0% reported tobacco use (cigarettes or chewed tobacco), 10% were using *paan* and 30% were using *supari*. The terms I'll return to in a bit.
- The important point to grasp is that *paan* products are a form of chewed tobacco and when surveillance and intervention research is conducted, it is very important to be cognizant of the cultural meaning of the terms used. Chewing tobacco and *paan*, although very similar in product type, may result in drastically different statistical responses.
- The results of using "Western" survey prompts, for instance, could incorrectly lead people to conclude that tobacco products are not a contributing factor for not only oral diseases, but other pronounced health disparities, such as cardiovascular disease.

### Subgroup Differences

- In India, the tobacco problem is a big deal: 675 billion *bidis* are consumed annually there.
- 20% of Indians aged 13-15 (in India) were using 5 packets of *guthka* daily.
- More than half of Bangladeshi women (in England) were chewing *paan* with *zarda*.
- A study in Leicester (graph in powerpoint) found a variety of substance use patterns by generational status, religion, and gender.
- It's not just an overall South Asian problem; there are unequal patterns of use by region of origin, gender, religion, and age/generational status.

### What's being done about this?

- In California (which has a huge density of South Asians), they are beginning to look at these things.
- A needs assessment survey conducted in Southern California found that a quarter of South Asians were using a variety of these items.
- The California Asian Indian Tobacco Survey (CAITS) found that acculturation was a predictive factor in tobacco use in this population.

- This sheds light on the importance of culturally-appropriate surveying and designing targeted intervention strategies focusing on the most at-risk South Asian subgroups.

### South Asian Tobacco Products

- A preliminary list is provided in the powerpoint-- this list is not exhaustive by any means.
- Many of these items are not included on “validated” tobacco surveys.
- South Asian culture is very marketable: Oil of Olay has an Ohm lotion available.
- Similarly, *bidis*— Indian cigarettes smoked by the poor which has up to five times the nicotine that in a Western cigarette—were very popular among youth about five to ten years ago as an “exotic” product.
- Looking at how other South Asian tobacco products are marketed, it is easy to see why there are certain subgroups that are more at risk.
- Who do you attract when you package *bidis* in strawberry and chocolate flavors and make them cheap? How about when you claim they are “safe and natural”? (Youth)
- This is how *bidis* are packaged; they look exactly like a packet that candy would come in.
- Cultural sensitivity is also very integral in understanding these patterns.
- *Paan* and/or *paan masala* are culturally valued products: they are distributed at cultural events of importance, such as weddings and religious activities.
- The constituent ingredients of these products—betel nut and tobacco—are heavily carcinogenic; putting them together makes them really bad.
- There are also many other ingredients in these products, such as *chunna* or *chunnum* (lime paste or calcium hydroxide), which are also heavily cancer causing.
- Basically, by chewing a *paan*, you are putting a whole wad of cancer in your mouth.
- As Dr. Barnett indicated in the previous presentation, the length of time that these ingredients sit next to vulnerable tissues contributes greatly to the likelihood of causing cancer.
- When you buy these homemade produced things from *paan-wallahs* (vendors), there is no standardization of what and how much of any ingredients are put in there; the vendor is not going to say, “Oh, I put my standard two pinches of tobacco in there.”
- The symbol of the blue bottle (Pan Parag) is the manufactured version of homemade *paan*.
- There are a lot of different kinds of these manufactured products.
- Look how “nicely” they are labeled (powerpoint reference): Aren’t they colorful? (sarcastic)
- These class of chewed products avoid the stigma and visibility of using smoked products.

- You can pretty much use them anywhere, except for the whole spitting (expulsion of consumed product) part.
- Someone once told me that if you really want to do a behavioral needs assessment of South Asian tobacco use, just go look at any sidewalk in a South Asian community to see how red it is (spittle from *paan* and *guthka* use).
- I'm not sure if this is true in Edison, NJ, but in Cerritos and Sunnyvale, CA (densely-populated South Asian communities), these red sidewalks are obviously visibly apparent.
- I don't care what any survey says, if you look at any sidewalk in a South Asian community and it's red, there's a tobacco product use problem there.
- You fill a betel leaf with a whole bunch of crap and chew it; people chew these things 10, 15, 20 times a day.
- The marketing strategy of the tobacco industry plays on the fact that these things look benign and are very tasty.
- My other comment is that flavor contributes a lot to the use of these products.
- Betel-nut is already sweet and they add a multitude of other sweeteners to make them attractive for use: the manufacturers want you to get hooked on them.
- *Zarda*—tobacco mainly used by South Asian Muslims (Pakistanis and Bangladeshis)—is packaged basically as candy imitating tobacco (with a whole gamut of sweeteners in them).
- These are some of the most popular products used by South Asian natives and community members in Britain, although there are no studies to date comprehensively looking at this in South Asian Americans.
- *Supari* is actually betel-nut, which is not tobacco in and of itself, though it is often combined with tobacco for its stimulatory and laxative effects.
- It is not only carcinogenic, but also has many cardiovascular risks.
- It plays a similar role as nicotine in these products for its addictive properties.
- However, it has tremendous cultural value, like many of these products.
- The cultural importance and value ascribed to these products should not be marginalized. To simply go into a cultural community and say stop using your cultural valued products and cease your culturally valued behaviors is not only disrespectful from an ethnic and cultural vantage point, it is very ignorant in thinking such a recommendation would be effective.
- To recap: 3-5 more times more nicotine; unfiltered; wherever the smoke goes, you're exposing vulnerable tissues to carcinogens. Chewed products are also incredibly carcinogenic with betel-nut, tobacco, and all the other added ingredients. People also add heavy metals to these products, such as gold and silver flakes (also found on many South Asian sweets). They are also portable and you can consume a large quantity of it without people noticing; again, I don't know where the spit goes.

### Marketing and Ascribed Cultural Value

- Manufacturers claim that these products are actually beneficial.
- *Paan* is a digestive aid (so are cigarettes; doesn't make it good for you)

- *Supari* improves memory
- *Guthka* allows you to perform superhuman feats (as marketed by Manikchand—the *paan/guthka* equivalent of Camel—)
- The marketing of these products allows for community internalizations of these health benefit myths.

### What do we do now?

- We need to better understand South Asian subgroup differences by disaggregating data and being cognizant of the diversity of the South Asian population, as is true for the Asian/Pacific Islander community.
- We need to understand how these products are getting here and through what mechanisms they are being disseminated in the public: I went to my local Indian grocery store in Sunnyvale, CA and bought *guthka* that didn't have the warning label mandated by FDA, meaning that they were brought directly from India and being sold without going through export and health regulations.
- Harm reduction model: do we want people to chew *paan* without tobacco? Does that do anything for oral health?
- We need to understand the role of the tobacco industry in targeting ethnic groups (with Asian countries being a huge target): Marlboro introduced a new cigarette in India, mimicking the exoticness of a *bidi*. Basically, the *bidi* is a poor man's cigarette so Marlboro is trying to say, don't smoke the Indian poor man's cigarette, smoke our Indian cigarette. This targeting pattern is not exclusive to South Asians, it is true for many ethnic and cultural groups.
- We need to better examine current tobacco reduction and cessation mechanisms. For instance, the California QuitLine has many Asian languages; none of them are South Asian (never mind addressing use of South Asian indigenous tobacco products).
- One common theme through this conference and in general is that we need more research. There aren't many that state that we need more interventions. And we need to give equal attention to designing and implementing culturally-appropriate, targeted, and effective intervention strategies.
- Here is an example of a South Asian tobacco intervention I found in England (reference to powerpoint). One of the aspects it emphasizes is the effects of tobacco on the family unit, not the individual. You hear this story often: for instance, my dad only quit smoking because he didn't want to impact my health, not because it was bad for him. The magnitude of what the consequences are of your behaviors on your family, especially your children, is a very culturally-appropriate intervention strategy.
- This slide is a great one (powerpoint reference) for those of you interested in tobacco control in India, but it's 275 pages, so they wouldn't let me put it in the conference syllabus. It led to the banning of tobacco products in six states in India (here's the article on it), although the enforcement of these policies is questionable.

## Conclusion

- I'm a firm believer of communities being empowered to take ownership of their own health prospects.
- In India (and I only keep repeating India not to marginalize the other South Asian countries but because most of the examples I found are from India), youth are doing exactly this: taking a big role in advocacy against tobacco (powerpoint reference). It is not somebody else going into the community and saying, "you should stop this, that, and the other", it is people from the community saying, "this is bad for our community; there's no reason why we should be doing this; we don't want to be targeted by the tobacco industry."
- There is a movement starting up; this article is from 2003 (powerpoint reference)
- I think it'll take another five to ten years for this to sort itself in India, but is a key example of what participation and empowerment can do.
- I believe we as community members have not only a responsibility to watch out for our own health, but the health of others.
- With that, if you have any questions about SAPHA, please feel free to contact me or my Co-Chair (who seems to have escaped from here) or Reena, who is our SAPHA Board Members, at any time. I'll be here all day.
- So, thank you for your time.