



AN INSIGHT INTO TOBACCO USE AND CONTROL IN INDIA FROM THE PAST TO THE PRESENT

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ABSTRACT

Tobacco smoke is harmful not only to smokers but to non-smokers as well. Smoking cigarette and other tobacco products impose a large and growing global public health burden. Responsible for almost 5 billion deaths per year worldwide, it is one of the major causes of premature deaths. The 21st century is likely to see 1 billion tobacco deaths, most of them in low-income countries. Christopher Columbus introduced tobacco to the world; he discovered tobacco among the treasures of the New World in 1492. India got introduced to tobacco by the Portuguese 400 years ago and they established the tradition of tobacco trade in their colony at Goa. Prevalence and practices of tobacco use is varied and disparate in India now. Tobacco related legislation in India has only a short history so far. Though, significant impetus has been there recently to come up with a multi-faceted national control measure which has a promising future ahead. Health care organizations have started to provide structured smoking cessation services now, and recognize the value of this health maintenance intervention. As a signatory to FCTC, India with renewed fervor is now actively involved in combating the menace of tobacco.

KEYWORDS: Tobacco, Tobacco Cessation, Cigarette Smoking, Public Health, Legislation.

INTRODUCTION

Smoking and other forms of tobacco impose a large and growing global public health burden. Responsible for almost 5 billion deaths per year worldwide, it is one of the major causes of premature deaths.^[1] Tobacco smoke is harmful not only to smokers but to non-smokers as well. At least 250 of the 4,000 chemical substances found in tobacco smoke are considered harmful, with over 50 being carcinogenic.^[2]

Conditions proved to be related to tobacco smoking include cancer such as lung cancer and cancers of the esophagus, larynx, stomach, kidney, bladder, uterine cervix and acute myeloid leukemia; cardio-vascular disease and chronic obstructive pulmonary disease (COPD). Recent investigations have also identified the use of tobacco as a constant behavioral risk factor for poor dental health.^[3] It causes a reduction in the gingival blood flow with a decreased number of circulating cells and less oxygen reaching the gingiva, thus weakening its defense reparative posture.^[4] Smoking also has a strong association with trauma-related and fire-related injuries.^[5]

Moreover, on current smoking patterns, annual tobacco deaths are expected to rise to 10 million by 2030. The 21st century is likely to see 1 billion tobacco deaths, most of them in low-income countries.^[6] Thus, Cigarette smoking and other forms of tobacco use impose a large and growing global public health burden.

Health care organizations now provide structured smoking cessation services, recognizing the value of this health maintenance intervention. Smoking cessation treatment has indeed become a service that providers of primary care are widely expected to deliver, and which can be tracked as a quality measure in most of the health care organizations.^[7]

TOBACCO GAINS ENTRY

Christopher Columbus introduced tobacco to the world; he discovered tobacco among the treasures of the New World in 1492. Later in the late 15th century the followers of Columbus, the Portuguese and the Spanish sailors carried it to all parts of the world.^[8]

The Portuguese introduced tobacco to India 400 years ago and established the tradition of tobacco trade in their colony of Goa.^[8] Soon, tobacco as a barter commodity

gained entry into the royal courts of India by the Portuguese to train Indian textiles in the 17th century.^[9]

Tobacco was further glorified by the British East India Company as a cash crop and promoted its production for domestic usage and foreign trade. Due to the increasing demand for tobacco in India, the Imperial Tobacco Company was established in 1910, nearly a decade after its inception in 1901 following the amalgamation of 13 tobacco companies, now known as the Indian Tobacco Company (ITC) Limited.^[9]

A few decades later, the beedi industry gained entry into the tobacco arena. Due to the low unit value of beedi it became a popular product among the working class, and its usage soon surpassed cigarette usage in the country. Historically, beedi smoking was one of the most common forms of tobacco consumed worldwide, until recently when cigarettes overtook in the early 20th century. On the other hand, the chewable tobacco industry has grown to become the most popular form of tobacco consumed in India.

Today, prevalence and practices of tobacco use in India are varied and disparate. In 1997, World Health Organization (WHO), reported the prevalence tobacco habits in India to be , bidis (34%), cigarettes (31%), chewing tobacco (19%), hookah (9%), cigarcheroots (9%), and snuff (2%).^[10] But the prevalence was revealed to be cigarettes (20%), bidis (40%) and the remaining 40% consumed as chewing tobacco, pan masala, snuff, gutkha, masher and tobacco toothpaste as reported by Cancer patients aid association of India in 2004.^[8]

Bidis, however, account for the largest proportion of tobacco consumption in India as the teeming poor in India are 8-10 times more likely to smoke bidis than cigarettes.^[11] Worldwide 85% of the tobacco cultivated is being used to produce cigarettes.^[9] Over the years, India's has risen from the position of being the third largest to the second largest unmanufactured tobacco consuming country in the world. This therefore suggest that compared with cigarettes, more of the other forms of tobacco are consumed in India and that this trend seem to be increasing every year.^[12]

Thus, the above statistics help distinguish the current tobacco consumption pattern in India from the rest of the world. The 52nd National Sample Survey conducted by the National Sample Survey Organization in 1995-96 was the first nationally representative household survey to collect data on tobacco consumption in population, 10 years and older, using surrogate household informants.^[13] The recently conducted national cross-sectional household survey found the highest prevalence of tobacco use in South Bihar (94.7%), followed by Uttar Pradesh (87.3%), and high rates in the north eastern states. The lowest rates were found in Kerala (20.6%).^[14]

Moreover, the consumption is higher among males than in females, and in older age groups as compared to younger age groups. The National Survey of Drug and Alcohol Abuse conducted in 25 states, also reported that 55.8% of males aged 12-60 years currently use tobacco.^[15] Amongst women, smoking was more common in the North eastern states, Jammu & Kashmir and Bihar.^[16] Also, the Global Youth Tobacco survey revealed that among 13-15 year old school children, the current use of any tobacco product varies from 3.3% in Goa to 62.8% in Nagaland^[17] and half of such smokers initiated smoking before 10 years of age.^[18]

Unequivocally, health consequences arising from tobacco consumption virtually affect every organ of the human body leading to ill health, morbidity, and mortality. Broadly these can be categorized as cardiovascular disease, pulmonary disease and oral cancer, although it also affects reproductive health, digestive process, vision, bone metabolism, oral health, and virtually every functioning cell.

Additional effects include emotional burden to family, early school dropout and child labor apart from the pain and suffering due to the dreadful diseases. Smoking alone causes 5% of all deaths in women and 20% of all deaths in men aged 30-69 years, totaling to 1 million deaths per year in India, this was estimated in a recent nationwide study. Tobacco consumption continues to grow at 2-3% per annum, and the condition is such that by 2020, it is predicted to be accountable for 13% of all deaths in India.^[19] In the coming years, the tobacco industry would mushroom unabated with increasing numbers falling prey to the "demerit good".

ANTI-TOBACCO POLICIES AND PRACTICES

In the initial decades of independent India, tobacco merely had a pecuniary status and was considered as a source of revenue from taxes and exports rather than as a harmful commodity. The pioneering anti-tobacco activity in Indian legislature dates back to 1975 when the Tobacco Board Act was introduced to develop the tobacco industry, which facilitated regulation of production and curing of tobacco, fixed minimum prices and provided subsidies to tobacco growers.^[10]

Again in 1975, Cigarettes Act of 1975 was passed.^[19] It was India's first national level anti-tobacco legislation and prescribed all packages to carry the warning "Cigarette smoking is injurious to health". The act did not include the non-cigarette products. It failed to accomplish much success, as it had feeble and fragile provisions. Several other single faceted national attempts to control tobacco use have been made in the past. The Prevention and Control of Pollution Act of 1981 included smoking in the definition of air pollution and the Motor Vehicles Act of 1988 made it illegal to smoke or spit in a public vehicle.^[20]

The Indian government in 1990, utilized the provisions of the 'Prevention of Food Adulteration Act (1955)',^[21] to prescribe health warnings stating chewing of tobacco to be injurious to health. Closely following this, in 1992, the Central government banned the sale of toothpastes and toothpowders containing tobacco under the 'Drugs and Cosmetics Act' of 1940.^[22] Finally, the Cable Television Networks Amendment Act of 2000 prohibited the transmission of tobacco and liquor advertisements on cable television across the country.^[23]

In February 2001, Indian Prime Minister Vajpayee's union cabinet introduced Cigarettes and other Tobacco Products Bill. This was a multi-faceted anti-tobacco legislation to replace the Cigarettes Act of 1975.^[19] According to this bill, smoking in public places would be outlawed, sale of tobacco to people under 18 years of age would be prohibited, tobacco packages required to have warnings and it also prohibited tobacco companies from advertising and sponsoring sports and cultural events.^[24] The bill covers most tobacco products like cigarettes, cigars, bidis, cheroots, pipe tobacco, hookah tobacco, chewing tobacco, panmasala and gutkha. A first time offender will result in a fine of Rs 200 and a second time offender will result in a fine of Rs 1,00,000 and imprisonment for up to three years.

The Indian Parliament passed the 'Cigarettes and Other Tobacco Products Bill, 2003' in April 2003. This Bill became an Act on 18 May 2003. Rules were formulated and enforced from 1 May 2004. This law was intended to protect and promote public health, encompass evidence based strategies to reduce tobacco consumption and impose penalties to the violators. The chief provisions of the act were banning of direct and indirect advertisements of tobacco products, prohibition of smoking in public places, sale of tobacco to minors and smoking within a radius of 100 yards of educational institutes.

In 2004, a modified and comprehensive Tobacco Control Bill was passed which provided the Advocacy Forum for Tobacco Control, a national alliance against tobacco with opportunities for all key tobacco control.^[9] The World Health Assembly of the World Health Organization (WHO) adopted the Framework Convention on Tobacco Control (FCTC) at its 56th Session in May 2003. India ratified the convention on 5 February 2004 and commenced enforcement of the national tobacco control law in May 2004. It was the eighth and the largest country to ratify the treaty.

CONCLUSION

So far, India has a short history of tobacco related legislation. Recently though, there has been significant impetus to come up with a multi-faceted national control measure which shows a promising future ahead. India, as a signatory to FCTC, is actively involved in combating the menace of tobacco with renewed fervor.

In view of the presented evidence, there is now a need to mobilize financial and human resources for the application of the various methods and interventions for tobacco control. Continuous efforts should be made to establish national and international coordinating mechanisms to integrate tobacco control into health and development.

A colossal burden of disease and death is imposed by tobacco leading to catastrophic health, social, economic and environmental effects. Prevalence and practices of tobacco use is varied and disparate in India and consumption of tobacco continues to grow at 2–3% per annum, and it is predicted that by 2020 it will account for 13% of all deaths in the country.^[1]

India is demonstrating a steely resolve to curb the menace of tobacco now through comprehensive control strategies that combines several measures in reducing its demands and supply. The first anti-tobacco legislation was passed in India at the national level in 1975, though it was largely limited to health warnings and thus proved to be inefficient. An advance in tobacco control was showcased in the 'Cigarettes and Other Tobacco Products Bill, 2003' which included measures aimed at reducing demand by outlawing smoking in public places, forbidding tobacco sale to minors, mandating more prominent health warning labels, and also by banning advertising during sports and cultural events.

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