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# Tobacco problem: Indian perspective

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***Abstract*** *: India's tobacco problem is very complex, with a large use of a variety of smoking forms and an array of smokeless tobacco products. Many of these products are manufactured as cottage and small-scale industries using varying mixtures and widely differing processes of manufacturing. Bidis are mostly manufactured in the unorganized sector while cigarettes are mainly manufactured in large-scale industries. Nearly all tobacco use begins in childhood and adolescence. In all, 88% of adult smokers who smoke daily report that they started smoking by the age of 18 years. This is a time in life of great vulnerability to social influences, such as those offered through the marketing of tobacco products and the modeling of smoking by attractive role models, as in movies, which have especially strong effects on the young. This is also a time in life of heightened sensitivity to normative influences: as tobacco use is less tolerated in public areas and there are fewer social or regular users of tobacco, use decreases among youth. So, as we adults quit, we help protect our children. A study in North India showed a significant association of chewing tobacco and oral cancer with direct relation between quantity and duration of use. India has one of the highest rates of oral cancer in the world, with over 50% attributable to smokeless tobacco use. Tobacco leads to clearing of forests for cultivation, stripping fuel wood for curing and forest resources for packaging thus damaging the environment. Tobacco depletes the soil nutrients at a very rapid rate and displaces the indigenous flora and fauna thus becoming a source of pests for other crops. Tobacco, education, and health in a human population are inter-related in ways that makes sufferings and deaths caused by tobacco use even more tragic than normally realized as they occur most often among least educated and under-privileged sections of the society.*

***Key words:*** *Tobacco, education, health, WHO*

## Introduction

Tobacco use kills nearly six million people worldwide each year. According to the World Health Organization (WHO) estimates, globally, there were 100 million premature deaths due to tobacco in the 20th century, and if the current trends of tobacco use continue, this number is expected to rise to 1 billion in the 21st century.[1]

India's tobacco problem is very complex, with a large use of a variety of smoking forms and an array of smokeless tobacco products. Many of these products are manufactured as cottage and small-scale industries using varying mixtures and widely differing processes of manufacturing.[2] Bidis are mostly manufactured in the unorganized sector

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Tobacco use including both the smoking and the nonsmoking forms of tobacco is common in India. The few reports of tobacco use in different population groups report its prevalence from about 15% to over 50% among men1-7. Differences in its prevalence are rather wide for the nonsmoking forms. Tobacco smoking in most parts of India except Punjab, Maharashtra and Sikkim is reported in about one fourth to half of adult men of over 15 years of age 8. Amongst women, smoking was more common in the North Eastern states, Jammu & Kashmir and Bihar, while most other parts of India had prevalence rates of about 4 percent or less 8. In other reports, ever smoking among the school going youth of 13- 15 years age, studied as a part of the Global Youth Tobacco Survey (GYTS) study was reported on an average in upto about 10 percent individuals9-12. All these reports clearly indicate a higher prevalence of tobacco smoking in adult men[3]

## Historical Overview of Tobacco in India

The history of global tobacco trade is integrally linked with the history of India. It was to discover a sea route to this fabled land, reputed for its spices, silk and gems, that Christopher Columbus set sail in 1492. His wayward journey took him instead to America. This discovery of the New World was accompanied by the discovery of tobacco by Portuguese sailors. This plant, treasured by the American Indians for its presumed medicinal and obvious stimulant properties, was eagerly embraced by the Portuguese who then moved it to the Old World of Europe. Even though their quest for easy access to Indian spices was delayed by some years, the Europeans did not fail to recognize the commercial value of this new botanical acquisition. When the Portuguese eventually did land on India shores, they brought in tobacco. They introduced it initially in the royal courts where it soon found favour . It became a valuable commodity of barter trade, being used by the Portuguese for purchasing Indian textiles. The taste for tobacco, first acquired by the Indian royals, soon spread to the commoners and, in the seventeenth century, tobacco began to take firm roots in India. Thus, tobacco travelled to the real Indians from their curiously named American cousins, through the medium of European mariners and merchants who sailed the seas and spanned the continents in search of new markets and colonies. It was with the establishment of British colonial rule, however, that the commercial dimensions of India tobacco

production and consumption grew to be greatly magnified. Initially, the British traders imported American tobacco into India to finance the purchase of Indian commodities. When the American colonies declared independence in 1776, the British East India Company began growing tobacco in India as a cash crop. Attempts were made, under the colonial rule, both to increase the land under tobacco cultivation and to enhance the quality of the leaves produced. The British East India Company and its successor, the British Raj, used tobacco as an important cash crop, both for domestic consumption and foreign trade. The manufacturing industry was, however, not established till much later, as the British believed in exporting the leaf to Britain and re-importing cigarettes to India, with considerable value addition in the process.

Tobacco was first introduced in the kingdom of Adil Shahi, the capital city of Bijapur, presently in Karnataka in south India, along the trading route of the Portuguese. Asad Beg, ambassador of the Mughal Emperor Akbar, visited Bijapur during 16041605 and took back large quantities of tobacco from Bijapur to the Mughal Kingdom in the north and presented some to Akbar along with jewel-encrusted European-style pipes. Several nobles in Akbar s court were also given tobacco and pipes, and tobacco was appreciated by everyone. The presentation of this herb to the emperor was discussed animatedly in the court of Akbar.[4]

As domestic consumption of cigarettes rose, the Imperial Tobacco Company commenced production within India, retaining control and repatriating the profits. In the late nineteenth century, the beedi industry began to grow in India. The oldest beedi manufacturing firm was established around 1887 and by 1930 the beedi industry had spread across the country. The price differential from cigarettes favoured the use of beedis by the working classes and this domestic product soon supplanted cigarettes as the major form of tobacco consumption. The tax policies adopted by the Indian Government after Independence also favoured the beedi in comparison to cigarettes. This further fostered a growth in beedi consumption. While tobacco chewing was practised for many centuries, commercial production and marketing have been markedly upscaled recently, with the introduction of the gutka. The rate of growth of consumption of gutka has overtaken that of smoking forms of tobacco. As a result, oral tobacco consumption has opened a new and broader front in the battle between commercial tobacco and public health in India. The economics of tobacco, which introduced it into India and entrenched it during the colonial rule, also provided a compelling reason for continued state patronage to the tobacco trade, even in free India. The ready revenues that bolster the annual budgets, the ability to export to a tobacco-hungry world market and the employment opportunities offered to millions provided the rationale for encouraging tobacco, both as a crop and as an industry. While economics may have been the principal force propelling the seemingly inexorable advance of tobacco in India, there are also a multitude of social and cultural factors which need to be recognized, so that the variations in its use across social, religious and ethnic subgroups can be comprehended. Such factors have operated since the time tobacco entered India, though the nature of the

sociocultural determinants that influence individual and community responses to tobacco may have varied over time, region, religious denomination and social class. It is this tapestry of international linkages, powerful economic factors and distinctive cultural influences which make the history of tobacco in India a fascinating study.[5]

**Hazard of Tobacco Use**

Tobacco is deadly in any form. It has been unequivocally established that exposure to tobacco smoke causes death, disease and disability. According to the International Agency for Research on Cancer (IARC) monograph, there is sufficient evidence in humans that tobacco smoking causes cancer of the lung, oral cavity, naso-, oro- and hypo-pharynx, nasal cavity and paranasal sinuses, larynx, esophagus, stomach, pancreas, liver, kidney (body and pelvis), ureter, urinary bladder, uterine cervix and bone marrow (myeloid leukemia). Colorectal cancer is seen to be associated with cigarette smoking, although there is insufficient evidence for it to be causal.[10] Ninety percent of all lung cancer deaths in men and 80% in women are caused by smoking. Causal associations have been clearly established between active smoking and adverse reproductive outcomes, chronic obstructive pulmonary disease and cardiovascular diseases. Studies on bidi smoking, the most common form of tobacco smoking in India, provide evidence toward causality of it as carcinogenic substance. Case–control studies demonstrate a strong association of bidi smoking with cancers at various sites, such as oral cavity (including subsites), pharynx, larynx, esophagus, lung and stomach. Almost all studies show significant trends with duration of bidi smoking and number of bidis smoked.Smoking was associated with excess deaths among smokers between 30 and 69 years, mainly from tuberculosis and also from respiratory, vascular or neoplastic disease. The risk of tuberculosis deaths among bidi smokers was 2.60-times higher than never-smokers in Mumbai.[6]

A study in North India showed a significant association of chewing tobacco and oral cancer with direct relation between quantity and duration of use.[7] India has one of the highest rates of oral cancer in the world, with over 50% attributable to smokeless tobacco use.[8]

There is sufficient evidence in humans for the carcinogenicity of smokeless tobacco. Several studies have established a causal association between use of smokeless tobacco and cancers of oral cavity, esophagus and pancreas. Smokeless tobacco causes acute increases in blood pressure and heart rate, and has been associated with a small increase of cardiovascular disease risk. Effects on insulin sensitivity, glucose tolerance and the risk for diabetes from smokeless tobacco use are plausible. The use of smokeless tobacco causes reproductive and developmental toxicity, and its use during pregnancy increases the risks for preeclampsia and premature birth, causes increased placental weight and reduces mean birth weight. Smokeless tobacco use by men causes reduced semen volume, reduced sperm count, reduced sperm motility and an increased frequency of abnormal spermatozoa.[9]

Tobacco leads to clearing of forests for cultivation, stripping fuel wood for curing and forest resources for packaging thus damaging the

environment. Tobacco depletes the soil nutrients at a very rapid rate and displaces the indigenous flora and fauna thus becoming a source of pests for other crops.

Second-hand tobacco smoke (SHS) kills 600,000 people each year. Globally, about one-third adults are regularly exposed to SHS. The GATS-India shows that 52% of the adults (rural-58%, urban-39%) were exposed to SHS at home.[10] SHS is three- to four-times more toxic per gram of particulate matter than mainstream tobacco smoke. More than 4000 chemicals have been identified in tobacco smoke, at least 250 of which are known to be harmful. Toxic chemicals from SHS cling to rugs, curtains, clothes, food, furniture and other materials. These toxins remain even in the presence of windows, fans or air filters, and can recycle back into the air through the filters. They coat the surfaces of rooms, materials and smoker's belongings, and are sometimes referred to as "third-hand smoke". There is conclusive evidence linking passive smoking to an increased risk of cardiovascular diseases, lung cancer and other cancers, asthma and other respiratory diseases in adults and asthma and other respiratory diseases, ear infection and sudden infant death syndrome in children, to name but a few of passive smoking's harmful effects.[11]

**Legislation and enforcement**

Legislation is recognized as the critical driver for meaningful progress in tobacco control. The WHO framework convention on tobacco control (WHO FCTC) is a global public health treaty developed as a global response to the globalization of the tobacco epidemic, which aims at reducing the burden of disease and death caused by tobacco. It was adopted by the World Health Assembly in May 2003, and India was the eighth country to ratify it on 5 February 2004. The FCTC embraces scientific evidence-based approaches that have shown effectiveness in reducing tobacco consumption. It does not lay down a law, but sets out guidelines for various national and international measures that would encourage smokers to quit and restrain nonsmokers from taking the habit. The success of the WHO FCTC, which as of July 2009 had more than 160 parties covering 86% of the world's population, demonstrates the global political will for making tobacco control far more comprehensive and successful.[12] The WHO has established the MPOWER package to help countries comply with the WHO FCTC. This is a package encompassing six most important and effective tobacco control policies: Monitoring tobacco use and prevention policies, Protecting people from tobacco smoke, Offering help to people to quit tobacco use, Warning everyone about the dangers of tobacco, Enforcing ban on tobacco advertising, promotion and sponsorship and Raising taxes on tobacco.

In India, since 1975, it is mandatory to display a statutory health warning on all packages and advertisements of cigarettes because of the Cigarettes (Regulation of Production, Supply and Distribution) Act, enacted by the Government of India (GOI). Further restrictions on tobacco trade were initiated along with efforts to bring forth a comprehensive legislation for tobacco control during the 1980s and 1990s. The Indian Parliament passed the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Bill, 2003 in

April 2003. This Bill became an Act on 18 May 2003.[13] Rules were formulated and enforced from 1 May 2004. The Act is applicable to all products containing tobacco in any form, and extends to the whole of India. The act lays emphasis on Prohibition of smoking in public places (including indoor workplaces). This has been implemented from 2nd October 2008 in the whole of India.Prohibition of advertisement, direct and indirect (point-of-sale advertising is permitted), sponsorship and promotion of tobacco products. Prohibition of sales to minors (tobacco products cannot be sold to children less than 18 years of age and cannot be sold within a radius of 100 yards of any educational institutions). Regulation of health warning in tobacco products packs. English and one more Indian language to be used for health warnings on tobacco packs. Pictorial health warnings also to be included. Regulation and testing of tar and nicotine contents of tobacco products and declaring on tobacco products packages.

## Conclusion

Tobacco, education, and health in a human population are inter-related in ways that makes sufferings and deaths caused by tobacco use even more tragic than normally realized as they occur most often among least educated and under-privileged sections of the society. Tobacco cessation is an essential component for reducing the mortality and morbidity related to tobacco use, as the lack of it may lead to an additional 160 million global deaths among smokers by 2050. Tobacco cessation provides the most immediate benefits of tobacco control and maximizes the advantages for a tobacco user who quits the habit. Tobacco cessation services should be made widely accessible to tobacco users and should cater to the wide range of products used in India. Capacity-building strategies for the identification and management of tobacco use and disorders related to its use must strengthen the services available through the existing health care facilities. Involvement of the community is an essential component of a tobacco cessation program. Effective implementation may be affected by the tobacco industry lobbying power, partly due to political constraints and the country's overall commitment to tobacco control.

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