PROBLEMS OF TOBACCO INDUSTRY IN INDIA

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ABSTRACT

Tobacco control with particular reference to the Indian scenario. The information on prevalent tobacco habits in India, health hazards and environmental hazards due to tobacco use, passive smoking and its impact, economics of tobacco, legislation to control tobacco in India, the tobacco cessation services and the way ahead for effective tobacco control are discussed. Tobacco is a leading preventable cause of death, killing nearly six million people worldwide each year. Reversing this entirely preventable manmade epidemic should be our top priority. This global tobacco epidemic kills more people than tuberculosis, HIV/AIDS and malaria combined. This epidemic can be resolved by becoming aware of the devastating effects of tobacco, learning about the proven effective tobacco control measures, national programmes and legislation prevailing in the home country and then engaging completely to halt the epidemic to move toward a tobacco-free world. India is the second largest consumer of tobacco globally, and accounts for approximately one-sixth of the world's tobacco-related deaths. The tobacco problem in India is peculiar, with consumption of variety of smokeless and smoking forms. Understanding the tobacco problem in India, focusing more efforts on what works and investigating the impact of socio cultural diversity and cost-effectiveness of various modalities of tobacco control should be our priority. This paper focuses on the Problems of Tobacco Industry in India.

Key Words: *Preventable, Approximately, Problems of Tobacco, Consumption, Smoked.*

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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 have estimated that around 1 million deaths a year in India will be attributable to smoking by the early 2010s. Gupta et al. have estimated the tobacco-attributable mortality among Indian men and women from their Mumbai cohort study. Based on these estimates, nearly 23.7 per cent of the deaths among men (527,500) and 5.7per cent of the deaths among women (83,000) aged 35–69 years are due to tobacco-attributable illnesses. Another cohort study from southern India reported mortality risks for all-cause and tobacco-related cancer mortality, respectively, for tobacco chewing, while with smoking, the respective

According to the National Family Health survey, conducted in 2005–06, tobacco use is more prevalent among men, rural population, illiterates, poor and vulnerable section of the society. The estimates of the Global Adult Tobacco Survey (GATS) conducted among persons 15 years of age or older during 2009–10 indicate that 34.6 per cent of the adults (47.9 per cent males and 20.3 per cent females) are current tobacco users. Fourteen percent of the adults smoke (24.3 per cent males and 2.9 per cent females) and 25.9 per cent use smokeless tobacco (32.9 per cent males and 18.4 per cent females). According to the Global Youth Tobacco Survey (GYTS) conducted among 24,000 students aged 13–15 years in 2009, 14.6 per cent students were tobacco users.

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.[1]

TOBACCO CESSATION SERVICES IN INDIA

There are several policy measures of tobacco control being implemented at the national and international level to fight the battle against tobacco. However, these efforts may not directly benefit the current tobacco user as nicotine in tobacco is very addictive, making quitting difficult. It has been estimated that a lack of cessation services may lead to an additional 160 million global deaths among smokers by 2050. A majority of tobacco users (nearly 70 per cent) wish to quit the habit, but only 3–5 per cent actually succeeds in doing so. The WHO in collaboration with the MHFW, GOI, set up 13 tobacco cessation centres (TCC) in 2002 spread across India in diverse settings (cancer treatment centres, psychiatric centres, medical colleges and NGOs) to help people quit tobacco. This number has now increased. The WHO algorithm for tobacco cessation consists of assessing the tobacco habit and then going through the procedures of simple advice, behavioural counselling and pharmaceutical treatment as per requirement.[2]

THE ECONOMICS OF TOBACCO IN INDIA

The tobacco industry claims that it has a major contribution to economy with its employment generation in agriculture and manufacturing and revenues in the form of exports and taxes. Economic measures to reduce tobacco use that are part of a comprehensive tobacco control program can counteract these. In 2009, India was the third largest producer of tobacco in the world. It produced 620,000 (MT) of tobacco worth 987,513 in 2009. India exported 230,804 tonnes of unmanufactured tobacco, with a worth value of 748,553 ($1000) in 2009.

According to the World Bank Report, the tobacco industry estimates that 33 million people are engaged in tobacco farming, of which 3.5 million are in India. Many women and children manufacture bidis and various forms of smokeless tobacco products working from home. It is estimated that bidi manufacturing provides employment to more than 4.4 million workers. Alternate cropping and alternate livelihoods need to be provided by the Government to replace tobacco farming and employment in the tobacco products manufacturing. In India, four major cigarette players dominate the cigarette market worth an estimated 60 billion rupees viz. Indian Tobacco Company (ITC), Godfrey Phillips Limited, Golden Tobacco and National Tobacco. Bidis still remain a major tobacco market, with a predicted sale of 1031 billion bidis in 2007. Smokeless tobacco products like Gutkha and pan masala are available in attractive colourful small sachets for as low as half a rupee, and have become increasingly popular with aggressive marketing and advertisements.[3]

OBJECTIVE OF THE STUDY

The main objective is to study the Problems of tobacco industry in India.

METHODOLOGY

This paper is based on secondary data. Secondary data from various books, reports, journals, and existing work on the topic has been analyzed to arrive at certain results in India.

PROBLEMS OF TOBACCO INDUSTRIES IN INDIA

The problems of tobacco industry in India as follows:

Beedis:

Crushed and dried tobacco is wrapped in tendu leaves and rolled into a beedi. Beedis are smaller in size than the regular company-made cigarettes so more beedis are smoked to achieve the desired feeling caused by nicotine. Beedi smokers are at least at an equal risk of developing cancers as cigarette smokers due to use of smoked tobacco.

Beedi making is a source of livelihood for many families. In some families, everyone including children – helps make beedis. The frequent inhalation of tobacco flakes has similar effects as the actual use of the tobacco product. Therefore, these families have an increased risk of lung diseases and cancers of the digestive tract. And, addiction is common among these families.

Cigarettes and cigars:

A cigar is a roll of tobacco wrapped in leaf tobacco, and a cigarette is a roll of tobacco wrapped in paper. Cigarettes may come with filters, as thins, low-tar, menthol, and flavored – to entice more users,

including women and youth and also to suggest the cigarettes have a lower health risk, which they do not. Many people view cigar smoking as less dangerous than cigarette smoking. Yet one large cigar can contain as much tobacco as an entire pack of cigarettes. Cigarette smoking is more common in the urban areas of India, and cigar use is seen in the big cities. Cigarette smoking in on the rise and is now also seen among teenage girls and young women.[4]

Chillum:

This involves smoking tobacco in a clay pipe. Chillum smoking increases chances of oral cancer and lung cancer. A chillum is shared by a group of individuals, so in addition to increasing their risk of cancer, people who share a chillum increase their chances of spreading colds, flu, and other lung illnesses. A chillum is also used for smoking narcotics like opium.

Hookah:

Hookah smoking involves a device that heats the tobacco and passes it through water before it is inhaled. It is not a safer way to use tobacco. The use of hookah was once on the decline, but it has increased in recent years. Hookah is thought to be a sign of royalty and prestige and is available in highpriced coffee shops in flavors like apple, strawberry, and chocolate. It is marketed as a "safe" recreational activity, but it is not safe and is finding increasing use among college students of both sexes. Use of tobacco in this form can result in tobacco addiction.

Chutta smoking and reverse chutta smoking: Chuttas are coarse tobacco cigars that are smoked in the coastal areas of India. Reverse chutta smoking involves keeping the burning end of the chutta in the mouth and inhaling it. This practice increases the chance of oral cancer.

Health

Tobacco is deadly in any form or disguise. Scientific evidence has 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. 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. Forty percent of the tuberculosis burden in India may be attributed to smoking. Significant association is seen between passive or active exposure to tobacco smoke and tuberculosis infection, disease and tuberculosis mortality. 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. Workers engaged in tobacco cultivation suffer from an occupational illness known as green tobacco sickness (GTS), an acute form of nicotine toxicity resulting from absorption of nicotine through the skin

Environment

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.

Passive smoking

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 per cent of the adults (rural-58 per cent, urban-39

percent) were exposed to SHS at home. 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.[5]

CONCLUSION

The present study of tobacco problems of Andhra Pradesh. Public health awareness, raising a mass movement against tobacco, sensitizing and educating all health care professionals for tobacco control and cessation by incorporating the topic in medical undergraduate curriculum, nursing curriculum, various, conferences, scientific meetings, workshops, etc. is vital. Eventually, if all healthcare professionals participate in tobacco control and cessation, it will have a huge impact. Expansion to the periphery to reach the community, making them more accessible and widely acceptable, will facilitate millions of current tobacco users to quit the habit. Most of the graduates initiated smoking during their undergraduate course. There is lack of wholesome awareness on health effects of smoking. There was high acceptance among smokers that the anti-tobacco legislations were not being strictly implemented. A large number of smokers supported following measures for the prevention of smoking among youth: There is necessity for initiation of school based antitobacco campaigns and reinforcement of such programs during graduation courses. The community itself must monitor the implementation of tobacco control laws and the government must provide support to the community.

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