Submission from our organization is enclosed. We are unable to attend the hearings in person.

Faithfully yours,

Gajalakshmi Vendhan MBBS, DPM, MSc(Canada), ScD (Finland)
Associate Prof. & Head, Division of Epidemiology & Cancer Registry, &
Shanta V  MD, DGO
Executive Chairman, Cancer Institute(WIA), Chennai, India


Submitted on August 31, 2000

The Cancer Institute (WIA) is located in the state of Tamil Nadu in South India and is a Regional Cancer Center for cancer research and treatment in the Ministry of Health and Family Welfare of the Government of India. It is an autonomous non-profit organization comprising of four components: a teaching hospital of 413 beds; a Research Center comprising the laboratories of Microbiology, Immunology, Biochemistry, Molecular Oncology, Biophysics, Cytogenetics and Electron Microscopy; the Division of Epidemiology and Cancer Registry and the College of Oncologic Sciences recognized by the Medical Council of India.

In India the estimated number of new cancer cases in 2001 is 800 000. Out of this 48% of male cancers and 20% of female cancers are tobacco related. Unlike in developed countries, the prevalence of smoking is increasing in developing countries and large populations in developing countries, except for China, do not have adequate number of direct epidemiological studies on tobacco-attributable mortality. The Division of Epidemiology and Cancer Registry at the Institute is involved in conducting population based large
prospective and retrospective epidemiological studies in the State of Tamil Nadu on tobacco use to monitor the tobacco epidemic and assess the tobacco attributable mortality. The survey done by us on 200,000 population in Tamil Nadu shows the prevalence of smoking among males aged 35 and over is 40% in urban and 45% in rural areas. Less than 1% of women smoke tobacco. The percentage of tobacco chewers is higher among females compared to males. The case-control study conducted in Chennai, India, on 28,000 adult male deaths and 20,000 adult male controls shows a risk ratio (adjusted for age, educational level and tobacco chewing) of 2.1 (95% confidence interval of 2.0-2.2) among smokers compared to nonsmokers. This indicates that 50% of smokers die due to smoking. A substantial majority of tobacco attributable deaths among males in Chennai involves death from tuberculosis. If eventually the 2-fold difference in male death rates between smokers and nonsmokers is found in many other parts of urban and rural India, then about 30% of the male deaths in middle age (plus about 10% of the deaths in old age) will be attributable to smoking.

These studies are primarily funded by direct support from the UK Medical Research Council to the University of Oxford Clinical Trial Service Unit and Epidemiological Studies Unit, UK with additional support from the WHO, Geneva and the World Bank, USA.

Submission:
We strongly feel that the FCTC is an important step towards curbing the epidemic of tobacco in the world, especially in developing countries.

Studies in India show that the prevalence of smoking is high in less educated, the tar and nicotine content is high in bidi (compared to cigarette) which is smoked by 80% of male smokers and the prevalence of smokeless tobacco is high among females (less than 1% of women smoke) than males. The tobacco-attributable mortality in developing countries is predicted to rise sharply compared to developed countries. So we submit that

FCTC should guide the developing countries in formulating and implementing effective domestic tobacco control policies; provide support and encouragement to ban smoking in closed public places and in the area within about 2 Km around schools and colleges; have protocols not only to reduce cigarette smoking but also bidi smoking and using smokeless tobacco and, recommend to include the health consequences of tobacco use in the syllabus of school children aged 10 and over.