Submission for the Public Hearings regarding the Framework Convention on Tobacco Control on 12th - 13th October 2000, at WHO, Geneva

By
The Community Health Cell (CHC), Bangalore, India, which is the functional unit of a registered Society for Community Health Awareness, Research and Action (SOCHARA).

1. Introduction

1.1 CHC is a professional resource group working in the area of community health and public health, in the voluntary sector in India, since sixteen years. Major strategic approaches in work include training, research, advocacy, information dissemination, and networking on major health issues/problems including tuberculosis, malaria and vector borne diseases, HIV/AIDS, Tobacco control, women's health, rational therapeutics, promotion of indigenous systems of health care and addressing poverty and health relationships. In recent years there is increased interaction with government and the Health University in Karnataka State. The team comprises of 18 members including health and social science professionals, supported by an informal network of 25 professionals.

CHC has recognised tobacco related health problems as a major public health issue since long, but has become more actively involved since the past 1½ years. As part of our tobacco control work we collaborate with the Indian Medical Association - Karnataka branch, with the National Organisation for Tobacco Eradication and others. We have participated internationally with the NGO Forum for Health, INGAT and the Global Alliance for tobacco control. Locally we also undertake awareness programmes/education and training programmes in schools, colleges and with NGO's on health effects of tobacco use and on tobacco cessation.

Our sources of funding include the Government of India, State government of Karnataka, WHO-Geneva, Misereor - Germany, Cordaid - Netherlands and for one year DFID - UK, besides local donations and payment for services.

1.2. Summary

Research and experience over 20 years in India indicates an alarmingly
increasing trend in tobacco use, both smoked and chewed. Adverse, serious, health and economic effects have been documented by the Tata Institute of Fundamental Research, the Indian Council of Medical Research, the Kidwai Institute of Oncology and by academic and NGO studies. Given that 40% of India's population or approximately 400 million persons live below or around the poverty line, spending on tobacco use and on meeting health care costs, which are substantially out of pocket expenditures, result in worsening the poverty cycle and in denying positive spending on nutrition, child care, education etc. This is unacceptable ethically to the public health community and to civic society.

We recognize the need for a public health approach. We support the global strategy to ensure tobacco control, as multinationals with easier access to markets through the process of Globalisation are using questionable marketing methods. South Asian populations are particularly vulnerable and at risk in the current context. We support the proactive efforts of the Tobacco Free Initiative of the WHO to contain the tobacco industry through the FCTC. We also address the local tobacco industry in India, particularly those producing and marketing bidis and chewed tobacco. Recent studies in Mumbai found 74% of adult men and 60% of adult women chewing tobacco, a habit that starts at 11-13 years of age and which accounts for 30% of tobacco use. The hazards to which the unorganized workers are exposed and their working conditions need attention. Thus a public health approach will also need to respond to the dynamics and specificities of tobacco growth, production, sale and use in the country.

2. Personal Health and Public Health Consequence of tobacco use

2.1 Over the past 50 years, studies conducted globally, including the outstanding work by Richard and Doll in the UK, have established the link between tobacco use and various forms of cancer, cardiovascular disease, gastrointestinal disease, diseases of the reproductive tract including pregnancy wastage and impotence Studies in India also bear this out.

The cause effect relationship between tobacco use in smoked or chewed
form and several adverse ill health consequences on an individual is thus well established. This needs to be kept in mind during the negotiations.

2.2 The WHO, the public health community and policy makers need to also take cognisance of chewed tobacco (gutka, pan masala, zarda etc) accounting for 27-30% of tobacco use in India. Chewed tobacco is also used elsewhere in the Indian subcontinent, with potential for spread globally. Habitual chewing of 4-5 packets per day leads to gingivitis, leukoplakia, erythroplakia and to the disabling oral submucous fibrosis (OSMF). Over 2-3 decades, a ten-fold increase in incidence of OSMF is noticed with a shift in age group from those above 40 years to younger persons between 25-35 years.

2.3 The effects of passive smoking/ETS have been accepted by courts.

2.4 More recently the highly addictive nature of nicotine has entered the public knowledge domain, along with the fact that this critical information was kept secret and also used to manipulate the product by the tobacco industry. The consequence and cost to public health and to individuals resulting from this act by the industry, (which talks of free choice) is enormous.

2.5 The magnitude of tobacco related morbidity and mortality, place it among the league of major public health problems, resulting in the following: much preventable human suffering to affected persons and their families; to premature death; to increased health care costs; to loss of productivity; to shift in household income from nutrition and children's education to spending on tobacco; and to an overall economic loss to national economies, which economically poor countries can ill-afford. A recent report of a 6 year prospective study by the Indian Council of Medical Research substantiates the last point.

2.6 For the larger public good, there is need for urgent public policy interventions to mitigate the above. The protection of public health and public good is the mandated role of governments (national and local); of professional bodies who have access to knowledge; of international bodies such as WHO, particularly when there are global dimensions to health problems and health risks; and of civil society itself, when action by other mandated agencies is ineffective.

2.7 An objective review of tobacco control interventions especially in developing countries reveal that they have been weak and ineffective. Rates of tobacco use have in fact increased, starting at very young ages during childhood, where again the free choice theory fails to hold. As a medical doctor specialised in epidemiology and health policy analysis, it is evident that interventions focussed on cessation, counselling and group health education / awareness concerning the health ill effects of tobacco, fail to address the determining cause of spread of this
behaviour or habit related problem, namely the dynamics and ingenuity of
the tobacco industry which actively grows, manufacturers, promotes and
sells the product in collaboration with governments. These major
stakeholders need to be held accountable and responsible for their
decisions and actions, from a public health ethics point of view.

Given the present global evidence, these stakeholders need to make
informed choices, and based on currently globally accepted human rights
instruments to compensate individuals/families for the harm caused.

3. We support a series of policy measures for tobacco control that
include:

3.1 Crop diversification, alternative employment and protection of
tobacco workers.

3.2 Reduction and elimination of government/public subsidy to tobacco
growth, production, manufacture and sale.

3.3 Banning sponsorship of sports & entertainment by the tobacco
industry.

3.4 Banning of public advertisement of tobacco products.

3.5 Preventing and protecting children and young people from getting
addicted.

3.6 Widespread education and awareness raising about consequences of
tobacco use.

3.7 Tobacco cessation efforts - support to smokers/chewers.

3.8 Banning smoking in public places.

3.9 Support to the WHO in developing and implementing the Framework
Convention for Tobacco Control (FCTC).

3.10 Labelling and regulating nicotine, tar and carbon monoxide content
of cigarettes.

3.11 Banning chewed tobacco.

3.12 Control of Smuggling.

3.13 Increasing taxes and using money thus collected for tobacco
prevention education.
4. Country specificis

4.1 In India it is reported that 20% of tobacco use comprises cigarettes, 27-30% chewed tobacco (gutka etc) and 50-53% beedies. We need more accurate data on the sale of unbranded beedies and of gutka which are unaccounted for and totally unregulated. There is need for greater product regulation and safeguarding of health and working conditions of workers in these sectors who are most often women, children and the poorest sections of society.

While on the one hand the industry talks of generation of employment and wealth, the latter is largely in the hands of larger farmers and business owners. Field studies reveal that women in the home-based industry work 10-12 hours a day for a relatively small remuneration. Since it is homebased work, children often help out after school hours. Undercutting and exploitation of women, who may often be uneducated is often being done.

Support is required for research and for dialogue with the different departments and ministries of Government, including agriculture, labour, commerce and trade, education and health, greater involvement of NGO's, health professional bodies and educational institutions is required.