Tobacco Control in India: A Dentist's Perspective

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Abstract

The legalization of tobacco was an accidental event in the history. It would be a fallacy to assume that a product which kills half its consumers was given a legal status by way of logic. Portuguese introduced tobacco to India 400 years ago. Ever since, Indians have used tobacco in various forms. Addictive nature of nicotine leads to tobacco dependence. Tobacco causes over 20 categories of fatal and disabling diseases including oral cancer. In the future it is imperative to impose a ban on oral tobacco products, strengthen enforcement of existing regulations, establish coordinating mechanisms at the levels of central and state and mobilize people to combat the problem. Taxes on tobacco products should be raised and the generated revenue could be spent for the strengthening of the tobacco control program. This article reviews the tobacco use in India, tobacco dependence among people, laws to stub the tobacco inflow in the society and role of dental professionals in tobacco use cessation.

Key Words : Addiction, legislation, dependence

Introduction

Tobacco use in India

In India, the burden of tobacco related cancer was alarmingly high, contributing to almost 120,000 deaths in 2010 - over 40% of male, and nearly 20% of female cancers (Centre for Global Health Research, 2012 [1]. By 2020 it is predicted that tobacco will account for 13% of all deaths in the country. With respect to smoking, India contributes to approximately 10% of total smokers in the world, the second largest group, first being China (Singh et al., 2011)[1].The Global Adult Tobacco Survey (GATS) India Report[1] 2009-10 estimates 34.6% of India's adult population (aged 15 years and above) use tobacco in some form or other. About 29% of adults use tobacco on a daily basis and an additional 5% use it occasionally. Smokeless forms of tobacco like pan, zarda and gutkha are more commonly used than smoking forms like bidi and cigarettes. 3% population uses smoking forms of tobacco, while 36%, smokeless forms (GATS, 2010).

Law and Tobacco

The WHO Framework Convention on Tobacco Control (FCTC) was a response to the global tobacco epidemic. It is a powerful global instrument containing binding provisions on member countries. Tobacco control legislation in India dates back to 1975, when the Cigarettes (Regulation of Production, Supply, and Distribution) Act, 1975[2] required the display of statutory health warnings on advertisements, cartons, and cigarette packages.

To counter the deadly effects of tobacco, even before and parallel to the FCTC, the government of India notified a comprehensive tobacco control legislation The Cigarettes and Other Tobacco Products (prohibition of advertisement and regulation of trade and commerce, production, supply, and distribution) Bill, 2003, was a more comprehensive description for the control of tobacco as stated: A bill to prohibit the advertisement of, and to provide for the regulation of trade and commerce in, and production, supply and distribution of, cigarettes and other tobacco products and for matters connected therewith or incidental there to. COTPA banned smoking at public places (Section 4: came into effect in May 2004, revised in October 2008), sponsorship of any sport/cultural events by cigarette and other tobacco product companies (Section 5: implemented in May 2004), sale of tobacco products to and by minors (Section 6: implemented in December 2004), sale of tobacco products within 100 yards of educational institutions (Section 6b: implemented in December 2004), and provision of specified and mandatory pictorial warnings, including in imported products (Section 7: implemented on 31 May 2009). [2]

Pictorial warnings on all tobacco products were made mandatory following the Supreme Court directives (GOI, 2003). Research has shown that larger and colorful warnings placed on packaging are more effective for informing consumers and general public. However, primarily due to powerful lobbying by the industry, pictorial health warnings in India experienced constant delay in introduction and dilution of content. The new Cigarette and other Tobacco Products (Packaging and Labeling) Amendment Rules, 2012, notified on September 27, 2012, dictates that all tobacco product packs in the country had to carry new pictorial warnings consisting of drawing of a scorpion on smokeless forms of tobacco and pictures and X- rays of diseased lungs for smoking forms notified by the Union Ministry of Health. The Health Ministry had also for the first time inserted the word 'Warning' in the new pictorial warnings and mandated that this word be printed in 'red' color along with the messages -- 'Smoking kills'

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and 'Tobacco kills' to prevent the industry from diluting the effectiveness of such pack warnings. The notification on pictorial warning says "The size of all components of the specified health warning shall be so kept as to maintain a ratio of 0.75: 1 between the vertical length and horizontal length of the specified health warning," and also to place the health warning in at least 40 per cent of the principal display area of the tobacco package. Loopholes in the law show poor display of pictorial warnings comprising images of diseased mouth, lungs and throat for smokeless and smoking forms each. Tobacco product retailers and distributors who fail to comply with the new rules can face a fine extending to Rs 1000 with imprisonment up to one year or both under Section 20 of Cigarettes and Other Tobacco Products Act, 2003 (COTPA). On their first conviction, they can face fines up to Rs 5,000 or imprisonment up to two years or both. [3]

COTPA provides for a complete prohibition on direct advertisement, promotion and sponsorships of tobacco products. However, in India surrogate advertisements on print and electronic media, both indoors and out-doors are in abundance. Voices of Tobacco Victims directed their efforts to have the gutkha ban implemented by state legislators, and in April 2012, Madhya Pradesh became the first Indian state to ban gutkha. According to Global Adult Tobacco Survey (GATS) - India 2010, tobacco use is a major preventable cause of death and disease. Approximately 5.5 million people die around the world every year - with India accounting for nearly a fifth of this Kerala, Mizoram, Gujarat, Bihar, Rajasthan, Maharashtra, Haryana, Chhattisgarh, Jharkhand and Delhi soon followed and most recent to join the list is Tamil Nadu. [3]

In a country where up to 50% of cancers in some registries are directly attributable to tobacco, our society appears to be very tolerant of such violations and do not seem to consider it as an important public health issue. Chandigarh is the only city in India that can boast of good compliance with this law; this has been possible thanks to a relentless campaign by anti-tobacco activists, which made it the first smoke-free city of India.

Tweaking Indian law

When in the beginning of 19th century, tobacco was commercially used for the first time, it became a lucrative business. It was cheap to produce and easy to sell tobacco since a customer had no other option but to continue consuming it till the end of his or her life. Large profits made it easy for companies to start lobbying with the governments to scuttle out all opposition. The manipulation goes on till today even though we have enough scientific proof which links tobacco consumption with cancer, heart disease and other ailments. India does not seem to have any policy related to tobacco control. Whenever tobacco industry is cornered, the interest of the farmers is thought. The fact is that the poor farmer gets less than 1 per cent of the net value of any kind of tobacco product sale. Now, going by the law of fair play, tobacco should face a ban similar to narcotics.Therefore more tobacco users mean more tax money from the product sale and hence higher economic growth. Need a stronger hand to stub it out.

Blowing it on the face of Tobacco

Raising taxes on all tobacco products to act as a disincentive for purchase, especially for youth on the threshold of tobacco experimentation, generation of additional tax revenue for tobacco control, curbs on smuggling and programs to aid tobacco farmers for alternative livelihood are the interventions that would provide the backbone for tobacco control in India. The district team in charge of enforcement of COTPA in the grass root level must play a positive and receptive role for violation reporting. Similarly, active advocacy at the village, block and district level is a pre-requisite for improving the compliance with COTPA. One cross-sectional survey among 300 adults revealed that low public support, lack of information and awareness, low political commitment, cultural acceptability of tobacco and less priority for tobacco control are the main barriers to successful implementation of COTPA. [4] Medical graduates, Dentists and Nurses have a critical role to play role in success of COTPA. Since doctors and nurses interact with the community and dentists have expertise in dental as well as oral care, so they can contribute to smoking withdrawal program. Oral health professional should include counseling practices in their routine practices. In a study conducted in 600 people in Karnataka it was observed that awareness and impact of pictorial warning on tobacco consumption are poor among the population and hence more effective pictorial warning should be introduced to have a successful implementation of COTPA act 2003. [5]

A major step has to be taken to control what the World Health Organization, has labeled a 'smoking epidemic' in developing countries. Preventing the use of tobacco in various forms as well as treating nicotine addiction is the major concern of dentists and physicians. The dental encounter probably constitutes a "teachable moment" when the patient is receptive to counseling about life- style issues. Both policy makers and health professionals must work together for achieving a smoke free society for our coming generations.

Role of Dentist in Tobacco Control Measures

A Dentist makes a unique and important contribution to the smoking withdrawal programme. Oral health professionals should integrate tobacco use, prevention and cessation services into their routine and daily practice. [6] They should participate in lectures, demonstrations and assist in group discussions A four-step approach referred to as the "four A's" in dental office setting will help patients in tobacco cessation. [6] The dentist will first ASK the patients about tobacco use (frequency, whether attempts were made to quit and if he is

interested in quitting). Following which he will ADVISE tobacco using patients to quit, citing appropriate reasons specific to the individual and concentrating on any of the patient's current dental problems that may be aggravated by smoking (stained teeth). Next step is to ASSIST those who are interested in quitting by helping the patient select a quit date, provide self-help materials, consider prescribing nicotine gum, transdermal patches, especially for highly addicted patients. Last but not the least he should ARRANGE patient follow-up services by setting a follow-up visit within one to two weeks after the quit date, having an office staff member call or write to the patient within seven days after the initial visit, reinforcing the decision to stop and reminding the patient of the quit date and setting a second follow-up within one to two months.

Barriers mitigating provision of smoking cessation counseling

1. Many smoking patients do not have the motivation to quit.
2. Health professionals do not have sufficient skills to provide counseling to prevent /quit smoking.
3. Dentists do not consider smoking counseling part of their professional role.
4. Dentists do not have time to provide smoking cessation counseling during clinical consultations.
5. A myth among dentists that giving unwanted smoking cessation counseling may upset the dentist-patient relationship. [7]

Conclusion

Clearly, the road ahead is a long one but it's one that has to be traversed with purpose. The war on tobacco consumption must be fought both on the demand and the supply side - reducing the power of advertising to spur demand and reducing accessibility to tobacco products by increasing taxes and banning the sale of tobacco products in public places and areas accessed by minors.

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