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Editorial

World No Tobacco Day 2011: India's progress in implementing the Framework Convention on Tobacco Control

A global epidemic of tobacco use continues more than a half century after cigarette smoking was causally linked to lung cancer and other diseases. This epidemic has not spared India, home to 17.5 per cent of the world's population and over 275 million tobacco users[1,2]. India's tobacco consumption is the second largest in the world, surpassed only by China[3]. The tobacco epidemic in India is notable for the variety of smoked and smokeless products that are used and for their production by entities ranging from the loosely organized manufacture of bidi and smokeless products to multinational corporations. An estimated one million Indians die annually from tobacco-caused diseases, and projections forecast that by 2020, tobacco will account for 13 per cent of deaths in India[4].

The state of the epidemic of tobacco use in India was comprehensively described in the recently completed Global Adult Tobacco Survey (GATS), an internationally standardized survey designed to track tobacco use around the world[1]. The findings document the unique characteristics of tobacco use in India, highlighting the challenge for tobacco control. The GATS data show that India faces diverse epidemics of tobacco use involving cigarettes, bidis, and various forms of smokeless tobacco. The epidemics differ by sex, with men more often smokers and women more often users of smokeless tobacco, by population subgroup, and by state. Over 35 per cent of adults in India use tobacco, primarily smokeless (about 164 million), but there are 42 million users of both smokeless and smoked products, and an additional 69 million who only smoke. The majority of adults are exposed to secondhand smoke (SHS)[1].

In response to the globalization of the tobacco epidemic, the World Health Organization (WHO) led the negotiation of the Framework Convention on Tobacco Control (FCTC), the world's first public health treaty[5]. The FCTC provides a framework to "protect present and future generations from the devastating health, social, environmental, and economic consequences of tobacco consumption and exposure to tobacco smoke." Now in force in 172 nations, the FCTC supports the implementation of a broad range of evidence-based tobacco control policies that aim to reduce demand and supply, with a primary focus on measures to reduce tobacco demand using both taxes as well as non-price measures. Specific binding obligations in the treaty include a comprehensive ban on advertising, promotion and sponsorship of tobacco products; placement of warning labels covering at least 30 per cent of the front and back of all tobacco packaging; and protection of non-smokers from tobacco smoke in all public places. The treaty also addresses a number of supply issues, including recognizing the need to control illicit tobacco trade and sales to minors. The FCTC was unanimously adopted by the World Health Assembly in May 2003 and India, acknowledging the undisputed peril of tobacco in the country, signed the FCTC on September 10, 2003 and ratified it on February 4, 2004. Reflecting the FCTC's selection as the theme for the 2011 World No Tobacco Day, here we review the status of FCTC implementation in India, remarking on progress as the country enters the seventh year since ratification.

Efforts to control tobacco use in India antedate its ratification of the FCTC. That experience is relevant to identifying potential obstacles as India implements the FCTC. Early efforts date to 1975 with the 'Cigarettes (Regulation of Production, Supply and Distribution) Act'. This legislation placed health warnings on cigarettes alone and was consequently largely ineffective. Over the following 30 years, the Indian

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legislature passed a series of bills that added little to the tobacco control arsenal. It was not until 2003 with the 'Cigarettes and Other Tobacco Products Act' that India took a more aggressive stance in tobacco control. The bill offered comprehensive legislation for all tobacco products, developed after expert consultants identified tobacco as a "demerit commodity" in India. Despite this advance, implementation was a struggle. The law called for the community to be aware of what defined violations, and it necessitated the presence of a regulatory agency to monitor and enforce the legislation[3,6,7]. Although the bill called for graphic warnings, these were not implemented until 2009 after many delays and following an order of the Indian Supreme Court. However, litigation continues.

These false starts, before ratification and implementation of the FCTC, raise concern that India may continue to pass legislation that is poorly enforced and challenged in the courts. Seven years have now passed and progress can be gauged in implementing the FCTC. For an assessment of India's progress, we turn to the annual Global Tobacco Control Report (GCTR), assembled by WHO to monitor the status of tobacco control against the MPOWER framework. Building on the FCTC framework, WHO released its first 'Report on Control of the Tobacco Epidemic' entitled 'MPOWER' in 2008[8]. MPOWER stands for a set of six key tobacco control measures that reflect and build on the policy approaches embedded within the WHO FCTC, including Monitoring the epidemic, Protecting nonsmokers from exposure to SHS, Warning smokers of the health effects of smoking with strong, effective health warnings, Enforcing advertising bans, and Raising the price of tobacco products[8].

By using the GCTR, India's current level of policy development and implementation can be measured against the expectations of the MPOWER package. The 2008 GTCR noted moderately strong and enforced policies for advertising, promotion, and industry sponsorship, but the policy on smokefree environments, while classified as moderate, was poorly enforced[8]. The 2009 report identified only five places within India that had smokefree policies, including, for example, the city of Chandigarh which became smokefree in 2007[9,10]. Effective smokefree policies are particularly important because of their denormalization of smoking and promotion of cessation.

India initiated a movement towards national protection of nonsmokers with the 2008 legislation that banned smoking in all public places, consistent with Article 8 of the FCTC. Following the passage of the law, signs were erected in restaurants, bars, hospitals, canteens, and government buildings stating that tobacco usage was forbidden[6]. Enforcement lies at the State level. The punishment for breaking this law is only 200 rupees, ($4.50 USD), an insufficient deterrent for restaurant owners who may fear to lose business if they forbid the use of tobacco[11]. There is still inadequate surveillance to track progress towards the goal of a smoke-free India.

The GCTR confirms the lack of enforcement; smoke-free environments are required in health-care facilities, educational and government buildings, but are lacking in restaurants. Studies of markers of SHS in indoor air point to ongoing exposure. In our recent study, air was monitored in a convenience sample of 20 restaurants in Mumbai for small particles and nicotine (unpublished data). The average concentration was above the acceptable standard in the U.S. for outdoor air particulate matter. A recent study of indoor exposures to small particles in Asian countries, including China, Malaysia, Pakistan, Sri Lanka, found that levels were highest in India[12]. As India enhances enforcement of the 2008 rules on smokefree places, progress towards smokefree indoor spaces should quicken.

India, like many countries, does not have the infrastructure to provide cessation treatment for tobacco users who desire to quit, as called for by Article 14 of the FCTC. India lacks well-established clinics and quitlines. According to the GATS survey, 38 per cent of smokers made an attempt to quit in the previous 12 months, but only 9 per cent of smokers used counselling and only 4 per cent used pharmacotherapy[1]. There is a concerning lack of counselling in the offices of health professionals; in fact, according to GATS, less than half of smokers were advised to quit by their healthcare provider. The figure was even lower for users of smokeless tobacco; only 27 per cent of individuals were advised by their physicians to stop using[1].

The GATS findings also point to a need for greater education. FCTC Article 12 explicitly calls for "infrastructure to raise public awareness … [and] ensure sustained education, communication and training programmes."[5] According to GATS findings, only half of adults are aware that smoking causes stroke and less than two-thirds understand the connection between smoking and heart disease. Without effective education programmes, there will be little diminution in the number of smokers in the coming generations.

India faces particular challenges as it moves forward in meeting its FCTC obligations. Its size and the heterogeneous picture of tobacco use across the country are obstacles, and litigation can slow progress. For example, efforts to ban images of smoking in films have been challenged in the courts. The manufacture and distribution of bidis and smokeless products at local levels complicates control strategies.

Fortunately, India has many assets as it confronts these challenges. It has strong tobacco control leaders and advocates, a committed national office, and active non-governmental agencies. The need for capacity-building has been recognized and is being addressed by the Ministry of Health and the Public Health Foundation of India. Consequently, we are optimistic that India will move forward progressively in meeting its FCTC obligations.

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