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Tobacco cessation in India

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Abstract
This is a review paper comprehensively encompassing the different aspects of tobacco control with particular reference to the India. 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 studied in past. 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 sociocultural diversity and cost-effectiveness of various modalities of tobacco control should be our priority.

Keywords: Cigarettes and other tobacco products act, framework convention on tobacco control, hazards of tobacco, tobacco control.

Introduction
Tobacco was introduced to the world by Christopher Colombus, who discovered tobacco among the treasures of the New World in 1492. Later the followers of Colombus, the Portuguese and the Spanish sailors carried it to all the parts of the world in the late 15th century.

Tobacco use in India
1) Historical overview of tobacco in India
From the Middle ages to modern times
Tobacco cultivation has a history of about 8000 years. Europeans were introduced to tobacco when Columbus landed in America in 1492. Portuguese traders introduced tobacco in India during 1600. Tobacco's easy assimilation into the cultural rituals of many societies was facilitated by the medicinal (and perhaps intoxicating) properties attributed to it. Tobacco became a valuable commodity in barter trade and its use spread rapidly.
Introduced initially in India as a product to be smoked, tobacco gradually began to be sued in several other forms. *Paan* (Betel quid) chewing became a widely prevalent form of smokeless tobacco use. Although some Chinese and European systems of medicine supported the use of tobacco ayurveda – the Indian system of medicine – never supported the use of tobacco as medication. The ill effects of tobacco use on human health were recognized even in the sixteenth century, which led to restrictions on its use. Tobacco thrived everywhere in the world despite social (and some religious) disapproval.

Pre-Independence Period
The following steps were taken by the Government (British India) to introduce tobacco as a major crop:
1787 Establishment of the Botanical Gardens at Sibpur, Calcutta (trials to grow tobacco were conducted).

1829 The Government decided to promote cultivation of superior tobacco. Imported seeds were made available to the Agrihorticulture Society of Calcutta and trials on an improved variety continued for several years.
1875 Attempts were made to produce Virginia tobacco at Ghazipur in Uttar Pradesh.
1875 Growing and curing of tobacco continued in the Pusa farm in Bihar.
1901 The British and American Tobacco Company expanded their trade into India and set up three companies, which later together became the Imperial Tobacco Company India, i.e. the present Indian Tobacco Company (ITC) ltd.,
1903 The establishment of the Imperial Agricultural Research Institute and College at the Pusa farm initiated the cultivation of a new variety of tobacco.
1920 The Indian Leaf Tobacco Division (ILTD) of ITC experimented on the black soils of Guntur, Andhra Pradesh and successfully cultivated Virginia tobacco in 1928.
1929 Commercial and large scale production of tobacco was initiated by the ILTD. The company established demonstration barns, provided technical guidance to them and encouraged local farmers to grow tobacco by providing financial assistance to construct barns, purchase fertilizers, wood fuel, etc. Slowly, tobacco cultivation spread to all the coastal districts of Andhra Pradesh.
1933 The ILTD introduced flue – cured Virginia (FCV) tobacco into the international market.
1936 A cigarette tobacco research station was established in Guntur to study the effect of soil and manure on the flavour of tobacco.
1937 Tobacco cultivation was introduced in Karnataka (Mysore state) by the Mysore Tobacco Company Ltd.
1938 India produced 499 million kg of tobacco and ranked second in production next to the USA (628.7 million kg).
1940s Cultivation of FCV tobacco was initiated in North Bihar (1940), Uttar Pradesh (1940) and Gujarat (1945-1946). In the first year (1943-1944), excise revenue from tobacco was Rs.9.65 crore.
1943 The Government set apart an annual, non lapsable grant of Rs.10 lakh from the proceeds of excise duty imposed to extend the cultivation of high quality leaf and improve the production of tobacco.
1945 The Tobacco Grading Inspectorate was established at Guntur to ensure the quality control of tobacco for exports, and the Indian Central Tobacco Committee (ICTC) was set up to look after the cultivation, technical and economic aspects of tobacco cultivation in India.
(Adapted from ICTC 1960; Directorate of Tobacco Development 1997; Kori 1998; Tobacco Board 2002).

Post-independence period

1947 The Indian Central Tobacco Committee (ICTC) established the Central Tobacco Research Institute for undertaking research on cigarettes and the Lanka type of tobacco. Later, four research stations were established in Tamil Nadu (in 1948 for cigarette, cheroot and chewing tobacco), Bihar (in 1950 for hookah and chewing tobacco), West Bengal (9n 1952 for wrapper and hookah tobacco) and Karnataka (in 1957 for FCV tobacco).
1956 The Tobacco Export Promotion Council (TEPC) was established to support, protect and promote the export of tobacco.
1965 The ICTC was abolished.
1966 The Directorate of Tobacco Development was established to gather information on tobacco production, trade, marketing, export and consumption.
1975 The Tobacco Board was constituted under the Tobacco Act, 1975, replacing the TEPC. The Tobacco Board is responsible for regulating the cultivation, production, marketing and export of FCV tobacco.
1980-81The Agricultural Prices Commission recommended a minimum support price for FCV tobacco grown in light and black soils.
1983 The National Cooperative Tobacco Growers' Federation Ltd. (TOBACCOFED) was established by the Ministry of Agriculture and Rural Development to promote the production and marketing of non-FCV tobacco in India. However, TOBACCOFED has been defunct for a long time.
1984 Auction sale of FCV tobacco was introduced for the first time by the Tobacco Board in Karnataka and in Andhra Pradesh in 1985.
(Adapted from Tobacco Board 2002; Directorate of Tobacco Development 1997)

2) Present scenario of tobacco use in India

In 1997, World Health Organization (WHO), reported the prevalence tobacco habits in India to be, Bidis (34%), Cigarettes (31%), Chewing tobacco (19%), Hookah (9%), Cigars cheroots (5%) and Snuff (2%).
But the data reported by cancer patients aid association of India in 2004, reveals the prevalence tobe cigarettes (20%), bidis (40%) and the remaining 40% is consumed as chewing tobacco, pan masala, snuff, gutkha, masheri and tobacco toothpaste. These two statistics reveals the changing pattern of tobacco consumption in India.
16.6% of the smokers live in India. Sixty five percent of all men and 33% of all women use tobacco in some form. 35% of men and 3% of women smoke.

Health consequences of tobacco consumption

The use of tobacco is harmful to general health, as it is a common cause of addiction, preventable illness, disability and death. The use of tobacco causes an increased risk of oral cancer, periodontal disease, oral mucosal lesions and other deleterious oral conditions and it adversely affects the outcome of oral health care including esthetics. It has been scientifically proved that tobacco causes over 20 categories of fatal and disabling diseases including cancer, cardiovascular and chronic respiratory diseases.
In India, in 1990, 1.5% of total deaths were tobacco related. Tobacco consumption is growing at a rate of 2-3% per annum. By 2020, it is predicted that it will account for 13%of all deaths in India.
Smokeless tobacco is an important etiological factor in cancers of the mouth, lip, tongue and pharynx. India has one of the highest rates of oral cancer in the world. 65% of all cancers in men and 33% of all cancers in women are tobacco related. Annual incidence of oral cancer is said o be 10 per 1,00,000 of males.

India's tobacco industry and market

India is world's third largest tobacco growing country. The liberalization of trade has contributed to a growth in tobacco consumption. Bidi manufacturing is the largest tobacco industry in India. In 1998, a total of 858 billion bidis were sold in India and sales are projected to reach 1031 billion by 2007. Gutkha and panmasala have become increasingly popular with young people. These mixtures, containing areca nut and flavoured additives are sold in colourful small sachets for as low as half a rupee. The four Indian tobacco companies

are Indian Tobacco Company, Godfrey Phillips Ltd. Tobacco, Golden Tobacco and National Tobacco. These companies face significant competition from the unorganized bidi manufacturers, which are largely protected from high taxes because of their status as small scale industry.

Tobacco legislation in India

Indian Law – At a Glance

Key provisions of the cigarettes and Other Tobacco Products Act, 2003

- Ban on smoking in public places (including Indoor workplaces)
- Ban on direct and indirect advertising of tobacco products
  - Point of-sale advertising is permitted.
- Ban on Sales to minors
  - Tobacco products cannot be sold to children less than 18 year of age
  - Tobacco products cannot be sold within a radius of 100 yards of educational institutions
- Pictorial health warnings
- English and one or more Indian languages to be used for health warnings on tobacco packs

Testing and regulation: Ingredients to be declared on tobacco product packages (tar and nicotine).

Role of health professionals

The major goal for the members of health profession is to use their knowledge and skills to contribute to control what the WHO, has labeled a 'smoking epidemic' in developing countries.

1. Preventing children from becoming addicted to tobacco
2. Providing effective protection from involuntary exposure to tobacco smoke
3. Providing effective programme of health promotion and health education
4. Effective smoking cessation programme
5. Prominent health warnings on tobacco product packing
6. Progressive elimination of tobacco advertising
7. Financial measures to discourage tobacco consumption

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 smoking counseling.
3. Dentists do not consider smoking counseling part of the 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.

References

1. WHO. Tobacco or health: A global status report. WHO Publication: Geneva, 1997.
2. Shimkhada R, Peabody JW. Tobacco control n India. Bull World Health Organ 2003; 81:48-52.
3. Watt RG, Daly B, Kay EJ. Prevention. Part 1: Smoking cessation advice within the general dental practice. Br Dent J. 2003; 194:665-8.
4. Rikard Bell G, Groenlund C, Ward J. Australian dental students' views about smoking cessation counseling and their skills as counselors. J Pub Health Dentist. 2003; 63:200-6.