INTRODUCTION

Nearly one in two men and one in five women in India consume tobacco in one form or another.1 Directly or indirectly, tobacco kills one million adult Indians every year.2–4 At the family level, expenditure on tobacco crowds out spending on education and essential items such as food.5 At the societal level, we are yet to come to terms with the ecological impact, through deforestation and environmental degradation, of large-scale tobacco farming and manufacturing processes. In the past decade, the Government of India started making attempts to intervene to reduce the consumption of tobacco.6 In 2003, the Cigarettes and Other Tobacco Products (prohibition of advertisement and regulation of trade and commerce, production, supply and distribution) Act (COTPA) was passed by Parliament. India ratified the World Health Organization’s Framework Convention on Tobacco Control (FCTC) in 2004. The Union Ministry of Health and Family Welfare (MoHFW), the nodal agency for these legal commitments, launched the National Programme for Tobacco Control in 2007. In late 2013, the then Prime Minister of India stated that a combination of multisectoral policies and public awareness was required for the achievement of tobacco control.7 On World No Tobacco Day 2014, the then Health Minister mentioned the need for a strong social movement against tobacco, and the need to engage all sections of people.8

In this commentary, we expand and extend the notion of multisectoral action for tobacco control. The policies are already rooted in various government sectors, but they are still sub-optimal and at times, conflicting. We argue that the Indian health sector can and should assume a stronger stewardship role to improve the health of the population and achieve health equity. For this, it is necessary to systematically scrutinize the impact of tobacco policies on health across different sectors and seek synergies which result in the most favourable impacts. This would be a welcome application of what is known as the Health-in-All (HiAP) approach.9

Far from being new, HiAP is based on the long-standing accumulation of evidence for the social, political and economic root causes of ill health and inequity.10,11 It takes the recommendations of the Commission on Social Determinants of Health12 to the policy level. Based on the notion of multisectoral action for health and equity, it relies on mobilization through a proactive health sector10,13,14 The advocates of HiAP argue that tobacco control is a natural candidate for this approach. Unlike most health issues, the tobacco epidemic already permeates the agenda of a range of government and non-government sectors, and tobacco control has proved to be most successful when based on national coordination involving the widespread participation of stakeholders.15 We briefly discuss four components of tobacco control in India today, describing the achievements and limitations, and outline three challenges that the health sector has to overcome to make effective tobacco control possible within a HiAP framework.

COMPONENTS OF TOBACCO CONTROL IN INDIA

Prohibition on tobacco smoking in public places

In India, it was not the health but the transport sector that was the first to deal with smoking in public places. The Motor Vehicles Act, 1939 enabled state governments to make rules to regulate the conduct of passengers in motorized vehicles. The rules included prohibition on smoking in such vehicles. Half a century later, the Railways Acts, 1989 prohibited people from smoking in trains when other passengers objected, and eventually expanded this to an outright ban on smoking in trains. In response to a public interest litigation (PIL), the Kerala High Court in 1999 prohibited tobacco smoking in public places in the state, considering it a violation of individuals’ right to life, which is guaranteed under Article 26 of the Indian Constitution.16 The court drew upon the 1981 Air (Prevention and Control of Pollution) Act and the 1960 Indian Penal Code to deem smoking in public places as a form of air pollution and public nuisance, respectively. In response to another PIL, the Supreme Court in 2001 prohibited tobacco smoking in eight categories of public places across India.17

It was only in 2003 that the Union Government, facilitated by the MoHFW, enacted COTPA, section 4 of which prohibited smoking in public places. The detailed rules for this section and its enforcement came into force in October 2008.

Ban on chewable tobacco products

The chewing of tobacco in different forms has a long history in South Asia. It has become more common over the past three decades, with large commercial units manufacturing tobacco products that are chewed, such as gutka and pan masala. These products were widely available in cheap plastic sachets and their use was inconspicuous compared to that of tobacco products which are smoked. Hence, they became popular among children and the youth, often serving as a starter product for tobacco addiction.

In response to this trend, in 2001, the food authorities in Tamil Nadu and Andhra Pradesh banned the manufacturing, storage and sale of tobacco products that are chewed, variously known as gutka, pan masala (with tobacco), zarda, khaini, etc. under the 1954 Prevention of Food Adulteration Act. Three more states followed suit: Maharashtra in 2002, and Goa and Bihar in 2003. However, gutka manufacturers challenged the ban in the Supreme Court, which directed the states to lift the ban in 2004. The Court held that the Prevention of Food Adulteration Act conferred the power to impose such a ban only on the Union Government. Meanwhile, a PIL was filed in the Rajasthan High Court, demanding that tobacco manufacturers be restrained from using plastic in the packaging of tobacco products that are chewed. The petitioners demanded that the court invoke the ‘polluter pays principle’, which holds the polluter liable for damages to the natural environment. In 2007, the court ordered tobacco manufacturers not to use plastics in the sachets.18 The manufacturers challenged this order in the Supreme Court, which upheld the High Court order.19

In 2011, new regulations were framed under the 2006 Food Safety and Standards Act, according to which tobacco and nicotine
shall not be used as ingredients of any food product. State
governments can now take action in cases in which these ingredients
are found in any food product. Madhya Pradesh was the first to
take such action, and banned gutka and similar products. This set
off a chain reaction: within a short period, 26 states and 7 Union
Territories passed similar ban orders.

**Tobacco production and taxation**

All tobacco-growing countries find that their efforts to control
tobacco products are challenged by the tobacco industry.India, the
country with the highest tobacco consumption, is no exception.4
National policies in the commerce, finance and agriculture sectors
are often at odds with those pursued by the health sector. The
Tobacco Board of India, which was established under the Union
Ministry of Agriculture and has its headquarters in
Guntur, Andhra Pradesh, with several branches in Karnataka and
Andhra Pradesh, provides financial, material and technical inputs
to tobacco farmers to promote tobacco farming and trade. The
Central Tobacco Research Institute, which was established under
the Union Ministry of Agriculture and has several branches,
strives to enhance the quality and yield of the tobacco crop
in India. In fact, tobacco production has been on the rise; the
production of tobacco leaves increased from over 500,000 tonnes
in 2000 to nearly 600,000 tonnes in 2009.4

Given this scenario, the implementation of the FCTC’s core
recommendation of increasing taxation to reduce demand is not an
easy task. In fact, between 2001 and 2007, all major forms of
tobacco (bidis, tobacco products that are chewed and cigarettes)
actually became more affordable.20 The possible gains of increased
taxation would nevertheless be considerable: for example, raising
the tax on the retail price of bidis from 9% to 40% and on that of
cigarettes from 38% to 78% is estimated to reduce the number of
smokers by 23 and 4.7 million, respectively. This would help save
many lives and increase government revenue.20 India does not even
come close to using taxes on tobacco to finance the health system
(while reducing tobacco consumption), as advocated by both the
WHO21 and Planning Commission of India.22 Besides, the taxation
structure for tobacco products is very complex, with the Central
and state governments using different types of tax assessment, collection
and exemption structures. There are no uniform taxes across the
major forms of tobacco products. This complexity easily diverts
attention from the fact that tobacco is highly under-taxed in India.
Small manufacturers of bidis are even exempted from taxes. Only
cigarettes, while still under-taxed, generate government revenue to
a moderate extent.20 This is in contrast to the consumption pattern
of tobacco in India, where of 34.6% of all the current tobacco users,
only 5.7% are cigarette smokers.1

Recently, some states have started increasing the value added
tax (VAT) on tobacco. Rajasthan increased VAT on all tobacco
products from 20% in 2008–09 to 65% in 2013–14. However,
Rajasthan remains an exception. The rate of VAT imposed on
tobacco products is variable across the states, with at least five
states levying zero VAT on bidis. In 2014, the Health Minister
recommended to the Ministry of Finance that the tax on the retail
price of cigarettes be raised from 45% to 60% in the Union
budget.23 Subsequently, in 2014, the excise duty on cigarettes was
increased by 11%–72% depending on the type of cigarettes.24

**Tobacco promotion and advertisements**

The 1975 Cigarette Act failed to address the promotion and
advertisement of tobacco. It was not until 2003, under a particular
provision of the COTPA, that all forms of tobacco advertisements
were prohibited. A decade earlier, the media and broadcasting
sector—highly influential with the younger section of the
population—had already taken action. In 1991, the Union Ministry
of Information and Broadcasting notified guiding principles for
the Central Film Certification Board. One of these was that it
should be ensured that films do not contain scenes which tend to
encourage, justify or glamorize the use of tobacco or smoking. As
for television, the 1995 Cable Television Networks (Regulation)
Act eventually led to self-regulation in 2008. The portrayal of
tobacco use and smoking was restricted to content that is certified
for adult viewing, and then too, the justification or promotion of
tobacco use was not allowed. The rules initially framed under
section 5 of COTPA prohibited the depiction of tobacco use in
films and television. However, a film director challenged these
rules and in 2009, the Delhi High Court struck them down as they
were beyond the ambit of the authority of COTPA and impinged
on the freedom of artistic expression guaranteed in the Indian
Constitution.25 In 2011, the COTPA rules were reframed. The
rules made health spots, scrolls, disclaimers and health warnings
mandatory; prohibited the promotion of tobacco and tobacco
product placements; and mandated masking of the brand names
and logos of tobacco products in films and television.

With film and television protected from tobacco promotion to
some extent, the tobacco industry has increasingly been using so-
called socially responsible activities to promote its image, and
indirectly, that of tobacco consumption.2 In this respect, the
government has not followed the FCTC’s recommendation to de-
normalize the tobacco industry’s corporate social responsibility
(CSR) activities. The amendment to the Companies Act (2013),
facilitated by the Union Ministry of Corporate Affairs, is
particularly problematic. The amendment requires every company
with a net worth of Rs500 crore (5 billion) or more and/or a net
profit of Rs5 crore (50 million) or more during any financial year
to spend at least 2% of its average net profits from the preceding
three financial years on CSR activities. This reform legitimizes
CSR activities by tobacco companies, which will ultimately divert
public opinion from the lethal nature of tobacco. For example,
in 2013, ITC Ltd.—India’s major cigarette manufacturer—
collaborated with the municipal corporation of Bengaluru to help
source recyclable plastic waste and create sustainable livelihoods
for ragpickers and those who collect municipal waste. This was
part of a CSR initiative called “Wealth Out of Waste.”26 Such
initiatives enhance the public image of the tobacco company and
provide easy access to government authorities.

India’s tobacco control policies did not originate in the health
sector and were multisectoral from the start. This makes it difficult
to overcome an equally multisectoral counteraction and has resulted
in a lack of synergy to do so. It can reasonably be argued that the
health sector—through the MoHFW, which has been given charge
of tobacco control under the COTPA—should play the key role in
bringing about the needed synergy.14 The examples of the
interventions made by the MoHFW with the Ministry of Finance, as
well as the Ministry of Information and Broadcasting, in the areas
of taxation and depiction of the use of tobacco in films, illustrate
that the MoHFW has the potential to promote a HiAP approach for
tobacco control. The question then is whether the Indian health
sector has the capacity to catalyse actions from across various
sectors. Without this capacity, no HiAP can be successful, be it in
the case of tobacco control or any other health issue. To build this
capacity, three major challenges need to be overcome.
CHALLENGES

Overcome the neglect of social determinants of health

The dominance of a biomedical paradigm and of curative and personal health services within the health system too often results in the neglect of action needed to address the social determinants of health. Health workers and their institutions are less inclined to work on the non-curative and non-personal aspects of population health. Engagement with policies in other sectors is, therefore, not seen as part of their ‘business’. This is unfortunate because the social status of health workers, and their intimacy with patients who suffer visible harms from tobacco, could work in their favour and help them to be heard and respected by policy-makers. The Voice of Tobacco Victims, a movement facilitated by cancer surgeons of people who survived tobacco-related cancers, is a good example of how health workers and patients can gain access to influential policy-makers and have their important policy-related demands heard.

Build skills for advocacy and mediation

Health workers may also lack the skills for effective engagement with other sectors. These skills include, but are not limited to, interaction with the media, knowledge of and advocacy for policies and familiarity with processes in other sectors, and mediation between different and often conflicting interests. The discourse surrounding tobacco control is full of intensely conflicting interests, e.g. raising taxes on tobacco versus banning tobacco products that are chewed and the potential impact on the livelihoods of tobacco and areca nut farmers. Effective mediation by health advocates is required to deal with the conflicting interests of different sectors. Such mediation should lead to negotiated policy outcomes that prioritize health concerns to a reasonable extent. The health advocates involved in the mediation must have expertise in diverse disciplines, such as economics, politics, journalism, human rights and law.

Mainstream health impact assessments

Last but not the least, India has no structural requirement for policies and programme development processes in sectors other than health to consider the potential impact of these policies and programmes on individual and population health. Ahuja,27 in an earlier issue of this Journal, elaborates on how health impact assessments could be carried out in India by drawing lessons from the currently mandated environmental impact assessments. Causse and colleagues28 have made a similar case for Southeast Asia, as have Collins and Koplan29 for the USA. For all member countries, the WHO advocates the assessment of ‘health impacts of policies either through a stand-alone assessment or as a part of an integrated assessment to inform the engagement process. Examples of tools include health impact assessment, health and health equity lens analysis, environmental impact assessment, policy audits, and budgetary reviews’.14 Without mandatory health impact assessments, the health sector will never have enough bargaining power to influence policies in other sectors, and HiAP will remain a distant dream. Without a HiAP, we feel, tobacco control in India will remain sub-optimal.

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