COMMENTARY

Tobacco Control in India: Present Scenario and Challenges Ahead

Tarveen Jandoo[1], Ravi Mehrotra[2]*

Abstract

Tobacco imposes a colossal burden of disease and death leading to catastrophic health, social, economic and environmental effects. Prevalence and practices of tobacco use in India are varied and disparate. Tobacco consumption continues to grow at 2–3% per annum, and by 2020 it is predicted that it will account for 13% of all deaths in the country. India is now demonstrating a steely resolve to contain the menace of tobacco through a comprehensive control strategy that combines several demand and supply reduction measures. India's anti-tobacco legislation, first passed at the national level in 1975, was largely limited to health warnings and proved to be inefficient. The 'Cigarettes and Other Tobacco Products Bill, 2003' represented an advance in tobacco control. It included demand reduction measures like outlawing smoking in public places, forbidding sale of tobacco to minors, requiring more prominent health warning labels, and banning advertising at sports and cultural events. India, as a signatory to FCTC, is actively involved in combating the menace of tobacco with renewed fervor. There is a need to devise innovative methods of mobilizing financial and human resources for tobacco control, establish efficient national coordinating mechanisms, integrate tobacco control into health and development programs and periodically evaluate these activities. The Government must also introduce policies to raise taxes, control smuggling, close advertising loopholes, and create adequate provisions for the enforcement of tobacco control laws.

Key Words: Policy - economy - tobacco control - legislation - India

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Introduction

The flagrant misuse of tobacco has caused a colossal burden of disease and death in India and is responsible for the devastating health, social, economic and environmental effects. The lugubrious prevalence and practices of tobacco consumption have been predicted to cause a rapid rise in disease burden, health care costs and other fiscal losses (Gajalakshmi et al 2000; Jha and Chaloupka, 1999; 2000).

The compelling need to curb the catastrophic consequences of tobacco use and addiction emphasizes the necessity to review the challenges faced by India and further actions to be taken to exterminate this problem. The objective of this paper is to synthesize the available scientific knowledge on tobacco use in India with a view to assessing the magnitude of the problem, identifying the gaps in knowledge, recognizing health hazards, reviewing the user practices and attempts to reduce the burden of tobacco as well as evolving future tobacco control policies.

Facts and Figures for Tobacco Use in India

Prevalence and practices of tobacco use in India are varied and disparate. Only 20% of total tobacco consumption is in the form of cigarettes. (WHO, 1997) A common alternative to traditional cigarettes is the bidi, a hand–rolled, filter-less form of smoking tobacco. Tobacco is also used in the hookah (a traditional water pipe), as pan masala or gutka (a chewing tobacco containing areca nut), as chutta (a clump of tobacco smoked with the lighted end inside the mouth), and mishri (a powdered tobacco rubbed on the gums as toothpaste). (WHO, 1997) 'Dohra' is an indigenous form of tobacco and slaked lime used in and around Allahabad, a city in Eastern Uttar Pradesh, India. (Mehrotra et al., 2003). Bidis account for the largest proportion of tobacco consumption in India (around 40%) as the teeming poor in India are 8-10 times more likely to smoke bidis than cigarettes (Narayan, 1999; Malson et al., 2001).

In India an estimated 65% of all men and 33% of all women use some form of tobacco. (WHO,1997) The prevalence of smoking among men and women differs substantially: 35% of men and 3% of women smoke, while -- both use smoke-less tobacco products to approximately the same extent. (WHO,1997) Tobacco consumption continues to grow in India at 2–3% per annum, and by 2020, it is predicted that it will account for 13% of all deaths in India. (WHO 1997; Mehrotra et al., 2008; Narayan, 1999; Malson et al., 2001; Kumar, 2000)

Nationally representative and reliable prevalence data

*Departments of Pharmacology[1] and Pathology[2], Moti Lal Nehru Medical College, Allahabad, India. *For correspondence: rm8509@gmail.com*

on tobacco consumption are scarce in India. The 52nd National Sample Survey conducted by the National Sample Survey Organization in 1995-96 was the first nationally representative household survey to collect data on tobacco consumption in population, 10 years and older, using surrogate household informants. The prevalence rates of consumption of tobacco in any form were found to be 51.3% for men and 10.35% for women, 15 years and older. (Rani et al 2003) The study provided an insight into the socioeconomic, cultural and demographic correlates of tobacco consumption. It concluded that the prevalence of both chewing and smoking forms of tobacco was significantly higher in rural, poor and uneducated population. Sporadic studies have been undertaken to show that education and occupation have an important simultaneous and independent relationship with tobacco use and this requires attention from policymakers and researchers. (Sorensen et al., 2005)

India is now demonstrating a steely resolve to contain the menace of tobacco through a comprehensive control strategy that combines several demand and supply reduction measures. Many factors in the Indian tobacco control initiatives have collectively contributed to this national consensus. These include: increasing awareness of the health, environmental and developmental damages caused by tobacco; growing global support for tobacco control; developing policies and programs for effective action and decisive interventions by the activists, non-governmental organizations and the Indian government.

Anti-Tobacco Policies and Practices in the Past

In the initial decades of independent India, tobacco merely had a pecuniary status and was considered as a source of revenue from taxes and exports rather than as a harmful commodity. The pioneering anti-tobacco activity in Indian legislature dates back to 1975 when the Government of India implemented the 'Cigarettes (Regulation of Production, Supply and Distribution) Act', mandating display of a statutory health warning on all packages and advertisements of cigarettes. (GOI 1975; Corrao et al., 2000)

The act did not include the non-cigarette products. It failed to accomplish much success, as it had feeble and fragile provisions. Several other single faceted national attempts to control tobacco use have been made in the past. The Prevention and Control of Pollution Act of 1981 included smoking in the definition of air pollution and the Motor Vehicles Act of 1988 made it illegal to smoke or spit in a public vehicle. (Corrao et al., 2000) The Indian government in 1990, utilized the provisions of the 'Prevention of Food Adulteration Act (1955), to prescribe health warnings stating chewing of tobacco to be injurious to health. (GOI 1954) Closely following this, in 1992, the Central government banned the sale of toothpastes and toothpowders containing tobacco under the 'Drugs and Cosmetics Act' of 1940 (GOI 1940). Finally, the Cable Television Networks Amendment Act of 2000 prohibited the transmission of tobacco and liquor advertisements on cable television across the country. (The Cable Television Networks Act, 1995)

The positive impact of anti-tobacco activities in the developed world has fostered the development of a social stigma towards smoking. This attitude marks the dawn of a moralizing approach and is a signal of public health achievement. (Bayer and Stuber, 2006). Slowly, but surely, a similar change is likely to be seen in resource challenged countries including India.

Recent Legislative Gestures

The Cigarettes and other Tobacco Products Act.

The Indian Parliament passed the 'Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Bill, 2003' in April 2003. This Bill became an Act on 18 May 2003. Rules were formulated and enforced from 1 May 2004. This law was intended to protect and promote public health, encompass evidence-based strategies to reduce tobacco consumption and impose penalties to the violators. The chief provisions of the act were banning of direct and indirect advertisements of tobacco products, prohibition of smoking in public places, sale of tobacco to minors and smoking within a radius of 100 yards of educational institutes. (GOI, 2003)

The WHO Framework Convention on Tobacco Control (FCTC) and its Implications for India

The World Health Assembly of the World Health Organization (WHO) adopted the Framework Convention on Tobacco Control (FCTC) at its 56th Session in May 2003. India ratified the convention on 5 February 2004 and commenced enforcement of the national tobacco control law in May 2004. It was the eighth and the largest country to ratify the treaty. India advocated strong provisions in the FCTC and was unanimously elected as the coordinator of the countries belonging to the WHO South-East Asian Region. The FCTC does not clearly lay down a law which shall be universally applicable, but sets out guidelines for various national and international measures to encourage smokers to quit and restrain non-smokers from taking to tobacco as a habit. As a signatory to the treaty, the Indian Government has been pursuing a proactive and bold strategy for tobacco control.

Fiscal Facts: Fastidious, Not Fatuous

The trade of tobacco has been sustained in India because of the huge domestic demand, burgeoning population and export potential. The growth index of industrial production for beverages, tobacco and tobacco products is the highest compared with other industries, being 314.7 in 2003-2004, compared to the base year of 1980-1981. (GOI, 2004) The retained earnings of tobacco product manufacturing companies, as percentage of profit after tax, were 73% in 2001-2002. (Center for Monitoring Indian Economy Pvt Ltd (CMIE), 2004) Generation of huge amount of profits enable these companies to have massive reserves. The total sales value of major cigarette and chewing tobacco companies was Rs. 99.38 billion and Rs. 12 billion, respectively, in 2001-2002. (CMIE,

2004) The advertising costs of tobacco product companies were 5.1% (of their net sales) in 2001-2002, being the highest as compared to other industries. These figures reveal the sound financial base of tobacco product manufacturing companies, akin to more developed economies.

The tobacco lobby has argued that tobacco control measures can negatively impact the economy by creating massive employment loss. Simulation of the net impact of tobacco control on the Indian economy has not been adequately investigated, making it difficult to assess accurately the effect of control measures. However, studies from other countries demonstrate that employment losses occur in the sectors that are immediately associated with cigarette production; however, these losses can be outweighed by increases in employment in all other industries, particularly in labour–intensive service industries. Jobs lost in retailing tobacco are likely to be replaced by those related to other products which people can purchase with the money formerly spent on tobacco. (Jacobs et al 2001) The overall impact of fiscal measures for tobacco control on economic, social and human development, including its contribution to the goal of health for all in the 21st century, is likely to outweigh any short term dislocation that may follow (Yach, 1998).

The positive pay off from tobacco control is substantial in terms of multiplied effects of improvement in public health and reduced disease and death that inevitably follow measures to ward off the tobacco epidemic. This baffling situation neither causes economists to take umbrage nor does it deter them to vouch that there is no immediate danger to the existing economic interests as a result of measures to lower tobacco use (GOI, 2001).

The Tobacco Epidemic: Threats Ahead

The gloomy and mournful predictions about the growing magnitude of tobacco's threat to India relate to a rise both in the proportion of deaths attributable to tobacco and in the absolute number of persons who consume tobacco. The World Health Organization (WHO) estimated that the proportion of deaths that result from tobacco-related diseases will rise in India, from 1.4% of all deaths in 1990 to 13.3% of all deaths in 2020. (World Health Organization, 1996). The models presented in the 2002 report of the Economic and Social Council (ECOSOC) of the United Nations predict that the number of persons consuming tobacco is likely to rise. (United Nations Economic and Social Council, 2002) In India's case, the population is expected to grow by about 300 million between 2000 and 2020. (Lewis and Wackowksi, 2006). Most of the expansion will occur in the age group of 15-59 years. This is the age group most vulnerable to acquiring and continuing the tobacco addiction.

Some glamorous products and marketing innovations like flavored cigarettes are likely to target youth and have important potential implications of increased smoking experimentation and consumption (India Vision 2020, 2002). These observations foist upon us to raise a clamor for interventional steps in tobacco control before the tobacco epidemic goes berserk.

Tobacco Control: What is Needed

Resourcing: Financial Resource Mobilization and Human Resource Development

Financial resources can be generated from a variety of sources: increased government allocations, an earmarked tobacco tax or cess, regulatory levies, penalties, private sector resources, civil society resources and international financial assistance. The revenues earned from such a tax/cess/levy have been utilized for funding not only tobacco control programs but also a variety of other health promotion activities (Guindon, 2003; Karki, 2003; Chaloupka et al., 2008).

Regulatory levies are mechanisms by which funds for tobacco control can be generated, through a fee collected by the National Regulatory Authority (NRA) for testing and regulating tobacco products. This can be done both prior to the introduction of a new tobacco brand into the market, and also for annual renewal of the permission to market the brand, as is being practiced in Brazil (Government leadership in tobacco control, 2008). Adequate attention should be paid to developing committed human resources, including grass level workers, community-level activists and medical professionals.

Coordination: Establishment of a National Coordinating Mechanism

To implement the provisions of the Indian Tobacco Control Act and FCTC, establishing a national coordination mechanism is essential. Article 5.2 (a) of the FCTC obliges the ratifying parties to establish or reinforce and finance a national coordinating mechanism for tobacco control. (WHO, 2003) This mechanism should have four types of agencies-a National Regulatory Authority (NRA), a National Coordinating Body, an Inter-ministerial Coordination Committee and a State-level Coordinating Body.

With the establishment of ANVISA (Agencia Nacional de Vigilancia Sanitaria) or National Health Surveillance Agency and National Commission on Tobacco Use (NCTU) Brazil has become a world leader in regulating and controlling tobacco products. (Government leadership in tobacco control, 2008) Similar bodies should be established in India to ensure smooth interaction between the coordinating agencies at the central and state level and this should leave no scope for ambiguity in interpreting the laws related to tobacco control at any level.

Integration of Tobacco Control into Health and Development Programs

Tobacco control can be integrated into the existing delivery systems such as the health care system and other developmental programs. The vast human resources available with various programs such as the AIDS Control Program and Malaria Control Program can be used additionally for tobacco control, especially for health education activities. This will have immense benefit coupled with a low incremental cost. As the relationship between tuberculosis and smoking is well known, the Tuberculosis Control Program may be used to impart

health education as well as screen patients for tobacco use.

The tobacco control program in India should be kick-started by integrating it into various developmental programs such as poverty alleviation, rural development, women and child development, and tribal welfare, with extensive reach and widespread presence at the grassroots level.

Curbing the Menace of Tobacco

There are several ways in which the menace of tobacco can be countered and diminished. It requires a political will and collective societal commitment to strengthen tobacco control in India. A number of possible important steps are detailed below:

1) Raising taxes on all tobacco products to increase prices and generate revenue for tobacco control. The World Bank estimates that a 10% increase in price reduces demand by 8% in low or middle-income countries. [The World Bank, 1999] Since most of India's tobacco is consumed by the poor, with an increasing trend towards use by youth, price increases are likely to be effective with these groups which are the most price sensitive. (The World Bank, 1999) The additional revenue can be spent on social sector initiatives benefiting the poor and on strengthening tobacco control programs.

2) A complete ban on smoking in public places by law. If that is not possible, designated smoking areas should be separated from non-smoking areas through specified engineering guidelines. Strict adherence to engineering criteria should be followed in all public places.

3) Impose a ban on oral tobacco products such as gutka, pan masala and dohra. Strengthen enforcement of existing laws and regulations. Develop and implement specific, practical, innovative strategies and interventions which society and the Government (central, state, and local) can take to ensure consistent, long-term enforcement of the legal provisions.

4) Establish coordinating mechanisms at Central and State levels. Tobacco control committees as suggested by the central government should be formed immediately at the state level and central level. A National Coordinating Mechanism should be immediately established to monitor effective enforcement of tobacco control legislation in India.

5) Mobilize the people through mass education and community empowerment. Manager/owners of the hotel or restaurant or owner/occupier of any public places should be properly sensitized and subsequently held responsible (liable for fine /prosecution) if the customers smoke in the smoke free area. This person should be responsible for taking all reasonable steps to ensure that no person smokes in violation of the provisions of the law. Penalties need to be strict and specific.

6) Smoking should be prohibited in all closed workplaces either privately or publicly owned. Warning boards containing "No Smoking Area- Smoking Here is an Offence" have to be prescribed and supplied by central government in a fixed pattern with the Government of India's emblem. Smoke sensors and alarms should be placed in all public buildings to detect tobacco smoke.

7) All identity cards, driving licenses, railway tickets and utility bills should carry anti-tobacco messages and messages highlighting benefits of having smoke-free workplaces. All government/ private health care facilities should carry anti-tobacco messages on case papers.

8) Chief Executives, Officers, Administrators and Chief Managing Directors of industrial worksites and other corporate workplaces, should be informed and sensitized about the Act. They should be motivated to make their own organization's premises tobacco free and prohibit the use of any kind of tobacco product within their worksite campus. Employers should be informed about benefits of giving preference to non-tobacco using candidates as employees and cessation help should be provided for employees who are tobacco users.

9) Students in professional colleges (like engineering, medical, IT etc.) should be sensitized to keep their college campuses tobacco free and subsequently when they get promoted to administrative positions to give due importance to have smoke-free worksites.

10) Sensitization of public through display of anti-tobacco messages on television as a ticker during the news and through other communication channels. Consumer groups can play a key role in strengthening recommendation to the government on various issues related to tobacco control. Special focus should be given in selecting the media. Media should be actively involved to spread the anti–tobacco messages among the masses. A special task force should be created at each state level to monitor implementation.

11) Law enforcers should be informed and sensitized about the various provisions of Indian Tobacco Control Act through various sensitization workshops and awareness and advocacy campaigns. Toll free help line number should be available to lodge complaints against the violations of the law. More government officials should be empowered to monitor and enforce the provision of ban on smoking in public places. Include NGOs as well in the enforcement machinery using the provision of Sec. 24. Exact details of who is responsible for enforcing the law should be laid down. Relying on the already-overstretched arms of the police force may not be feasible. A special force, akin to the tourist police in tourist areas abroad is a possibility. It should be trained for this purpose and adequately motivated to perform their functions with consistency and commitment.

12) Restrict the import of tobacco products into India. It is also possible that with higher taxes on tobacco products in India, smuggling of these products from neighboring countries with lower tax rates will become a problem. Although there is little experience and research on the effectiveness of various anti-smuggling measures, successful ones may include placement of prominent tax stamps and local-language warnings on packages and the aggressive enforcement of penalties to deter smugglers (Joossens et al., 2000).

13) Progressively reduce the area of land under tobacco cultivation in India.

14) The tobacco industry in India should be prevented from increasingly investing in and extensively advertising

non-tobacco products by the same brand name. Such surrogate advertisements have been shown to influence young minds (International Agency on Tobacco and Health, 2004). Despite a vigorous ban imposed by legislature, a plethora of advertisements appear on media channels. Attractive schemes such as bravery awards (Simpson, 2003) and movie awards have also been sponsored by several tobacco companies, indirectly promoting their products. Such practices should be checked.

15) Interventions that reduce price differentials amongst various marketed products should be introduced to maximize public health benefit of cigarette excise taxes. Hyland et al concludes that smokers who purchased low-taxed cigarettes were less likely to attempt quitting as compared to smokers who bought full-priced cigarettes, however cessation rates in the two groups showed a non-significant trend (Hayland et al 2005).

Evaluation of Tobacco Control Programs

Evaluation helps ensure that only effective approaches are implemented and that resources are not wasted on ineffective programs. The Government should also routinely monitor the implementation of tobacco control policies. This includes tracking the development of ordinances, laws and rules. The national indicators which should be studied include: land area under tobacco cultivation, annual tobacco production, annual domestic consumption of home grown and manufactured tobacco (including major categories of tobacco products), annual export of tobacco, tax revenue from tobacco and cause specific mortality of tobacco-related diseases.

At least 10% of the budget of each local project should be used for tobacco control. Experience in California and Massachusetts has shown that these funds can be used both for statewide systems and to increase the technical capacity of local programs to perform evaluation activities. (Centers for Disease Control and Prevention (CDC), 1999)

Regional Practices of Tobacco Use and Control

Increasing globalization makes the countries of the Asian subcontinent vulnerable to changing lifestyles. The WHO and the Federation Dentaire Internationale (FDI) have highlighted facts about tobacco. Presently there are 1.3 billion smokers worldwide. Of these, 900 million are in developing countries (Tobacco or oral health, 2005). In recent years, a potential increase in tobacco consumption has been predicted for the low income countries.(Dagli E et al 1999) A high incidence of smoking amongst youth has been reported by Bangladesh, India and Indonesia (http://w3.whosea.org/EN/Section313/Section1524_6877.htm, Accessed Sept 11, 2008). Lack of awareness of the potential, probable and definite health hazards associated with tobacco and the tactics of the tobacco industry to target the vulnerable population of women and youngsters are important factors that espouse the increase in tobacco consumption seen in these countries. (Mackay and Crofton, 1996)

In comparison to smoking, chewable forms of tobacco are being preferred by the teeming poor in developing countries. Betel quid chewing is the commonest traditional chewing habit in the Asia-Pacific region. It has been reported from many countries like India, Pakistan, Bangladesh, Sri Lanka, Thailand, Cambodia, Malaysia, Indonesia, China and migrant populations in Europe, Africa, North America and Australia (Gupta and Ray, 2004). Recently, Cambodia and Thailand have reported a decline in betel quid chewing habit (Reichart and Philipsen, 2005), but data are sparse from other countries.

The migration practices and the cultural and geographical diversities require that the nations develop an entente relationship to collaboratively combat the menace of tobacco. Health officials in Taiwan have devised three national plans to combat the problem viz. Scheme of Betel nut Problem Management (1997-2001), Community Oral cancer Screening Programme (2002-04) and National Cancer prevention and Control Initiatives-Oral Cancer Prevention and Control (2005-09). The Ministry of Health in Cambodia has included oral cancer in the National Oral Health Plan and is keen to develop a National Cancer Registry for the same. In 2001, the Ministry of Health in Sri Lanka launched an eighteen-point programme, which identified prevention of tobacco consumption as a high priority area. The Philippines reports no active involvement of health professionals in control of risk factors like tobacco use for prevention of oral cancer. Indonesia has tried to investigate the prevalence and practices of tobacco use and has felt the need to actively intervene. The National cancer control and prevention strategy of Malaysia targets tobacco use, unhealthy nutrition and other risk factors for oral cancer. The public sector in majority of these countries continues to spearhead implementation of legislation and policies, health education and promotion programs. These facts highlight the arduous approaches being made to face the problem of tobacco use with pugnacity (Proceedings from 'Oral Cancer in the Asia Pacific-A regional update and networking, 2006).

Conclusions

Tobacco use in India is projected to have devastating consequences. Given the low level of tobacco control activities so far and the sparse resources allocated till now for that purpose, a comprehensive well resourced National Program for Tobacco Control is likely to have a high impact. A ban on oral tobacco products too will have an immediate impact. The complete ban on advertising and the countrywide ban on smoking in closed places in India can go a long way to help eliminate this menace.

India should aim to achieve at least a 30% reduction in the prevalence of tobacco consumption by 2020 and a 25% reduction in tobacco-related mortality by 2050. These targets are not modest, considering the large projected rise in tobacco-attributable mortality that has been forecast for India. However, a comprehensive tobacco control program, which combines high levels of passion, planning, performance and perseverance, has a very good chance of accomplishing these goals, or even in fact bettering them.

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