

The looming challenge of the mixed marketplace for tobacco products

Jonathan M. Samet and Heather Wipfli

Throughout the world, as use of manufactured cigarettes has dropped, the tobacco industry has taken steps to diversify its product offerings with the overall goal of assuring a steady market of nicotine-addicted people. In the United States, the industry has a long history of developing and testing alternative products that deliver nicotine, but can be marketed as having possibly lesser risk than conventional cigarettes. 'Premiere', developed and test-marketed by Philip Morris is an early example – a product that did not directly combust tobacco so that sidestream smoke emissions were reduced. More recently, other similar products have been developed and the industry is moving aggressively to bring snus, the oral moist product from Sweden into the marketplace as well. The availability of multiple tobacco products complicates tobacco control as oral products offer an alternative to cigarettes for maintained nicotine dosing in environments where smoking is not allowed and taxation strategies need to be developed with consideration of the range of products available. Additionally, a divisive debate around 'harm reduction' has arisen and laboratory-testing strategies for predicting the potential risks of new products with certainty are still undeveloped¹.

Tobacco control in India already faces the challenge of the availability of diverse products that span a wide range of prices. Manufactured cigarettes account for a comparatively small percentage of the tobacco consumed, about 20% overall, while the majority of tobacco, about 53%, is used in the form of bidi^{2,3}. A diverse group of oral products constitutes the remainder. Patterns of use vary substantially by sex, region of the country, and level of urbanization.

The implications of this range of products for tobacco control in India are obvious and substantial. The target for tobacco control in reality consists of many distinct populations, using different products, and consequently needing appropriately targeted strategies. There is also variation in language, culture and educational level across the populations

that needs to be taken into account. Unlike China or the US, where tobacco use is uniformly manufactured cigarettes, the diversity of products and the ties to specific locales in India call for carefully tailored tobacco control strategies that will need to be developed at state and local levels.

The diversity of products and the wide range of prices may also hinder strategies based around increasing prices through higher taxes. While there are ample data demonstrating the price elasticity of smoking demand, the studies have largely been conducted in countries where the primary form of tobacco use is manufactured cigarettes. In India, higher taxes on one form of tobacco may simply drive tobacco users to cheaper products; bidi, which is cheap, is particularly problematic for taxation strategies in India. Country-specific evidence is needed on the topic of taxation, and taxation strategies will be needed that cover bidi sales.

The diverse products also complicate potential approaches for product testing, a strategy proposed by the 'WHO Study Group on Tobacco Product Regulation'⁴. Such strategies might be feasibly implemented in countries like the US where tobacco is still largely used in the form of manufactured cigarettes and only few companies sell cigarettes. Given the uniformity of the product, representative testing should be possible. By contrast, there are numerous products in India for which testing methods have not yet been developed and for which the test compounds and biomarkers have not been established. Even the development of protocols for obtaining representative samples would be difficult, given the likely heterogeneity of tobacco and its products across regions of the country.

As the tobacco industry continues to mutate its products, it will be difficult to develop scientific testing techniques that accurately assess the health risk associated with long-term use. It took the public health community nearly 40 years to conclude that 'light' and 'low tar' cigarettes offered no health benefits over higher-yield cigarettes. During this time

millions of smokers made the deadly choice to switch instead of quit and millions more chose to start smoking under the false belief that they were choosing a healthier alternative.

The diverse products also raise challenges with regard to the type and content of health warnings. Health effects differ between diverse products and specific warnings for some products are well established. Lung cancer risk, for example, is high for cigarettes but not for oral smokeless tobacco. Oral lesions are common with oral smokeless tobacco. Many products in India have received little study and new products will emerge for which epidemiological data do not exist. In such cases, warnings will need to be based on the basis of their ingredients and previously established effects of those ingredients and all tobacco products should contain warnings that they pose the risk of addiction, death and disease. Now that some tobacco products in India have large graphic health warnings, many consumers may conclude that products without such warnings pose relatively little health risk, as has been the case with cigars, waterpipes and other products in the US.

Despite these challenges, science-based guidance is needed in the regulation and communication about the diverse tobacco market. Ongoing research and capacity development is needed to support the regulatory environment outlined by the Framework Convention on Tobacco Control in Articles 9–11. In the meantime, comprehensive tobacco control programmes focused on taxation of all tobacco products, tobacco-free public places, effective warning labels, and tailored communication campaigns are needed to reduce tobacco consumption, regardless of the delivery mechanism, in India and throughout the world.

1. Institute of Medicine. *Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction*, National Academy Press, Washington DC, 2001.

2. Gupta, K. S. and Asma, S. (eds), *Bidi Smoking and Public Health*, Ministry of

- Health and Family Welfare, Govt of India, 2008.
3. Reddy, K. S. and Gupta P. C. (eds), *Report on Tobacco Control in India*, Ministry of Health and Family Welfare, Govt of India, 2004.
4. WHO, The scientific basis of tobacco product regulation, World Health Organization, Geneva, 2007.
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GENERAL ARTICLE

Building tobacco control training capacity in India

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There are immediate and long-term needs for tobacco control capacity development in India. In the short term, the development of in-person and virtual training programmes aimed at increasing the number of people educating the population about tobacco offers a critical and cost-effective approach to expanding the knowledge-base regarding tobacco. For the longer term, a core of tobacco control professionals is needed, who will sustain tobacco control initiatives across the country for decades to come. This article identifies past courses that offer core curriculum and various training models that could be used to reach a large and diverse audience in India.

Keywords: Bidi, control and training initiatives, public health, tobacco.

GLOBALLY, we are in a new era of tobacco control. The Framework Convention for Tobacco Control (FCTC) has been ratified by most of the world's nations and is now in force. Many countries, states, and municipalities have strong, enforced smoke-free laws in place and the prevalence of smoking is declining in most Western countries. Additionally, major funders, particularly Bloomberg Philanthropies, and the Bill and Melinda Gates Foundation, are now supporting tobacco control in developing countries.

The past decade has also seen remarkable progress in tobacco control in India. The Indian government took an active and progressive lead in the negotiations of the FCTC and was one of the first countries in the world to ratify the treaty. The government also passed 'The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act' in May 2003, which aims to protect public health by prohibiting smoking in public places; banning advertising of tobacco prod-

ucts; banning the sale of tobacco products to minors and near educational institutions; prescribing strong health warnings, including pictorial depiction on tobacco products, and regulating tar and nicotine contents of tobacco products. The Ministry of Health has followed up its commitment to tobacco control with dedicated funds for the states to use them for educational and cessation programmes through the Rural Health Mission.

Civil society groups have also increased activism in the area of tobacco control, especially in the courts where they have directed the government to take the steps needed to control tobacco use and have successfully challenged the opposition of the tobacco industry to elements of the 2003 Act. There are strong and capable national tobacco control leaders setting directions in India. These leaders have worked tirelessly to compile the data necessary to support tobacco control in India and have founded civil society groups advocating the implementation of evidence-based tobacco control programmes^{1,2}. Both the Indian government and the civil society groups have been the key partners and benefactors in the Bloomberg Initiative to Reduce Tobacco Use, which has resulted in a flow of additional resources for tobacco control into the county.

Despite these many recent accomplishments, India still faces unique challenges as it controls tobacco use within its borders. Many of the lessons learned in Western,

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