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COMMENTARY

Tobacco-related health harms among Indigenous communities in India: Commercial determinants of health perspective

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Abstract

Tobacco use has remained high among Indigenous communities in India over time, compared to other social groups. In this commentary, I use the lens of "commercial determinants of health" to understand commercial drivers of tobacco-related health harms among Indigenous communities, at three levels: the products, industry activities, and structural factors. At the level of products, we need to recognise diverse products and patterns of tobacco use, while differentiating the traditional use of tobacco from commercial tobacco use. Certain industry activities including "sachetisation" of tobacco products, occupational hazards in the bidi sector, and tobacco industry influence on public policy impacting Indigenous community health are examined. Macro-economic factors, not always specific to Indigenous groups/areas, also create the broader environment in which commercial forces operate. Tobacco control efforts need to consider the unique contexts of Indigenous communities, regulate the tobacco industry, and promote policies that provide safer livelihood alternatives alongside supply reduction measures.

Keywords: *Indigenous communities, Adivasis, tobacco, commercial determinants of health, bidis*

Introduction

Tobacco use took firm root in India only at the beginning of the 17th century, a little over 400 years ago [1]. However, its use spread rapidly, making it part of the economic and sociocultural milieu of Indian society, including that of Indigenous communities. The 2018 report of the expert committee on tribal health, set up by the Government of India, identified "controlling the use of addictive substances and providing de-addiction and mental health care" as one of the ten special challenges faced in enhancing the health of Indigenous communities [2]. The report, based on the National Family Health Survey (Round 3) data, reported that tobacco use among men belonging to the Scheduled Tribes was higher (71.7%) than among men from other social groups (56.3%) [2].

I do not come from an Indigenous community but have been researching and addressing tobacco control for nearly two decades, with recent work in the related area of commercial determinants of health. In the last few years, I started engaging with scholars working with Indigenous communities and participated in a few initiatives that specifically explore and/or address substance use among Indigenous communities. It is in this context of limited familiarity with Indigenous communities and my interest in tobacco and social inequities, that I develop this commentary to look at tobacco and Indigenous communities through the lens of commercial determinants of health.

Tobacco as a commercial driver of the health of Indigenous communities

While I recognise the importance of sociocultural and historical factors in understanding tobacco use among Indigenous communities, I want to limit the focus of this commentary to the commercial and economic dimensions of how tobacco use became an essential part of the life of Indigenous communities in India, through the useful lens of "commercial determinants of health". Here, I go by the framing of commercial determinants of health by Kickbusch et al as "strategies and approaches used by the private sector to promote products and choices that are detrimental to health" [3]. I further use Melissa Mialon's three-level view of how commercial determinants operate [4], as (i) the products or services, whose consumption harms health; (ii) the various activities of businesses to expand their markets, run their business, or initiate corporate political activities to build their image and soft power; and (iii) the macro-level factors or structures (eg, mode of economic production, legal frameworks) that are beyond the business framework but shape how businesses behave.

About tobacco consumptions and its cultural significance

High use of tobacco among Indigenous groups

There is enough evidence to establish that tobacco, consumed in any form or quantity, is hazardous to human health. The limited available data imply the relatively high prevalence of tobacco use among Indigenous communities in India. My analysis of the comparable rounds of the National Sample Surveys over the 1990-2012 period revealed the stark difference in household-level tobacco use prevalence across social groups with "scheduled tribes" having the highest prevalence (compared to other groups) throughout the period [5]. Also, while tobacco use has declined over time, the disparities in its use across social groups have increased, with the least decline in tobacco use shown among people in the scheduled tribe category [5]. A recent analysis of the Global Adult Tobacco Survey India

(2016-2017) corroborates the earlier findings. It shows that the prevalence rates of both smoked and smokeless tobacco use among people aged 15 years and above, were highest among scheduled tribe communities (smoked 8.3%; smokeless 27.7%), followed by scheduled castes (smoked 8.2%, smokeless 20.7%) and other castes (smoked 6.0%, smokeless 16%) [6].

There is limited data about the nature of tobacco use among specific forest-dwelling Indigenous groups (also referred to as Adivasi or tribal communities) in India. I synthesised some of the published studies providing data on tobacco use and related attributes among Indigenous groups in different parts of India, in a table format in Supplementary Table 1 (available online only). These studies suggest that while the extent and forms of tobacco use, as well as gender-based distribution of tobacco users, vary widely among different Indigenous communities in India, its prevalence is considerably higher among Indigenous communities (compared to national surveys averages). The tobacco products in use are diverse, including several non-standardised, non-packaged formulations. There is need to better understand these products in terms of their addictive appeal and toxic nature, including the patterns of use of specific products, as such data will help healthcare providers tailor tobacco cessation services, making them acceptable and effective. The dominant tobacco cessation models/protocols have remained focused primarily on cigarettes, and only recently have there been some efforts to develop cessation support specific to smokeless tobacco products prevalent in our country [7,8].

Traditional vs commercial use of tobacco

We do know from international contexts (especially, those of Canada and the United States) that commercial tobacco use ought to be perceived differently from traditional tobacco use (also called, sacred or ceremonial tobacco use) by Indigenous communities [9]. While tobacco was introduced in India by Portuguese traders at the beginning of the 17th century [1], it went on to become part of the cultural practices of many of the Indigenous communities in India, some even growing tobacco for personal use. I outline below how this occurred.

In 1961, Koppad and team documented the use of tobacco leaves in marriage rituals of the Soligas, a community mainly concentrated in the Biligiriranga (BR) hills and Male Mahadeshwara (MM) hill forests of Karnataka [10]. They mention that "The bride-price (Tera) is given after the *tali* tying ceremony…This is followed by a simple ceremony in which a small metal plate filled with jaggery, tobacco, betel leaves, betel nuts, etc. is worshipped and handed over to the 5 members belonging to the 5-kulas..." [10]. Later, in 1977, SG Morab also documented a similar practice among Soligas, wherein he noted, "The bridegroom brings new cloths and ornaments to the bride as marriage gifts. He also brings a small cloth bag containing betel, betel leaves and tobacco." [11]

Verrier Elvin documented, at length, the sociocultural place of tobacco among Murias (a subgroup of Gonds) in Chhattisgarh [12]. He wrote that in *Ghotuls* (social institutions wherein unmarried boys and girls stay together to learn about tribal culture, social norms, and traditions), "As the girls go round for Johar (salutation/welcome greeting), the Belosa (the leader of girl members of Ghotul) and her assistant put a few pinches of finely-powdered tobacco into the chelik's (boy's) hands…to ask for tobacco is itself a polite way of asking a girl for sexual congress."[12] In fact, Murias have their own tale of the origin of tobacco and how it comes to them [12]. Verrier Elwin also documented the importance of tobacco in the social lives of the Baigas, including their friendship and death rituals [13]. Both Murias and Baigas have been shown to grow their own tobacco supplies in small land patches [12,13].

This is not to claim that "traditional tobacco" (and here, I mean tobacco that is not produced commercially and that is locally integrated into the culture of Indigenous communities) is safe. However, there is a difference between traditional and commercial tobacco in terms of why they are used, how they are produced, and the essential absence of commercial interests in the former variety. Also, for "traditional tobacco", there is certainly a generational understanding of the substance informing how people embrace and manage its use, compared to commercial tobacco products, wherein there is a strong incentive to expand the consumption market for profit. Hence, public health efforts must prioritise the curbing of commercial tobacco.

Promotional activities of the tobacco industry

The tobacco industry is among the major industries (the others being mining, tourism, alcohol, ultra-processed foods, fishing etc) that shape the health of Indigenous communities worldwide [14,15]. One way to understand tobacco industry activities is to think in terms of three buckets: (i) activities oriented towards expanding the market (ie, marketing and pricing strategies); (ii) business-oriented activities that could include tobacco production and complying with the various statutory provisions; and (iii) corporate political activities (eg, corporate social responsibility, lobbying etc,) that are not directly about production or sales, but about building their "soft power"[4].

Marketing activities

At present, we lack much published literature about tobacco industry marketing and advertising practices in the context of Indigenous communities. In some countries, the tobacco industry has co-opted Indigenous cultural symbols/ messages to market commercial tobacco products to Indigenous communities, including the youth [15, 16, 17]. Another related marketing technique is the so-called "sachetisation" or sachet marketing — not, of course, specific to tobacco, nor to Indigenous communities — where

smokeless tobacco in small packets, as well as smaller packs of bidis and cigarettes are now made available, making them affordable and accessible even in remote rural and tribal areas [18]. Koppad and team had documented that in the erstwhile Mysore state (now Karnataka), petty traders or iterant merchants, typically from outside of the Indigenous communities, played an important role in introducing tobacco to some Indigenous groups, selling tobacco to them in exchange for cash or other items of their interest [10].

Business-oriented activities

An important linkage here is the participation of members from Indigenous communities as precarious workers in supply chains of the bidi industry, and the resultant health harms.

Tendu leaf collection

Tendu (Diospyros melanoxylon) leaves form an essential ingredient for bidi production. These leaves are collected from the central Indian forest by Indigenous communities, sun-dried and sold through state forest department mediation. As per the Ministry of Tribal Affairs (Government of India) about 7.5 million workers are engaged in tendu leaf collection. While it forms an important source of livelihood, *tendu* collection is a seasonal employment, typically in the summer months from April to June [19]. *Tendu* leaf collectors face hardships including having to walk long distances, risking snake bite, wild animal encounters and, to a lesser extent, those with extremist groups operating in these forested areas [20, 21].

Bidi rolling

In 2016, a national news daily reported that 0.9 to one million tribal women were employed in bidi work [22]. In 2021, another media outlet indicated the prevalence of bidi rolling work among Indigenous communities in Satna, Rewa and Panna districts of Madhya Pradesh [23]. Bidi rolling has been documented as putting bidi rollers at higher risk of diseases of the respiratory system (including asthma and tuberculosis), the skin, musculoskeletal system, eyes, gastrointestinal issues and gynaecological problems among women bidi workers, including low birthweight and stunting among infants and children of bidi workers [24, 25, 26, 27].

Lack of better livelihood alternatives

Our analysis of parliamentary questions from 1957-2022 revealed that Members of Parliament have often raised questions relating to neglect of the welfare of bidi workers from tribal districts of Gujarat, Bihar, Uttar Pradesh, and Andhra Pradesh [27]. A majority of workers engaged in *tendu* leaf collection remain dissatisfied with the remuneration they receive [20, 28]. It is primarily the lack of other means of income/livelihoods during the lean agricultural months in the summer that force most marginalised households to rely on *tendu* leaf plucking. Poverty obliges them to involve even their children in both *tendu* leaf plucking and bidi rolling to varying extents [21, 26]. While a majority of the Indigenous people engaged in bidi rolling recognise the adverse aspects of their work (including long hours of work, health issues, and the negative impact on their children's education); and wish for their children not to go into bidi work, they continue in this work given its availability, the convenience of working from their own homes and the relative lack of equally remunerative alternatives [28]. Hence, it remains a paradox that while income from tendu/bidi work is crucial for these households, engaging in such work is due to the absence of an alternative; and this exposes them to health harms, unfair working conditions and low wages.

Corporate political activities

Corporate social responsibility

Tobacco manufacturers in India are known to engage in corporate social responsibility (CSR) activities [29]. In fact, the Indian government mandates large businesses to engage in CSR. Some of the major Indian cigarette manufacturers claim to help tribal communities through their CSR schemes. In the year 2023-2024, ITC Pvt Ltd, the largest cigarette manufacturer in India, partnered with the NABARD Tribal Development Fund and the Tribal Co-operative Marketing and Development Federation of India in order to help train tribal farmers in organic farming and enhanced market linkages [30]. It was also claimed that their social forestry programme that promotes crop and tree plantation by small-holder farmers (providing food and wood security) had achieved greening of over 33,900 acres of land and benefitted over 10,800 households during the year, most of whom were small-scale and tribal farmers [30].

While such CSR efforts seem beneficial to Indigenous communities, CSR by tobacco companies has itself been considered problematic in public health. The World Health Organization (WHO) sees so-called CSR by the tobacco industry as more of a public relations strategy, given the inherent conflict between the core business of producing lethal products and socially productive goals [31]. The WHO Framework Convention on Tobacco Control, a widely ratified United Nations treaty that India has signed and fully ratified, requires governments to de-normalise CSR by the tobacco industry [32]. There have also been concerns that CSR directed towards tribal development needs to be especially well thought out, planned, and informed by the needs of Indigenous communities in consultation with them, given that large businesses are essentially among the major actors behind displacement and dispossession of Indigenous communities [33].

Lobbying

Lobbying by the industry to resist regulation or influence policies is another element of exercising corporate political power. The tobacco industry's activities in India, using a range of tactics to influence public policies to serve its

commercial and vested interests has been well documented [34, 35]. While it is not easy to find direct links between tobacco industry lobbying and Indigenous communities, some of the policy influences are of specific relevance to Indigenous communities, eg, the tobacco industry's (often successful) lobbying to resist the implementation of minimum wages and labour welfare measures, and deliberately operating as unregistered or smaller manufacturing units to escape these laws [36, 37, 38]. Such actions have a negative impact particularly on the health and wellbeing of workers from Indigenous communities.

Structural factors shaping tobacco businesses

While the very nature of the capitalist mode of production and the neoliberal economic reforms carried out in India affect the health and wellbeing of Indigenous communities in general; we lack studies that specifically explore such linkages for the tobacco sector. But clearly, the weakening of labour and environmental norms is likely to have a negative impact on the already precarious labour of members of Indigenous communities in tobacco supply chains, as well as on natural resources, including forests that remain intricately linked to the sustenance and wellbeing of Indigenous communities.

There has been some progress in regulatory measures to safeguard marginal workers (especially bidi workers) in the tobacco sector [40,41], to protect the health of tobacco consumers through restrictions on sales and marketing [41]; to reduce tobacco industry interference in public health through codes of conduct for public officials in dealing with the tobacco industry [42, 43]; and to mandate large tobacco businesses to disclose their impact on society and environment [44]. However, there is a need for far more effective enforcement of these regulations that are poorly complied with. Also, there remain conflicting interests within governments wherein, tobacco control and tobacco-promoting interests coexist. For instance, while the health ministry aims to reduce tobacco consumption through tobacco control programmes and regulations, the commerce and agricultural ministries, through the Tobacco Board of India and the Centre Tobacco Research Institute respectively, seem to promote tobacco cultivation and trade [45].

Tobacco control interventions: ethical considerations

Tobacco control efforts in India, while intense, have mainly comprised of large-scale interventions informed by a top-down approach. While this has yielded some gains in terms of overall decline in tobacco use over time, these gains have been unequal across social lines, be it gender, income, or social/ethnic identity [5, 6]. In this context, the recent initiatives promoting deliberations, research and action on tobacco use among Indigenous communities are welcome [46, 47, 48]. However, there is a need to enhance the representation and leadership of scholars and members from Indigenous communities to ensure that efforts at addressing tobacco use are meaningful, acceptable, effective, and, importantly, address the social injustice at the core of the unequal health impacts.

The use of the lens of commercial determinants of health helps us identify commercial and economic interests at various levels (consumers, businesses, political-economic structure) that could potentially impact the Indigenous communities' health and wellbeing, through varied pathways (consumption, labour practices, environment, politics). In this exercise, I could find evidence of some factors and pathways impacting Indigenous health; while for certain other levels/pathways, either there is negative evidence or there is no research available. On the whole, I find this lens useful as it helps us look beyond the routine and dominant concern related to consumption of tobacco products and recognise how the health and wellbeing of Indigenous communities get impacted through labour, environment and governance/regulatory practices. This exercise reveals complex intertwining links between tobacco and Indigenous communities. The efforts at addressing harms ought to go beyond just behavioural change interventions at the individual level and focus on the behaviour of the tobacco industry, as well as the larger economic and political systems that sustain and often promote/perpetuate the tobacco trade.

This commentary, while choosing to spotlight the commercial drivers, also seeks to reveal how the commercial is inseparable from the social – that the prevailing social inequities intersect with and shape how commercial drivers affect health outcomes differently across social groups. While working in tobacco supply chains brings in a much needed, if meagre, income, a majority of workers embrace exploitative and poorly remunerative work in the absence of alternative options. Unless we enhance the opportunities for non-tobacco and viable alternative livelihoods, the tobacco control measures aimed at reducing tobacco supply/production may end up further aggravating the already precarious position of these workers. The WHO Framework Convention on Tobacco Control requires member governments (including India) to provide safer and viable alternatives to workers employed in the tobacco sector. We need to embrace a complex approach in our tobacco control endeavours, where efforts to reform the conditions of marginal workers in tobacco supply chains, and to find safer and viable non-tobacco livelihoods go hand in hand with supply reduction measures.

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