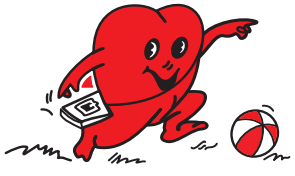
A Handbook for NGO Personnel

EFFECTIVE STRATEGIES

FOR TOBACCO CONTROL ADVOCACY



HRIDAY HEALTH RELATED INFORMATION DISSEMINATION AMONGST YOUTH

EFFECTIVE STRATEGIES FOR TOBACCO CONTROL ADVOCACY

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A HRIDAY Publication

Introduction

Tobacco as an epidemic remains a serious public health challenge for the country, despite the enactment of a comprehensive law to reduce tobacco burden, resulting in enormous disability, disease and death.

Non Governmental Organizations (NGOs) are acknowledged as important partners and stakeholders in the tobacco control movement, not just in India but across the world. The World Health Organization (WHO) has established a Civil Society Initiative (CSI) to formalize the partnership of working together towards achievement of the health goals in both developed and developing countries. NGOs can play a significant and multi-dimensional role in supplementing tobacco control efforts of the government by spearheading awareness and advocacy campaigns, monitoring the enforcement of tobacco control laws, reporting violations to authorities, engaging in litigation and building capacity of law enforcement officials to implement the law. They can also motivate and groom fellow NGOs to get involved in tobacco control.

The purpose of this handbook is to provide NGO personnel with relevant background information about the magnitude of the tobacco problem, the Indian tobacco control law enacted by the Government of India and the role NGOs can play in the field of tobacco control including planning, developing and executing effective advocacy campaigns.

India played a strong leadership role in the global fight against tobacco. In terms of legislation, a beginning was made in the form of the Cigarettes Act, 1975. The *Advocacy Forum for Tobacco Control* (AFTC), a national alliance against tobacco, provided a unique opportunity for all key tobacco control advocates to join in an effective campaign for tobacco control resulting in a modified and comprehensive tobacco control Bill that was tabled in the Parliament in late February, 2003. The Bill finally became an Act of Parliament after receiving assent from the President on May 18, 2003. The Legislation came into force on May 1, 2004.

AFTC is a coalition of 55 pan-India NGOs working in the area of advocacy, awareness promotion and research related to tobacco control in India. AFTC's main goal is to advocate policies for control of tobacco. AFTC includes public health experts, health professionals, research scientists and representatives of several Indian NGOs (www.aftcindia.org).

The handbook is divided into four sections:

Section I: The Burden of Tobacco

Section II: Tobacco Control Legislations and Litigations in India and the Framework Convention on Tobacco Control

Section III: Role of Civil Society in Tobacco Control

Section IV: Case Studies

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A HRIDAY Publication

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Section I:
The Burden of Tobacco

The tobacco epidemic: Global and Indian scenario

The course of the tobacco epidemic globally

Tobacco use began after Europeans, especially British, Spanish and Portuguese explorers, came in contact with the inhabitants of the American continent. Tobacco was used in many forms. People smoked pipes, cigars and even a primitive form of cigarettes, inhaled snuff and chewed dry tobacco. These different forms were adopted by the Europeans and, like fashions, rose and fell with time.[1]

A few events close in time on both sides of the Atlantic Ocean combined to lead to a tremendous upsurge in cigarette smoking in the world. Indeed, the tobacco epidemic, as we know it globally, has become a cigarette epidemic.[2] The return of the British soldiers in 1856 from the Crimean war, during which they had learnt to smoke Turkish cigarettes, shared with them by their Turkish allies, boosted the sale of cigarettes in England. Cigarettes were already being sold in England by Philip Morris since the opening of a shop in London in 1847. The development of cheap and mild tasting, flue-cured "bright" tobacco began in North Carolina in 1839, and a good market had emerged for it in Virginia and North Carolina by 1860.[3] During the Civil War (1860–1865), soldiers of both the North and South received tobacco as rations, and on returning home, they spread the demand for bright tobacco in the northern region as well. The hand-rolling method used in cigarette factories was replaced by cigarette-rolling machines, which were developed and adopted in the early 1880s, permitting large-scale production at a lower cost. In the 1880s, representatives of tobacco companies travelled abroad to market cigarettes, mainly in areas already opened to trade by the British, such as Australia, Canada, South Africa, China, Japan and India, and in the early1900s, also in Argentina and Brazil. With the demand soaring, cigarette manufacturers soon set up factories in most of these areas.[4]

During the first half of the twentieth century, the increase in cigarette use by young adults was mainly among men in the developed countries, but in the second half, there was an increase in use by women in the developed countries and men in the developing countries.[5]

A follow-up study of 35,000 doctors by Doll and Hill was published in England in 1954, confirming the link between smoking and cancer. Most doctors gave up smoking as a result. This marked the beginning of a decline in smoking in Britain.[6]

The 1964 US Surgeon General's Report held that cigarette smoking was responsible for a 70% increase in the mortality rate of smokers, when compared to non-smokers. The report estimated that on an average, smokers had a nine- to ten-fold risk of developing lung cancer compared to non-smokers; heavy smokers had at least a twenty-fold risk. The risk rose with the duration of smoking and diminished with the cessation of smoking. The report also identified smoking as the most important cause of chronic bronchitis. Further, it noted a correlation between smoking and emphysema, as well as smoking and coronary heart disease. It pointed out that smoking during pregnancy reduced the average weight of the newborn. The release of the report was a major news

event, occupying the front pages of newspapers for many weeks.[7] Successive Reports of the Surgeon General confirmed and extended the grim findings.

Due to rising public awareness of the dangers of tobacco use, especially of the risk of lung cancer, the prevalence of cigarette smoking began to fall in England in 1950[6] and in the USA in 1965.[7] There followed a decline in smoking, especially among males, in other developed countries as well, but the epidemic started increasing in the developing world,.

From the late 1970s, commercial cultivation of tobacco began shifting to low-income countries, due to lower production costs. The transnational manufacturers currently purchase 85%–90% of tobacco, the raw material, from the developing world and manage to keep the prices of their manufactured products low. Tobacco growing countries in the developing world benefit economically from growing the crop, which brings in foreign exchange, for example. However, they also suffer environmental damage, including that caused by the heavy use of pesticides, besides deforestation and loss of biodiversity. In addition, the cultivation of the crop is associated with social and health problems, such as child labour and child malnutrition. An overemphasis on growing tobacco has become a threat to food security.[8]

As the prevalence of smoking and cigarette consumption fell in many developed countries due to greater awareness and tougher tobacco control measures, multinational tobacco manufacturers intensified their efforts and investments in growing tobacco, manufacturing and selling cigarettes in the developing countries. Here, awareness was lower, tobacco control legislation was non-existent or weak, and governments possessed fewer resources for controlling the use of tobacco. Advertising and promotion campaigns in these countries played a major role in increasing demand.[9]

Since the adverse effects of tobacco use do not become apparent in a major way until several years after the onset of use, the consequences in terms of disease and death are far from reaching their peak in the developing countries, where tobacco use is still on the rise.[5] For example, the incidence of lung cancer among males in the developed countries (56 per 100,000) is currently about twice that in the developing countries (26 per 100,000).[10]

Global tobacco epidemic facts[11,12,13]

- Tobacco use is the number one killer in the world.
- Tobacco causes 1 in 10 deaths (10%) worldwide, nearly 5.4 million a year.
- More than 80% of these deaths occur in the developing countries.
- Tobacco kills up to half of its regular users.
- Of the 1.3 billion smokers alive today, 650 million will eventually be killed by tobacco, 325 million of them between the ages of 35 and 69 years.

- Tobacco use is a risk factor for at least six of the eight major causes of death in the world.
- 900 million smokers, or 84% of the world total (1.3 billion), live in developing and transitional economy countries.
- The total global prevalence of smoking is 29%, and 47.5% of men and 10.3% of women smoke.
- A hundred million deaths were caused by tobacco in the twentieth century. If the current trends continue, there will be one billion deaths in the twenty-first century.
- By 2030, 70% of the deaths attributable to tobacco will occur in the developing world. The aggressive marketing practices of multinational companies, which target the youth and women, play a large role in this.

The epidemic in India

Tobacco production has been growing in India since 1950. India is currently the third largest producer of tobacco after China and Brazil, and exports about one-fourth of its production. Until 1950, tobacco was mainly smoked in hookahs or chewed. Thereafter, there was a tremendous increase in beedi and cigarette smoking. The first beedi manufacturing firm was established in 1887 and the first cigarette factory in 1906 by the Imperial Tobacco Company. A beedi (a type of hand-rolled cigarette wrapped in tendu leaf) is very cheap and is the dominant product for those who smoke tobacco in India, while Western-style cigarettes constitute a fraction of tobacco use. Commercially prepared smokeless tobacco products, which were introduced in the 1970s, have grown in popularity among all social groups, most notably among the youth and women.[17]

Tobacco toll in India

- Each year, 9 lakh Indians die because of tobacco-related diseases. All these deaths are preventable.
- More than 2200 Indians die every day due to tobacco use.
- Every day, 5500 Indian youth start smoking. They must be protected.
- India has the highest number of oral cancer cases in the world and 90% of all oral cancers are tobacco-related.
- Tobacco use is responsible for 40% of all cancers in India.
- By 2010, nearly 1 million (10 lakh) people will die every year due to smoking.
- Of the smokers who will die, 70% will be between the ages of 30 and 69 years.

Prevalence of tobacco use among adults in India

According to the National Family Health Survey-3 (NFHS-3), conducted in 2005–06:

- The prevalence of tobacco use in India is very high, with 57% males and 11% females using tobacco in some form.

- The vast majority of women who use tobacco chew it, rather than smoke.
- Tobacco use among men and women is higher in rural areas than in urban areas (35% of rural men between the ages of 15 and 49 years smoke cigarettes or beedis, compared to 29% of urban men).
- The north-east region has the highest rates of tobacco use, the prevalence exceeding 60% in some states.

Prevalence of tobacco use among youth in India

According to the Global Youth Tobacco Survey (GYTS), 2006, a school-based tobacco-specific survey that focuses on adolescents of 13–15 years of age:

- 36.9% of children start smoking before the age of 10. Of these, boys constitute 55.1% and girls 32.1%.
- 4.2% of students smoked cigarettes, the rate being significantly higher among boys than girls.
- 11.9% of students used other tobacco products.
- The rate of cigarette smoking among the youth is high in the central, southern and north-eastern regions (12%).
- Exposure to second-hand smoke (SHS) in public places is as high as 40.3%.

Diversity of tobacco use in India

Smoked forms of tobacco	Smokeless forms of tobacco	Nasal/inhaled forms of tobacco
◆ Cigarettes ◆ Beedis ◆ Cigars ◆ Cheroots ◆ Chuttas ◆ Dhumtis ◆ Kreteks ◆ Pipes ◆ Chillum ◆ Hooklis ◆ Hookah	◆ Gutkha ◆ Zarda ◆ Khaini ◆ Paan masala ◆ Paan with tobacco ◆ Tobacco water ◆ Meetha mawa	◆ Snuff **Forms applied to teeth and gums** ◆ Gul ◆ Gudhaku 'dant manjan' ◆ Creamy snuff ◆ Mishri

The tobacco epidemic may be declining in the industrialized countries but is on the rise in the developing countries. There is an urgent need to implement effective tobacco control policies in these countries. In India, the tobacco problem is especially complex because of the large spectrum of tobacco products and the numerous methods of using tobacco.

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Effects of tobacco use on health

Tobacco use is harmful to the health. This chapter briefly explains the many dangers of tobacco use and attempts to clear up some common misconceptions regarding the subject in India. First and foremost, tobacco is addictive. Addiction is caused by the chemicals that make up tobacco and its smoke, which are responsible for the other harmful effects as well. Tobacco users tend to have shorter lives than non-users. Respiratory diseases, circulatory diseases, cancers, dental and other problems, as well as premature ageing are more common among tobacco users than non-users.

Tobacco products: a dangerous chemical concoction

Tobacco in the unburnt form and smokeless tobacco products contain the psychoactive addictive drug, nicotine, and nine other alkaloids. Nicotine is highly addictive in nature and causes an increase in the heart rate, blood pressure and level of blood fats. Various other harmful chemicals are added during the processing of tobacco products, making the latter more addictive and injurious to the human body.[1] The inclusion of arecanut (*supari*) in tobacco products adds arecanut-specific alkaloids and their respective carcinogenic nitrosamines.[2] The other harmful constituents of tobacco include arsenic and heavy metals, such as cadmium, lead, nickel and polonium.[1] Benzopyrene, a carcinogenic combustion product (like other polycyclic aromatic hydrocarbons), occurs especially in roasted or flue-cured tobacco, such as *masheri* (also called *mishri*), consumed mainly in Maharashtra, Gujarat and eastern India, apart from cigarettes.[1,3] Alkalinizing agents, such as carbonates of calcium, magnesium, sodium and ammonium, are added to most smokeless products to raise the pH and improve nicotine absorption through the unbinding of the nicotine chemically.[1]

The smoke of burning tobacco contains about 4800 chemicals, in the form of particles and gases. Many of these chemicals are harmful and 69 are known to be carcinogenic. The particulate phase contains nicotine and other alkaloids, carcinogenic tobacco-specific nitrosamines,[4,5] heavy metals and sticky solids called "tar", including polycyclic aromatic hydrocarbons (such as benzo[a]pyrene), and aromatic amines. The gas phase contains harmful gases, such as carbon monoxide (produced by incomplete combustion), ammonia, nitrogen oxides, hydrogen cyanide and hydrogen sulphide, as well as

Fig.1: Hazardous chemicals in a cigarette

volatiles such as benzene, toluene, styrene, acetone, acetic acid, formaldehyde, acetaldehyde, acrolein, acetonitrile, acrylonitrile and pyridine. Substances added to reduce irritation, including clove oil, menthol and glycerol, do not make smoking less harmful. They just act as masking agents, making the intake of tobacco smoother and more pleasurable, thereby increasing its intake.

Addiction

Tobacco use is highly addictive, which is the main reason why many people continue to use it many times daily over their lives. Nicotine, an alkaloid, is the major addictive substance in tobacco. Nicotine acts on the brain, triggering an excess and prolonged release of brain chemicals such as dopamine that cause a feeling of reward (euphoria), as well as alertness. It also speeds up the metabolism and permits the user to go without food for a while, something which many users exploit to cope with heavy work schedules or other "stress". After about an hour, as the level of blood nicotine falls, the state of "high" is followed by a "low", or a period of withdrawal symptoms, which include irritability and lack of concentration. Avoiding tobacco use during the painful withdrawal period would eventually bring the brain's chemical equilibrium back to normal, but the addicted user takes a new dose to avoid the discomfort. This cycle is repeated many times daily to keep functioning "normally" and it is difficult to break. A person who has succeeded in quitting may relapse into the addictive cycle if s/he uses tobacco "just one more time".[7]

Shorter lifespan

Tobacco kills half of those who use it. On an average, tobacco consumption reduces a person's life by 15 years.[8] In India, smoking is responsible for a quarter of all male deaths between the ages of 25 and 69 years, and smaller fractions of deaths at other ages. Those killed in middle age would be losing about 20 years of life expectancy. Compared to those who do not use tobacco, smokers of the age of 35 years and above have a 37% higher risk of dying early if they smoke cigarettes and a 64% higher risk if they smoke *beedis*. Smokeless tobacco users have a 25% increased risk of death. Large research studies conducted in rural and urban Tamil Nadu, Mumbai and other parts of India have concluded that smoking causes between 700,000 and one million premature deaths in the country per year, while smokeless tobacco causes 100,000–125,000 deaths per year.[9,10]

Tobacco kills in so many ways that it is a risk factor for six of the eight leading causes of death in the world. These are ischaemic heart disease, cerebrovascular disease, chronic obstructive pulmonary disease, tuberculosis, lower respiratory tract infections and cancer in various parts of the body.[8] The following box depicts the various problems and diseases caused by tobacco consumption.

Effects of tobacco use on health

Tobacco starts having a negative effect on a person's health as soon as s/he starts using it in any form, either regularly or even occasionally.

Short-term effects occur when a person uses tobacco for a few hours or days. These include:

- Bad breath
- Bad odour in hair and clothes
- Stained nails and teeth
- Tooth decay
- Breathing problems
- Asthma

Long-term effects occur when a person uses a tobacco product for months or years. These include:

- Circulatory diseases (including heart attack)
- Reproductive disorders (including impotence)
- Birth defects (in the newborns of pregnant women who smoke)
- Brain shrinkage/cognitive dysfunction
- Alzheimer disease
- Stroke
- Cataract/blindness
- Cancers (oral, oesophagus, lung, adrenal gland, stomach, bladder, pancreas, liver, cervical, kidney, larynx, breast)
- Respiratory disorders (including tuberculosis, bronchitis, emphysema)

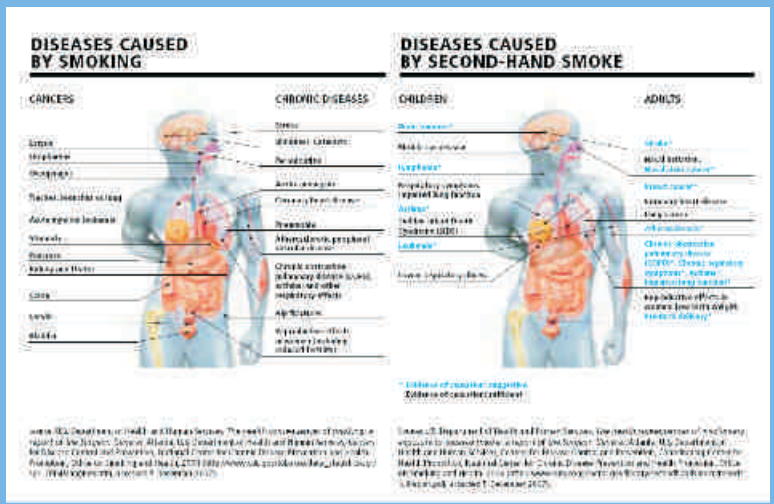

Fig.2: Health hazards of smoking and passive smoking

Source: MPOWER, WHO 2008

Respiratory diseases

Tobacco smoke, like any smoke, irritates the respiratory tract. New smokers cough and feel a constriction or tightness in the airways. This is the body's way of warning, "Stay away from smoke". This irritation and a lowering in the body's immune response make smokers and those exposed to passive smoking more vulnerable to respiratory infections, including influenza, pneumonia[11,12] and tuberculosis.[13] Smoking also aggravates asthma.[11] In India, *beedi* and cigarette smokers have at least a 300% higher risk of contracting pulmonary tuberculosis than non-smokers.[9] This is true of smokers of any social class, given the fact that tuberculosis is widely endemic in the country. Young adult smokers who have stressful lives, keep irregular hours and eat irregularly are especially vulnerable to tuberculosis.

Smokers have a 200%–1100% greater chance than non-smokers of developing chronic obstructive lung diseases, such as asthma, chronic bronchitis and emphysema.[11] If the determined smoker ignores the initial warning and begins to smoke regularly, early inflammatory changes appear in the small (<2 mm) airways of the lung. These are evident in some smokers after the first few years of smoking, but after 10–15 years, the majority of smokers have chronic inflammation and narrowing of the small airways, with increased airway resistance. Some smokers develop chronic bronchitis/cough, but many have abnormally low lung function without any related symptoms. Quitting smoking at this stage can resolve most of the symptoms, such as cough, excess mucus and wheeze. Continuing to smoke leads to a progressive decline in lung function in all smokers (compared to non-smokers), eventually leading to chronic obstructive pulmonary disease (COPD) in about 15% of smokers.

Cancers

In India, doctors are diagnosing at least 250,000 new tobacco-related cancers each year, or 960 every working day.[14] The rates of incidence of cancer of the tongue, throat and oesophagus among Indian women are some of the highest in the world, mainly due to the use of tobacco, especially with *paan*. The incidence rates of oral and throat cancer among men in India are also among the highest.[18] Tobacco users are constantly bathing their upper respiratory and digestive systems with carcinogens. Smokers are inhaling carcinogens into their lungs with every puff. Some particles are lodged permanently or semi-permanently in the lungs, causing black "smoker's lung". In addition, some amounts of tobacco carcinogens are absorbed into the body through the mucous membranes. Some of the carcinogens enter the cells of the body and attach themselves to the chromosomes. Depending on where they attach themselves, they disrupt normal cell function. In tissue areas where tobacco carcinogens have been deposited, some of the cells may begin to multiply out of control.[11] The body's immune defences may not be able to catch and kill every one of these rogue cells and a cancer may appear. Smoking is a known cause of many cancers: mouth and tongue (oral), throat (pharynx), food-pipe (oesophagus), voice box (larynx), nasal cavity, nasal sinuses and lung.[11,16] Men who smoke have a 9–14 times higher chance of getting lung cancer, as indicated by follow-up studies.[19] Smokeless tobacco is a known cause of cancer of the oral cavity and pancreas.[20] Tobacco users may have precancerous lesions or white patches in the mouth that are painless and are thus given no importance by them. It is important to create awareness of the need for oral screening, early diagnosis and

initiating preventive therapy for these lesions. Cancer can be cured if detected early, but may lead to death if ignored till a late stage.[21] The surgical treatment of advanced stages of cancer is expensive and a large segment of the affected population cannot afford it. Thus, early screening and, of course, cessation of tobacco use are the best and most inexpensive ways of avoiding cancer.

Circulatory diseases

Cardiovascular disease (CVD) is the fastest growing and largest category of cause of death in India today. It was the cause of 29% of deaths in 2005.[22,23] Cardiovascular diseases include coronary heart disease, stroke and peripheral vascular disease. The symptoms of peripheral vascular disease may include limb pain, numbness, coldness or skin ulcers. The main causes of CVD today are decreasing physical activity and increasing dependence on a diet rich in fats, salt or sugar and poor in protein, fibre, vitamins and minerals, but tobacco use is also a major risk factor.[24] Smokers have a much higher chance than non-smokers of getting clogged arteries, a heart attack or heart disease.[11]

Tobacco use, either in the smokeless or smoked form,[25,26] has multiple effects on the circulatory system. It injures the inner lining of the arteries; alters the levels of fat and cholesterol in the blood, increasing the risk of arteriosclerosis; restricts blood flow by vasoconstriction (narrowing of blood vessels); and raises blood pressure, putting a strain on the functioning of the heart. The inhalation of carbon monoxide reduces the capacity of the blood to deliver oxygen. Smoking even one cigarette or *beedi* increases the risk of blood clots, can cause irregular heartbeats and is associated with sudden death from heart attack. In addition, smokers with COPD may suffer from congestive heart failure. Quitting smoking begins to rapidly reverse the risk of heart disease, heart attack and stroke, and eventually begins to reduce the risk of peripheral vascular disease.

Reproductive health effects

Tobacco use has adverse effects on the sexual and reproductive health both of men and women.[11,27,28] Men who use tobacco are more likely to have sperm of poor quality and lower sperm counts (infertility). Smoking increases the risk of impotence by around 50% in men in their 30s and 40s. Indian women who use tobacco during pregnancy are more likely than non-users to: (i) lose the baby during childbirth; (ii) lose the baby in the first month of his/her life; (iii) give birth to underweight babies, who are more vulnerable to infection; and (iv) lose male babies more often than female babies.[29,30] Exposure to SHS during pregnancy has been associated with the birth of infants with lower than normal birth weight.[29] About one-fourth of stillbirths in India may be attributed to the use of smokeless tobacco by the pregnant mothers.[31] Female tobacco users should be advised to quit using tobacco as soon as they know they are pregnant, for the duration of the pregnancy and even after the birth of the child.

Second-Hand Smoke and passive smoking: a serious health hazard

Non-smokers inhale what is known as environmental tobacco smoke (ETS) or SHS. Second-hand smoke is a mixture of mainstream smoke, which is drawn through cigarettes/*beedis* when puffs are taken and sidestream smoke, which is emitted from the burning of cigarettes/*beedis* in between puffs. It is equivalent to mainstream smoke in terms of potential toxicity. When a person smokes tobacco, it increases the risk of other persons in his/her proximity to various diseases, making what is known as *passive smokers* out of them. These diseases include respiratory infections, worsening of asthma, sudden infant death syndrome (SID), weakening of the immune system, reduction in lung function, COPD, middle ear disease, eye, nose and throat infections and lung cancer. [32] Since a person has no control over SHS, s/he is in no position to protect herself/himself from its harmful effects. The menace of SHS can be controlled effectively by prohibiting smoking in public places and indoor workplaces. India has a law prohibiting smoking in all public places and indoor workplaces. This law came into effect on 2 October 2008.

Third-Hand Smoke: a new health hazard

Third-Hand Smoke (THS) is contamination from tobacco smoke that remains after a cigarette/*beedi* has been extinguished. It is the invisible yet toxic brew of gases and particles clinging to smokers' hair and clothing (even cushions, carpeting, etc.) that lingers long after SHS has cleared from a room. The residue includes heavy metals, carcinogens and even radioactive materials, which young children can get on their hands and ingest, especially if they are crawling or playing on the floor.

Among the substances in THS are hydrogen cyanide, used in chemical weapons; butane, which is used in lighter fluid; toluene, found in paint thinners; arsenic; lead; carbon monoxide; and even polonium-210, the highly radioactive carcinogen. Eleven of the compounds are highly carcinogenic.

Tobacco use causes a host of health problems affecting almost every part of the body without any true benefit, so it is best avoided. It is also one of the most addictive substances and makes a person completely dependent, thereby disrupting the normal physiological mechanisms of the body. During health visits, tobacco users need to be counselled on the importance of not exposing unborn children and their families to tobacco smoke, the harmful effects of tobacco and the benefits of quitting. They also need to be screened for oral cancer and the other health problems they are likely to develop.

Some myths about tobacco use

Myth: Low-nicotine and low-tar cigarettes are less harmful than regular ones.

Truth: On the contrary, smokers tend to compensate by puffing such cigarettes more frequently or inhaling more deeply to get the amount of nicotine they are used to. They thus expose themselves to a similar amount of harmful tar as would be the case with ordinary cigarettes.

Myth: Tobacco use helps relieve stress.

Truth: Tobacco use increases the release of dopamine, which causes a euphoric feeling for a short period of time and thus, a tobacco user temporarily experiences relief from stress. However, as the effect wanes, the person again develops a craving for tobacco.

Myth: If you are destined to die at a certain time, there is nothing you can do about it.

Truth: Tobacco users who quit tend to live longer than those who persist in using tobacco. On an average, tobacco consumption reduces the lifespan by 15 years.

Myth: Light or mild cigarettes protect you from respiratory diseases.

Truth: While some cigarettes seem milder on the throat than others and pose less of a risk of acute respiratory infections, continued smoking damages the lungs and leads to reduced lung function. Those who smoke light and mild cigarettes can get COPD, tuberculosis and lung cancer, like those who smoke other cigarettes.

Myth: Eating more fruits and vegetables mostly removes one's risk of getting cancer and one can safely go on smoking or chewing as much tobacco as one likes.

Truth: Eating more fruits and vegetables helps the body defend itself from cancer, but cannot negate the entire risk. The carcinogens in tobacco are too abundant and toxic to risk consuming.

Myth: A heart patient should never quit smoking suddenly or completely.

Truth: The sooner the heart patient quits tobacco totally, the longer he is likely to live. Quitting tobacco use causes temporary withdrawal symptoms, like irritability, anxiety and insomnia, but these do not pose a health risk.

Myth: Tobacco use boosts one's energy/endurance.

Truth: Tobacco use may cause a brief adrenaline boost, but destroys one's health and fitness. Strength and ability come from a good diet and hard work or exercise.

Myth: Tobacco use is good for relieving toothaches.

Truth: Tobacco use may deaden the pain of a toothache, but causes degeneration of the teeth and necrosis. It is best to chew on a clove, which has antiseptic and anaesthetic properties, and then see a dentist. Lack of access to dental care promotes tobacco use.

Myth: Tobacco use is needed to facilitate morning bowel movements.

Truth: This happens only to the nicotine addict. The need for tobacco for this purpose eventually wears off within a week of quitting.

Myth: Smokeless tobacco causes less harm than the smoked form.

Truth: Smokeless tobacco is even more dangerous as it is kept inside the mouth and this leads to the creation of nicotine depots in the oral cavity. These act as a reservoir of nicotine and never let the blood nicotine level fall, which is even more dangerous for the health.

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Economics of tobacco

This chapter presents a brief discussion on the economics of tobacco in India. It attempts to explain the demand for tobacco and indicate why tobacco consumption cannot be justified on the strict principles of rationality. Further, it emphasizes that though tobacco is a major source of excise revenue and foreign exchange, and supports millions engaged in activities ranging from farming to retail trade, governments cannot continue to play the dual role of promoting cultivation and restricting consumption in the light of the high mortality and large disease burden associated with tobacco consumption, as well as passive smoking. The details on the extent of death and illness associated with tobacco have been dealt with in Chapters 1 and 2.

The consumption and production of tobacco raise certain ethical questions. Should society prefer the long-term gain of avoiding health hazards or the short-term gain of bringing in export earnings and providing job opportunities to the poor? If avoiding health hazards is considered more important than economic gains, then obviously, tobacco production and consumption have to be discouraged. Further, it must be taken into account that the collective cost in terms of disease and death, and the costs of providing health care to those suffering from the ill effects of tobacco use may be larger than the economic gains accruing from the job opportunities and export prospects associated with the production of tobacco. There is a high expenditure involved in the construction and maintenance of cancer hospitals, tuberculosis hospitals, and cessation and rehabilitation programmes to minimize the health hazards arising from tobacco use.

The question in a nutshell is which would be a more expedient and cost-effective approach to tobacco control: a collective or macro approach or a case-by-case micro approach?

A collective intervention for tobacco control can take different forms:

i. Discourage the consumption of tobacco either through heavy taxation or through methods of moral persuasion (issuing statutory warnings about the adverse effects of tobacco consumption on the health, creating awareness and organizing mass campaigns).
ii. Discourage production through direct controls or through the provision of income support to farmers in the initial stages.

Micro-economics of tobacco

In most countries, including India, tobacco and its products have been the target of heavy taxation. The Government of India levies heavy excise duties on tobacco. Though such a levy is imposed on the producer, the tax is entirely shifted on to the consumer (purchaser) of tobacco. Although smokers are heavily taxed under the Central Government budget every year, they continue to smoke despite the high price of the products, especially cigarettes. A comparison of the reports of the National Family Health Survey (NFHS)-3,[1] 2005–2006, and the NFHS-2, 1998–1999, reveals that the percentage of men who smoke has gone up from 29.4% to 33.3%

(in the age group of 15–49 years).[2] The percentage of men chewing tobacco and using other forms of tobacco has also increased, from 28.3% to 38.1%. There are around 200 million adult tobacco consumers in India.[3] In 2001, *beedis* accounted for 48% of the total tobacco consumption, while cigarettes and other products accounted for 14% and 38%, respectively.[4]

The National Council for Applied Economic Research (NCAER) worked out an estimate of elasticity in the case of cigarettes only, using the data on per capita consumption of cigarettes, index of the real price of cigarettes (on an average basis, and not on individual price segments), and per capita private consumption expenditure during the period 1981–82 to 1992–93. Elasticity of per capita consumption with respect to the real price of cigarettes was –0.67, indicating that a 10% increase in the real price of cigarettes would lead to a reduction in the per capita consumption to the tune of 6.7%.[5] Though prices can reduce the level of consumption, the effect is not uniformly spread. John, using the socio-economic survey data collected by the National Sample Survey Organisation (NSSO) during 1999–2000, has estimated price elasticity for different tobacco products.[6] The estimates range from –0.4 to –0.9, where elasticity is lower for cigarettes (rural –0.4 and urban –0.18; closer to unity for leaf tobacco and *beedis* [–0.88 to –0.91]). The effect of price on consumption is less marked in the case of cigarettes, particularly in the urban areas. The estimates of price elasticity, as well the dissection of the tax structure for *beedis* and cigarettes in India by Sunley,[7] make a strong case for increasing taxes on these two products, aiming for an increase in revenue as well a reduction in smoking.

Rationality of choice for tobacco (Sovereignty of the consumer)

The demand for tobacco is, to some extent, a created demand or supply-induced. The decision to consume tobacco may be the result not of necessity but of the demonstration effect, which, in turn, could lead to addiction. As Adam Smith (1976:936)[8] rightly points out, tobacco is a consumer good that is not a necessity. The high degree of inelasticity of demand is an indication of addiction rather than of the product being a necessity with an invariant demand.

It is said that a rational consumer arranges his consumption so as to achieve the maximum satisfaction. If one has to apply this concept to tobacco, and claim that for an informed tobacco consumer, the benefits of consuming tobacco may balance its cost, one must first assume that people derive utility from consuming tobacco. One must also assume that the consumer has all the information needed to enable him to make a rational choice. However, the addictive nature of tobacco weakens the argument that the consumer is rational and should exercise his sovereignty over the consumption of this commodity. Taking the dangers of tobacco consumption into consideration, it cannot be said that there is a welfare gain to tobacco smokers/chewers. Besides, the consumer does not always have perfect information on the hazards of tobacco consumption.[9] Also, the social costs associated with tobacco consumption must be balanced against individual benefits or satisfaction.

Tobacco crop in India

India is the third largest producer of tobacco in the world. India accounts for 10% of the world's area under tobacco cultivation and about 9% of tobacco production. Flue-cured Virginia (FCV) tobacco accounts for 3.3% of the world's production. The prices of FCV tobacco in India are lower than in other countries, so it is cheaper in the international market. India accounts for more than 85% of the world's *beedi* production. Nearly 40% of the FCV tobacco produced in India is used for the domestic cigarette industry, while the rest is exported.

On an average, India produces 600 million kg (dry weight) of tobacco. Forms of tobacco that are chewed, FCV tobacco, tobacco for *beedis, hookahs*, cigars and cheroots, snuff, and *natu* and burley tobacco are grown in different parts of the country. (*Natu* tobacco is used in the manufacture of cigarettes and tobacco mixtures for pipes.) Flue-cured Virginia and *natu* tobacco are grown in Karnataka and Andhra Pradesh. A small quantity of FCV tobacco is grown also in Orissa (Rayagarh) and Maharashtra (Gadchiroli). *Beedi* tobacco is grown in Gujarat, Karnataka and Maharashtra. While cigar tobacco is grown in West Bengal and Tamil Nadu, cheroot tobacco is grown in Tamil Nadu and Andhra Pradesh. *Hookah* tobacco is grown in Uttar Pradesh, West Bengal (Jati), Bihar, Assam and Orissa. Rustica tobacco, used for chewing and snuff, is cultivated in Uttar Pradesh, West Bengal, Assam, Bihar, Tamil Nadu, Orissa, Kerala and Gujarat. The motihari variety grown in West Bengal is the strongest *hookah* tobacco. For chewing and snuff, leaves which have a thick texture, bitter aroma, dark colour and bitter taste are used.
Of the total area under tobacco cultivation in the country, *beedi* tobacco accounts for 30%–35%. The available figures reveal that the area under tobacco cultivation is around 4 lakh hectares. The positive indication is that the index of area under tobacco cultivation (base: triennium ending 1981–1982=100) for the period 1970–1971 to 2006–2007 has declined from 96.3 to 84.7.[10]

Economics of tobacco cultivation in India

Tobacco, a half-yearly crop, is considered to be resistant to disease and drought and is not eaten by farm animals. Indian farmers have been growing tobacco for several years and are acquainted with cultivation practices. In Karnataka, Gujarat and Andhra Pradesh, the net returns from tobacco are on an average two to four times higher than those from other crops like groundnut, cotton and black gram. This is the reason why farmers go in for tobacco cultivation. Of course, these net returns do not take into account the health and social costs associated with tobacco production and cultivation.

A study on the beedi tobacco growing regions in Karnataka revealed that the net return per rupee of investment was 0.57 for beedi tobacco, compared to 0.87 for sugarcane and 0.43 for soybean.[11] Table 1 presents the difference between the net returns from tobacco and other crops in several states. Even the next best crops yield low returns compared to tobacco. However, growing tobacco can be remunerative only if marketing is assured, particularly in the case of FCV tobacco. The total cost of cultivating FCV tobacco was Rs 41,161 per hectare during 1996–1997.[12]

Table 1: Difference between net returns from tobacco and other crops

State	Crops giving next best returns	Difference between net returns from tobacco and specified crop (Rs) per ha
Andhra Pradesh (NLS)	Bengal gram	4405
Andhra Pradesh (SBS)	Chillies	875
Karnataka	Cotton	4500
Gujarat	Pearl millet	2305
Bihar	Maize + Potato	2729
West Bengal	Potato	5134
Tamil Nadu	Groundnut	2825

Various studies[3,14,15] reveal that tobacco is a lucrative crop, the net returns from tobacco being higher than those from other crops. The returns from FCV tobacco are the highest as assured returns are facilitated via the regulation of production, arrangement of auction sale, marketing and export promotion. Although the returns per rupee of investment are higher for other crops,[11] farmers do not realize the difference as they are carried away by gross returns. The constraints imposed on reaching higher output levels per unit area discourage the substitution of tobacco by other crops, despite the fact that they would yield a higher income per rupee of investment.[14]

Tobacco-related employment

Tobacco is a labour-intensive crop, which employs a large number of people on farms and in curing and processing activities. Nearly 35 million people are said to be directly or indirectly dependent on tobacco for their livelihood (*see* Table 2). Those earning their living from tobacco include people involved in farming, curing, processing, grading, marketing, packaging, and retailing and export activities. The *beedi* industry provides employment to nearly 4 million people, particularly unskilled labour comprising women and children. There is a large variation in the estimates of employment in the tobacco sector, particularly for *beedi*-making. Since 90% of *beedi*-making is done at the household level, there is under-reporting of employment. Households and *beedi*-making units do not reveal the exact number of workers employed, as children are also engaged in rolling *beedis*, which is done on a contractual basis.

Table 2: Tobacco-related employment in India

Category	Employment (in millions)	Data source
Farmers	6.0	22nd report of the Parliamentary Committee on Subordinate Legislation, 1995
Farm labour	20.0	
Beedi workers	4.4	Lok Sabha, 17 May 2000
Tendu leaf pluckers	2.2	M.P govt. advertisement (TOI, 8 June 2000)
Traders/retailers	2.0	ORG-MARG research data
Total	34.6	

Source: The Tobacco Institute of India, 2002 [16]

Employment of human labour is the highest in tobacco farming, being 247 man-days per hectare for marginal farms and 95 man-days for large farms.[8] According to another estimate,[14] *beedi* tobacco provides 241 man-days of employment per hectare, next to paddy, which provides 266. Employment of human labour is the highest in FCV tobacco farming, being 322 man-days per hectare. This may be compared to paddy and ragi, which provide 110 man-days. In Gujarat, while *beedi* tobacco provides nearly 125 man-days of labour, rustica tobacco provides employment of 135 man-days per hectare.[17]

Tobacco products

Tobacco products include cigarettes, *beedis, gutkha, zarda,* snuff, tobacco paste, *hookah* and tobacco for chewing. There are nearly 17 factories and 11 companies producing cigarettes in the country.[18] The Indian Tobacco Company (ITC), Godfrey Philips India Ltd (GPI), Vazir Sultan Tobacco Company (VST) and Golden Tobacco Company (GTC) are some of the main cigarette companies, controlling 95% of the country's cigarette market. The ITC, GPIL and VST have foreign collaboration. Other small companies generally do not have a direct marketing channel. They produce cigarettes for large companies. The tobacco products industry recorded 21.9% growth in profit after tax (PAT) during the period 2001–2007. During 2006–2007, the PAT was Rs 2905 crore.[19]

Production of tobacco products

India's cigarette production accounts for about 1.7% of the world's production and its cigarette exports account for less than 1% of the world's cigarette exports.[13] In 2007–2008, the volume of cigarette exports declined by 9% as compared with the previous year. In 2005, India's share of tobacco and tobacco products in world exports was 0.9% in value terms. Growth in foreign exchange earnings, which was –3.5 in 2000–2001, rose by 25% in

2006–2007.[20] The Indian tobacco products industry has recorded a compound annual rate of growth (CARG) of around 17% in terms of income and sales during the period 2001–2007, and the investments have risen by 235% during the same period (CMIE, 2008).[21] All these figures indicate that the tobacco industry is making steady progress.

The manufacture of *beedis* consists of rolling, sorting, drying, labelling and packing. The *beedi*-making industries are located largely in Maharashtra (Nasik and Pune), Madhya Pradesh (Jabalpur, Sagar and Raipur), Gujarat, Karnataka (Mangalore, Mysore and Nippani), Andhra Pradesh (Nizambad, Karimnagar and Warangal), Tamil Nadu (Tirunelveli and Chennai), Kerala (Cannanore), Orissa and West Bengal. As per the Indian Market Research Bureau (IMRB) report of 1996, around 37% of India's tobacco production goes into *beedi*-making (DTD, 2000). The *beedi* and chewing tobacco sectors contribute 20% of the total revenue from tobacco. The *hookah* industries are located in Uttar Pradesh, Gujarat and Kolkata (DTD, 2000).[13] Nearly 50% of the tobacco produced in the country is for domestic consumption. According to the Annual Survey of Industries (EPW, 2007),[22] there were 3078 industries in the tobacco manufacturing sector in 2003–2004.

Tobacco taxation and revenue

Though tobacco accounts for only about 0.25% of the total cropped area in the country, it has gained importance as exports of tobacco earn nearly Rs 850 crore by way of foreign exchange and tobacco contributes Rs 6000 crore as excise revenue to the government. Excise revenue from tobacco amounts to nearly 12% of the total excise collections. Excise revenue has increased from Rs 38 crore in 1950–1951 to Rs 8182 crore in 2001–2002, but its share in the total excise collections has remained almost the same, at around 12% (Table 3).

Table 3: Central excise revenue from tobacco in India (in Rs crore)

Year	Cigarettes	Other tobacco products	Total	Revenue as % of total excise collection
1951-1952	8	30	38	48
1961-1962	----	----	63	13
1971-1972	193	84	277	13
1981-1982	685	150	835	11
1991-1992	2,386	310	2,696	9
1997-1998	4,492	721	5,213	10
1998-1999	4,592	1,945	6,537	12
1999-2000	4,863	2,553	7,416	12
2000-2001	----	----	8,182	12

Source: Tobacco Board, 2002;[23] Sury MM, 2004;[24] TII, 2002;[25] DTD, 1997[16]

In India, the taxation policy with respect to tobacco has always been targeted at resource mobilization rather than curbing consumption. Cigarettes, which are consumed largely by the middle class and the rich, have been the target of heavy taxation. *Beedis* and other products were not covered under excise duties for a long time. Even today, unbranded *beedis* and other tobacco products, and unmanufactured tobacco are not taxed. Ad valorem duty was levied on branded *beedis*, chewing tobacco and other tobacco products on the basis of the assessable price for 1993–1995. This was replaced by ad valorem duty based on the MRP in 1995–1996 and by specific duties based on the length and type of the tobacco product in 1997–1998.

The tax rates in India are supposed to be discriminatory against cigarettes. Taxes, including cess, range from more than Rs 150 to Rs 2000 per 1000 for different types of cigarettes, based on length and quality. As for *beedis,* in 2007–2008, the tax rate was Rs 14 on hand-made *beedis* and Rs 26 on machine-made *beedis* per 1000. The cigarette industry demands lower rates on cigarettes on the ground that the tax structure distorts production and consumption, and also on the ground that of the tobacco products, cigarettes contribute nearly 80% of tax revenue and 80% of export revenue (at bottom of page, it says 30%) (including cigarette leaf tobacco), while they account for only 14% of the total tobacco consumption. The difference between the tax on *beedis* and manufactured cigarettes is given in Table 4.

Table 4: Tax differentials between beedis and cigarettes

Product	2008 (Rs per 1000)
1. Beedis	
a. Machine-made	26
b. Hand-made	14
2. Cigarettes	
a. Filter > 85 mm	2163.00
b. Filter <= 70 mm	819.00
c. Non-filter > 60 mm	546.00
d. Non-filter <= 60 mm	168.00

Source: Sunley 2007[7]

Exports of tobacco

Tobacco exports account for about 4% of the total value of India's agricultural exports and bring in substantial foreign exchange earnings. India ranks fourth in exports of total tobacco and occupies fifth place in the export of FCV tobacco, next to Brazil, Zimbabwe, China and the US. It exports to 100 countries worldwide, and accounts for 5% (by volume) and 0.7%–0.9% (by value) of the world's trade in tobacco (import and export). Cigarettes and cigarette tobacco account for 85% of India's total tobacco exports.

Of the 200 exporters registered with the Tobacco Board, 31 are major exporters. Fifty are exporting unmanufactured tobacco. *Beedis* are imported by 56 countries across the world. The UK, Russia, Bulgaria, Italy, Japan, France, the Netherlands, Germany, Nepal and Egypt are our traditional markets. India has made an entry into Spain, Tunisia, Romania, Brazil, Turkey and Canada in recent years. Chewing tobacco/*zarda* and cigarettes are the main tobacco products exported (in value terms), contributing 44% and 80%, respectively, of the export revenue from tobacco products. In 2001–2002, they constituted 32% of the total tobacco exports. Unmanufactured tobacco exports contribute nearly 70% of the revenue, the bulk share coming from FCV tobacco (about 55%).

Economics of tobacco control: What is the right approach?

Though the consumption of tobacco is reported to be on the decline in the developed countries, there is no indication of such a reduction in India. While the consumption of cigarettes and *beedis* has declined in India,[26] the total consumption of tobacco has increased due to the introduction of *gutkha* and *paan masala*.

The major question is whether we should continue to support tobacco cultivation while trying to impose restrictions on tobacco consumption by way of taxation and by imposing restrictions on places of consumption and sale. The contribution of tobacco to the Indian economy in terms of revenue and employment, and the international and domestic demand for FCV and *beedi* tobacco, respectively, resulting in an assured market, are the main factors responsible for the extension of government support to tobacco. The Government of India thus follows the dual policy of controlling tobacco consumption and promoting tobacco cultivation side by side. There cannot be a balance between the two approaches.

The aggregative macro measures to indirectly control tobacco production generally get countered systematically so that production continues to grow, and as the adage goes, "supply creates its own demand", so that consumption also continues to grow unabated in response to the supply. As the fiscal measures swell the government revenues and foreign exchange earnings, policy-makers might well prefer to be "pragmatic" and "rational" and refrain from launching an intensive anti-tobacco drive. It was this "pragmatism" and "rationality" which forced some states in India to abolish prohibition—making hard drinks easily available could fetch large revenues to the exchequer.

The adoption of two approaches seems to be necessary. First, the measures for controlling tobacco consumption have to be effectively integrated with the measures needed to control the production of tobacco. Second, the aggregative measures need to be replaced or supplemented with the micro measures involving case-by-case tackling of different types of tobacco consumers and tobacco producers.

It is also necessary to gather supportive data and formulate a comprehensive policy for rehabilitating those who depend on tobacco cultivation, *beedi*-making and tendu leaf collection for their livelihood. Alternative employment should be provided to people employed in retailing, processing, and industries manufacturing

cigarettes and chewing products. It is the unskilled *beedi* workers and farmers who will require the maximum help to shift from their occupations. If tobacco cultivation cannot be stopped at all for economic reasons, alternative and less harmful uses of tobacco are recommended, e.g. for the purpose of producing fertilizers and manures.

The government can initiate micro studies in all the tobacco-growing regions to explore the feasibility of cultivating alternative crops and also to estimate the likely burden on the state exchequer on account of facilitating the shift. Similar studies may be carried out on *beedi* workers and *tendu* leaf collectors in selected states with the help of non-governmental organizations (NGOs).

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Section II:
Tobacco Control Legislations and Litigations in India and the Framework Convention on Tobacco Control

Enforcing tobacco control legislation in India

Tobacco is freely allowed to kill one person every eight seconds, globally. Of the 1.1 billion people who smoke worldwide, 182 million (16.6%) live in India. By 2020, it is predicted that tobacco will account for 13% of all deaths in India. Further, tobacco use is more varied in India than in most other countries.

It has been observed that legislation is at the heart of effective tobacco control. It institutionalizes and makes binding a country's commitment to tobacco control, creates a focus for tobacco control activity, and regulates private and public conduct in ways in which informal or voluntary measures cannot.

A. Introduction to the tobacco control law in India

India has played a strong leadership role in the global fight against tobacco. In terms of legislation, a beginning was made in the form of the Cigarettes Act, 1975. During the 1980s and 1990s, civil society groups and the media started making effective use of scientific data to create awareness of tobacco-related health issues among the people and advocated with the policy-makers for stronger policies. Gradually, all the stakeholders, led by the Advocacy Forum for Tobacco Control (AFTC), joined hands to launch a collective campaign for tobacco control. This resulted in a modified and comprehensive tobacco control Act, namely, the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA), 2003.

The COTPA is designed essentially to protect people from the hazards that tobacco poses to the health of its users, as well as to that of non-users through passive smoking. The legislation also aims to prohibit sale of and access to tobacco by minors, prevent their initiation into a harmful addiction, and restrict promotion of tobacco products by prohibiting their advertisement. It also makes it mandatory for tobacco products to carry the statutory health warnings (including a pictorial warning), as well as the tar and nicotine contents.

However, what is necessary is the effective enforcement of these provisions. As the Central Government makes rules for this purpose from time to time, NGOs can assist and support it, and help monitor the implementation of the provisions of the law.

1. Prohibition of smoking in a public place

- Section 4 of the COTPA categorically declares that no person shall smoke in any public place.

- "Public place" means any place to which the public has access, whether as of right or not. It includes auditoriums, hospital buildings, health institutions, amusement centres, restaurants, public offices, court buildings, educational institutions, libraries, public conveyances and other places visited by the general public. It does not include any open space, though smoking is prohibited at such open spaces visited by the public as open auditoriums, stadiums, railway stations and bus stops. It is to be noted that hotels with less than 30 rooms and restaurants with less than 30 seats have to be

absolutely smoke-free. However, hotels with 30 or more rooms, restaurants with 30 or more seats and airports may provide for a separate smoking area or space.

- Section 21 of the Act provides that any person found smoking in a public place shall be liable to be punished with a fine of up to Rs 200.

- Section 25 enables the Central Government or state governments to appoint one or more persons as authorized officers who shall be responsible for taking action against any person committing an offence under Section 4 or Section 6.

Rules notified on 25 February 2004: The initial rules on prohibition of smoking in a public place were notified on February 25, 2004. The rules had a few gaps, as a result of which new rules superseding them were notified on May 30, 2008.

Rules notified on 30 May 2008, enforced from 2 October 2008 (across India): These rules require that the management of a public place shall ensure the following.

- No person shall smoke in a public place (including restaurants and hotels).

- The management should prominently display the specified board (shown in Figure 1) at:

  a. each entrance,
  b. each floor,
  c. each staircase,
  d. each entrance of the lift, and
  e. conspicuous place(s) inside

Fig 1: Government of India's smoke-free signage

- The name of the person to whom a complaint may be made in case of a violation of the law should be prominently displayed.

- No ashtrays, lighters, matchsticks or other things designed to facilitate smoking are to be provided.

- There should be no “smoking area or space” at the entrance or exit of restaurants with a seating capacity of 30 or more, of hotels with 30 or more rooms and of airports, and such an area should be distinctively marked “smoking area” in English and one Indian language, as applicable.

- A “smoking area” is to be used only for the purpose of smoking and no service(s) should be available therein.

- If the owner, manager, supervisor or in-charge fails to act upon any complaint, he shall be liable to pay a fine equivalent to the sum of the fines for the individual offences.

Smoking area or space

As defined under Section 2(e), the smoking area or space must be a physically separated and separately ventilated room, with walls of full height on all four sides. It should be fitted with an automatically closing door, which is normally kept closed. The air from the smoking area must be exhausted directly to the outside, through a non-recirculating exhaust ventilation system, an air cleaning system or a combination of the two, so that it does not mix back with the air supply of the building and the non-smoking area therein.

Separate smoking room

A separate smoking room may be designated in a hotel with 30 or more rooms under the following conditions.

- The room should be in a separate section of the floor or wing. In case there is more than one floor/wing, the smoking rooms should be on a separate floor/wing.
- The room should be distinctively marked “smoking room” in English and one Indian language, as applicable.
- The smoke from the room shall be ventilated outside and should not mix back with the air of the non-smoking areas of the hotel.

Authorized officers

The new rules designate 12 fresh categories of authorized officers to implement the provisions of Section 4 of the Act. Besides others, the Head of Institution/HR Manager/Head of Administration is also authorized to impose and collect fines against the violation of the law.

Why prohibition of smoking in a public place?

Public license for smoking may give non-smokers, especially the youth, the impression that smoking is acceptable and normal.

It prevents damage to the health both of smokers and non-smokers. It encourages smoking cessation.

A recent survey conducted in Mumbai by the Healis shows that a majority of people, including smokers, are in favour of the ban.

People working in restaurants or hotels appear to be 50% more likely than the general population to develop lung cancer because of exposure to tobacco smoke on the job.

2. Prohibition of advertisement of tobacco products

The COTPA prohibits both direct and indirect advertisement of cigarettes and other tobacco products. This covers anything that suggests the promotion or sponsorship of tobacco products.

- For the purpose of prohibiting advertisements of tobacco products, the Act empowers authorized officers to enter, search, seize and confiscate advertisements, cigarette packages and any other tobacco packages that are in contravention of the provisions of the Act.

- Any person acting in contravention of the provisions of Section 5 shall be liable to a punishment of imprisonment for two years or a fine of Rs 1000, or both. In the case of a second or subsequent conviction, the fine is Rs 5000 and the term of imprisonment five years.
- On conviction for contravention of the provisions, the advertisement material may be forfeited to the government and disposed of in accordance with the rules prescribed for the purpose.

Rules notified for prohibition of advertisements: Rules prohibiting all direct and indirect advertisements have been notified by the government from time to time. The rules prescribe the following specifications for the display board that may be used for advertisement at the entrance of a warehouse or shop where tobacco products are sold.

- The board should measure 60 cm x 45 cm.
- The top edge of the board, measuring 20 cm x 15 cm, shall contain one of the following warnings.
  - "Tobacco causes cancer"
  - "Tobacco kills"

- The warning should be prominent, legible and in black, with a white background.
- The board should only list the type of tobacco products available, with:
  - No brand pack shot
  - No brand name
  - No promotional message or picture
  - No backlight or illumination

Prohibition of advertisement in cinema and television programmes: The rules to this effect were struck down by the Delhi High Court in the Mahesh Bhatt case. The same order has been stayed by the Supreme Court in an appeal filed by the Government against the Delhi High Court order.

Steering committee to look into violations of Section 5: A steering committee was constituted vide the rules dated 30 November 2005, to look into specific violations under Section 5 of the Act. The

Why prohibition of advertisements?	
To counter marketing strategies targeted at children	The products are placed at a low height and next to candy at points of sale, which gives children access to them.
To minimize harmful Influence on youth	Children who have seen sports events being sponsored by a tobacco company are more likely to start smoking.
To reduce consumption	A comprehensive ban on advertising, promotion and sponsorship reduces the consumption of tobacco.

committee can act on complaints of violations and can also take suo motto cognizance of cases.

Complaints to be referred to the committee may be addressed to the Health Secretary, Ministry of Health and Family Welfare, Nirman Bhavan, New Delhi–110011.

The Central Government has also issued orders vide the constitution of such steering committees at the state and district levels to check violations of the provisions of Section 5.

Further, specific complaints relating to violations of the codes prescribed for television and the print media may be addressed to a similar committee at the Ministry of Information and Broadcasting, Shastri Bhavan, New Delhi–110001.

Other laws restraining tobacco advertisements:

i. Rule notified in 1991 under the Cinematograph Act, 1952: The Central Government directed that in the exercise of the power conferred by Sub-Section (2) of Section 5 B of the Cinematograph Act, 1952, the Board of Film Certification, while sanctioning films for public exhibition, shall ensure that "scenes tending to encourage, justify or glamorize the consumption of tobacco or smoking are not shown".

ii. Advertising code for broadcasting by All India Radio (AIR) and Doordarshan: The code has strict provisions, such as the prohibition of advertisement of tobacco products (including paan masala) and liquors.

iii. Cable Television Networks (Regulation) Act, 1995: This Act was amended in 2000, when the Advertising Code rules were framed under it. Rule 7 prohibits advertisements that directly or indirectly promote the production, sale or consumption of cigarettes and tobacco products (besides alcoholic beverages, infant milk substitutes, infant food and feeding bottles). The rule was amended by a notification issued on 9 August 2006, and an exception was inserted to the effect that a product using a brand name or logo which is also used for cigarettes, tobacco products, wine, alcohol, liquor or other intoxicants may be advertised on cable service subject to the following conditions.

   a) The story board or visual of the advertisement must depict only the product being advertised and not the prohibited product in any form or manner.

b) The advertisement must not make any direct or indirect reference to the prohibited product

c) The advertisement must not contain any nuances or phrases promoting the prohibited product.

d) The advertisement must not use the particular colours, lay-out or presentation associated with the prohibited product.

e) The advertisement must not use situations typical for the promotion of the prohibited product.

The rule further provides that all such advertisements shall be previewed and certified by the Central Board of Film Certification as suitable for unrestricted public exhibition prior to telecast, transmission or retransmission.

Under the Act, the district magistrate or sub-divisional magistrate has the power to take action against offending cable operators if he receives a complaint against them. A district-level monitoring committee has been formed to improve the enforcement of the advertising code. This committee also has representatives from NGOs and government departments concerned with the welfare of women and children. It acts as a pool of knowledge and has the responsibility of helping the district magistrate take fair decisions on complaints received on violations of the provisions of the Cable Television Networks (Regulation) Act, 1995.

iv. The Advertising Standards Council of India: The Advertising Standards Council of India Voluntary Code of 1998 envisaged the prohibition of advertisements targeting underage consumers, as well as of suggestions that using tobacco products is safe, healthy or popular.

3. Prohibition of sale of tobacco products to and by minors

- Section 6 of the COTPA provides for the prohibition of the sale of any tobacco product to a person below the age of 18 years. Sale is also prohibited within a radius of 100 yards from any educational institution (from the outer radius of the institution).

- If a person contravenes the provisions of Section 6, he is liable to a fine of up to Rs 200.

- The offence under both section 4 and Section 6 are compoundable by the authorized officers and where required, shall be tried summarily in accordance with the procedure provided in the Code of Criminal Procedure, 1973.

Rules notified for prohibition of sale of tobacco products to minors: The rules to this effect require that the owner/in-charge of a place where cigarettes or tobacco products are sold should ensure that:

- A board measuring at least 60 cm x 30 cm, in the applicable Indian language, is displayed at a conspicuous place, saying, "The sale of tobacco products to a person under the age of 18 years is a punishable offence."
- The tobacco products are not displayed in such a way that they are visible.
- No tobacco product is sold through a vending machine.

Why protect youth and children from tobacco?

- Children in India experiment with tobacco at an early age and become addicted thereafter.
- Beginners starting at a young age are more likely to suffer from serious diseases and die prematurely.
- Sale by a minor gives a message to that child, as well as to other children, that it may be all right to use tobacco.

- No tobacco product is handled or sold by a person below the age of 18 years.

The owner or person in charge of an educational institution must display, at a prominent place, a board stating that the sale of cigarettes and other tobacco products in an area within a radius of 100 yards from the educational institution is strictly prohibited, and that the offence is punishable with a fine of up to Rs 200.

4. Specified health warnings on all tobacco products

The first statutory warning, "Cigarette smoking is injurious to health" (which is still in force), was stipulated under Section 2 (m) and Section 3 of the Cigarettes Act, 1975. It was laid down that all cigarette packages must carry the warning in the language used in the brand. Other tobacco products, notably beedis and gutkha, were not covered under this stipulation.

The COTPA went a step further and provided for more effective package warnings. Now, every package of cigarettes and all other tobacco products are required to carry a specified warning with a pictorial depiction, as well as such other warning as may be prescribed.

- Section 7 of the COTPA provides that every package of cigarettes and other tobacco products shall bear the specified warning thereon, or on its label. It also prohibits the import of cigarettes unless the packages have the specified warning. The specified warning contains a health warning ("Smoking kills" or "Tobacco kills") and a pictorial representation of the health message.
- Section 8 says that the specified warning on packages of cigarettes and other tobacco products shall be legible, prominent, and conspicuous in size, colour and style. The lettering should be in bold and clearly presented, in distinct contrast to the background of the packaging or its labels. The manner in which a specified warning shall be printed or inscribed shall be such as may be prescribed in the notified rules.
- Section 9 prescribes the language in which the warning should be written.

- Section 20 prescribes the punishments for non-compliance with the provisions on labelling. For the producer, in the case of the first conviction, the punishment is imprisonment for up to two years or a fine of up to Rs 5000, or both. On the subsequent conviction, the term of imprisonment may extend up to five years and the fine may go up to Rs 10,000. For the seller, in the case of the first conviction, the punishment prescribed is imprisonment for up to one year or a fine of up to Rs 1000, or both. On the subsequent conviction, the term of imprisonment may extend to two years and the fine may go up to Rs 3000.

Rationale for pictorial health warnings

A picture paints a thousand words	Images reinforce the impact of the written health warnings. They help smokers visualize the nature of tobacco-related diseases and convey health messages in a clearer way. They also have an emotional impact.
Comprehensible to the illiterate	Pictorial warnings can be understood by those who cannot read, i.e. the illiterate and children.
Global results	Results from many countries suggest that pictorial warnings are 60 times more effective in encouraging cessation and prevention than text-only labels. Evidence from Canada, Brazil and Australia shows that picture warnings attract the attention of smokers, increase awareness of the health risks of smoking and decrease cigarette consumption.

- If an offence is committed by a company, the person in charge at the time when the offence was committed would be held guilty under Section 26 of the Act. But if the person in charge proves that the offence was committed without his knowledge, then he/she would not be liable for the offence.

Rules notified for warning labels on tobacco products: The first set of rules on pictorial health warnings were notified on 5 July 2006. The Central Government modified these rules on 29 September 2007 to have the skull-and-bone sign removed. The rules were to come into effect on 17 March 2008. However, this date was postponed to 30 November 2008 due to objections raised by the tobacco companies in the courts, and has now been deferred to 31 May 2009.

These rules specify the manner in which tobacco products should be packaged and labelled. They stipulate that the warnings must be exactly as specified in the schedule of the rules. The manufacturer and seller have to ensure that the health warning occupies at least 40% of the principal display area of the pack. They must also ensure that the package and label do not carry any information which is false or misleading. The specified health warnings shall be rotated every 12 months or earlier as may be decided by the government.

B. Enforcement of the tobacco control law: Opportunities and barriers

The implementation of our tobacco control legislation has its challenges, the biggest being the lack of awareness of the tobacco problem among the public and policy-makers; the lack of human, technical and other capacity, as well as of infrastructure and resources; and the continuing opposition of the tobacco industry and its affiliates and allies. It is important to counter this opposition and success depends on a strong and continual political commitment throughout the life of the legislation.

It has been globally demonstrated that passing legislation alone is not enough. It is often heard in the corridors of the judiciary: "What good is the law if it is not implemented?" Although the Indian law is comprehensive and indeed very robust, a major problem has been its implementation. The effective implementation of any legislation requires adequate enforcement and compliance mechanisms, backed by financial and technical resources, political support, and educational and awareness-raising strategies. A major problem in the implementation of this particular law is lack of sensitization and awareness of its requirements among key stakeholders, including officials from the ministries concerned.

The enforcement of the law has not been effective or visible. Pro-tobacco forces often orchestrate high-profile violations of the law, which are then promoted in the media to undermine public support for and compliance with the law (e.g. Shahrukh Khan smoking in a stadium, a public place). If such violations are dealt with promptly and decisively, compliance with the law would improve. *Unfortunately, the Ministry of Health and Family Welfare (MOHFW) has not yet created a regulatory framework for the effective monitoring and enforcement of the COTPA.* The Act confers the power of enforcement upon:

"…any police officer, not below the rank of sub-inspector or any officer of the State Food or Drug Administration or any other officer, holding an equivalent rank being not below the rank of Sub-Inspector of Police, authorized by the Central Government or by the State Government…"

While this broad authority is good, it also provides for a situation in which the responsibility is so diffused that no agency feels the need to take action. It is important to clarify this situation by placing specific responsibilities on various authorities and making them accountable. The MOHFW at the Central level and the state, district and city health departments at the state level must take direct responsibility and be accountable for failure to enforce the law

There are several other constraints to effective enforcement. First, tobacco control laws may be relatively low on the list of enforcement priorities for many jurisdictions. Though health leaders and tobacco control advocates think that tobacco is a serious problem, the enforcement agency staff may not believe that it is a priority. Besides, the quality of enforcement is likely to be affected by the beliefs, personal convictions and attitudes of the enforcing officers.

It is important to weigh the pros and cons of using the existing enforcement authorities as against creating new enforcement authorities and institutions. The enforcing agency should be completely free of influence

from the tobacco industry, competent and sufficiently trained to enforce the legislation effectively, and committed to the success of the legislation. The enforcement operations could be designed so that they can be undertaken both by national and local authorities. A part of the funds for enforcement activities could come from fining violators, licensing fees, filing fees and earmarked tobacco tax revenues. Furthermore, penalties for breach of the legislation need to be tailored to avoid difficulties in enforcement and must be serious enough to deter violations, but not so excessive as to undermine public support. The procedures used to impose sanctions should meet the basic standards of fairness and transparency and should be consistent with the jurisdiction's legal and constitutional standards of due process of law and procedural fairness.

The implementation of tobacco control legislation needs to be carried out in a phased manner to ensure compliance by the public. The implementation mechanisms should be preceded and complemented by mass media campaigns aimed at raising the awareness of the public, policy-makers, opinion leaders, enforcement agents and the media. The best legislation is that which can rely on voluntary enforcement by the public. By raising mass awareness, the public can be empowered to support the law and its implementation. In this, NGOs can become partners of the government.

A survey conducted by three legal officers from HRIDAY enumerated several barriers to the enforcement of the tobacco control law. These barriers and the possible remedies are listed in the following table 1.

Table 1: Barriers to and opportunities for enforcing tobacco control law in India

Barriers	Opportunities
1. Enforcement officials have often been seen to lack awareness of the COTPA and its implementation mechanisms. They also do not have timely updates on new rules.	1a. Workshops/training sessions can be conducted to sensitize law enforcers on the COTPA. These can include information on the dangers of tobacco use, as this will help them understand the rationale for the Act. 1b. Help can be provided to coordinate communication between the MOHFW and enforcement authorities. The latter should be informed about the MOHFW website.
2. The quality of coordination among government departments, e.g. the police and food and drug authorities (FDA), and within departments is rather poor.	2. This can be addressed at sensitization workshops. Agencies should outline a clear division of responsibilities between or among themselves to eliminate confusion. This can be achieved, for example, by including some joint sessions for the police, FDA and other notified departments on their respective duties. Annual sensitization workshops are necessary to refresh memories, encourage renewal of priorities and reach new personnel, as some may get transferred to other departments.

Barriers	Opportunities
	a. The FDA needs compulsory and thorough training on "no smoking in public places" (for restaurants and hotels). When the FDA inspects restaurants and hotels for their level of hygiene, it could easily incorporate into its routine the duty of checking for compliance with the COTPA. Surprise checks could also be instituted. There is a need for monitoring, for which a mechanism should be devised and made known to the NGOs. b. The police should be trained to check for the illegal sale of tobacco within 100 yards of educational institutions, sale to minors and illegal advertising at points of sale (wrong type of boards and misleading words, such as "low", "light", and "mild") when they do their rounds and during random checks. The police can also be sensitized to enforce the ban on smoking at airports and railway stations. They can check for the warnings on packs at points of sale once the new pictorial warnings come into force. Also, those responsible for surrogate advertising need to be booked. c. School and college personnel should be sensitized on the subject of tobacco use on school premises and the sale of tobacco within 100 yards of an educational institution. d. Personnel in health care facilities should be educated on the law and encouraged to work out a system of enforcement in their facilities.
3. The existing resources, both in terms of manpower and vehicles, are inadequate.	3. Advocacy is required for increasing resources. Section 25 of the COTPA provides for the appointment of personnel as public servants to take action against persons smoking in public places (of which there is a long list), sale to and by minors, and sale within 100 yards of educational institutions.
4. Social acceptance of tobacco is a huge barrier, which leads to a large number of violations, e.g. smoking in public places and the failure of small shops to put up warning signs. Such acceptance arises from a lack of awareness of the dangers of tobacco and SHS,	4. There is a need to create awareness of the laws and the dangers of tobacco use. a. Public awareness should be created about the COTPA, its rationale and the related laws (including broadcasting codes and the Indian Railways Act), through exhibitions/videos at railway stations, cinema slides before the screening of films in movie theatres (the MOHFW could do this), newspaper articles, public service

Barriers	Opportunities
and of the COTPA. Some examples of barriers that reinforce social acceptance: a. Since many enforcement personnel use tobacco themselves, they may not feel motivated to enforce tobacco control laws. b. Actors and models use tobacco, especially in the form of cigarettes.	announcements on television, messages in trains and public toilets, etc. Through these media, citizens should be motivated to report violations. Such means have been used effectively to inform citizens about laws, crimes or health problems. Some examples are the prohibition of the use of cell phones while driving, calls for alertness for the presence of parcels on trains and buses, polio immunization and HIV/AIDS transmission. b. Enforcement activity should be concentrated in a few prominent places as the media coverage this would attract could influence people in less prominent places. c. Enforcement personnel should be encouraged and supported to quit. d. From time to time, letter-writing and media campaigns can be organized on frequent and common violations. e. In each town, some printing shops can be designated to print the signboards required by the COTPA and by the rules for shops and restaurants, so that the owners of these establishments can easily order them.
5. Tobacco use (public smoking) by foreigners is a barrier. Also, the focus of the law enforcers reverts to drug use and trafficking during the tourist season.	5. Leaflets must be given to all arrivals on planes, buses and trains from outside India, informing them of the provisions of the COPTA and the harmfulness of tobacco use. Also, information should be given on the illegality of the use and trafficking of narcotics.
6. Restaurant owners are not clear on the division of smoking and non-smoking areas.	6. The enforcement agencies should jointly approach the all-India and city owners' associations for restaurants, bars and hotels to offer information on the COTPA and practical suggestions for the correct implementation of the provisions on smoke-free areas.
7. Tobacco products are smuggled across international borders in the north-east. This problem has not been given priority.	7. Advocacy campaigns about smuggling should be conducted. Preferably, tobacco and narcotics should be prioritized together.

Barriers	Opportunities
8. The geographical inaccessibility of places near the north-east interstate borders causes jurisdictional problems for enforcement personnel.	8. The mass media can be used to create public awareness of the harmfulness of tobacco and of the COTPA. Joint meetings of the relevant authorities from the different north-eastern states could promote cooperation and coordination. The number of vehicles should be increased and they should be utilized for multiple purposes.
9. There are loopholes in the law. In addition to lack of notification at the state level, non-implementation continues.	9a. NGOs can take the initiative to approach the MOHFW and state health departments. They can use the procedures under the Right to Information Act. 9b. The Central Government and even the state governments can upscale the law through amendments to meet the Framework Convention on Tobacco Control (FCTC) mandates and international standards of best practices. For example, the pecuniary penalties under the law may be increased to act as a sufficient deterrent. It is to be noted that the states need not notify the COTPA as such. What is required of them is to notify officers who shall enforce various provisions of the COTPA, especially Sections 4 and 6, within their respective jurisdictions.

Clearly, many barriers exist but each one presents an opportunity for action. Readers are encouraged to think creatively and find their own opportunities to change the situation.

C. Role of NGOs in tobacco control

NGOs have been the first to identify threats to society. Whether it is the question of landmines, substitutes for breast milk, saving trees, the world's water resources or protecting future generations from a nuclear holocaust, it is the NGOs that have pushed governments and policy-makers to act on the evidence. Their role has been particularly remarkable in the area of human rights and individual freedoms. Public health is one of the areas in which NGOs have been active.

In India, many local, national and international NGOs are working, individually or in networks, towards comprehensive tobacco control. Some are working in collaboration with the national government and others independently in areas like health education, promotion of health, community outreach services, advocacy, litigation, enforcement of legislation, tobacco cessation, clinic services and mobilization of resources.

NGOs working for tobacco control can play a role primarily in the following areas:

- **Public interest litigations:** NGOs have played a significant role in filing public interest litigations to curb the menace of tobacco in various ways.
  - The Voluntary Health Association of India (VHAI) filed a petition in the Delhi High Court against surrogate advertising by tobacco companies by way of sponsorship of sports (the sponsorship of the Indian cricket team by the Wills brand of cigarettes, manufactured by the ITC).
  - In 1984, VOICE filed a complaint against the contest organized by the ITC on television with the intention of advertising its brand and promoting the use of cigarettes.
  - Burning Brain Society, an NGO, recently filed public interest litigation in a high court to restrain Godfrey Phillips India's awards function, as it promoted and advertised its cigarette brand, Red and White. The result was that the company agreed to drop the name of the cigarette brand during its awards function.
  - The Consumer Education and Research Society (CERS) initiated a class action suit for compensation on behalf of some patients with oral cancer, who developed the illness due to addiction to *gutkha*.
  - Besides public interest litigation, individual actions may also be initiated against violations of the tobacco control laws. Non-governmental organizations such as NOTE in Goa are very active in taking legal action to promote tobacco control and have served legal notices to big Bollywood stars, like Amitabh Bachchan and Shahrukh Khan, for violating provisions of the Indian Tobacco Control Act.

  The NGOs in various states should learn from such instances and play a proactive role in supporting tobacco control through legal tools.

- **Research:** Many Indian NGOs have produced research in the area of tobacco control that has influenced policy and the NGOs have subsequently called for public health action in the area. The Global Youth Tobacco Survey (GYTS), conducted by some Indian NGOs in different states, revealed facts which brought home the immediate need to protect the youth in India. HRIDAY (Health Related Information Dissemination Amongst Youth), a Delhi-based NGO engaged in awareness, education, advocacy and research related to tobacco control among the youth, conducted Project MYTRI (Mobilizing Youth for Tobacco Related Initiatives in India) in collaboration with the University of Texas, USA from 2004–2006. Project MYTRI was a multi-component intervention trial designed to reduce tobacco use among the youth. It covered students of classes VI to IX in 32 government and private schools of Delhi and Chennai. The curriculum developed by the project for the prevention of tobacco use was successful in reducing the use of tobacco at the time, reducing intentions of using it in the future and increasing the students' knowledge of the serious health hazards of tobacco use.

The involvement of NGOs in tobacco control and health research is necessary to ensure the generation of knowledge and the effective use of the knowledge. Their research would also help the government to formulate rules and regulations, implement the law, and evaluate action plans.

- **Advocacy:** Advocacy is an organized approach to promoting an issue or a cause and motivating others to take action in relation to that issue or cause. Advocacy efforts by NGOs have played a major role in the proposal and enactment of comprehensive legislation for tobacco control in the country. Advocacy by NGOs can play an even larger role in the implementation of the law through various means. The activities that can be undertaken include disseminating awareness in society through various health education and health promotion strategies, and producing audiovisual material for health education and health advocacy. Advocacy campaigns should be conducted from time to time to keep up the support for the cause.

  Since 1992, HRIDAY has been actively involved in advocacy with policy-makers and the media on various burning issues related to tobacco control (including the implementation of pictorial health warnings, prohibition of smoking in public places and direct & indirect advertising of tobacco products).

- **Awareness:** Awareness of an issue is a prerequisite for social change. Only if an individual is informed about the effects of tobacco will he/she follow a law pertaining to it. If a person completely understands the reasons for which a law has been enacted, he/she is more likely to comply with it. Therefore, it is essential for NGOs to launch campaigns to educate the people on the harmful effects of tobacco and the need for the law on tobacco control. The next step should be to inform the people about the provisions of the law, so that they know which provisions to follow, and when and where to follow them.

  Awareness must be spread not only among the masses, but also the enforcement officials, all of whom might not understand the importance of the law. Awareness campaigns should be a regular practice, so that the masses and officials are kept up to date on the latest information on the law and the effects of tobacco use. Non-governmental organizations should also support and promote the development of academic curricula which would integrate tobacco control into secondary and tertiary education.

- **Capacity-building:** Capacity-building of NGOs is important to ensure that they can participate actively in tobacco control activities in each state. Capacity-building workshops and programmes can be conducted by the MOHFW, the World Health Organization (WHO) and/or NGOs. Such programmes have been conducted in the past and should be held at regular intervals. They should also be extended to various schools and communities in urban, rural and tribal areas, as well as to slums and areas with marginalized populations.

- **Assistance in implementation of the law:** Most NGOs are capable of undertaking operational research, which can improve the implementation of programmes and the realization of policy. It is important to

enable NGOs to undertake community-based research relevant to the implementation of tobacco control measures and pursue authentic advocacy in this sphere.

School and college student activists working with NGOs have documented evidence of several ways in which the tobacco industry contravenes the regulations related to points of sale and the ban on advertisement of tobacco products as per the Indian Tobacco Control Act, 2003. Youth activists have requested the strict enforcement of these regulations and the imposition of penalties by the government. Students participating in campaigns carried out by HRIDAY have distributed copies of the Act and rules to managers and owners of hotels and restaurants to sensitize them to the rules on the prohibition of smoking in public places.

Non-governmental organizations can also be involved directly in the implementation of the law. The Chandigarh administration has already involved the chairperson of the Burning Brain Society in the implementation of the provisions of the Indian Tobacco Act, 2003, which is a noteworthy step.

D. Tobacco control and reporting of violations

Currently, India has a good law in place (albeit poorly implemented) to deal with the different aspects of tobacco manufacture, storage, sale and distribution. But we do not have proper guidelines or procedures for checking, recording and reporting misuse and violations of the provisions of the law. Table 2 gives some guidelines that can be followed by individuals, NGOs and their representatives or other health care institutions and health care professionals to check, monitor, control and report violations and/or misuse of the law by any organization, authority, agency or individual in the interest of public health. While reporting violations, one must consider not only the COTPA but also the relevant state Acts, e.g. The Delhi Prohibition of Smoking and Non-Smoker's Health Protection Act and the Goa Public Health Act.

Table 2: Guidelines for reporting legal violations for effective tobacco control

S. No.	Provisions of the Act	Areas or aspects to be observed/checked	Person held responsible to obey the law	Competent officers authorized to act under the Act
1	Prohibition of smoking in a public place (COTPA, Section 4, and rules thereunder)	Smoking in a public place Compliance to the provisions described under section A of this chapter	Individual/owner/ manager /person in charge of affairs of a public place	The officers notified by the Central Government and the State Governments

S. No.	Provisions of the Act	Areas or aspects to be observed/checked	Person held responsible to obey the law	Competent officers authorized to act under the Act
2	Prohibition of smoking in public vehicles (Delhi Act, 1996)	Public service vehicles as defined in Section 2(h35)[1] of the Motor Vehicles Act, 1988	Passengers/driver /conductor of the vehicle	The notified officers
3	Prohibition of advertisement of cigarettes/other tobacco products (COTPA, Section 5, and rules thereunder)	Any public place* On any public vehicle (Delhi Act) Electronic media Print media Radio Internet Cinema Compliance to the provisions as explained under section A of this Chapter *Exception: on a package of tobacco product or at a shop or warehouse of tobacco products	Person producing, supplying, distributing tobacco or having control over a medium of communication	Police officer not below the rank of sub-inspector or any officer of the State Food or Drug Administration, or any other officer holding an equivalent rank not below the rank of sub-inspector of police, authorized (notified) by the Central Government or by a the State Governments
4	Prohibition on sale of cigarettes or other tobacco products within 100 yards of an educational institution (COTPA, Section 6, and rules thereunder)	All educational institutions Compliance to the provisions described under section A of this chapter	Owner or manager or person in charge of the affairs of the educational institution	The officers notified by the Central Government and the State Governments
5	Prohibition of sale of cigarettes or other tobacco products to minors (COTPA, Section 6, and rules thereunder)	All tobacco vendors Compliance to the provisions described under section A of this chapter	Owner of shop, salesperson	The officers notified by the Central Government and the State Governments
6	Display of statutory warnings at points of sale and on tobacco packages (COTPA, Sections 5 and 7, and the rules thereunder)	All tobacco vendors All tobacco products Compliance to the provisions described under section A of this chapter	Owner or in-charge of shop	Competent person/officer as notified by the government

[1]Motor Vehicles Act, 1988: Available from: http://www.netlawman.co.in/acts/motor-vehicles-act-1988.php?pageContentID=1670

Formation of a task force for detecting and reporting violations

Wherever feasible, a task force may be formed to detect and report violations. The duties and responsibilities of its members should be clearly defined.

1. The task force members should have a good knowledge of the provisions of the law, and keep themselves informed of new rules and other government policies.
2. The members should act as watchdogs. They should forward their reports of violations of the law to the appropriate authorities and the NGO concerned, so that appropriate action may be taken against the erring individuals and/or organizations.
3. A list of the names, complete addresses and contact details of the task force members should be made available to the members of the AFTC.
4. All reports should be generated electronically, in an appropriate format, and stored on CDs. Hard copies of these reports must be signed and filed properly.
5. The information gathered and the action taken may be shared with the AFTC and other NGOs.
6. The members of the task force may also share reports appearing in the media with the AFTC members and keep the latter up to date on developments relating to tobacco control activities.

A draft format for reports on violations of the provisions of the Act is attached as Appendix 1.

Appendix I
Observation/check report on misuse/ violations of the provisions of the Tobacco Control Act

Place: _____ Date: _____ Time: _____	Report no: _____ Report date: _____ Report by: _____ Approved by: _____ Pages: 1 of _____

Name of person/owner/in-charge of organization which violated the provisions of the Act	
Address Principal Officer/person Tel. No. Mobile No. e-mail ID	
Brief details of activity/business	
Brief nature of violation/misuse	
Past history, if any, of any such violation	
Documentary proof 1. 2	
Suggested course of action	
Address of concerned authority for remedial action(with phone number)	
Any other information	

Signature:
Name:
Designation:
Telephone No:
Name of NGO:

National Tobacco Control Programme

The problem of tobacco in India is complicated by the varied nature of tobacco use. Hence, the control of tobacco can be carried out effectively only through a multi-sectoral approach. Strategies for the different sectors are at present being identified to help in the planning of the national strategy for tobacco control.

During the XI Five-Year Plan, the Government of India launched the National Tobacco Control Programme (NTCP) on a pilot basis in two districts each of the nine states of Rajasthan, Assam, Karnataka, West Bengal, Tamil Nadu, Uttar Pradesh, Gujarat, Delhi and Madhya Pradesh.

The components of the NTCP are as follows:

- District tobacco control programme with a strong monitoring mechanism at the state/central level
- Information, education and communication (IEC)/mass media campaigns
- Research and training
- Capacity-building of existing laboratories for testing tobacco products
- Monitoring and evaluation, including Adult Tobacco Survey (ATS)

District tobacco control programme

Under this programme, specific anti-tobacco activities will be identified and planned for each district. These would be subsequently integrated into the implementation framework of the National Rural Health Mission (NRHM). The aim of the district programme would be to bring about public awareness of the seriousness of the adverse effects of tobacco consumption on the health. It will include a local IEC campaign, a school programme, the monitoring/enforcement of anti-tobacco laws and extension of support to the cessation of tobacco.

A tobacco control cell will be set up in each district under the district programme. This cell will be responsible for:

- Monitoring and implementing anti-tobacco laws
- Launching IEC/ mass media campaigns
- Conducting health and awareness programmes in schools
- Initiating training and capacity-building activities for the enforcement of the provisions of the Act.
- Promoting tobacco cessation
- Identifying partnerships with NGOs/Panchayati Raj institutions (PRIs)/urban-level bodies (ULBs) for involving the community to take the programme forward

The Centre will support the State Governments by facilitating the appointment of a psychologist and a social worker on a contractual basis, during the 11th Five-Year Plan, with the understanding that, the states will create regular posts through their own allocation by the end of the Plan.

The aim of the school programme will be to create awareness among schoolchildren so that they may become ambassadors for advocating a healthy lifestyle and a smoke-free environment. The IEC and mass media campaign will have specific district-level interventions.

The training and capacity-building programme will target school teachers, health workers, law enforcers, self-help groups (SHGs) for women and other civil society organizations. Training/ sensitization on tobacco control may also be integrated into the training programmes under the NRHM and other national programmes, such as (non-communicable diseases, cancer etc.).

The states will be encouraged to create their own monitoring and implementation mechanisms. Partnership with civil society groups, such as women's SHGs, NGOs, ULBs and PRIs, and the creation of awareness among school teachers, health workers and law enforcers would be the keys to sustainable action for the effective implementation of the tobacco control laws.

Dedicated tobacco cessation centres under the supervision of government medical officers would be an integral part of the district programme. Such centres could also be set up in government medical/dental college hospitals in each state. The establishment of such centres is considered essential as there is widespread ignorance of tobacco consumption and tobacco cessation strategies among medical/dental students (Global Health Students Survey, 2006). Local NGOs/civil society groups will be involved in the implementation of some of the district-level components.

Since the state/district health society is already being supported under the NRHM, it is proposed that funds for the district tobacco control programme be allocated through the NRHM framework. This will facilitate synergistic use of the resources available under the NRHM and of the programme management/monitoring tools already developed for the NRHM framework, as well as financial due diligence. Under the pilot phase (2007–2008), of NTCP funds have already been released to nine states to set up state tobacco control cells and 18 districts to set up district cells. Approximately 100 districts would be taken up during each of the remaining four years of the Plan period, the aim being to cover approximately 450 districts by the end of the XI Five-Year Plan. The total expenditure for each district in the Plan period shall be around Rs 17.40 lakh. The total projection for the Plan period is Rs 193 crore.

Setting up of state tobacco control cells

The NTCP envisages building the capacity of the states for the effective enforcement of anti-tobacco legislation. There is also a need to effectively coordinate/monitor the proposed initiatives under the district tobacco control programme. The establishment of state tobacco control cells is expected to facilitate both these tasks. The nodal officer at the state level will be responsible for the overall coordination, monitoring and evaluation of the programme at the district level. Each state tobacco control cell will be established at a cost of Rs10.40 lakh (see below), with a component of a one-time grant of Rs 5 lakhs for the establishment of an office, office automation, and so on. A part of the funds will be dedicated to IEC activities, training and monitoring.

All the above will be implemented in a phased manner in the 28 states and seven union territories (UTs) during the Plan period. The budgetary estimate for one state shall be Rs 57 lakh. The total projection for five years is Rs 17.14 crore.

National-level public awareness campaigns

The government has sporadically aired anti-tobacco spots on the radio and television. It has also supported, in a limited way, NGOs working on tobacco-related cancer and other diseases to create awareness of the the health hazards of tobacco use. However, due to the want of proper allocation of funds, the government's efforts have been disjointed and intermittent, so the results achieved have been negligible. The public at large is unaware that the innocuous-looking and traditionally accepted *paan* and tobacco that they chew can create dire health problems. It is also not aware of the various provisions of the COTPA and the rules notified under it. Thus, there is no awareness of the ban on smoking in public places and on the sale of tobacco products near educational institutions, or of the right to protect oneself from SHS.

There is a need for a sustained campaign to build public awareness regarding all forms of tobacco, as well as the provisions of the anti-tobacco legislation. The campaign may be launched through the mass media, which can reach rural audiences and the lower socio-economic classes. An allocation of Rs 115 crore is proposed for this purpose for the remaining four years of the XI Five-Year Plan, the per annum allocation being Rs 23 crore.

Research and training

The initiatives being taken in the sphere of training and capacity-building for tobacco control need to be supported. There is also a need to gather empirical evidence and carry out action intervention studies, especially as these can help bring about behavioural change among those who consume tobacco. A budgetary estimate of Rs 25 crore is proposed for research and training activities.

Capacity-building of laboratories

The establishment of testing laboratories for tobacco products is an important component of the programme. It is proposed to have one apex laboratory and five regional/referral testing laboratories. The apex laboratory will be a validation laboratory with all laboratory and research facilities, including facilities for training. The regional/referral laboratories will be only for routine testing. The existing laboratories, both government and private (e.g. laboratories of the Central Pollution Control Board [CPCB] and state pollution control boards, food/drug laboratories and Indian Council of Medical Research [ICMR] laboratories), could be taken up for capacity-building. Some private laboratories, e.g. the The Energy Research Institute (TERI) and Shriram Laboratories, which are already accredited by ministries / departments other than Health, could also be taken up for capacity-building. The technical assistance for capacity-building would come from WHO/Centers for Disease Control and Prevention (CDC), Atlanta. Of the laboratories that are proposed to be upgraded, one could be further scaled up, in collaboration with WHO/CDC Atlanta, to serve as an apex/validation laboratory. This laboratory could also serve as a collaborating centre for WHO in the South-East Asia Region and support other countries in the region. A revenue-generating model could be developed, with the laboratories involved in testing of various batches of tobacco products, so that user charges could be used for maintaining the tobacco testing facilities.

Once the national tobacco regulatory authority is set up, it would take over the supervision and monitoring of the tobacco testing laboratories. A budget of approximately Rs 50 crore is proposed for the capacity-building of five or six laboratories.

Smoke-free environment in India: Policy, enforcement and compliance

Scientific evidence has firmly established that there is no safe level of exposure to Second-Hand tobacco Smoke (SHS). As has been discussed in Section I (Chapter 2), SHS causes or is associated with many health problems, including low birth weight, sudden infant death syndrome (SIDS), ear infections, respiratory diseases, heart disease, brain and kidney damage, stroke and lung cancer. Exposure to SHS in workplaces is estimated to cause 200,000 deaths worldwide per year. Half of the world's children and 50 million pregnant women are regularly exposed to SHS, making them vulnerable to its adverse effects. According to the Global Youth Tobacco Survey (GYTS), 36.4% of teenage students in India are exposed to SHS inside their homes and nearly 48.7% exposed to it outside. The only effective way to protect the population from the harmful effects of exposure to SHS is by creating a 100% smoke-free environment.

India is the country with the second highest prevalence of smoking, next to China, and has been reeling under the ill-effects of tobacco use. Indians are exposed to SHS not only from cigarettes, but also from *beedis,* cigars, hookahs and cheroots. The form used varies according to socioeconomic, demographic and geographical factors. Nearly 50% of tobacco is smoked in the form of *beedis,* mostly among the poorer sections of the population. This makes women and children in poor households especially vulnerable to SHS.

Though legislative action is the most important policy initiative to create a smoke-free environment, a comprehensive measure would also involve administrative, executive and judicial interventions. In India, civil society has been active in seeking judicial intervention to protect the population from SHS, and has been especially active in the fight against smoking in public places.

The comprehensive policy framework in India culminated in the enactment of the "Cigarettes and Other Tobacco Products (prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA)", in May 2003, the details of which have been discussed in Section II (Chapter 1), is a comprehensive legislation that is well supported by appropriate executive and administrative measures at the national level. However, the implementation of the policy requires an equal and complementary effort at the sub-national level from all the state governments, *panchayats,* municipalities and local self-governments. They must notify and designate officers to implement the ban on smoking in public places to ensure an environment that is free of tobacco smoke. Civil society and non-governmental organizations (NGOs) have a significant role to play in ensuring the effective enforcement of the laws at the grassroots level. Besides monitoring the enforcement regime, it is imperative for the NGOs to work in close coordination with the local government and administration to disseminate the policy, impart awareness and build capacity among various stakeholders to strengthen the enforcement of the law.

A smoke-free policy is a good policy. However, a policy is good only to the extent it is enforced. The extent of enforcement will decide the level of tobacco smoke in the environment and the loss it is allowed to cause to the

general public. Owing to the lack of awareness of the harmful effects of SHS and the law, the social acceptability of smoking in some types of restaurants, the large size of the population, and the socio-economic and demographic diversity of the country, the enforcement of smoke-free laws in India is a herculean task. Further, it has not been a priority of the enforcing agencies.

It is important that the officers notified under the law carry out their role in implementing the smoke-free laws as part of their routine work and take action where it is warranted. Proper funding should supplement the enforcement efforts so that the vigil on public places can be constant and effective.

The people's participation is the key to the successful implementation of a social legislation such as the COTPA. Their participation is all the more important because SHS concerns them directly. Greater awareness regarding SHS will empower them to object and raise their voices against individuals smoking in public places. A major public awareness campaign is required to motivate the general public against tobacco use. Civil society, NGOs, private organizations and the government machinery must make collective efforts to sensitize the public, in general, and the enforcement machinery, in particular, about the smoke-free laws and the positive impact that their implementation would have on health and the environment. This would result in a better understanding and hence, greater support for the legislation, and a high level of public support will translate into a high level of compliance.

In India, the enforcement of a law is a responsibility of the State Governments. Many states have tried to implement smoke-free laws within their jurisdiction. There are some notable examples of the creation of smoke-free environments, which are worthy of replication. Varnavasi in Tamil Nadu is the first Indian village to go smoke-free. The village head, who is an illiterate man, has declared the village a tobacco-free area. The first Indian town to achieve complete literacy, Kottayam (in Kerala), is looking to add yet another jewel to its crown by becoming the first tobacco-free town in the country. The action plan, prepared by the Kerala Voluntary Health Services, has identified the office of the superintendent of police, district mass media office and National Social Service (NSS) units of the M.G. University as the major coalition partners. A capacity-building workshop has been conducted to train volunteers to carry out this ambitious plan.

In the state of Goa, a pioneer in tobacco control in India, the government and civil society have developed a partnership to tackle the menace. During the past five years, the government of Goa has taken bold initiatives to combat and control the ill-effects of the consumption of tobacco products. Besides enforcing the COTPA, the officers of the collectorate, police department, Directorate of Health Services and Directorate of Foods and Drugs Administration also enforce the Goa Prohibition of Smoking and Spitting Act, 1997 and the Goa Public Health (Amendment) Act, 2005.

The government of Delhi has actively implemented the smoke-free laws. The administration has issued public notices in the press, urging people to follow the rules and refrain from smoking in public places. Besides other activities aimed at freeing the city's environment of tobacco smoke, the anti-smoking cell under the Directorate

of Health Services and the Delhi police carry out surprise checks at public places to penalize those who violate the rules. Such places include hotels, restaurants, colleges and public offices.

A path-breaking effort at the grassroots levels has been made in the district of Jhunjhunu, 180 km from Jaipur, in Rajasthan. The decision to make Jhunjhunu, the district headquarters, smoke-free (22 July 2006) was the brainchild of the Rajasthan Cancer Foundation. It was resolved to make Jhunjhunu smoke-free by 31 May 2007. District MLAs, the district administration, the media, NGOs and the youth collaborated in this initiative, which gave the community "visibility". The endeavour has been supported by grants from the MOHFW, Government of India, WHO and Indian Oil Corporation Limited. The Jhunjhunu model can be replicated in other states to make the second-level cities and townships smoke-free.

Given India's diverse demography, it is important to translate the law into simple terms for the common man and for various populations. Further, effective enforcement mechanisms could be designed to meet local requirements. To aid this process, NGOs must utilize their potential and play a decisive role in the implementation of the law.

How Chandigarh became smoke-free

An example that merits detailed consideration is the NGO–Government partnership in the city of Chandigarh to promote and ensure smoke-free public places. On 15 July 2007, the city, which is spread over 114 sq km and has a population of more than a million, became the first city in India to go smoke-free. The Chandigarh administration made additional efforts in notifying officers, within the mandate of the COTPA, to carry out the duty of enforcement. It created awareness through public notices, utilizing the press, cable network and cinema. All stakeholders were encouraged to participate, and meetings were held with hotel and restaurant owners, as well as taxi and cab operators. Mass campaigns, such as rallies, were also organized. These measures helped to mobilize public support for the law and made its implementation easier.

a) First step towards tobacco-free Chandigarh

The first step was taken when the district magistrate of Chandigarh issued an order under Section 144 of the CrPC on 9 January 2002. The order, which came into effect on 9 March 2002, banned smoking in auditoriums, hospital buildings, educational institutions, libraries, court buildings, public offices and public conveyances, including trains, in accordance with the judgment in the Murli Deora case.

b) Administrative commitment

The commitment of the Chandigarh administration is reflected in the coordination among its various departments with regard to the distribution of work for the implementation of the provisions of the COTPA. Under the overall guidance of the Home-cum-Health Secretary and representatives from the departments

of Police and Health, the District Megistrate, Estate Officer, Education, Public Relations, Transport, Municipal Corporation and Legal departments complete their respective jobs within a set timeline.

The Police department coordinates with traders' organizations and auto/taxi unions to promote compliance with the provisions of the law. It is also active in removing advertisement material and booking offenders who smoke in public places. The Municipal Corporation sees to it that warning boards are displayed in public places, and takes action against unauthorized road-side tobacco vendors and those selling tobacco products within 100 yards of educational institutions.

The transport department is responsible for ensuring that warnings are displayed in public conveyances, including public taxis and autos, while the education department is responsible for seeing to it that warning boards are displayed as per the law in all educational institutions. The health department is responsible for overall coordination, enforcement action through drug and food inspectors, health education, and empanelment of international experts who can assist and offer advice on how to keep the city smoke-free. The public relations department has developed the logo depicting the city's smoke-free status, as well as the website. The legal department issues annual licences to hotel and restaurant owners once the latter have declared that they are complying with the provisions of the legislation, and the department is also responsible for issuing licences to tobacco vendors under the Prevention of Food Adulteration Act.

c) Education, circulars

Schoolchildren and the youth are educated on the harmful effects of smoking through seminars, workshops, rallies, poster and painting competitions, and other activities for generating awareness. All stakeholders, including the law enforcers, need to be educated about their responsibilities and commitments under the law. Public notices are issued in the press to educate the public and promote compliance. Slides are shown in cinema houses and scrolls are run on the city cable highlightingthe ill effects of tobacco consumption. Posters are displayed to generate awareness of the harmful effects of smoking and of the ban on smoking in public places.

Circulars are issued to all heads of department, asking them to neither participate in any activity of the tobacco industry, nor accept any direct/indirect/in-kind sponsorship or funding from any corporate or individual engaged in the tobacco trade or commerce.

The logo depicting the city's smoke-free status is shown. This logo is being used for ongoing information, education and communication (IEC) activities.

d) Empanelment of international experts

Chandigarh has constituted a panel of international experts to assist and advice the administration in its effort to maintain a smoke-free status. Of the 12 experts approached, two have expressed the desire to assist and offer advice to the administration.

e) Modes of enforcement

Nodal officers have been appointed in various departments, such as the police and health departments and the Municipal Corporation, to supervise day-to-day activities. These officers are expected to submit weekly reports. Notified officials of the police and health departments carry out regular checks/special drives to book offenders. The media offers help by covering such events and thus generating awareness.

f) Public support, civil society organization, media

The active involvement of all stakeholders is the key to the successful implementation of the Act. Implementation can be more effective if the law is supported by the public and civil society organizations. Members of the general public have offered to assist the police in their capacity as members of the Chandigarh Tobacco Control Cell (CTCC). The media has come forward to help by covering the drive against offenders, issuing public notices and carrying articles on the hazards of smoking.

Chandigarh Tobacco Control Cell

The CTCC comprises official members from various departments and non-official members from various walks of life. The CTCC meets regularly, under the chairmanship of the health secretary, to monitor and assess the progress of the anti-tobacco drive, and to take decisions necessary for the maintenance of Chandigarh as a smoke-free city. The members of the CTCC are also authorized to take action in case of violations of Section 5 of the COTPA. The nodal officers of the various departments are expected to submit weekly reports to the department of health.

All these efforts have resulted in considerable compliance with the law in Chandigarh.

International best practices in smoke-free laws

Every individual has the right to breathe in clean air. There is clear scientific evidence on the hazards of exposure to Second-Hand tobacco Smoke (SHS) and the fact that there is no safe level of exposure to it. It is only a 100% smoke-free law that can protect workers and the public from the diseases and death caused by SHS. Smoke-free laws prevent people, especially the young, from getting into the habit of smoking and provide smokers with a strong incentive to reduce or quit smoking altogether.

Several countries and hundreds of sub-national and local jurisdictions have already taken action by passing laws requiring all public places and indoor workplaces to be 100% smoke-free, without encountering significant challenges in enforcement. The new smoke-free laws recently adopted in France, Turkey and Germany reflect the growing movement across the world to enact such laws and protect non-smokers from the serious health hazards of SHS. The evidence from these jurisdictions proves not only that smoke-free environments are enforceable, but that they are popular and become more so following implementation. Besides, they improve health and do not harm business.

WHO FCTC (Article 8) and the guidelines on smoke-free laws

The World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) acknowledged the unequivocal scientific evidence that tobacco consumption and exposure to tobacco smoke cause death, disease and disability, and that prenatal exposure to tobacco smoke has adverse effects on the health and development of children. Therefore, the Convention determined to give priority to the right of the public to protect its health against the hazards of tobacco smoke. Article 8 of the FCTC obligates member countries to adopt, implement and promote effective legislative and executive, administrative and/or other measures providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

Keeping in view the objectives of the Convention, at the second meeting of the Conference of the Parties to the WHO FCTC in Bangkok in June–July 2007, the Member countries adopted comprehensive guidelines on protection from exposure to tobacco smoke. The guidelines draw on the best available evidence and the experience of the Parties. They also identify the key elements of legislation necessary to effectively protect people from exposure to tobacco smoke.

Salient features of the guidelines

- The duty to protect people from tobacco smoke is grounded in the fundamental human rights and freedoms, inter alia, the right to life and the right to the highest attainable standard of health.

- A strong political commitment is necessary to take measures to protect all persons from exposure to tobacco smoke.

- Total elimination of smoking and tobacco smoke in a particular space or environment is required to create a 100% smoke-free environment (ventilation, air filtration, etc., do not work).

- Good planning and adequate resources are essential for the successful implementation and enforcement of smoke-free legislation and its progress should be monitored and evaluated at regular intervals.

- Civil society has a central role to play in building support for and ensuring compliance with smoke-free measures. Civil society, along with the general public, should be included as an active partner in the process of developing, implementing and enforcing legislation.

- The law should be strengthened, if necessary by amending the legislation, for improved enforcement.

WHO policy recommendation on smoke-free laws

The WHO has been guiding nations in the implementation of the FCTC obligations. Some of the best policies enumerated by the WHO with regard to protection from exposure to SHS are as follows:

- Involve civil society in promoting and implementing smoke-free laws. Civil society has greater freedom of communication and has access to networks to which governments may not have access.

- Develop an implementation and enforcement plan, and put in place an infrastructure for enforcement.

- Monitor implementation and, ideally, measure the impact of the steps taken and document experiences.

- Anticipate the tobacco industry's opposition.

Smoke-free laws: Best practices

The following jurisdictions have smoke-free laws that are worth emulating.

Ireland

Ireland's smoke-free law, the first law of its kind, has had a far-reaching impact globally. The law, which received vast public support, has reduced exposure to toxic tobacco smoke, improved workers' health and inspired smokers to quit. Since Ireland became smoke-free, air pollution has decreased by 83% and there are 80% fewer airborne carcinogens. Perhaps the most important message from Ireland is that political leadership can make a real difference to health.

New Zealand

The Smoke-free Environments Amendment Act, 2003 provided the basis for the creation of a smoke-free New Zealand. From December 2004, all public places, workplaces and hospitality centres have become smoke-free. The law received wide public support, generated by civil society organizations. A 12-month study of smoke-free New Zeeland provided evidence that the introduction of smoke-free bars and restaurants hurts only the tobacco industry.

The other main findings of the study were as follows:

- There has been an increase in the number of calls made to the Quit-line.
- There is strong public support for smoke-free bars and restaurants.
- Compliance with the legislation is high, with 97% of bars and taverns being smoke-free, according to the latest survey.
- Non-smokers have been attracted to bars and cafes due to the smoke-free environment.
- Smokers smoke less when they are not able to smoke indoors in a social setting.

Scotland

Scotland had the highest smoking rates in any part of the UK, with an estimated 1500–2000 non-smokers dying per year due to exposure to SHS. Convinced by the scientific and medical evidence on the dangers of exposure to tobacco smoke, the Scottish Parliament enacted a law aimed at creating a 100% smoke-free environment. Campaigning groups, health charities, professional associations, and unions joined forces to support the law.

The Scottish smoke-free legislation is, above all else, about health. People are no longer exposed to SHS in public or at work. All of Scotland's enclosed public places—from pubs and bars to railway stations—are now smoke-free. The law covers even private members' clubs.

- All public places that are more than half enclosed are also included.
- The instantly recognizable “no smoking” symbol is to be seen everywhere.
- “No Smoking” signs are now mandatory in all public places, and must include the name of an employee to whom people can complain if the law is being violated.

The largest ever study comparing air quality before and after the enactment of the smoke-free legislation in Scotland found that there was an 86% reduction in exposure to SHS. In addition, bar workers suffer fewer respiratory symptoms, and more than nine out of ten Scottish bar staff members say that their workplaces are healthier because of the law.

Uruguay

Before the enactment of its smoke-free law, Uruguay was among those countries in Latin America that had the highest rates of smoking, with the highest level of exposure to SHS. It was on the heels of the "Smoke-free Americas Initiative" of the Pan-American Health Organization in 2003 that the Ministry of Health and civil society committed themselves to working together to achieve a 100% smoke-free Uruguay. The President elected in 2005 announced a ban on smoking in public offices, and the ban was later extended to public places. By 2006, all public and private places were declared smoke-free. The law has received support from all sections of the population and the rate of compliance is high.

The policy is enforced by inspectors of the Ministry of Health and the citizens, who collaborate with the inspectors, acting as observers. All public places are required to post a notice announcing the ban on smoking and public buildings must have no ashtrays. The fine of $1100 for smokers who violate the law is a major deterrent.

United States of America (USA)

Though the USA has not ratified the FCTC, many of its States and cities have incorporated the tobacco control principles set forth in the Convention. Many of them have State-level legislation, including smoke-free laws, for tobacco control. In 2003, New York implemented a State law requiring virtually all indoor workplaces and public places (including restaurants and bars) to be smoke-free. A great deal of advocacy and campaigning by civil society and the local authorities were required to make New York smoke-free. The activity-based campaign programmes were a huge success with the people and the business community. The quit-line (even available on the health department's website www.health.state.ny.us) and the complaint line ensured that any violation of the law is reported and appropriate action taken.

Now, more than 100 million people live in states that are 100% smoke-free. Millions more live in smoke-free cities and towns, and the majority of Americans work in smoke-free environments.

Thailand

Restrictions on smoking in public places in Thailand are extensive. The places covered include public transportation, elevators, hospitals, educational institutions and restaurants. The tobacco control community in partnership with the government is seeking to declare Thailand a smoke-free country and is working to designate limited smoking zones throughout the country.

Canada

Seven of Canada's 13 jurisdictions (provinces and territories) are 100% smoke-free. The scientific process for the development of the "Gold Standard By-laws" in Canada ensured the success of the smoke-free laws. Gold Standard by-laws are those that prohibit smoking in all public places, including restaurants, bars, billiard halls, bingo halls, bowling alleys, and casinos/slots (where applicable). There is no allowance for Designated Smoking Rooms in Gold Standard by-laws.

Smoke-free bars and restaurants

In Hong Kong, all restaurants and karaoke lounges are 100% smoke-free, while in New Zealand, Australia (Sydney, New South Wales, Queensland, South Australia, Tasmania and Victoria), Bhutan, Norway, Ireland, France, Uruguay and Canada (Alberta, Labrador, Manitoba, Winnipeg, New Brunswick, Newfoundland, Nunavut, Northwest Territories, Nova Scotia, Ontario Saskatchewan and Quebec), all restaurants and bars are 100% smoke-free. In the Islamic Republic of Iran, all restaurants (and any roofed area) are 100% smoke-free.

Smoke-free airports

A number of airports today are 100% smoke-free. The areas that are smoke-free include airline clubs, passenger terminals and non-public work areas. The Vancouver International Airport in Canada, Birmingham International Airport (the first smoke-free airport in England) and Macau International Airport are just some of the at least 119 smoke-free airports across the globe, and the list is growing.

Penalties for violation of smoke-free laws

Heavy fiscal penalties for the violation of smoke-free laws act as the immediate deterrent for smokers, discouraging them from lighting up at places designated as smoke-free. Laws in both the developed and developing countries impose hefty fines for the violation of smoke-free laws. If we consider the Indian subcontinent, in Pakistan, the fine for the first violation is up to Rs 1000 and for a subsequent violation, not less than Rs 100,000. In Sri Lanka, the fine for each violation is Rs 2000. In Mauritius, the fine for the first conviction is Rs 1000–2000 and for the second, Rs 2000–5000, while the third conviction is punishable by three months' imprisonment.

In New Zealand, the penalty is paid by the institution, owner or person in control, and generally extends up to $4000 for body corporates and $400 for non-body corporates. If action is not taken on a complaint, the fine in the case of body corporates is $1000 and that in the case of non-body corporates is $100. Ireland imposes an on-the-spot fine of up to €3000, Uruguay $1100, Portugal up to €1000, Italy up to €275, Fiji $500 (upon conviction), and Canada not more than $500 (on summary conviction) on individuals violating smoke-free rules. Much higher fines are imposed on institutions and persons in control of the affairs of smoke-free places.

An analysis of the best practices described in this chapter highlights that any comprehensive smoke-free law must aim at creating a 100% smoke-free environment, with no exemptions. Devices such as ventilation or air filtration must not be resorted to as they are scientifically proved ineffective in protecting from SHS. The law must protect everybody, and should be backed by effective implementation and an adequate enforcement mechanism. The members of the public need to be sensitized and educated, so that they are motivated to reduce exposure to SHS on their own.

Much damage has been done and continues to be done. We must take action, keeping the international best practices in mind and remembering that success in creating smoke-free environments has been possible only through collective efforts and dedicated partnerships. To save lives, we must act now and act unitedly.

Ongoing tobacco litigations in India

Nature and scope of tobacco litigation

A controversy before a court or a "lawsuit" is commonly referred to as “litigation”. Worldwide, the major reasons for tobacco litigation are the lack of enforcement of the provisions of tobacco control laws or of laws prohibiting deceptive conduct. Tobacco litigations have mostly arisen from direct action by Non Governmental Organizations (NGOs). Many of the cases are related to second-hand smoke (SHS) and compensatory damages. Counter-attacks by the tobacco industry also form a part of the tobacco-related litigation.

Relevance of tobacco litigation

- The lack of enforcement of tobacco control measures as set forth in legislation leads to litigation by various stakeholders, such as public-spirited citizens, lawyers, public health experts and institutions and NGOs working in the area of public health.

- NGOs employ litigation as a means to force governments and tobacco companies to take the existing laws seriously. Violations of the provisions related to issues such as smoke-free places and packaging and labelling, have been raised before the courts to obtain judicial orders for the speedy implementation of such provisions.

- Litigation spreads awareness of the dangers of tobacco use, of exposure to tobacco smoke and of the social irresponsibility of tobacco manufacturers. For example, the landmark Murli Deora case in the Supreme Court of India highlighted the harmful effects of exposure to tobacco smoke.

- Vigorous counter-efforts by tobacco manufacturers and their executives require to be repulsed by legal sanctions, both civil and criminal. For example, when the Government of India, through notification number GSR-443(E) dated 30 April 1992, prohibited the manufacture and sale of toothpastes/ toothpowders containing tobacco, a legal challenge was mounted by the industry on the ground that notification adversely affected the fundamental right of a citizen to carry on trade, business or profession of his/her choice. The case (Laxmikant vs Union of India and others; case 739 of 1997) was decided in favour of the government, and the Supreme Court upheld the ban.

- Litigation against the tobacco industry in developed countries has helped in procuring secret industry documents that have revealed the falsity of declarations made by the industry. For example, on 17 August 2006, in the US government's landmark lawsuit against the major tobacco companies, District Judge Gladys Kessler issued a final opinion that the companies had violated civil racketeering laws and defrauded the American people by lying for decades about the health risks of smoking and about marketing cigarettes to children.

Tobacco litigation in India: By upholding the cause of tobacco control since the late twentieth century, the courts in India have given a positive thrust to legislation on tobacco control. They have traditionally upheld the right to a healthy life by a meaningful and just interpretation of the right to life and by calling upon the government to fulfill the duties of a welfare state. They have imposed a positive obligation on the state to take effective steps for ensuring the right of the individual to the enjoyment of a healthy life. This was reflected in the following landmark judgements on the prohibition of smoking in public places.

K. Ramakrishnan vs state of Kerala (AIR 1999 Ker 385)

Section 268 of the Indian Penal Code (IPC) on public nuisance was used by the Kerala High Court to uphold the declaration of smoking in public places in Kerala as illegal. It was declared that "Smoking in public places causes non-smokers to involuntarily inhale smoke from smokers nearby therefore smoking in public places is to be treated as public nuisance under Code of 1860". The court held that smoking in public places shall be barred and directed authorities to implement the said prohibition effectively.

Murli Deora vs Union of India (AIR 2002 SC 40)

It was held by the Supreme Court in the Murli Deora Case that the right to live with human dignity enshrined in Article 21 of the Constitution derives its life and breath from the directive principles of state policy, particularly Articles 39(e) and (f), 41 and 42. These articles include the protection of health as envisaged in the directive principles. Without a guarantee of health and well-being, most of the fundamental rights cannot be exercised fully. Thus, the right to a healthy life is the basis for the other constitutional guarantees. While giving orders on the case, the Supreme Court imposed constitutional, legislative and public health obligations on the Government of India and provided guidelines to the Union and State governments for creating smoke-free places.

The ongoing litigations for and against tobacco control are listed in Tables 1–6. These include cases for and against the implementation of the various sections of Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003(COTPA). Table 1 lists cases for and against the prohibition of advertisement. Table 2 deals with cases challenging the validity of the rules under the Act. Table 3 is a list of cases on the implementation of the prohibition of the sale of tobacco products near educational institutions. Table 4 enumerates cases against the prohibition of smoking in public places. Tables 5 and 6 deal with cases for and against the implementation of the packaging and labelling rules. Most of these have been filed as public interest litigation by individuals, NGOs and social groups against the tobacco industry or the government. Some have been filed by the government against tobacco industries, while others have been filed by the industry against the government.

Many cases that came up after the notification of the COTPA have already been disposed of. These were filed mostly by NGOs, social groups, individuals, tobacco product manufacturers and the government. Some of these cases had a positive impact on provisions like the prohibition of advertisements and promotions. Promotion campaigns, such as the Wills Made for Each Other Contest and the Red and White bravery awards, and sponsorship of cricket matches by Wills were withdrawn due to the pressure mounted on tobacco companies by various petitions challenging the advertisement and promotion of tobacco products. Plastic packaging was ordered to be stopped in the case of gutkha sachets on the basis of the polluter pays principle in India Asthma Care Society Vs State of Rajasthan. This was, however, not upheld by the Supreme Court. The final outcomes of a few of these litigations did not give absolute results for tobacco control.

Ongoing Litigation in India

Table 1. Cases for and against advertisements

CASE	ACTION	STATUS	SIGNIFICANCE
1. Action Council Against Tobacco-India (ACT-India) and 3 others, public interest litigation (PIL) 42/2007, filing date 20 April 2007 (Bombay High Court). (The petitioner is a renowned NGO.)	Writ petition(WP) under 226 for the implementation of all provisions of the COTPA 2003, particularly for implementing rules on advertisements	Last heard on 28/8/2008, case pending	The case seeks the implementation of all the provisions of the COTPA in public interest
2. Kasturi and Sons vs Union of India (UOI), WP(C) 12344/2005 (renumbered as 7411/2006), (Delhi High Court). (The petitioner is Hindu Newspaper, Madras)	WP seeking the declaration of Sections 3(a), 5, 12, 13, 14, 22, 23 and Rule 4(7), which ask media to crop/mask to ensure that brand names/logos of tobacco products are not visible, as *ultra vires.*	Judgement issued by the Delhi High Court on 23/1/2009 struck down the Centre's October 2006 notification banning scenes depicting smoking in films, saying onscreen smoking was part of an artist's creative licence and allowed indirect advertising in the print media, saying that films and print media cannot be classified differently. This judgement followed a split verdict by a two-judge bench on 7/2/2008 in a petition by Hindu Newspaper and film director Mahesh Bhatt challenging the curbs imposed by the government. The Government appealed against this order in the Supreme Court. The Supreme Court has stayed	This case challenges the prohibition of advertisements of tobacco products in the print media.

CASE	ACTION	STATUS	SIGNIFICANCE
3. Mahesh Bhatt vs UOI, WP (C) 18761/2005	WP challenging the COTPA Advertisement	the Delhi High Court order.	This case challenges the prohibition of
(Delhi High Court). (The petitioner is a film director and producer.)	Rules 2005, particularly sub-rule 6 of Rule 4, against the prohibition of indirect advertisements in films/TV serials	Judgement issued on 23/1/2009 (as above)	advertisements of tobacco products in films/TV serials.
4. Namdeo Kamathe vs UOI, WP(C) 8763/2005 (Bombay High Court). (The petitioners are shopkeepers selling tobacco products and a wholesale dealer of cigarettes.)	WP under Section 226 claiming Rules 4(1) to (5) on point-of-sale advertising violate freedom of speech under Article 19(1)(a) and are thus ultra vires: Rule 4(1) has reduced the size of the boards in an illogical manner and Rule 4(4) has imposed the unreasonable restriction of not even putting brand names on boards in contravention of the original Rule 4; thus the substituted Rules 4(1) to (5) have worsened the transgression by imposing a virtual prohibition on advertisements at the point of sale	Last hearing on 27/3/2006, case pending	This case has challenged the point of sale advertisement rules on the grounds that they violate the right to freedom of speech and are framed in an illogical and unreasonable manner.
5. Shivam vs UOI, WP(C) 491/2006 (Bombay High Court). (The petitioner is a shopkeeper selling tobacco products.)	WP against the confiscation of advertising material by state authorities	On board, to be heard with connected cases , case pending	This case is against confiscation of advertisement material by state authorities in accordance with point of sale laws.

Table 2. Case against the validity of the Tobacco Control Act

CASE	ACTION	STATUS	SIGNIFICANCE
6. Sridhar Kulkarni vs UOI, WP(C) 6151/2005 (Bombay High Court). (The petitioners are engaged in the business of distributing cigarettes.)	WP under Section 226 challenging the constitutional validity of the COTPA on the grounds that it is beyond the legislative competence of the Union legislature, since the legislation is to protect public health, and under Entry 6 of List II of the Seventh Schedule of the Constitution, the state legislatures alone are competent to legislate on public health	Heard with Namdeo Kamathe, last hearing on 27 March 2006, case pending	This case is aimed at challenging the validity of the COTPA on grounds of conflicting jurisdictional areas of legislative competence between the Union and the states.

Table 3. Case for notifying the section on prohibition on sale of tobacco products near educational institutions

CASE	ACTION	STATUS	SIGNIFICANCE
7. Sumaira Abdul Ali vs UOI, PIL 182/07 (Bombay High Court).	PIL for notifying Section 6(b) of the Tobacco Control Act	Preadmission stage, not listed (rules implementing the said provision already notified on 1/9/2004), case pending.	This case asks the government to notify Section 6(b), which prohibits the sale of tobacco products within 100 yards of educational institutions.

Table 4. Case against prohibition of smoking in public places

CASE	ACTION	STATUS	SIGNIFICANCE
8. ITC and others vs UOI, 6985 of 2008, 6986, 7013, 7014 of 2008 (Delhi High Court). (The petitioner is a leading tobacco company). UOI vs ITC and others (transfer petition in the same case to the Supreme Court).	The petitioner prayed for a stay on the implementation of the prohibition of smoking in public places in the Delhi High Court. The petition was transferred by the Government to the Supreme Court.	Last hearing on 29/9/2008, the Supreme Court refused stay on implementation of prohibition of smoking in public places.	This case challenges the smoke-free rules of 2008, which were to be implemented from 2/10/2008. The constitutionality of these rules needs to be examined by the Supreme Court.

Table 5. Cases for packaging and labelling rules

CASE	ACTION	STATUS	SIGNIFICANCE
9 Ruma Kaushik vs Naresh Dayal & Anr Contempt petition 14/2007(Shimla High Court). Ruma Kaushik vs Naresh Dayal CMP 968/2007 Ruma Kaushik vs State of Shimla CWP 1259/2007 (The petitioner is a lawyer.)	Writ petition under Section 226, to direct the respondents to incorporate legislation to amend the existing Section 3(o), Section 8, 9, 10 of the COTPA 2003 and to notify the specified health warnings and language to be used in the warnings and the size of the letters and figures in the rules immediately.	Last hearing on 12/8/2008, case disposed of	This case was for the implementation of the rules on pictorial warnings on all tobacco products The case was disposed of without any directions from the court
10. SK Mathur vs UOI, 5748/2005 (Rajasthan High Court, Jaipur Bench).	WP for the implementation of pictorial/specified warnings on tobacco packs	Last listed on 17/1/2007, case pending	This case is for the implementation of pictorial/specified warnings on tobacco packs.
11. Savita Godra vs UOI, WP(C) 2790/2007 (Rajasthan High Court, Jodhpur Bench).	WP for implementing packaging and labelling rules	Last heard on 15/04/2009, Case pending	This case is for the implementation of the packaging and labelling rules.

CASE	ACTION	STATUS	SIGNIFICANCE
12. Struggle against Pain vs UOI, WP25097/2007 (Allahabad High Court). (The petitioner is an NGO.)	WP for implementing packaging and labelling rules	Case pending. Last heard on 10.04.2009.	This case is for the implementation of the packaging and labelling rules.
13. Narinder Sharma & Anr. vs UOI others, WP(C) 518/2007 (Supreme Court). (The petitioner is a lawyer.)	WP on the right of the consumer to know the ingredients of tobacco (percentage of tar, nicotine, etc., present). It is mandatory for tobacco companies to print the internationally recognized text warning on every pack of cigarettes and every single cigarette should contain the warning text, such as "smoking kills. Right of the consumer regarding information concerning number of people who died every month due to smoking-related diseases to be printed on every pack of cigarettes.	Last heard on 25/1/2008, notice issued to UOI for filing reply. Case pending	This case is on implementing the pictorial warnings and packaging and labelling rules of 2006.
14. Health for Millions Vs UOI and Others, WP 549/2008 Supreme Court of India. (The petitioner is a NGO.)	WP for implementing packaging and labelling rules	In a ruling dated 06.05.2009, the Supreme Court has ordered for implementation of pictorial warnings from 31.05.2009.	This case is for the implementation of the packaging and labelling rules.

Table 6. Cases against packaging and labelling rules

CASE	ACTION	STATUS	SIGNIFICANCE
15. Gupta Tobacco & Anr vs UOI, WP(C) 4119/2007 (Delhi High Court). (The petitioner is a tobacco manufacturer.)	WP claiming packaging and labelling rules are discriminatory to gutkha manufacturers	Last heard on 5/3/2008, reply filed by UOI, case pending	This case is against the packaging and labelling rules.
16. CM Tobacco vs UOI, WP(C) 520/2007 (Uttarakhand High Court). (The petitioner is a tobacco manufacturer.)	WP claiming packaging and labelling rules are discriminatory to gutkha manufacturers	Last heard on 14/5/2007. Listed on 18/6/2007 case pending	This case is against the packaging and labelling rules.
17. Mukesh Jain vs UOI, WP(C) 567/2007 (Uttarakhand High Court). (The petitioner is a tobacco manufacturer.)	WP claiming packaging and labelling rules are discriminatory to gutkha manufacturers	Last heard on 6/8/2007, the petitioner was given time for filing rejoinder till 31/8/2007, case pending.	The case is against the packaging and labelling rules.
18. Godawat Pan Masala vs UOI, WP(C) 7835/2007 (Karnataka High Court). (The petitioner is a tobacco manufacturer.)	WP claiming packaging and labelling rules are discriminatory to gutkha manufacturers	Last hearing on 3/12/2007, stay, along with WP 17858/2007, case pending	This case is against the packaging and labelling rules.
19. Karnataka Bidi Industries Association vs UOI, WP 17858/2007 (Bangalore High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Last listed on 15/11/2007, adjourned till further hearing, case pending	This case is against the packaging and labelling rules.
20. Central India Tobacco vs UOI, WP(C) 15780/2007 (Jabalpur High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Last hearing on 10/12/2007, stay granted, case pending	This case is against the packaging and labelling rules.
21. ITC vs UOI, WP 34906 to 34910/2007 (Madras	WP against packaging and labelling rules	Stay granted, case pending	This case is against the packaging and labelling

CASE	ACTION	STATUS	SIGNIFICANCE
High Court). (The petitioner is a tobacco manufacturer.)			rules.
22. ITC vs UOI, WP 35970/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Stay granted, case pending	This case is against the packaging and labelling rules.
23. TS & CTM vs UOI, WP 9606/2007 (Madras High Court, Madurai Bench). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
24. M/s PV Ramachandra Rao Beedi Business & Anr. vs Secretary, Ministry of H&FW, WP (i) 26427/2007 (ii) 26472/2007(Andhra Pradesh High Court (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Last listed on 28/1/2008, case pending	This case is against the packaging and labelling rules.
25. M/s. Hiralal Prabhuram & Co. vs UOI, WP 26462/2007 (High court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
26. M/s Dayalal Meghi & Co, & Ors. vs UOI, WP 7196/2007 (Bilaspur, Chhattisgarh High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Last listed on 28/1/2008, case pending	This case is against the packaging and labelling rules.
27. M/s A. Habeerbur Rahman Sons vs UOI, WP 36333/2007 (Madras High	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.

CASE	ACTION	STATUS	SIGNIFICANCE
Court). (The petitioner is a tobacco manufacturer.)			
28. M/s VK Abdul Jabbar Sahib Sons vs UOI, WP 36334/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
29. M/s Gowner Beedi Factory vs UOI, WP 36335/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
30. M/s Shaik Hussain Md. Ansar vs UOI, WP 36336/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
31. M/s Syed Habibullah Beedi Manufacturers vs UOI, WP 36337/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against packaging and labelling rules.
32. M/s Sun Beedi Traders vs UOI, WP 36338/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against packaging and labelling rules.
33. M/s Syed Nizammudin Beedi Manufacturers vs UOI, WP 36339/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.

CASE	ACTION	STATUS	SIGNIFICANCE
34. M/s Shaik Ismail & Son vs UOI, WP 36340/2007 (Madras High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against packaging and labelling rules.
35. SK Jaggi vs UOI, WP 2654/2007 (Bombay High Court). (The petitioner is a wholesale dealer in cigarettes.)	WP under Section 226 claiming the provisions of the packaging and labelling rules, 2006 are ultra vires of the COTPA 2003 and Articles 14,19(1)(a) and (g) of the Constitution	Matter partly heard on 30/4/2007, no hearing date scheduled, case pending. Last heard on 25/5/2007, stay granted	This case is against the packaging and labelling rules.
36. Gopal Corporation vs UOI, WP (C) 2449/2007 (Guwahati High Court). (The petitioner is a tobacco manufacturer.)	The cause of action was that Section 7(1) of the rules on pictorial warnings dated July 2006 was not notified by the government and hence, they cannot be enforced. (Since the government has now notified Section 7(1) [on 16 November 2007], the cause of action is no longer valid.)	case pending	This case is against the packaging and labelling rules.
37. M/s Abbas & Co. vs UOI, WP 61725/2007 (Allahabad High Court). The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
38. Shyam Biri Works Ltd vs UOI, WP 17858/2007 (Allahabad High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.

CASE	ACTION	STATUS	SIGNIFICANCE
39. M/s BPT Vyapar Samiti vs UOI, WP 61731/2007 (Allahabad High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
40. M/s Samaj Biri vs UOI, (Allahabad High Court). (The petitioner is a tobacco manufacturer.)	WP against packaging and labelling rules	Case pending	This case is against the packaging and labelling rules.
41. GR Brothers vs UOI, (Andhra Pradesh High Court (The petitioner is a tobacco manufacturer.)	WP against packaging	Case pending	This case is against the packaging and labelling rules.

Litigation on tobacco control is helping to make the masses aware of the issue, with many of these cases being covered in the print media and on television and being publicized on the Internet. The major significance of such litigation lies in the fact that it is serving as a means of enforcement of legislative initiatives. In the absence of enforcement, laws remain dead letters. Further, such litigation has been successfully challenging the might of the tobacco industry and the high-handedness of the bureaucracy.

Framework Convention on Tobacco Control (FCTC): Status of implementation in India

Today, the major threat to public health is from a small number of shared risk factors, and tobacco use is one of them. Like most other health risk factors, tobacco use is linked to human behaviour. And it is not easy to change human behaviour, except by prevention. The FCTC, drawn up by WHO, is primary prevention at its best.[1] The Convention is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. By emphasizing the reduction both of the demand and supply of tobacco, it represents a paradigm shift in the development of a regulatory strategy to address addictive substances.

The need for a global resolve on tobacco control was felt in the wake of the globalization of the tobacco epidemic. The spread of tobacco use was exacerbated by cross-border factors, including the liberalization of trade, direct foreign investment, global marketing, transnational tobacco advertising, promotion and sponsorship, and international movement of contraband and counterfeit tobacco products. What was required was nothing less than a global treaty which was comprehensive enough to cover all the cross-cutting aspects of the spread of tobacco use, the single largest, preventable cause of death in the modern world.

The Member countries of WHO, determined to give priority to their right to protect public health, unanimously endorsed the FCTC, which become international law on 27 February 2005. Among the key preambular objectives of the FCTC is the protection of the "present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke".

India was among the front-runners in the negotiations for the FCTC and was the seventh country to ratify the treaty. The commitment it showed during the negotiations was reflected in the enactment of the COTPA. Though the development of the law was parallel to the treaty, the FCTC came into force on 27 February 2005, nearly a year after the COTPA was passed in the Indian Parliament.

Articles 47,[2] 51 (c)[3] and 253[4] of the Constitution of India, respectively, warrant the improvement of public health; respect for international law and treaty obligations; and give Parliament the power to legislate to give effect to international agreements. Being a party to the FCTC, India owes an obligation to respect the mandate of the Convention. Table 1 presents an issue-based analysis of the FCTC and its implementation through the COTPA and other measures gives an idea of the status of the FCTC in India and points out the lacunae that may be plugged to upscale the Indian tobacco control legislation so that it may conform to the Convention's mandate.

Table 1. FCTC vs COTPA

Issues raised in FCTC	FCTC mandates	COTPA provisions	Status of implementation
Article 8: Second-hand smoking	The Parties shall adopt and implement measures to provide for protection from exposure to tobacco smoke in public places.	Section 4 covers this aspect, but makes an exception for hotels, restaurants and airports, where smoking is allowed in a physically segregated area. A physically segregated smoking area is well defined in the rules notified on 30 May 2008.	The rules for prohibition of smoking in a public place were notified on 25 February 2004, but were weakly enforced. Revised rules on the same have been implemented from 2 October 2008.
Article 13: Advertising, promotion, sponsorship of tobacco products	The Parties shall implement a comprehensive ban within 5 years of the convention entering into force.	Section 5 imposes a ban on all forms of tobacco advertising, promotion and sponsorship, except that advertisements at points of sale are permitted, but the rules restrict such advertising. Various rules have banned all forms of tobacco advertising, promotion and sponsorship. However, the rules on prohibition of smoking in films and television and on point-of-sale advertisement have been challenged in court.	The ban on direct advertisement of tobacco products is implemented quite effectively. However, the level of implementation of the ban on indirect forms, like brand stretching and surrogate advertising, is low. A Delhi High Court ruling on 23 January 2009 has struck down the rules on prohibition of smoking scenes in films and television. This has been stayed by the Supreme Court in an appeal by the Government.
Article 11: Health warnings	It recommends that at least 30%, but preferably 50%, of the principal display area of packages of tobacco products should carry rotating health warnings, which are large, clear and visible, and may be pictorial.	Section 7 suggests prominent warnings, including pictorial warnings.	Newly notified pictorial health warnings introduced in March 2008 on every package of tobacco products will occupy at least 40% of the principal display area/s of the pack. Also, the health warning on tobacco packs shall be rotated every 12 months or as decided by the Central Government.

Issues raised in FCTC	FCTC mandates	COTPA provisions	Status of implementation
			There have been several delays in the implementation of the rules for pictorial health warnings since 2006, when they were first notified. The fresh date for implementation is 31 May 2009. Even the FCTC obligation to implement the health warnings within 3 years (i.e. by 28 February 2008) has not been complied with by the government. Despite the Packaging and Labelling rules of March 2008, pictorial warnings still need to be implemented. In a fresh notification in May 2009, the warnings were further diluted to occupy 40% of the front panel only. As per the Supreme Court order these warnings will be implemented from 31 May, 2009.
Article 11: Packaging and labelling	The Parties shall take measures, within 3 years of the entry into force of the convention, to ensure that tobacco packages do not give misleading descriptions, such as “low tar”, “ultra light” and “mild”.	There are rules related to packaging and labelling of tobacco products that also regulate the use of misleading words. The Act, however, requires that information regarding the nicotine and tar content of each tobacco product, along with the maximum permissible limit, must be indicated on every package of tobacco products.	There is no provision specifically prohibiting the use of misleading terms. Such prohibition was introduced while defining the rules related to packaging and labelling The same has not been implemented yet.

Issues raised in FCTC	FCTC mandates	COTPA provisions	Status of implementation
Article 16: Access by minors	The Parties shall implement measures to prohibit the sale of tobacco products to and by minors. The measures include: placement of prominent indicators at the point of sale about the prohibition of sale to minors, prohibition of sale of cigarettes individually or in small packs, and prohibition of sale of tobacco products to minors.	Section 6 and its rules ban the sale of tobacco products "to" and "by" minors. It also bans the sale of tobacco products through vending machines and makes it obligatory for sellers to display a board at the point of sale which says that sale to minors is prohibited. The Act goes beyond the FCTC and bans the sale of tobacco products in and around educational institutions. However, there is no provision to prevent the sale of cigarettes individually or in small packs.	The rules notified under this provision have restricted the accessibility of tobacco products to minors. However, the level of implementation is extremely low. Despite the display board stating "no sale to minors", there are children who are buying tobacco in huge quantities. There are still a number of shops selling tobacco around educational institutions.
Article 15: Illicit trade	It recognizes that elimination of illicit trade in tobacco products is necessary for tobacco control and directs the Parties to implement measures to ensure that all packages of tobacco products are marked to assist in the determination of the origin of the product.	The COTPA does not address the issue of illicit trade in tobacco products. However, the Customs Act prohibits illicit trade of all products including tobacco.	The protocol relating to illicit trade has been discussed. If India signs this protocol, it will need to amend the existing laws with stricter provisions for tracking and tracing illicit tobacco products.
Article 14: Tobacco cessation	It requires the promotion of effective measures for the cessation of the use of and dependence on tobacco.	The Act has no provision on the issue of tobacco cessation, but it is a core component of the NTCP. The MOHFW, in collaboration with WHO, has developed a model for	Nineteen tobacco cessation centres are functional in India to promote cessation.

Issues raised in FCTC	FCTC mandates	COTPA provisions	Status of implementation
		tobacco cessation at the state level, to be replicated at the district level as well.	
Article 17: Economically viable alternative activities	The Parties shall cooperate to promote economically viable alternatives for tobacco workers, growers and individual sellers.	The COTPA does not cover this issue. The ministries of agriculture, labour, commerce and health are consulting and deliberating on the issue. The Ministry of Commerce has announced that they will try to decrease tobacco cultivation in the next 10 years.	The pilot project for providing alternative sources of livelihood will be scaled up with the help of the Ministry of Labour and state governments.
Article 6: Taxes	The Parties may implement tax and price policies on tobacco products so as to contribute to the reduction of tobacco consumption. The FCTC recognizes this as an important way of reducing tobacco consumption.	This is not a part of the COTPA. The Ministry of Finance has been increasing taxes on tobacco products, but more efforts are needed for harmonization of taxes.	The imposition of high and uniform taxation on cigarettes and all tobacco products is much awaited.
Article 6(2)(b): Duty-free sales	This Article prohibits or restricts the sale or importation of tax- and duty-free tobacco products.	This is not covered by the COTPA. But the Customs Act places restrictions on duty-free sales.	
Article 10: Content regulation	Guidelines for testing and measuring the contents and emissions of tobacco products shall be proposed, so that they can be adopted and implemented by the signatories.	There is a provision for testing and measuring the nicotine and tar content of tobacco products, but rules to implement this have not yet been notified. In line with the FCTC, the Indian law requires the	At present, the capacity for testing, especially for smoked forms of tobacco, is limited. Laboratories need to be established and immediate notifications may be issued requiring the disclosure of the emission levels and contents to the

Issues raised in FCTC	FCTC mandates	COTPA provisions	Status of implementation
		display of information on the contents and emissions of tobacco products by the manufacturers.	licensing authorities. This will help make the public aware of the toxic constituents of tobacco products and the emissions they produce.
Article 26: Financial resources	The Parties shall provide financial support to the national tobacco control programmes.	The MOHFW has identified means by which adequate financial support can be mobilized. The 11th Five-Year Plan has launched the NTCP, which has allocated Rs 450 crores for the cause of tobacco control.	The states selected under the first phase of the NTCP were Rajasthan, Assam, Karnataka, West Bengal, Tamil Nadu, Uttar Pradesh, Gujarat, Delhi and Madhya Pradesh.
Article 12: Education, awareness and training	The Parties shall promote public awareness of tobacco control. NGOs and public and private agencies shall participate in such activities.	This is not a legislative measure, but it is an essential element of the NTCP. The awareness campaigns would be both at the national and state levels and reach out to the maximum number of people.	School health programmes have been organized in collaboration with NGOs at the district level.
Article 19: Liability	The Parties are encouraged to take legislative action to deal with civil and criminal liability, including compensation from the tobacco industry.	The COTPA does not cover this.	

An overview of the FCTC and the corresponding legislation in India suggests that in some areas, the provisions of the COTPA are stricter than the Convention's mandate, while some provisions require scaling up, and on many counts, there is no specific law at all.

Where upscaling is required

Although the rules notified under the COTPA have attempted to clarify the ambiguities in the definition of "public places", an exception has been made in the case of restaurants/hotels with 30 or more seats and rooms, respectively, and airports. These are allowed to have designated smoking rooms (DSRs). However, the smoke-free law has to aim to make public places 100% smoke-free and this cannot be achieved if certain public places have DSRs.

The ban on advertisement, promotion and sponsorship of tobacco products, though comprehensive, is not absolute. While the law regulates advertisements on packs and point-of-sale advertisements, it is silent on advertisement through the Internet. Besides, cross-border advertisements are not regulated, as required under Article 13 of the FCTC. The irony is that the provision was included in the treaty principally on India's initiative. What needs to be done now is to impose an absolute ban on all forms of tobacco advertisements, whether in the media (print and electronic) or cinema, on television, radio or the Internet, or through other cross-border channels, so as to bring the law at par with other domestic regulations.

Section 32 of the COTPA: "Nothing contained in the Act shall apply to any tobacco products or package of cigarettes or other tobacco products which are exported." This is unjust because if the law applies to tobacco products which are imported, it should also apply to the products exported.

Direct and indirect methods of advertising are defined clearly in the Act and the rules. The prohibition covers all forms of advertising and promotion, such as sponsorships, brand stretching, surrogate advertising, promotion through gift items, sponsorship of cultural events, and endorsement of sports products. What is required now is the effective implementation of the rules on indirect advertising.

The new Packaging and Labelling Rules came into existence on 15 March 2008, to be implemented from 30 November 2008. They stipulate that 40% of the principal display area of the packs of both smoked and non-smoked tobacco products should be occupied by specified health warnings and three pictograms. The date of implementation has been further postponed to 31 May 2009. What is positive is that the implementation of pictorial health warnings might no longer be a distant dream. However, the pictures being used are considerably weak and need obvious modifications.

Another essential requirement is the implementation of the rules on the prohibition of misleading and deceptive terms. Such terms continue to be used for the promotion of tobacco products, especially cigarettes, in spite of the rules and in contravention of the FCTC mandate.

Indian law and the FCTC seek to prevent minors from having access to tobacco products. However, contrary to the statutory requirements, tobacco products continue to be accessible to minors. One of the ways in which the rules are violated is that tobacco products are displayed in a a way that they are easily visible and accessible to minors. As in the case of other prohibited products, it is suggested that the law require tobacco products to carry a stipulation reading "not to be sold to a person below the age of 18 years". Besides, there should be strict implementation of the statutory prohibition on the sale of tobacco products within 100 yards of an educational institution to protect the youth.

Evolving new policies and synergizing with other laws

There is a need to evolve national policies on issues related to tobacco control that are not covered under the law. The special law on tobacco control is lacking on the following counts:

- Tobacco cessation
- Economically viable alternative activities
- Taxes
- Duty-free sales
- Financial resources for anti-tobacco activities
- Education, awareness and training
- Civil liability and compensation

India has a number of legislations and national-level policies, many of which also cover aspects that would contribute to tobacco control. It would be useful if the government formulated all its policies keeping tobacco control measures in mind. Whether the policies are being formulated for foreign direct investment, special economic zones or any other issue, the government departments should make sure that the aspect of tobacco control is kept in mind.

It is very important to have effective measures for the cessation of tobacco use and adequate treatment for tobacco dependence. Once tobacco control measures are implemented effectively, it becomes important to provide cessation facilities to people who consume tobacco products as more and more people would want to quit or reduce its use.

A policy on tax and price measures is essential to reduce the prevalence of tobacco consumption. Numerous economic studies have documented that an increase in the tax on cigarettes or in their price reduces both adult and underage smoking. Price increases are the most effective and cost-effective deterrent, especially for young people and others with a low income, who must, of necessity, be highly price-responsive. A price rise of 10% decreases consumption by about 8% in low- and middle-income countries. Higher taxes also generate additional government revenue, as per World Bank figures.

The Government of India also needs to focus on people who depend on tobacco economically. These are the tobacco growers (farmers) and the workers who are engaged in the manufacture of tobacco products. Efforts are required to find alternative employment for them and to rehabilitate them. The Parties to the FCTC have an obligation to promote economically viable alternative activities, and this must be implemented by India. For example, employees in the bidi sector live in difficult situations and their minimum wages have been declining. Bidi rollers often suffer from posture-related problems and complain of pulmonary diseases due to the inhalation of nicotine. Their access to health facilities is minimal. Therefore, it is essential to help them change their employment as bidi sector does no good to its employees and its users.
The FCTC prohibits the sale or importation of tax- and duty-free tobacco products, but the COTPA does not cover this. Free import is allowed of up to 200 cigarettes, 50 cigars or 250 grams of tobacco. This is an incentive for international travellers to bring in tobacco products. The products thus brought into the country might not carry a health warning or might violate some other provision of the Act. Duty-free sales should hence be restricted completely.

India needs to develop policies on issues related to liability and compensation. The FCTC encourages the Parties to take legislative action to deal with civil and criminal liability, including compensation by the tobacco industry. If an individual suffers due to a tobacco product then he/she has a right to claim compensation from the manufacturer of the product.

Education, communication and awareness can help reduce the use of tobacco. The efforts being made in this regard need to be strengthened by the involvement of multiple stakeholders and various ministries. There should be government-run campaigns to spread awareness, with the participation of NGOs, private agencies and the public. All these stakeholders may also be involved in the development of strategies for tobacco control.

The foremost challenge is the stringent enforcement of the provisions of the COTPA. This challenge can be met only if there is adequate awareness and understanding of the provisions of the FCTC and the COTPA among central and state-level policy makers, law enforcers and the general public. There is also a need for a monitoring mechanism to track violations of the provisions of the Act.

What may be done progressively?

India can upscale the provisions of its national law to bring it at par with the requirements of the FCTC by using the research data from Global Youth Tobacco Survey (GYTS), National Sample Survey Organization (NSSO), National Family Health Survey (NFHS) and the “MPOWER” report of the WHO. This exercise would help not only in strengthening the provisions of the law, but also in monitoring the impact of its enforcement and evaluating the progress made in achieving the goals of the FCTC. Effective enforcement of the provisions of the COTPA will show in decreasing figures for the prevalence of tobacco consumption, a reduction in health care costs and a reduction in the expenditures associated with tobacco use.

The government may effectively work towards:

- Supporting the participation of civil society organizations in tobacco control measures
- Developing a plan for the implementation of the FCTC, with definite goals and deadlines
- Evolving a formal mechanism for measuring the progress and effectiveness of FCTC implementation
- Releasing a part of the tobacco revenues to fund the National Regulatory Authority for Tobacco
- Making provisions for dedicated manpower and resources for tobacco control in the MOHFW at the national, state and district levels

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3. The State shall endeavour to foster respect for international law and treaty obligations in the dealings of organized peoples with one another.
4. Notwithstanding anything in the foregoing provisions of this Chapter, Parliament has power to make any law for the whole or any part of the territory of India for implementing any treaty, agreement or convention with any other country or countries or any decision made at any international conference, association or other body.

Section III:
Role of Civil Society in Tobacco Control

Advocacy for tobacco control

Everyone should be able to say what they want and need when decisions affecting their lives are going to be made. But sometimes, people have difficulty being heard by those who make the decisions. They may feel that the people in the system do not hear them or understand their situation.

“Advocacy” is making your views heard, or acting on another's behalf to make his/her views heard by people making decisions that affect you or the other person. Advocacy is an assertive and collaborative approach to problem-solving, rather than an aggressive and adversarial one.[1] It is an organized approach to promoting an issue or a cause and motivating others to take action in relation to that issue or cause. It involves influencing decision-makers in political institutions to make changes that have a direct impact on people's lives. Advocacy can be used to effect change in public policy, laws, regulations, allocation of resources and access to services.[2] It is the action of presenting an argument to gain commitment from political and social leaders and to educate a society about a particular issue. Here, advocacy is discussed in the realm of tobacco control.

There have been innumerable pro-tobacco influences, steered by the tobacco industry and other vested interest groups that have a stake in subverting the measures for tobacco control. Effective advocacy by various stakeholders in the sphere of tobacco control has helped to counter some of these influences. Advocacy for tobacco control is aimed at reducing the harm caused by the use of tobacco by changing the underlying political, economic and social conditions that encourage its use. In this effort, groups of citizens, or advocates, promote policies and practices that protect people from exposure to second-hand tobacco smoke (SHS), prevent young people from taking to tobacco, and create an environment that encourages people to quit using tobacco. Typically, science, politics and activism are combined to generate public support for these goals.[3] Although advocates for tobacco control often work with far fewer resources than those at the command of the tobacco industry, advocacy for tobacco control has been successful in effecting change in public policy, laws and regulations.

Advocacy for tobacco control represents a substantial extension of earlier public health efforts, which focused on educating smokers directly about quitting and on sensitizing the youth on the dangers of smoking. The advocates promote a variety of public and private policies at the national, state and local levels. Importantly, they focus on change at the community level, i.e. on improving the environment in which people make the decision on whether or not to use tobacco. This entails the need to raise public awareness, foster understanding and activate the people. Further, advocacy attempts to change the behaviour of individuals by targeting institutional policies and practices.[3]

Why the need for advocacy?

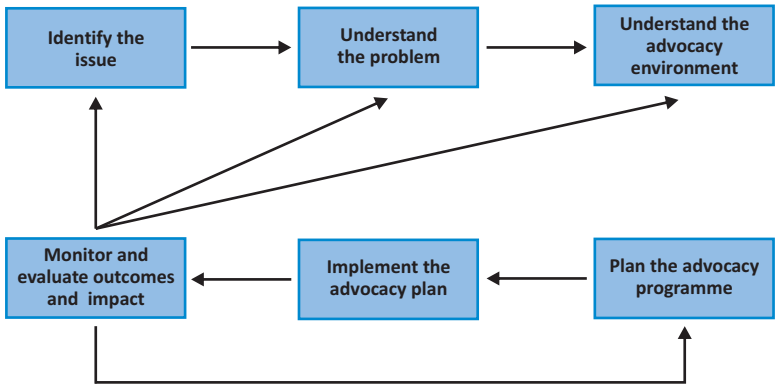
- To undertake activities related to tobacco control by effecting changes in:
  - Public policy
  - Laws and regulations
  - Allocation of resources, especially use of funds
  - Access to services
  - Health insurance and public benefits

- To reduce disparities between the privileged and minority/under-served populations

Four dimensions of advocacy

- Policy dimension: This refers to the aspect of working towards changes in policy, attitudes, practices, programmes and the direction of the allocation of resources (e.g. advocacy for the implementation of effective pictorial warnings in India).
- Civil society dimension: This refers to strengthening the capacity and power of civil society so that citizens can play an effective role in policy-making and decision-making (e.g. monitoring and reporting violations of the Indian tobacco control law).
- Democratic space dimension: This concerns the aspect of improving the accountability of those who lead and govern and increasing the legitimacy of the participation of civil society in policy-making and decision-making
- Individual gain dimension: This refers to improving peoples' material gains in terms of quality of life, as well as expanding their awareness of themselves as citizens with rights and entitlements, together with the responsibility to act on them[4] (e.g. protecting non-smokers from the hazard of exposure to tobacco use: prohibition of smoking in public places).

Fig. 1: The advocacy cycle



Source: Ian Chandler for INTRAC[5]

Table 1: Steps in advocacy process[2]

Step 1	Identify a problem: Choose an issue that corresponds to that problem.
Step 2	Determine the change to be made and set SMART (specific, measurable, achievable, relevant and time-bound) objectives.
Step 3	Identify the people and institutions that have the formal authority to make the change, as well as those who have the ability to influence these people and institutions.
Step 4	Determine the message each audience needs to hear.
Step 5	Devise strategies for addressing the possible obstacles that can be faced in delivering the message effectively to the target audience.
Step 6	Determine the best messengers for the group.
Step 7	Choose the methods to be used to deliver the message.
Step 8	Assess the resources needed.
Step 9	Train the messenger(s) to deliver the message by providing training and practice.
Step 10	Network with individuals and build coalitions of organizations to gain support for the cause.
Step 11	Determine the specific actions needed to deliver the message to the audience.
Step 12	Deliver the specific actions needed to deliver the message.
Step 13	Evaluate the process along the way.

Strategy-planning tool for advocacy campaigns[5, 6]

What do we want? (Goals)

Any advocacy effort must begin with an understanding of its goals. While considering the goals, it is important to make some distinctions. For example, what are the long-term goals and what are the short-term goals? What are the content goals (e.g. policy change) and what are the process goals (e.g. building a sense of community among the participants)? These goals need to be defined at the start, in a way that can help launch an effort, draw people to it and sustain it over time.

The ultimate goal of advocacy efforts for tobacco control is to achieve the enforcement of effective and comprehensive laws and policies on the issue.

Three areas may be examined while setting the objectives:

- The political environment
- The extent of public awareness of the hazards of tobacco use
- The degree of public support for strong laws on tobacco control

The more specific and well-defined the objectives, the more concrete and effective the strategic planning can be. In the early stages of tobacco control, advocacy strategies might need to focus on intermediate steps, such as generating support among influential forces in society and among individuals or groups that can influence the government officials who have the ultimate power to act.

At different stages, advocates may face barriers, such as public ignorance and confusion caused by the tobacco industry's propaganda. Hence, before developing advocacy strategies, it is very important to identify clearly the specific barriers that can be faced and to set advocacy priorities to address the most immediate of these barriers. In countries where the tobacco control movement is just beginning, tobacco control advocates usually have limited human or financial resources. Thus, they must restrict their efforts to narrowly focused strategies. They cannot, for example, afford to build public support by educating the general public on the need for and effectiveness of tobacco control legislation. They must choose the most effective strategies and focus on the most immediate obstacles and opportunities.

Who can give it to us? (Audience)

The next step is to identify the target audience for the advocacy campaign. In a country that is at an early stage of tobacco control, like India is, the public is often not yet fully aware of the severity of the health hazards of tobacco use. In such a setting, tobacco control advocates may need to broaden their target audience beyond government decision-makers/policy-makers and carry their message to the general public.

What do they need to hear? (Message)

Reaching audiences and persuading them about the need for action to control tobacco use requires the crafting and framing of a set of strong messages. These messages need to be tailored to the different audiences, depending on what they are ready to hear. In most cases, advocacy messages will have two basic components: (i) an appeal to what is right, and (ii) an appeal to the audience's self-interest.

An advocacy message needs to do much more than to present an argument. An effective message must be logically persuasive, morally authoritative, and capable of evoking passion. A campaign message must speak to the brain and the heart at one and the same time. Tobacco control advocates can develop motivating messages by presenting statistics that convey scientific truths in a way that can move an audience emotionally.

Who do they need to hear it from? (Messengers)

The same message delivered by different people can have a completely different degree of credibility, power and effect. The credibility of messengers who are "experts", for example, springs largely from their technical knowledge. On the other hand, the power of "authentic voices" lies in their ability to speak from personal experience. While deciding who will be the most effective messengers, we should take the following into consideration:

- Who is the most likely to influence our target audience favourably?
- To whom is our target audience politically responsive?
- Who does that audience most want to please?
- To whom is that audience politically (or financially) obligated?
- Who does it honour, trust, fear or like?

A variety of messengers can be helpful in sensitizing the masses about the harmful effects of tobacco use. Celebrities, health professionals, parliamentarians and the youth, for example, can serve as excellent messengers.

How can we get them to hear it? (Delivery)

Just as we need to analyse our target audience carefully to design the most effective messages and choose the best messengers, we must choose the most effective medium to reach and open the minds of the audience. There are many ways of delivering an advocacy message. The means that will be the most effective depend on the situation. The key is to evaluate them and apply them appropriately. The channels for delivering messages include newspapers, hoardings, television and radio spots.

What have we got? (Resources)

An effective advocacy effort takes careful stock of the existing advocacy resources that can be built upon. These include past advocacy work that is related to tobacco control, alliances already in place, the capacity of the staff and other people, information and political intelligence.

What do we need to develop? (Gaps)

After taking stock of the existing advocacy resources, the next step is to identify the advocacy resources that are required. Attempts must be made to explore alliances that need to be built, as well as capacities, such as outreach, media and research, which are crucial for the effort.

How do we begin? (First steps)

What would be an effective way to begin to move the strategy forward? This requires consideration of the potential short-term goals or projects that would bring the right people together, symbolize the larger work that lies ahead and create something achievable which could lay the groundwork for the next step.

How do we tell if it is working? (Evaluation)

The strategy needs to be evaluated and this can be done by revisiting each of the questions above (i.e. are we aiming at the right audiences, are we reaching them, and so on). It is important to be able to make mid-course corrections and to discard those elements of a strategy that do not work once they are actually put into practice.

Indian youth advocate with policy-makers for early and effective enforcement of pictorial health warnings on tobacco product packages

In May 2007, the Government of India was reconsidering the law to display pictorial health warnings on tobacco products. The Prime Minister had constituted a Group of Ministers (GOM) to discuss and decide the fate of the health warnings.

A meeting of the GOM was scheduled on 23 May 2007. On the same day, before the meeting, youth health advocates from 17 schools involved in HRIDAY's school health programmes met the Health Minister (a member of the GOM) to convey their support for pictorial health warnings on tobacco product packages. They presented an appeal to the Health Minister, requesting him to see to it that the pictorial warnings are not diluted further and that their implementation is not delayed further, and urged him to convey their request to the Prime Minister of India.

This well-strategized and timely advocacy initiative received widespread media attention and was successful in disseminating important messages regarding the health warnings among the public.

HRIDAY, an NGO comprising social scientists and health professionals, has been engaged in research, education and advocacy related to tobacco control since 1992. HRIDAY has harnessed the potential of the youth to act as agents of change aimed at promoting a healthy lifestyle, tobacco control being one of the areas in which they have been successfully involved. HRIDAY is a recipient of the WHO Director General's Award for contributions to tobacco control (2002). Its programme of youth-led health activism has been listed as a 'Best Practice Model and recommended for global replication by WHO.

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Role of coalitions in tobacco control

India has a long tradition of voluntarism. Traditionally, people help others in the event of any natural disaster, accident, illness, death, and so on. An initiative is often taken by motivated public-spirited persons, who may be joined by others, leading to institutionalized voluntarism. However, the nature of, voluntary action in India has undergone a tremendous change. There has been a sharp departure from the old tradition of voluntarism and new trends are discernible.

In the pre-Independence era, voluntary action was characterized by two dominant features: (i) to help the needy, and (ii) to root out social evils and bring about social reforms. Since the scope of State action was limited during that period, much was left to the initiative of individuals and organizations inclined to render public service and interested in making society more humanistic, rational and equalitarian. Charity was the guiding principle of social service, inspired by religious considerations. The volunteers were neither paid workers, nor were they professionally trained (social) workers, and social service was their part-time pursuit. Their voluntary action was individualistic, moralistic and paternalistic in approach. As a result, it responded to crisis situations and not to systemic constraints.

The major change in the nature of voluntary action took place after Independence, when the Constitution declared India as a Welfare State and laid down the “welfare” and “development” obligations of the State in the directive principles of the State policy. Institutionalization of social service became the hallmark of the country's policies and a lot of funds were made available for running a large number of State-sponsored welfare programmes for the weaker and vulnerable sections of society. The old values of voluntarism declined.

Soon, however, it became apparent that the Welfare State, however strong, would not be able to fulfil its mandate without voluntary action. The scope of the action required was so vast and the demands so complex that the State apparatus alone could not manage, with its total dependence on paid professional workers.

Between the 1950s and 1980s, the Government of India started welcoming voluntary action in various spheres of developmental activities. By now, the scenario is completely different from what it was half a century ago. The government policy is clearly one of promoting and strengthening voluntary action groups through recognition of their potential. New methods of cooperation between voluntary organizations and various departments of the government are being explored. This is the era of networking and coalitions, without which it may not be possible to effect major and sustainable changes in society. A simultaneous trend has been the professionalization of voluntary action. Highly qualified professionals have started making a career in the field. Globalization and change in various national and international policies have attracted many players to voluntarism. Professional courses in social work have introduced professionalism in the field. The growth of voluntarism also has something to do with the rapid decline in political commitment, which has brought society to a crossroads.

Coalitions for tobacco control

Coalitions in the context of advocacy mean alliances of organizations working together for a common cause. These organizations may belong to different sectors and may ordinarily be involved in different activities. A coalition is an association of different groups and organizations that are driven by a common concern. Therefore, "a coalition is a union, fusion, temporary combination of parties, groups, and/or organizations that retain distinctive principles but come together for a common cause. In the case of tobacco control, reaching out and forming alliances with other groups and individuals is an important step to build support for advocacy".
Advantage of coalitions in tobacco control

- Strength in numbers: Whatever you do becomes more effective when more people are involved, whether you are trying to educate the public on or lobbying for tobacco control. Working together can create pressure on decision-makers and confer legitimacy to the issue.

- Strength in diversity: Different types of groups (health, non-health, religious, etc.) have different bases of public and political support. Coalitions strengthen outreach and impact, and increase credibility. A coalition is often stronger when it draws together coalition members who are not usually seen as partners.

- Broadened skills and expertise: Different groups have different talents and knowledge. In this way, the efforts of a coalition are supported by a broader collection of skills (i.e. media, organizing, policy) and problems can be addressed in a more holistic way.

- Shared workload and resources: A diversity of talents, work styles and resources is needed to carry out a multifaceted action plan, which is what is required for the fight against tobacco in India. A coalition helps reduce the burden on any one organization.

- Cohesion and solidarity: Shared values, goals and experiences help the coalition partners overcome isolation, build confidence and renew their faith that change is possible. Coalitions in the sphere of tobacco control would thus strengthen the hands of the advocates.

Characteristics of a successful coalition

- It should be big enough to matter: Almost everyone you will want to engage is already going to be extraordinarily busy with some other work that they have. So the campaign or advocacy effort you initiate must be directed at achieving a goal that is big enough to motivate people give your effort priority. In the case of tobacco control, NGOs and individuals in our country have been able to motivate a large number of institutions and organizations to support the cause.

- It should produce some result: Once the organizations become involved and form a coalition, it is necessary that the campaign produces some worthwhile and visible results in the short term (six months to a year). These short-term results do not have to be a total victory. A short-term result could be greater visibility in the media, a partial victory or some other concrete result. Fortunately, in the case of tobacco control, it has been done by various organizations at the regional and state levels.

- The first campaign should symbolize the larger goals: It is unlikely that the first campaign will achieve all of the coalition's major goals, and its objectives are likely to be limited. However, the first campaign should symbolize the larger, long-term vision shared by the coalition partners. It should be a platform to publicize and build support for those long-term goals, and should lay the groundwork for future campaigns.

- It should build skill at the grassroots and leadership levels: The coalition's activities should be developed in a way that serves as a hands-on training to strengthen skills related to leadership, strategy, organizational matters, alliance-making and so on, as these skills are critical to all advocacy campaigns. This holds good for activities at the community level, as well as the activities of the coalition's leadership.

- It should engage the general public: The coalition should come up with a set of symbols and messages that allow the general public to easily grasp the issue.

Prerequisites for effective coalitions

- Clarity of goals and objectives
- Defining tasks and responsibilities
- Continuous communication and dialogue among members
- Strong leadership
- Building trust
- Conflict resolution
- Effective communication

Difficulties faced by coalitions and networks

- Communication gaps
- Unstable power structure
- Lack of confidence
- Lack of group coherence
- Poor leadership
- Poor commitment to the issue
- Unequal visibility for all the members
- Imbalanced delegation of responsibilities
- Inadequate sharing of the successes and failures of the coalition

The role of civil society in tobacco control

Civil society can play an important role in different aspects of tobacco control, at the national, state and local or community levels. It can advocate for policies at the national and state levels, and assist in and monitor the enforcement of tobacco control measures at the state and local levels. Besides working in tandem with the enforcement agencies, it can involve the media to support its efforts. Further, civil society can work for primary prevention among communities, helping to prevent the youth from taking up tobacco use. It can also work in the area of secondary prevention, educating tobacco users on the risks they are taking and helping them to quit. The Government of India recognizes the importance of involving civil society as active partners in tobacco control. This is reflected in the National Tobacco Control Programme (NTCP), which lays down guidelines for government–NGO partnerships in the area of tobacco control at the national, state and district levels.

Civil society organizations can contribute to the fight against tobacco in the following ways.

Creating awareness

- Preventing children and youth from taking up tobacco use: It is known that because of the strongly addictive nature of tobacco, tobacco users find it extremely difficult to give up their habit. Therefore, it is important to focus attention on ways of preventing initiation into tobacco use. Teachers in all schools and colleges should be trained to impress upon their students the dangers of using tobacco products. Students should be encouraged to try and excel in sports, gymnastics and cultural activities, such as dance, drama and music. Audio-visual programmes on tobacco should be arranged to reach the members of those sections of the population whose children and youth do not attend educational institutions.

- Educating the masses, especially the uneducated and less educated, on the harmful effects of tobacco use by:

  - Arranging for medical examination of tobacco users and providing them with referral services to cessation facilities.
  - Organizing interactive sessions with tobacco users on the benefits of giving up.
  - Educating the community on the harmful effects of passive smoking.
  - Encouraging Self-Help Groups of educated rural women to be totally tobacco-free and to compel other women and their male family members to give up tobacco use. These women can function as leaders of an anti-tobacco movement in their social group.
  - Utilizing the local print and electronic media to help turn public opinion against the use and promotion of tobacco.

Engaging in advocacy activities

Advocating for effective enforcement of the tobacco control law and the development of strong policies for tobacco control is an area in which civil society can play a major role. Advocacy initiatives targeting key policy-makers can be vital in promoting strong policy initiatives (e.g. increasing taxation on tobacco products, display of pictorial health warnings on tobacco product packages).

Partnership with the media can be instrumental in creating an enabling environment that increases the level of public awareness and involvement in tobacco control. Greater public awareness and involvement, in turn, can motivate the public to put pressure on the government to step up the enforcement of tobacco control laws and policies.

Monitoring and reporting violations of the law

Civil society should always be vigilant about indirect or surrogate forms of advertising or promoting tobacco products. It should publicly protest against such actions and disseminate the appropriate messages through the mass media. The following are some examples.

- The Red and White Bravery Awards, named after the Red and White brand of cigarettes, were instituted in 1990 and the logo of Godfrey Phillips India used to be displayed during the functions. Following protests by civil society, the company changed the name of the awards to “Godfrey Phillips Bravery Awards'' in 2003.
- A cigarette company tried to introduce in the market cigarettes with a smaller quantity of tobacco compared to ordinary cigarettes, stating that these products were less harmful than other cigarettes. The product was advertised in many newspapers. Civil society took the initiative to file an FIR in the local police station in the jurisdiction where the advertisements were seen.
- According to the COTPA, airports are supposed to be smoke-free, barring the special area designated for smoking. The Dabolim (Goa) airport has a “smoking enclosure'' which is maintained by a cigarette company, and where the company's logo is displayed. NOTE-India objected to the creation of this enclosure, since it is used for advertising a tobacco product.

Reporting violations of the Indian smoke-free rules which prohibit smoking in all public places and indoor workplaces across India is another provision of the law whose enforcement can closely be monitored by the civil society.

Capacity-building of NGOs and law enforcement officers

Organizations with extensive experience and expertise in the area of tobacco control can help build the capacity of fellow NGOs so that they can join the movement against tobacco. Learning from each other's experiences, both successes and failures, can be very useful.

The Government of India has notified certain enforcement officers who are responsible for monitoring the implementation of the tobacco control law and taking action on violations. Civil society organizations can team up with the government to train these officers in the technical skills required for executing their duties.

Litigation

Utilizing legal tools like public interest litigations, the Right to Information Act and caveats, civil society organizations can strongly oppose the challenges posed by the tobacco industry to the effective enforcement of tobacco control laws.

Role of NGOs as envisaged in the NTCP

Awareness generation campaigns: These are intended to create awareness of the ill effects of tobacco among school teachers, health workers, law enforcers, and so on.

Training and capacity-building programmes: Such programmes are aimed at school teachers, health workers, law enforcers, women's Self-Help Groups and other civil society organizations to educate and empower them with respect to the tobacco control law and other state-specific tobacco related issues.

School health programmes for tobacco control: These include the Tobacco-Free Schools Initiative and other activities for creating awareness about the provisions of the law, the ill-effects of tobacco use, and so on.

Widening the tobacco control movement: Engaging health professionals

Health professionals have a prominent role to play in tobacco control. They have the trust of the population, the media and opinion leaders, and their voices are heard across the entire range of the social, economic and political spectrum. At the individual level, they can educate people on the harmful effects of tobacco use and exposure to second-hand smoke (SHS), as well as help users overcome their addiction. At the community level, they can initiate or support policy measures by engaging, for example, in efforts to promote smoke-free workplaces and extend the availability of tobacco cessation resources. Health professionals can also lend their voice to national and global tobacco control efforts, such as campaigns for an increase in the taxes on tobacco products and the fulfilment of the objectives of the Framework Convention on Tobacco Control (FCTC). According to Doctors and Tobacco: Medicine's Big Challenge, health professionals are better suited than any group in society to promote a reduction in tobacco use and thus, in due course, a reduction in tobacco-induced mortality and morbidity.

WHO FCTC and health professionals

The WHO FCTC is an international legal instrument designed to control the global tobacco epidemic. It is the first public health treaty negotiated under the auspices of WHO. The preamble of the WHO FCTC specifically mentions the role of health professionals in tobacco control. Article 12 (which is on education, communication, training and public awareness) and Article 14 (which seeks measures for the reduction of tobacco dependence and for promoting cessation) of the Convention are of particular interest to health professionals. Efforts at tobacco control are more likely to be sustained when incorporated into the existing health structures at the national, state and district levels, and when linked with the existing staff positions and accountability processes. The involvement of the government health sector in tobacco control activities is expected to increase awareness among health professionals and contribute to the development of sustainable tobacco control programmes at the country level. Such a systematic approach would also pave the way for multisectoral acceptance of tobacco control efforts in the country's various states.

Role of health professionals

Health professionals have an essential role to play in the promotion of a tobacco-free lifestyle. In the course of their professional activities, they can help people by giving advice, guidance and answers to questions related to tobacco use and its effects on the health. They can serve as a reference for the media, and help educate the public and policy-makers. Further, they can use their professional associations to influence the government to effect policy changes aimed at more effective tobacco control at the national and international levels.

Health professionals as role models

In community and clinical settings, health professionals are the most knowledgeable in health matters and are expected to act on the basis of this knowledge. They are expected to be role models for the rest of the population. Since they are professionally respected and popularly revered, they should use their influence to change the current trends in tobacco use and spearhead a national anti-tobacco movement. Further, since health professionals are considered role models, their behaviour with respect to heath-related matters, such as diet and exercise, and particularly tobacco use, can exercise a great influence over the people. The reality is that many people become addicted to tobacco before they have made the decision to become health care professionals. In order to help them become tobacco-free role models, therefore, more efforts need to be made by organizations of health professionals and training institutes for health professionals.

Health professionals as cessation specialists

In the day-to-day health care setting, all health professionals need to address tobacco dependence as part of their standard practice. It has been suggested that questions about tobacco use should be included when monitoring a patient's vital signs and that during every encounter with a patient, the health care professional must assess whether the patient is using tobacco and note it on his/her chart. In the case of tobacco users, health professionals must give the advice that quitting tobacco is the best thing that one can do for one's own health and for the health of those around one. They must also try to make these patients aware of the immediate and long-term benefits of quitting and remind them that quitting at any age results in tremendous health benefits, though the earlier one quits, the better the results. This brief assessment and provision of advice would take less than three minutes. Simple advice from physicians has been shown to increase abstinence rates significantly (by 30%). Similarly, nursing-led interventions increase the chances of quitting successfully by 50%. Research has demonstrated that interventions using multiple providers are very effective and that all health care professionals can assist in tobacco cessation efforts. Essentially, the likelihood that a person will be able to quit tobacco use successfully increases with the number of times the person hears a consistent message from health professionals. The Treating Tobacco Use and Dependence? Clinical Practice Guidelines issued by the US Department of Health and Human Services recommends the “5As” approach:

- Ask about tobacco use
- Advise all users to quit
- Assess willingness to make a quit attempt
- Assist the patient to quit
- Arrange follow-up contact

Health professionals should also be instrumental in the development and dissemination of scientific and practical materials on cessation. These should be adapted to the culture, ethnic background, age, language and health status of patients, and should take into account their predisposition and attitude towards quitting tobacco use. Whenever possible, health professionals should make their advice relevant to the patient's existing diagnosis and current lifestyle.

Health professionals as educators

Health professionals play an important role in educating new generations of health professionals. They are involved not only in the training of students, including pre- and post-graduates, but also in continuing education and training activities, or in research and evaluation. According to research, training plays a role in changing the practice of health professionals . Research has also shown that the portion of the content of the curricula of health training programmes for professionals that pertains to tobacco control, both theoretical and practical, is inadequate. All aspects of tobacco control need to be incorporated into the existing curricula. Tobacco control can be taught as a separate subject or be taught as a part of the existing subjects (epidemiology, health promotion, prevention and treatment, etc.). It is important for students to learn about the policy aspects of tobacco control and its benefits for public health. The effects of tobacco on health can be incorporated into a variety of disciplines, and students should be given an opportunity to gain practical skills in assessing and giving advice on tobacco use and cessation. The training period would also serve as an ideal opportunity for offering support to students who are tobacco users and are trying to quit.

Many health professionals have leadership positions at different levels, from the local to the national levels, and several enjoy considerable public trust. Among the many activities that health professionals in positions of leadership can be involved in are policy-making and activities that advance the cause of tobacco control. The latter include promoting smoke-free workplaces, working for an increase in the taxes on and prices of tobacco products, organizing campaigns to prevent the youth from using tobacco, and raising funds for tobacco control programmes. Not all health professionals will be able to tackle all tobacco control issues at the same time, but they can all take small steps to address at least one issue at their own workplace (for example, promoting a smoke-free environment). Depending on their positions, they can tackle larger policy and political matters, as the opportunity arises. Those who belong to professional organizations can also influence their organizations to become involved in policy-making and to place tobacco control on their agenda, as stated in the Code of Practice on Tobacco Control for Health Professional Organizations.

Strategies to overcome barriers among health professionals

Some barriers to the full involvement of health professionals in tobacco control are the lack of knowledge of and skills related to tobacco control strategies, including the treatment of tobacco dependence and approaches to the cessation of tobacco use. Among the other barriers that prevent health professionals from actively participating in tobacco cessation efforts are concern about the time required for tobacco cessation counselling,

as well as about the effectiveness of such counselling. The lack of readily accessible materials to educate patients on tobacco dependence and cessation is another obstacle. Expected resistance from patients, the lack of organizational leadership and the fact that some professionals are themselves users are some other factors that prevent health professionals from becoming pro-active in tobacco control.

A survey on the health professionals' knowledge of and attitudes and barriers to tobacco cessation counselling could be conducted in order to develop country-specific modules for the education and training of health professionals in this area. Further, there is a need to build their confidence and skills in cessation counselling including appropriate training as a continuing education measure. These training courses can be tailored for different levels, such as rural and urban. Health professionals need to be told through their organizations that even three minutes of brief intervention help a lot of their patients quit tobacco. They should be informed that reviews of the evidence reveal that advice on the cessation of tobacco use is one of the most effective forms of health promotion. Many NGOs working in the health care sector provide materials to educate patients on tobacco control in different languages. Modules could also be developed to educate and train health professionals in the area of advocacy for tobacco control. The organizational leadership and the MOHFW, Government of India could help formulate policies on the curricula of health training programmes to make them more relevant to tobacco control. This would include making changes in the curricula of undergraduate courses. The policies could also provide for continued educational training in tobacco control to health professionals across India.

Dental professionals and students

Global studies have shown that dental professionals can play a significant role in preventing people from taking to tobacco, encouraging current smokers to quit and facilitating attempts at cessation. Tobacco or Oral Health—An Advocacy Guide of Oral Health Professionals, a joint publication of WHO and the World Dental Federation that was released to mark World No Tobacco Day, 2005 in Geneva, recommends that a joint effort be made by the health ministries, WHO country offices and national dental regulatory bodies to hold educational and skill-building workshops on the cessation of tobacco use and approaches to prevention. Studies have shown that even brief counselling by dentists on the dangers of tobacco use and the importance of quitting is one of the most cost-effective methods of reducing tobacco use substantively. In addition, the Global Health Professionals Survey (GHPS) of dental students in India has shown that students have a strong desire to provide cessation and prevention counselling to their patients. It also shows that only about 10% of students are currently receiving specialized training on the provision of tobacco cessation counselling to patients, whereas more than 90% of Indian dental students would like to receive such training. To fulfil the training needs of dental students and professionals in India, the Ahmedabad Dental College and Hospital, in association with the Dental Council of India and WHO's India office, successfully organized two national workshops in Delhi and Chennai for nominated professors/principals of dental colleges in India. The participants, numbering over 200, deliberated upon sensitization, education and training for dental students in the area of cessation of tobacco use, as well as approaches to cessation and advocacy. They made a unanimous recommendation to introduce and implement

mandatory education and training in the prevention and cessation of tobacco use, and advocacy for passing-out dental interns in India. As a result of this, the Dental Council of India included ”Tobacco Control Approaches” in the curriculum of the undergraduate Bachelor of Dental Studies course and got it notified in the Gazette of India (October 2007). The Council, a dental education regulatory body of the Government of India, intends to build national capacity to carry out effective and sustainable national tobacco control programmes assisted by the dental fraternity to boost the government's efforts towards making India a tobacco-free society

Behaviour change communication and tobacco control

Behaviour change communication (BCC) aims to foster positive behaviour; promote and sustain behavioural change; and maintain appropriate behaviour. BCC can be undertaken at the individual, community and societal levels. The process, when used to influence communities, is a multi-level and interactive one, in which an attempt is made to develop tailored messages and approaches to be conveyed through a variety of communication channels. The process of BCC entails the development of communication strategies that promote positive behaviours which are appropriate to the people's settings, and which provide a supportive environment that will enable the people to initiate and sustain positive behaviours. BCC is influenced by "development" and "health services provision" and that the individual is influenced by community and society. The community and society can also provide the supportive environment necessary for behavioural change.

The United Nations Children's Fund (UNICEF) calls BCC a form of "strategic communication". Strategic communication is based on a well-defined vision and is results-oriented, the strategy being driven by qualitative and/or quantitative data on the target audiences, their cultural, traditional and historical conditions, as well as circumstantial and structural barriers to change. Investment in such knowledge sharpens the focus of the intervention and provides a clear view on how to orchestrate change. Further, BCC employs a strategic, pervasive use of the mass media and interpersonal communication. It is a process in which the target audiences are no longer perceived as passive recipients of information. Rather, they are active players who contribute to the design and implementation of communication or outreach programmes, often themselves participants of the interventions that engender change, especially at the community level.

In the context of tobacco control, BCC is similar to counter-marketing efforts in reply to pro-tobacco messages and influences. The objective of this communication is to reduce initiation into tobacco use and the tobacco consumption of users, prevent exposure to SHS and promote cessation. This is done by means of denormoralizing tobacco use, and establishing norms and models for a tobacco-free lifestyle.

Before individuals and communities can reduce their level of risk or change their behaviour, they must understand some basic facts about tobacco use, adopt certain major attitudes, learn a set of skills, and be given access to appropriate commodities and services. People must also perceive that their environment supports behaviour change, besides helping them to maintain safe behaviour (including abstinence) and seek appropriate treatment for prevention, care and support.

The elements of BCC are:

1. Knowledge/information
2. Motivation

3. Skills
4. Enabling environments

Knowledge/Information

Helping the people know and understand that tobacco is harmful, addictive and destructive and has no positive qualities is the first step towards building a tobacco-free society. A process whereby users start questioning their use of tobacco cannot get under way unless this is made clear in a comprehensive manner.

Motivation

Experience has shown that providing people with information and telling them how they should behave ("teaching" them) is not enough to bring about behavioural change. While providing information to help people to make a personal decision is a necessary part of promoting behavioural change, BCC recognizes that behavioural change also requires that the user be motivated to change. Motivation to give up the use of tobacco comes from an understanding at a deep level, where the user also gets emotionally involved. The motivation to give up using tobacco can lead the person to contemplate quitting. It can also prevent a person from taking to tobacco in the first place.

Skills

Motivation will build the desire to consider taking the bold step. However, the step can be taken only if the person has the skill. Many persons feel that they should quit using tobacco but they do not know how. People have to be provided with skills either through training or by being referred to those who can help.

Enabling environments

The last link in the chain is an enabling environment. This provides support to people who do not want to start using tobacco or those who want to give it up. Such support can be provided at several levels: family and friends, community, locality, city or country. A person could have all the knowledge required, might be motivated to quit and might also have acquired the skills needed for this, but is likely to fail if he/she is not supported by family and friends. The support at the community and locality levels is built up by a process of dialogue and negotiations. That at the city and country levels is provided through policies and legislation, and is a very powerful tool to compel people to reject a lifestyle that includes tobacco use.

It has been established that comprehensive programmes for the prevention and cessation of tobacco use play a crucial role in the prevention of many health problems, such as cancer, heart disease and respiratory illness. Effective public education campaigns, as a part of BCC, are a vital component of any comprehensive programme for the prevention and cessation of tobacco use because they help prevent young people from taking to

smoking, encourage users to quit and change the social context of tobacco use so that pro-tobacco messages are no longer attractive. More specifically, campaigns build awareness and knowledge, change key beliefs and attitudes, increase quitting and lead to an overall increase in tobacco cessation.

Evidence suggests that mass media campaigns can have a greater impact on cessation than other methods due to their ability to reach a large number of users. However, before designing a campaign, it is important to be clear about exactly whose behaviour is to be influenced and which aspect of their behaviour should be the focus of change. Thus, one has to know who one's target population is, and one has to have a detailed knowledge of their lifestyle and their beliefs on life, in general, and on tobacco and health, in particular. More especially, beliefs which are likely to hinder efforts to promote a life without tobacco and present barriers to change should be well researched. The role of formative research in the designing of campaigns and strategies for behavioural change cannot be underestimated. The aim of such research is to make the campaign as relevant and responsive as possible to the audience. This approach has the unique ability to weed out all unnecessary and irrelevant elements that will confuse the audience. The skill of the researcher lies in the interpretation of research data and coming up with a highly "saleable" and acceptable product.

Therefore, in the sphere of tobacco control, BCC entails designing campaigns that will empower people with knowledge of the acute health consequences of using tobacco, motivate them to quit, and provide them with skills which will help them to quit either by themselves or by seeking help. To serve these purposes, the communicator has to build the campaign on the basis of an understanding of why people use tobacco, what need it addresses in them and what they believe they get out of its use. In order for the communication to be effective, it has to relate to their lives in an interesting manner. The use of familiar imagery will move and prompt them to question their use of tobacco.

The campaign must impel tobacco users to start thinking about two main questions: "Why quit?" and "How to quit?" To address the first question, the campaign must use hard-hitting material and messages on the consequences of tobacco use, messages that elicit negative emotions (anger, loss, sadness, guilt, fear). However, once again, research will have to be carried out to assess the right amount of arousal of negative emotions, such as fear, which, if too intense, has been observed to be counterproductive. When the fear created by a message is too intense, it can make people immobile and hopeless, i.e. it may lead to despair. The use of testimonials and emotional stories has been observed to motivate attempts to quit. Such messages are a cost-efficient means of influencing specific populations, who can identify with people like themselves striving to meet the same goal.

As for "how to quit", it is effective to show that people who take help have been successful in quitting. The communication should build hope in people, by communicating that quitting is a journey, not necessarily one event, and that "it is okay to slip the first time you try". The tone of a successful communication is positive, non-judgemental of the user, respectful of him, but emphatic.

Advertising and social marketing techniques make the communication attractive, worth trying and popular with the audience. Formative research helps the campaign maintain the delicate balance between “education” and “entertainment”, between weighty issues and engaging stories that appeal to the audience. Particular care should be taken to prevent the material from becoming overloaded with messages and to ensure that a serious issue is not treated flippantly. Further, a communication that speaks of the tangible benefits of quitting is more likely to achieve its objective.

A successful BCC programme requires careful research and thorough pre-testing of communication materials. It is important not to underestimate the effort that is needed to carry out good-quality behavioural research, which yields findings that:

- Are accurate
- Are useful
- Increase knowledge
- Stimulate community dialogue
- Promote essential attitudinal change
- Reduce stigma and discrimination
- Improve skills and self-efficacy

Using Right to Information Act for tobacco control

The Right to Information (RTI) Act

In recent years, there has been an almost unstoppable global trend towards the recognition of the right to information by countries, intergovernmental organizations, civil society and the people. The right to information has been recognized as a fundamental human right, which upholds the inherent dignity of all human beings. This right forms the crucial underpinning of participatory democracy—it is essential for ensuring accountability and good governance.

The Right to Information (RTI) Act, enacted by the Indian Parliament in 2005, gives the citizens of India access to the records of the Central and state governments. The Act gives the citizens the right to request information from a public authority, which is required to reply expeditiously or within 30 days.

Before the Act was passed, the Supreme Court in 1975 delivered a landmark judgment which held that "the people…have a right to know every public act, everything that is done in a public way, by their public functionaries". Laws providing for the right to information were first successfully enacted by the state governments of Tamil Nadu (1997), Goa (1997), Rajasthan (2000), Karnataka (2000), Delhi (2001), Maharashtra (2002), Madhya Pradesh (2003), Assam (2002), and Jammu and Kashmir (2004).

The Act is applicable to all constitutional authorities, including the executive, legislature and judiciary; and any institution or body established by an Act of Parliament or a state legislature. It also states that bodies established by order or notification of appropriate government, including bodies "owned, controlled or substantially financed" by the government, or non-governmental organizations "substantially financed, directly or indirectly by funds" provided by the government are also covered under the Act. The information that is accessible to the citizens has been defined in Section 2(f) as any material in any form including records, documents, memos, e-mails, opinions, advices, press releases, circulars, orders, logbooks, contracts, reports, papers, samples, models, data material held in any electronic form, and information relating to any private body that can be accessed by a public authority under any other law in force for the time being. Every citizen has a right to this information and can:

- Inspect works, documents and records
- Take notes, extracts or certified copies of documents or records
- Take certified samples of material
- Obtain information in the form of printouts, diskettes, floppies, tapes, video cassettes or in any other electronic mode

[1] *Raj Narain vs Union of India*

Procedure for filing of and acting on an RTI application

- Under the RTI Act, all complying departments must appoint a public information officer (PIO) who may be requested for information in any format, paper or electronic.
- It is the responsibility of the PIO to ensure that the information is obtained from the appropriate department within 30 days of the receipt of an RTI application. If the request pertains to another public authority, it is the responsibility of the PIO to transfer/forward the concerned portions of the request to a PIO of the other department within five days.
- Every public authority is also required to designate assistant public information officers (APIOs) to receive RTI requests and appeals, and forward these to the PIOs of the public authority they belong to. The requests received by them are to be complied with within 35 days of the receipt of the application.
- The citizen making the request is not obliged to explain why the information is needed.
- If the PIO transfers the request to some other public authority which is more concerned with the information requested, the time allowed to reply is 30 days, but this period is computed from the day after the request is received by the PIO of the transferee authority.
- Information about violations of human rights by security agencies is to be provided within 45 days, but with the prior approval of the Central Information Commission.
- In any of the above cases, if life or liberty is involved, the PIO has to reply within 48 hours.
- For Central departments, as of 2006, a person has to pay a fee of Rs 10 for filing the request, Rs 2 per page of information and Rs 5 for each hour of inspection after the first hour. States fix their own rules.

Information and authorities exempt from disclosure

A certain kind of information listed under Section 8 of the Act is exempt from disclosure as it would affect the sovereignty, integrity and security of India. There is a list of other information which is also exempt from disclosure, as stipulated in the Act

Central intelligence and security agencies, such as the Intelligence Bureau, Reaserch and Analysis Wing, Directorate of Revenue Intelligence, Central Economic Intelligence Bureau, Directorate of Enforcement, Narcotics Control Bureau, Aviation Research Centre, Special Frontier Force, Border Security Force, Central Reserve Police Force, Indo-Tibetan Border Police, Central Industrial Security Force, National Security Guards, Assam Rifles, Special Service Bureau, Special Branch (CID), Andaman and Nicobar, The Crime Branch (CID-CB), Dadra and Nagar Haveli and Special Branch, Lakshwadeep Police are exempt from the provisions on giving information. Agencies specified by the state governments through a notification will also be excluded from the purview of the RTI Act. The exclusion, however, is not absolute and these organizations have an obligation to

provide information pertaining to allegations of corruption and violations of human rights. Information relating to allegations of violations of human rights could be given, but only with the approval of the Central or State Information Commission, as the case may be.

Role of the government

Section 26 of the Act enjoins the Central and state governments to initiate necessary steps to:

- Develop educational programmes for the public, especially disadvantaged communities, on the right to information
- Encourage public authorities to participate in the development and organization of such programmes
- Promote timely dissemination of accurate information to the public
- Train officers and develop training materials
- Compile and disseminate a "User Guide" for the public in the official language
- Publish the names, designation, postal addresses and contact details of the PIOs, as well as other information, such as notices regarding the fees to be paid and the legal remedies available if a request is rejected.

RTI Act and tobacco control

The RTI Act can be used as an effective tool to ensure good governance and accountability, which are essential for tackling social issues, and tobacco control is a major social issue. Despite the fact that India has a good law for tobacco control (the COTPA), the results have not been satisfactory. The main reasons for this are poor implementation and the lack of political will. However, since there now exists a comprehensive law with certain authorities and structures defined under it, NGOs and citizens can file an RTI application if they feel that the law is not being implemented properly or if they require information regarding any government action. The RTI Act can aid in the successful execution of the tobacco control laws because it gives every citizen the enforceable right to question, examine, audit, review and assess government actions and decisions, and to ensure that these are consistent with the principles of public interest, probity and justice. By exposing the government to continuing public scrutiny, it would promote openness, transparency and accountability in administration.

The RTI Act has been used by NGOs for various issues, including issues involved in the area of tobacco control. An NGO in Chandigarh, the Burning Brain Society, has filed many RTI applications to ensure the implementation of the tobacco control law. It filed an RTI request with the Maharashtra prison department to know the reasons why Sanjay Dutt (a popular film actor) was allowed to smoke while in prison. The application, which was filed in 2007, pointed out that smoking is not a constitutional right, whereas breathing fresh air, free from toxins, is a

fundamental right guaranteed under Article 19 (right to life). In its reply, the government of Maharashtra said that prisons are not public places and, therefore, smoking is not restricted there. But Rule 35(ii) of the prisons manual clearly states that the superintendent of a jail has to restrict smoking and/or the sale of tobacco within the premises of the prison, according to the prevalent law. Prisons are not only places where prisoners are lodged, but are also workplaces where a large number of people work. Besides, since prisons are public buildings, the government is duty-bound to display no-smoking boards there and keep them smoke-free. The filing of an RTI application in such cases is an example of how the authorities can be reminded of their responsibility.

Another example of the filing of an RTI application in the context of tobacco control is that filed by Pasumai Thaayagam (Green Motherland), an NGO working in the state of Tamil Nadu. The application, sent to many government offices in Tamil Nadu, sought clarifications regarding the status of the notification and implementation of the COTPA. The government replied that it was in the process of notifying the COTPA to implement it completely. The MOHFW, Government of India, clarified that a law passed by Parliament or any national legislation does not require notification from the states. It said that a national law was for the whole country and had to be implemented all over India, and that the states just needed to notify officials who would be authorized to implement the law. The COTPA, a national legislation, did not require notification from the states for its implementation. Therefore, while the government of Tamil Nadu needed to notify officers to implement the Act, the Act was already enforceable.

These are two examples of applications being filed by NGOs under the RTI Act to ensure effective tobacco control. Other NGOs, too, can utilize this tool in their respective states to curb the menace of tobacco and to see that the law is implemented efficiently. The citizens have a right to assess and review what the government does, and the RTI Act is a helpful tool.

The format of the application for obtaining information under the RTI Act is provided on the next page.

ANNEXURE "A"

(See rule 3)

Affix court fee stamp of Rs. 10/-

Format of application for obtaining information under

The Right to Information Act, 2005

To: The State Public Information Officer,

(Name of the office with address)

1. FULL NAME OF APPLICANT:

2. ADDRESS:

3. PARTICULARS OF INFORMATION REQUIRED:

(i) Subject matter of information:

(ii) Period to which the information relates:

(iii) Description of information required: *(Details may be attached on additional A4 size paper, if required.)*

4. WHETHER THE APPLICANT IS BELOW POVERTY LINE:

(If yes, attach a photocopy of the proof thereof.)

Place :

Date :

Signature of the applicant

Section IV:
Case Studies

Cancer Patients Aid Association: Engaging celebrities in tobacco control

There are numerous reasons why individuals start using tobacco. These include cultural influences, the easy availability of different types of tobacco products, absence of tobacco control policies and strategies, and, perhaps most importantly, the tobacco industry's drive to promote tobacco use and undercut tobacco control strategies. In addition, celebrities play an important role in promoting the use of tobacco.

A WHO-supported survey of popular Indian films made from 1991 to 2002 revealed that 76% of these films portrayed tobacco consumption. The artistes depicted smoking included some of the biggest names in Bollywood. Images of popular heroes smoking help project the notion that smoking is "cool" and encourage fans to mimic the habit. In fact, celebrities from all fields have a great impact on their audiences, serving as role models.

The Cancer Patients Aid Association (CPAA) decided to use the finding of the study as the basis for a tobacco control strategy. It called upon celebrities to publicly pledge their support for tobacco control and to state that they do not personally smoke or use tobacco products. It has been the CPAA's constant endeavour to focus on spreading awareness of the ill effects of tobacco through programmes involving celebrities. Over the years, we have appealed to many well-known personalities and their positive responses have been heartening.

The following are some of the events organized in the past involving celebrities.

Drawing competition: In May 2004, children were invited to create posters on tobacco control and celebrities were requested to act as judges. Since the topic given by WHO that year was "Tobacco and Poverty", it was decided to call street children from various localities by enlisting the help of the NGOs working with them. The presence of celebrities as judges encouraged the participants to put in an extra effort and some praiseworthy drawings, which were subsequently used in posters, were the result.

Fashion show: A unique fashion show, involving 60 celebrities from different spheres, was organized in May 2003 at a five-star hotel in Mumbai. A large section of the city's glitterati formed a part of the audience. Eminent representatives of various professions, including fashion, films and advertisement, walked the ramp

to put on record their feelings against tobacco. The collections of several well-known fashion designers were presented. The master of ceremonies used the opportunity to ask the celebrities about their opinions on smoking. All of them gave a resounding thumbs down signal to the "disgusting habit" and shared their experiences on how to quit. A famous adman said, "I gave up smoking 20 years ago. Now every Sunday I visit my friends who didn't—at the graveyard." Another said, "Kiss a non-smoker and enjoy the difference." Yet another made a humorous comment on how he turned down a good offer to model for cigarettes in the past, and here he was, modelling for the anti-smoking cause for no money! It was remarkable that so many people who charge huge fees for just a fleeting appearance gave of their time so generously in this effort.

Music show: It is always hard to reach the actual target of our anti-tobacco message, namely, the youth. The young do not appreciate lectures and warnings, and feel that cancer and ill- health are something that they will never suffer from. So how can one reach out to this group in a stimulating manner? The CPAA decided to enlist the support of a leading rock band. At the show, held in May 2007, the rock band used its songs to send out the message "Tobacco Kills!" Some of the youth attending the concert were holding placards carrying the message. The audience, consisting of over 800 college students, was on its feet, dancing and singing. [This message was also conveyed in speeches given by the film actors who had helped in making anti-smoking spots which had been aired on television and in cinema theatres all over India].

Anti-smoking spots: In 2004, the CPAA requested a leading film director, Shaad Ali, to make three short advertisement films against the use of tobacco. The stars were chosen from different age groups so that the message would be appreciated by the old as well as the young. These stars were Urmila Matondkar, Vivek Oberoi and Shashi Kapoor. The advertisements were aired in cinema halls and on television channels all over India, and still run successfully because of the hard-hitting and easily understood message. They were recently uploaded on YouTube, the new frontier of media presentation. The stars were felicitated for their participation by WHO and the MOHFW.

Involvement in a film: The CPAA supported the film, "No Smoking", starring John Abraham, directed by Anurag Kashyap and produced by Kumar Mangat. The director and producer were both chain smokers, but gave up smoking during the making of the film. In May 2007, the cast, director and producer were felicitated by the CPAA, MOHFW and WHO for their success in delivering a hard-hitting message

Sports personalities: For many years, the Indian cricket team was sponsored by a tobacco company. After this was disallowed by the MOHFW, in May 2002, the CPAA decided to ask the team to support the cause of tobacco control. The entire Indian cricket team was asked to sign a cricket bat and a canvas stating that they supported the programme. The bat was subsequently auctioned at a celebrity dinner in 2008 by the ex-captain, Kapil Dev. In the 2002 event, the best known sportsmen from the fields of badminton, tennis, billiards and hockey were also asked to lend support. A poster and postcards were designed using their images.

Cricket match: Cricket is practically a religion in India. In May 2005, the game was used to involve health professionals from leading hospitals in Mumbai in the drive against tobacco. A match was organized between health professionals and celebrities to advocate for a healthy lifestyle. The head of surgery from the largest cancer hospital in India was captain of the team of doctors. Coincidentally, a film on the subject of sports was being released at that time, with some well-known actors in its cast. All the actors in the film readily agreed to participate in the match. The teams' outfits were specially designed to carry an anti-tobacco message. Each team played with a due degree of seriousness. It proved to be a win–win situation, since the event was highly publicized and helped to garner media attention for the film as a by-product. An audience of over 2000 watched the match. It consisted mainly of the youth, who cheered both for the actors as well as the relatively older and weaker team of doctors. An added attraction was the commentary, which was made by a well-known comedian. Before the event, a successful effort was made to create media hype through a press conference attended by Salman Khan, Suniel Shetty, Riteish Deshmukh, Arbaaz Khan and Aftab Shivdasani.

Anti-tobacco ambassadors: Well-known actors have been enlisted as ambassadors for the anti-tobacco cause. They use every opportunity to speak of the ills of tobacco. It must be added here that a Bollywood actor, who was often portrayed smoking in his films, was asked to become an ambassador for the tobacco control programme. In 2005, he was given the prestigious WHO Special Director General's award for his support. Subsequently, he returned a bravery award given to him by a tobacco company.

Press conferences: The CPAA motivates the media to attend policy-defining meetings by involving celebrities. This makes the event newsworthy.

Salaam Bombay Foundation: Harnessing youth power for advocacy against tobacco (Project Super Army)

This chapter describes an example of the efficacy of using the power of children to influence society to protect itself from tobacco. It gives an account of the experience of the Salaam Bombay Foundation, an NGO based in Mumbai, which has based its strategy on the belief that children make positive and healthy decisions if they are given access to correct information and provided with skills.

The Salaam Bombay Foundation has undertaken an innovative programme to build the awareness, life skills and advocacy skills of children in the sphere of tobacco control. This chapter presents the methods employed by the NGO over a five-year period, from 2002 to 2007, which is an adequate span of time to evaluate the efficacy of the strategy.

The NGO

The Foundation was established in 2002 with the objective of protecting the next generation from tobacco. Right at the outset, it adopted the strategy of working with children on the basis of the belief that educating children is the most enduring way of shaping India's future. The opinions, good habits and ideas inculcated in children at an early stage stay with them even in later years.

The target group

It was decided that the crusade against tobacco should be targeted at families in the lower income bracket because of the high prevalence of tobacco use among this section and its devastating impact on the health and life opportunities of the children belonging to these families. For this reason, the Salaam Bombay Foundation decided to work primarily with government-run schools, i.e. municipal schools, in which children from the lower socio-economic strata generally enrol. Children in the age group of 10–17 years were chosen as the target group.


Municipal Commissioner of Mumbaiinaugurating the Super Army Event

Project Super Army

Project Super Army is an innovative programme that aims to equip children with unique weapons, such as art, theatre and music, to fight tobacco. Today, over 40,000 students from all over Mumbai are part of the Super Army. They are working towards becoming better advocates for the implementation of the COTPA. They are also carrying the message to the media, police, civic authorities and the community at large, influencing them to join their war against tobacco.

Early steps towards Project Super Army

The Salaam Bombay Foundation's first project started as a part of the Mumbai's Outreach Department Programme of the Prince Aly Khan Hospital in 1999. It is a theatre-based intervention, Theatre against Tobacco, a Hindi street play in which eight theatre professionals are involved. The play covers information not only on the harmful effects of tobacco, but also on how to quit using tobacco and on misleading tobacco-related media imagery. The interactive, entertaining format of the intervention engages children and leaves a lasting impression on the child's mind.

The play, which has been very well received, serves as an entry point into schools. It has generated tremendous interest both among students and staff. The feedback is used to assess the intervention and determine what more needs to be done. The play has been staged 1,148 times, making it the longest running children's play that has never charged for a ticket.

On the strength of this experience, the Salaam Bombay Foundation launched Project Super Army in two schools in 2003–2004. There has been no looking back since then. It was extended to six schools in 2004–2005, 15 schools in 2005–2006 and 25 in 2006–2007. In 2007–08, the project was being implemented in 40 schools. Project Super Army is today the largest direct intervention undertaken by any single NGO that involves the youth as change agents in the movement against tobacco. It has already reached out to over 47,000 children in Mumbai.

Children performing an anti-tobacco song at the Super Army Event

The project

The project is implemented in a school set-up, with permission from the Education Department, Government of Maharashtra and principals of the schools. The sessions, which are held twice a month and are of 60–90 minutes' duration, are largely interactive. The children are involved in the project for a minimum of two academic years (Classes VIII and IX).

To help them become agents of change and equip them to advocate the cause, the children are provided information on tobacco and taught advocacy skills that will enable them to reach out to other children, the community, influential people and decision-makers. Further, the children are given training in life skills, and the programme also includes various initiatives for personality development and confidence-building. The programme steers clear of the traditional classroom lecture format and instead, makes use of different creative formats to engage the children. The Salaam Bombay Foundation has a core team of 25 facilitators from the fields of education, social work and research.

The Foundation has devised several types of interventions as a part of Project Super Army. Some of these are aimed at "attracting" the children and some at "sustaining" their interest in tobacco control. These are described in brief below.

The first year (Standard VIII)

The methods and media used to communicate the information and messages are simple and child-friendly. The children are first exposed to Theatre against Tobacco, which subliminally sensitizes them to the issue and creates an interest in participating in the project. Interactive activities and worksheets help the children realize their potential and thus, increase their self-confidence and self-esteem. Since personality-related factors are critical in keeping children away from tobacco, these sessions are used to build and reinforce a positive personality.

Games are used to enable the children to understand the importance of good communication. The mass media, which plays a key role in creating role models and introducing children to tobacco, is discussed with the children. The children are shown a film, in which smoking is depicted, in order to sensitize them to the representation of smoking in movies and advertisements. This is followed by a discussion on how such films and advertisements promote tobacco use and how the imagery misleads us. The importance of the media in creating a tobacco-free future is emphasized.
The children are shown another film in which a tobacco-user talks about his habit. He describes how he became addicted and how difficult it is for him to quit. He also talks about how he should not have succumbed to pressure from his friends and should have kept himself from picking up the habit then itself. The focus of this session is the importance of forming the right habits and being able to say no when necessary. The sessions also include role-plays.

Art, theatre and music workshops are held to encourage the children to present their views on the issue of tobacco. The children write their own scripts and songs related to harmful effects of tobacco. They also present their plays, songs and posters in various festivals to carry the message to the community.

The Foundation has set up a cricket academy where children are trained to play world-class cricket under very able coaches. To get admission to this prestigious academy, the children have to sign a declaration stating that

they do not use tobacco and will continue to avoid it. Cricket is used as a tool for character-building and to create positive tobacco-free role models among the children and their peers.

The second year (Standard IX)

In the second year of the intervention, the youngsters are made aware of the current legislation on tobacco and about the agencies implementing it. The children interact with the civic authorities, school authorities, the Food and Drug Administration Department and the police. They also conduct awareness workshops with these people. During this year, the children are encouraged to undertake work of a more practical nature than in the previous year, such as preparing a charter of demands seeking the implementation of an anti-tobacco law or appealing for a more stringent law. These practical projects are then presented to external audiences through press conferences or special programmes, such as melas, which provide the children with a platform to express their thoughts on the issue.

At the end of each year, there is a feedback and evaluation session that involves the children and teachers, besides others. Their views, ideas and reactions to the programmes are taken into consideration while planning for the next year's programmes. The worksheets, information sheets and audio-visual aids are all prepared before the academic year begins. These materials are constantly brought up to date, changed or discarded, depending on the feedback received.

Efficacy of the intervention

Many of the children who have participated in the programme continue to associate with the Foundation even after graduating, and help their juniors to create posters, songs, plays, and so on. Moreover, a good number of children have been able to prevail on their parents to give up chewing gutkha or smoking. Though there has been no formal documentation or quantification of the impact of the intervention, the anecdotal evidence is extremely encouraging.

The Salaam Bombay Foundation is in the process of carrying out studies on the children's awareness of and attitude to tobacco before and after the intervention. The study will be completed by February 2009.

Financial commitments

The cost of all of the programmes taken together works out to a broad aggregate of Rs 1000 per child per year, i.e. Rs 2.75 per day. This is less than the cost of a packet of bidis or three packets of gutkha or a single cigarette. In any case, the Salaam Bombay Foundation does not look upon its expenditure as a cost; it looks upon it as an investment in the health of our future generations.

HRIDAY: Engaging youth in tobacco control advocacy

Health Related Information Dissemination Amongst Youth (HRIDAY), a Delhi-based voluntary organization involving health professionals and social scientists, is engaged in creating awareness, undertaking advocacy campaigns and conducting research in the sphere of tobacco control. The NGO organizes health awareness programmes among the youth and promotes youth health activism throughout the country through its advocacy wing, the Student Health Action Network (SHAN).

HRIDAY is a recipient of the WHO Director General's Award for contributions to tobacco control (2002). Its programme of youth led health activism has been listed as a 'Best Practice Model' and recommended for global replication by WHO.

When HRIDAY was established in 1992, it initiated a set of programmes aimed at creating health awareness among the youth. The programmes sought to promote healthy living habits by augmenting their knowledge and altering their attitudes, and ultimately, their behaviours. The evaluation of these programmes helped to identify environmental barriers which prevented the adoption of healthy lifestyle practices, despite enhanced awareness. It was felt that several of these barriers needed to be addressed by policies that promote health, through enabling regulatory or legislative measures. Further, the members of the NGO realized that there was a need for school students, whose future health is determined by the present policies, to speak up and voice their views. The recognition of this need and the potential impact of such a movement led to the birth of SHAN in 1998.

Tobacco control is an important area of focus of the HRIDAY–SHAN advocacy campaigns, as the habit of using tobacco is initiated during youth and tobacco advertising especially influences the youth. This chapter aims to share the experiences of HRIDAY–SHAN in the sphere of advocacy for tobacco control and the influence of its activities on policy initiatives.

Campaign objectives

- To encourage and provide opportunities to the youth to actively articulate their demands for governmental policies (legislation/regulations) that are beneficial for their present and future health.
- To enhance the capacity of the youth to act as agents of change by equipping them with the requisite advocacy skills.

Advocacy with decision-makers

- **Appeal to Prime Minister:** SHAN organized debates (initially in 20 Delhi schools and later at the inter-school level) on the need for a ban on all forms of tobacco advertising and sponsorship. It subsequently conducted a signature campaign among school students. This culminated in the presentation of an appeal to the then

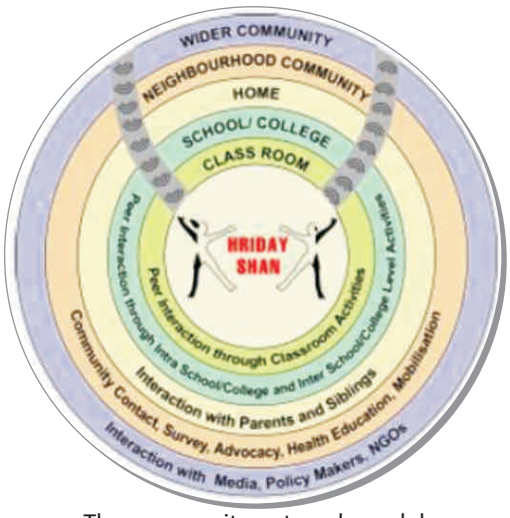
Prime Minister on 12 September 1998. The appeal was signed by 25,000 students from Delhi and its presentation to the Prime Minister marked the formal launch of SHAN. An appeal by the youth of a country is usually very difficult for political leaders to ignore, especially if it concerns the health of the youth themselves. At that time, the tobacco control movement in the nation had not really gathered momentum

Urging the Prime Minister of India to curb tobacco advertising

- **Appeal to Members of Parliament:** After writing to the Prime Minister, youth advocates sent out an appeal to all Members of Parliament (MPs), drawing their attention to the need for tobacco control. The advocates urged the MPs to initiate parliamentary debates and discussions in support of a national legislation on tobacco control.

This effort, along with other efforts by NGOs and international agencies, led to the introduction in Parliament of the Cigarette and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Bill in 2001. The Bill was tabled in the upper house of Parliament and referred to the Standing Committee for its recommendations.

HRIDAY–SHAN's youth activists decided to closely monitor the process of the Bill's reintroduction in Parliament, which was expected to take place after the Standing Committee submitted its recommendations. HRIDAY developed a detailed advocacy plan, consisting of two phases. The Phase I activities concentrated on education and mobilization of the community to make the environment conducive for the people to receive and accept the legislation. The Phase II activities focused on sensitizing policy-makers and advocating with them to support the Bill on its reintroduction in Parliament.



The community outreach model

Phase I activities

- Mobilizing the community: HRIDAY–SHAN's youth activists adopted a model of community outreach in Delhi to educate the community around their schools on the harmful effects of tobacco and the rationale for the need to regulate tobacco products. Schools thus became the portals of community health education.

- **Forming advocacy action groups:** The youth health activists of HRIDAY–SHAN in Delhi successfully mobilized the community by creating three advocacy groups: Teachers against Tobacco (TAT), Parents against Tobacco (PAT) and Students against Tobacco (SAT). These three groups support and guide the youth in their advocacy campaigns for tobacco control.

Glimpse of a community outreach programme

Phase II activities

- **Appeal to the Union Minister for Health and Family Welfare:** The Bill, together with the recommendations of the Standing Committee, was reintroduced in the upper house of Parliament in April 2003. Youth advocates from HRIDAY–SHAN, synchronizing their move with the approaching occasion of World Health Day (April 7), presented an appeal to the then Union Minister for Health and Family Welfare, reiterating their support for and commitment to ensuring early and effective implementation of the tobacco control legislation. They also expressed their gratitude to her for facilitating the reintroduction of the Bill.


Reiterating support for tobacco control policies with the Health Minister

- **Advocacy with policy-makers:** The youth activists wrote appeals to all MPs with the aim of allaying their concerns with regard to the Bill and countering the alarmist propaganda of the tobacco industry. The Bill was passed in both houses of Parliament with limited opposition in mid-May 2003.

- **Letter of felicitation to the Union Minister for Health and Family Welfare:** On the eve of World No Tobacco Day in May 2003, the youth representatives of HRIDAY–SHAN wrote a letter felicitating the Union Minister for Health and Family Welfare for having successfully steered the Tobacco Control Bill through both houses of Parliament, and for having obtained the President's assent on 18 May 2003 for the Bill to become an Act.


Youth advocates thank the President of India for approving the Indian tobacco control law

- **Meeting with the President:** Encouraged and invigorated by the fact that the President gave his assent to the Bill, a group of HRIDAY–SHAN activists called on


Youth watchdogs report violations of the law to the Health Minister

him on World No Tobacco Day in May 2003 to thank him for his decisive action. They made an appeal to the President, requesting him to share his vision of a tobacco-free India with the people of the country. They also demanded prohibition of the depiction of tobacc products in Indian films, which were being used as an attractive means of advertising and promoting tobacco products.

After COTPA

The HRIDAY–SHAN advocacy campaigns took a new turn once the Act was passed. The youth representatives prepared to take on the role of monitoring the enforcement of the legislation.

- **Sensitizing stakeholders to tobacco control policies:** Students against Tobacco conducted a needs assessment survey and found that the government had not adequately informed various stakeholders about the rules notified under the Act. The youth activists, therefore, organized awareness campaigns during April 2004 to inform the relevant stakeholders about the new rules notified under the Act before they came into force, i.e. 1 May 2004. The participating students distributed copies of the Act and rules to the managers and owners of hotels and restaurants near their schools so that they should be aware of the provisions on the prohibition of smoking in public places.

- **Reporting violations of the Act:** On World No Tobacco Day in May 2004, school and college youth activists of HRIDAY–SHAN presented to the Union Minister for Health and Family Welfare documented evidence of several ways in which the tobacco industry was flouting the regulations related to point-of-sale advertisements and the ban on advertisement of tobacco products. They sought strict enforcement of these regulations and the imposition of penalties by the government on the violators.

- **Advocacy and signature campaigns on notification of rules:** In 2004, HRIDAY–SHAN collaborated with PATH-Canada (now called HealthBridge) to organize an advocacy campaign aimed at pushing the government to notify rules related to pictorial health warnings on packages of tobacco products, as prescribed in the Act. The youth advocates presented postcards bearing suggested pictorial health warnings on tobacco-related diseases to the Union Minister of Health and Family Welfare. Appeals, signed by parents and teachers, on the importance of these health warnings for public education were presented along with the postcards. The activists also presented a plea, signed by 20,000 school students from Delhi, Lucknow, Goa and Himachal Pradesh, seeking early notification of the rules pertaining to this provision of the Act.

- **Advocacy campaigns supporting the decision to ban depiction of tobacco use in films and teleserials:** In 2005, the MOHFW decided to expand the scope of the regulations on the promotion of tobacco use to the depiction of tobacco use in films and teleserials. HRIDAY–SHAN mobilized its three advocacy groups, SAT, TAT and PAT to prepare an appeal supporting the notification. These advocacy groups conducted a signature campaign involving students, teachers and parents from Delhi and nine other cities. The signatures were compiled and presented to the MOHFW. The papers bearing the signatures were later used by the ministry's lawyers as support documents while filing a legal response to a case filed by a Bollywood director, Mr Mahesh Bhatt, challenging the legislation introduced by the ministry.

- **Advocacy for tobacco-free films:** To mark The International Day of Action announced by the Smoke-Free Movies Network in February 2005, student representatives of HRIDAY–SHAN appealed to the Central Board of Film Certification (CBFC) for a complete ban on the projection of tobacco use and brand identification of tobacco products in Indian films. The youth activists had already written to the CBFC about this issue in 2004, and had received an assurance from the chairperson that their request would be adhered to and that the CBFC would strictly discourage the glamorization of tobacco use in Indian films.

- **Advocacy for timely enforcement of health warnings:** The tobacco industry has been continuously lobbying for the delay of the enforcement of pictorial health warnings and the dilution of the warnings. In May 2007, HRIDAY organized the first nationwide NGO-led advocacy campaign on a tobacco-related issue and an appeal was submitted to the Prime Minister and other key policy-makers to put an end to the delay in enforcement. Student representatives from schools involved in the HRIDAY–SHAN advocacy programme presented an appeal to the Union Health Minister, Dr Anbumani Ramadoss, requesting him to ensure that the implementation of pictorial health warnings on tobacco products was not delayed further and the warnings were not diluted.

- **Signature campaign on global health promotion for youth:** In 2006, the global Youth for Health (Y4H) movement was launched on a vibrant note at the closing ceremony of the Global Youth Meet (GYM) on Health, an innovative health conclave. The meet, which was inaugurated by the Prime Minister of India, Dr Manmohan Singh, presented an opportunity to over 275 young health activists from 35 countries to learn from eminent global health and development experts. During the meet, a Youth for Health charter was drawn up on the basis of four days of intensive deliberations on several health-related themes, such as avoidance of tobacco and other addictions. Recognizing the grim health prospects faced by the youth today, on the occasion of United Nations Day (24 October 2007), a delegation of Y4H health advocates from India, Singapore and the US presented the Y4H charter, bearing the signatures of over 225,000 youths and adults worldwide, to the Secretary General of the United Nations, Mr Ban Ki-moon, to elicit support for health-promoting policies from various heads of state.

Global Youth Meet on Tobacco Control (GYM 2009)


Glimpses from GYM 2009, Mumbai

A two day Global Youth Meet on Tobacco Control (GYM 2009) was organized by HRIDAY in collaboration with Salaam Bombay Foundation, Healis Sekhsaria Institute for Public Health and Action Council against Tobacco – India (ACT – India) as a pre-conference to the 14th World Conference on Tobacco OR Health (WCTOH) from March 6-7, 2009. GYM 2009 provided a platform to approximately 137 international and national participants from 27 countries across the world and 7 states of India to discuss and debate issues related to tobacco control. Using a variety of interactive formats, youth delegates received leadership and advocacy skill building training at the workshop, which prepared them to actively participate in the 14th WCTOH. The conference empowered them to jointly plan youth led tobacco control advocacy activities worldwide and become agents of social change.

The aim of GYM 2009 was to encourage and empower youth with key leadership and advocacy skills, to get them actively involved in tobacco control awareness and advocacy, provide networking opportunities with a platform to discuss and debate on issues related to tobacco control and the FCTC. The two themes extensively dealt during GYM 2009 were 'promoting smoke-free environments' and 'ban on tobacco advertisement and promotion'.

As a celebrated outcome of GYM the participants from all regions of the world adopted the Youth 4 Health (Y4H) Charter 2009 that outlined the aspirations of youth for tobacco control.



HRIDAY youth activists monitoring enforcement of smoke-free laws in restaurants

The journey of HRIDAY–SHAN from 1998 to 2009 has been very rewarding for the organization and the youth activists, as their advocacy efforts have had an impact on policy developments and their role has been positively acknowledged by the media. This has strengthened the commitment of several of the youth activists to advocate for tobacco control. Further, HRIDAY–SHAN has by now grown in stature to become a global leader, which is representing India in various international fora.

Outcomes

- The HRIDAY–SHAN programme of youth-led health activism has been listed as a best practice model an recommended for global replication by WHO, which also awarded it the Director General's Award for contributions to tobacco control in 2002.
- HRIDAY–SHAN's activities have promoted a sense of ownership of advocacy of tobacco control among the student advocates involved in its campaigns. This is an important component of behavioural change and its sustainability in the long run.
- The efforts of the HRIDAY–SHAN have promoted the adoption of healthy living habits among the Indian youth, especially in the area of tobacco avoidance.

Key lessons

- It is important to identify stakeholders (e.g. the youth in this case study) who are legitimately concerned about the issue.
- The youth form a powerful group which has the potential to develop into agents of change and committed advocates.
- Advocacy campaigns should be planned keeping in mind days, dates and other things that are related to the issue of concern.
- Youth-led health activism attracts the attention of policy-makers and the media, and effectively solicits community support.

Rajasthan Cancer Foundation: Tobacco control in Jhunjhunu (2005-2007)

Background

The Rajasthan Cancer Foundation (RCF), Jaipur, aims to achieve state-wide control of cancer by working with the community at the micro-level. Between 2002 and 2004, the Foundation held sessions to spread awareness regarding effective cancer control, in coordination with over 200 organizations in 13 district cities of the state. In the course of this experience, the RCF realized that in order to to achieve its vision it would require resources that it could not possibly generate. The need for a collaborating partner was obvious. Although a few corporate organizations supported the RCF in some occasion-specific collaborative activities, there was no sustainable movement and such limited activities could not have a larger effect on the masses in the longer run.

In January 2005, the RCF began its efforts to extend advocacy of cancer control to the districts of Rajasthan along the guidelines of the National Cancer Control Programme (NCCP). The preceding year, the RCF's proposed guidelines (matrix) on cancer control had been accepted by the state government as it finalized its policy on referral guidelines for illnesses at the secondary and primary levels of health care.

The choice of district headquarters

While deciding on the nodal centre for its next level of activity, the RCF felt that the district headquarters were the logical choice, with the office of the district collector as the collaborating nodal agency. This was because the RCF's attempts to liaison with the state Medical and Health Directorate had not succeeded in making cancer control a priority over, or even equal to, other concerns, such as the control of acute and chronic infections and the reduction of maternal and child mortality. It was considered that choosing the district headquarters as the nodal centre would also provide a model that could be replicated in other districts of Rajasthan.

District Collectorate, Jhunjhunu observing WNTD 2006

According to the system that has been worked out, the district collector must be entirely committed to the goal of cancer control, must agree to take the mantle of leadership, and should involve the local government and non-government agencies, social groups, media, and so on, in the effort.

The choice of Jhunjhunu

In July 2005, Jhunjhunu became the fourth district to be involved in this process, the other three being Baran (the pilot site), Dausa and Bundi. The district collector of each of these districts was approached to appraise the needs of an effective cancer control programme in the district. This was done on the basis of statistics extrapolated from the findings of the National Cancer Registry Project (2004), an Indian Council of Medical Research (ICMR) undertaking, in collaboration with WHO, India, and the data derived from three districts of Rajasthan—Ajmer, Bikaner and Jaipur. It was suggested that the district collectors should hold a preliminary advocacy session for all the local government agencies (medical and health, police, education, social welfare, publicity and information, etc.), social groups, NGOs, media agencies, and so on. This was followed by separate empowering sessions for the local health workers, NGOs and media agencies to highlight the issues faced by the district and to present the possible solutions.

Jhunjhunu became the ideal partner for the RCF because of the response of the district collector and the fact that his office played a catalytic role in bringing together the local groups and their leaders. Another factor which significantly influenced the choice of Jhunjhunu as the partner was the possibility of garnering financial resources from the Narottam Seksaria Foundation, Mumbai, and the Seva Jyoti Foundation of the RR Murarka Foundation (Kolkata), as their patrons had their roots in Jhunjhunu.

The road to tobacco control

The need for advocacy for tobacco control became evident following some holistic steps undertaken for cancer control. Thus, it was realized that the ongoing efforts in Jhunjhunu should give priority to tobacco control to match with available resources locally.

District Collectorate, Jhunjhunu observing WNTD 2006

1. **Observance of World No Tobacco Day:** The district collectorate observed its maiden World No Tobacco Day in 2006, becoming the first district in the state to do so.

Notification on smoke-free Public places at Jhunjhunu Post Office entrance

2. **Empowerment of block-level NGOs for effective tobacco control:** The RCF collaborated with the Jhunjhunu Cancer Society (JCS) to hold empowerment sessions for the NGOs working on tobacco control in its eight blocks (sub-district units). These sessions were conducted with a special focus on developing local tobacco cessation counselling services. Many pre-sessions were held on the harmful aspects of tobacco use, development of tobacco cessation counselling service centres, enforcement of the rules of the COTPA, and working with local health professionals and the local media. The local media, which had been sensitized earlier, was also empowered through a specific session. Following the empowerment sessions, five of the eight blocks initiated regular tobacco cessation efforts, with a special focus on schools. Of these, Navalgarh block is worth mentioning since it can serve as a model for the others. Good leadership and team work are factors that have helped to advance the cause in this block. Efforts have been made to collaborate with the sub-divisional office and schools to raise community awareness and promote vigilance by the civil society so that they can help with the enforcement of the ban on the sale of tobacco products within 100 yards of educational institutions.

3. **Partnership with police for enforcement of notified rules:** To bring about the effective enforcement of the rules notified under the COTPA, a partnership has been established with the police department. This was achieved through advocacy sessions, followed by a specific session to help them quit tobacco. The sessions to help them quit were also attended by their families.

   The police were asked to focus on only one rule, i.e. the ban on the sale of tobacco products within 100 yards of educational institutions. In the first six months, they responded by registering 98 cases of infringement throughout the district. The strategy decided upon was that they should check for retail tobacco outlets while going on their routine rounds once a week. Stringent action was taken against defaulters. This included the confiscation of tobacco products and the filing of a challan, followed by the imposition of the maximum possible fine of Rs 200 for first-time offenders. Every case was reported in the local media, so that it acted as a deterrent for others.

4. **No smoking signs in public places:** As a result of the campaign, 90% of public places in the city of Jhunjhunu now display the standard notification on the ban on smoking in public places (at least two boards or wall writings measuring 60 x 30 cm, bearing the notice “No Smoking Area—Smoking Here is an Offence”). The

majority of educational institutions have declared themselves tobacco-free zones. Groups of youth from these institutions have been visiting public places, on a rotational basis, to educate tobacco users. They also hold rallies, demonstrations, plays, and so on, to raise public awareness on the tobacco-related issues. In 2006, six of these students represented Rajasthan and the RCF in the Global Youth Meet on Health (GYM 2006), an international youth health meet organized by Health Related Information Dissemination Amongst Youth (HRIDAY-SHAN) a Delhi based NGO.

5. **Jhunjhunu becomes the first smoke-free district:** The RCF proposed the concept of "Smoke-free Jhunjhunu City" to the Jhunjhunu district administration by WNTD 2007. Making Jhunjhunu smoke-free by 31 May 2007 was a task that would involve the district administration, municipal council, JCS, local organisations and the media. The RCF held sessions to advocate with all the relevant local agencies, and municipal byelaws were passed by the Municipal Corporation to facilitate the move for a smoke-free Jhunjhunu. The effort of the RCF was aided by the MOHFW, Government of India and the WHO's India office.

   Jhunjhunu was declared smoke-free by its Municipal Corporation on WNTD 2007. The State Tobacco Control Cell In-Charge presided over the function at which the declaration was made.

6. In recognition of its achievements, Jhunjhunu was recently identified as one of two state districts to run the MOHFW-aided National/District Tobacco Control Programme.

Recommendations

The RCF considers that the model developed by it is replicable in other districts countrywide if: (i) a national or state policy can identify the office of the district collectorate as the nodal government agency for the implementation of anti-tobacco laws, with the district collector as the nodal officer in charge of a district tobacco control programme; (ii) the principal collaborating agencies in the sphere of tobacco control are empowered optimally; (iii) the collaborating NGOs get the maximum and prompt support from the office of the district collector; and (iv) the local NGOs can be optimally funded (through either local or state resources) to be able to coordinate their activities with "autonomy" and sustain tobacco control activities for at least five years

Healis Sekhsaria Institute of Public Health: Mass media interventions for tobacco control

Mass media campaigns are a critical element of comprehensive tobacco control programmes. They help in creating mass awareness on the harm being caused by tobacco use, on tobacco control legislation and on the steps being taken by tobacco control advocates in the country. When targeted at specific audiences or groups of population, mass media campaigns have proven to be effective in transforming tobacco-related beliefs and attitudes. The effectiveness of such campaigns improves when they are used in conjunction with more direct contacts with the public. This chapter describes the practical steps involved in creating a mass media campaign.

Essentially, there are two ways of procuring mass media time:

a. Mass media advertising
b. Earned media

Mass media advertising can be further divided into paid advertising and free advertising. The latter is sometimes referred to as public service announcements (PSAs).

Earned media, which means news coverage, is another, and often feasible, means of securing media time. This usually has to be 'earned' by an effort to be considered newsworthy.

If one were to think of a tobacco control campaign in terms of a conversation, advertising is a more direct way of communicating than earned media. Earning media coverage through public relations (PR) is like communicating through an intermediary.

Mass media campaigns, especially in the case of tobacco control, often work best when paid advertising, PSAs, and earned media are used in conjunction.

Advertising uses simple messages along with pictures to get across major points. The pulse polio campaigns by the Central and state governments have been examples of the use of advertising for public health objectives. Some NGOs have designed simple anti-tobacco messages with pictures of tobacco products and people suffering from cancer to dissuade the masses from using tobacco. There is scope for more creative use of advertising for tobacco control.

Using public relations to earn media coverage

Public relations can be used as a means to get a message across to a wide section of the people. Effective PR results from working with the news media, opinion leaders and other existing or potential stakeholders. Since it

involves the integrated effort of several groups of individuals, media coverage generated from PR is often referred to as earned media.

In simple terms, the aim of PR is to encourage the dissemination of messages through others, most notably, the news media. The logical progression of the spadework for an effective PR campaign is as follows:

a. Planning a PR campaign
b. Targeting a specific audience
c. Targeting a suitable media outlet
d. Identifying ways to increase exposure through media outlets
e. Identifying external or existing platforms to increase media coverage

Once a PR plan has been identified and a PR firm engaged, the next crucial step involves working with the news media. The media fraternity uses various channels for coverage (print, television and radio), and also varies in terms of the information considered newsworthy. Further, the means by which the media can be persuaded to cover an event also vary.

Developing material

To get media attention, one needs to make one's message simple and the supporting items easy to find and use. The most effective way is to package material for the press in the form of a media kit. The general contents of such a kit are:

a. A media invite (an invitation to the media)
b. A media tool kit that comprises
    i. A news release
    ii. Contact details of the organization's main media liaison
    iii. Additional information
        - Printed materials/brochures
        - Press clippings of earlier media coverage
        - Biographies of key individuals, including spokespersons

Media invites are designed to persuade reporters to cover a specific story. The essential characteristics of a media invite are as follows.

a. It requires correspondence with one journalist at each publication or outlet.
b. It should be contextual.
c. It should be concise.
d. It should mention the contact details for further correspondence.
e. The key spokespersons should be listed.
f. It should seek to ensure a follow-up.

Example: A media invite was sent out before a press conference held on 17 January 2008 to discuss the delay and dilution of pictorial warnings on tobacco products to encourage media participation. The sample media invite is shown below.

~EXCLUSIVE MEDIA INVITATION~
Salaam Bombay Foundation
cordially invites media delegates to a press conference on:
"Delay and Dilution of Pictorial Warnings on Tobacco Packs"

Key highlights of the press conference:

- WHO perspective on pack warnings, with special reference to Framework Convention for Tobacco Control
- International evidence on the efficacy of pictures and size in reducing tobacco consumption
- Relevance of pack warnings for Indian population while dispelling the industry-propagated myths with scientific evidence
- Pictorial warnings In India—a conflict between economic interest and health priority?
- India—platform for the world's largest conference on tobacco in 2008, 14th World Conference for Tobacco & Health (WCTOH)

The press briefing will be addressed by:

Dr Douglas Bettcher

Director, Tobacco-Free Initiative, World Health Organization, Geneva

Dr Prakash C Gupta

Director, Research, Healis Sekhsaria Institute for Public Health, Mumbai

Dr Srinath Reddy

President, Public Health Foundation of India, Delhi

Dr Dileep Bal

Kauai District Health Officer, Hawaii

Dr Judith Mackay

World Lung Foundation

Day & Date: Thursday. January 17, 2008
Time: 12.30 pm
Venue: NCPA, West Room 1, NCPA Marg, Nariman Point, Mumbai

Please join us for lunch thereafter
Media RSVP: Contact persons from NGO and PR Agency—contact numbers, e-mail addresses.

News release: A news release (or press release) is a written or recorded announcement of something claimed as having news value, directed to assignment editors of the print media, or radio or television stations, to encourage them to develop articles or programme material.

A press release should be drafted in a language that communicates the newsworthiness of the issue immediately. There are five criteria for judging the newsworthiness of a story. A story should perform well in at least two of them. The five criteria are: timing (how recent), significance (number of people affected), proximity (geographical nearness or cultural affinity), prominence (eminent people and places) and human interest (emotion).

Press releases most often provide the foundation for a story or interview. The essential characteristics of a press release are:

a. The story, with pictures, if possible
b. The release date
c. The logo of the organization
d. Contact information (must be provided at the top of the release)

Example: A cumulative press release was issued to cover a human chain demonstration in Chennai, a walkathon in Shimla and a signature campaign in Bangalore to elicit support for the implementation of pictorial warnings. The events were held in close succession—the human chain demonstration was on 9 December 2007, and the walkathon and signature campaign were on 11 December 2007. They were timed specially to take place just before the hearing regarding pictorial warnings at the Shimla High Court, due to be held on 13 December.

Press conference: Holding a press conference is an effective way of getting information across to the media. The following should be considered while planning a press conference:

a. Choosing a location
b. Setting a date and time
c. Selecting speakers
d. Deciding pictures that would appropriately convey the intended message
e. Inviting public figures (eminent people, celebrities)

Example: On 17 January 2008, a press conference was organized to highlight the implications of the delay in the implementation and the dilution of the law requiring pictorial warnings on tobacco products. The press conference was scheduled to coincide with a planning meeting that was scheduled for 17–19 January 2008. This meeting was to be attended by several prominent representatives from international health organizations, including Dr Douglas Bettcher, Dr Judith Mackay and Dr Dileep Bal. Important national spokespersons of

considerable international acclaim, including Dr K. Srinath Reddy and Dr PC Gupta, were also invited. To elicit media interest, the organizers planned to use the human angle by inviting a patient who had lost his voice due to cancer.

Considering that the Mumbai Marathon was scheduled for 20 January 2008 and the fact that the weekend was approaching, it was decided that the press conference be scheduled for 17 January, which coincided with the first day of the planning meet. Further, the venue for the press conference was decided keeping in view the proximity of the planning meet and to ensure the maximum possible media attendance.

On 18 January 2008, a day after the press conference, this is how the event was covered in one of the leading newspapers of Mumbai, Daily News and Analysis.

Support towards pictorial tobacco warnings gains momentum
India Infoline News Service / Mumbai Dec 12, 2007 16:13

Walkathon and activities held in Shimla, Chennai and Bangalore—other cities to follo suit!

The much awaited implementation of the pictorial warnings law for all tobacco products has been postponed for the fourth time. Supporters of pictorial warnings that include YMCA, Shimla; Maharana Pratap Jan Kalyan Sansthan, Jubbal; Gramudyog Welfare Worker's Association; and Mahila Vikas Sadan, and the Advocacy Forum for Tobacco Control (AFTC) are actively demonstrating their support by means of different activities across cities.

The most recent was the Shimla Walkathon for Pictorial Warnings held on 11th December. Supporters from Healis Sekhsaria Institute for Public Health, Himachal Pradesh Voluntary Health Association (HPVHA), and other local health organizations along with hundreds of students participated in a walkathon with the common objective of reiterating their solidarity towards the government's decision.

The law, which mandates all tobacco products to carry images of cancerous tumours, supposed to be implemented from December 1, was postponed owing to various reasons cited by the tobacco manufacturers. Dr PC Gupta, Director: “Tobacco manufactures do not want to tell the truth to people because it may affect their profits. The arguments of size are specious—they can increase the pack size. If they are concerned about the plight of the workers let them provide health insurance and other benefits to the workers that they are entitled to by law.”

Shriniwas Joshi, Retd. IAS officer, said at the press conference held at Shimla after the Walkathon, “Today, 40% diseases are tobacco-related; Rs 45,000 crore are being spent annually

for the treatment of these diseases. Soft warnings do not help. Pictorial warnings will communicate these messages more effectively. Communities, including the public health organizations and the common public, have a major role in supporting such a cause and make a strong demand for its implementation."

The social organizations actively propagating the law conducted similar events in cities like Chennai and Bangalore. In Chennai, in the spirit of Human Rights Day on 9th December, hundreds of children came together to demand their right to a tobacco smoke-free environment and pictorial warnings on all tobacco products. A human chain demonstration with over 300 children and 100 adults was organized by Pasumai Thayagam, a social organization, in front of the State Guest House, Chapaulk, Chennai in order to communicate their support for immediate implementation of the current law. Similarly, a signature campaign was organized by SJ Chander, of the Institute of Public Health, Bangalore on 7th December. Students from various colleges signed the banners that read, "Save lives now! A day's delay is 2000 lives lost." The banners, with more than 10,000 signatures, were presented before the Governor of Bangalore, Rameshwar Thakur, along with a memorandum appealing to the Governor to support implementation, on 11th December by SJ Chander and representatives of various colleges. The Governor expressed his support towards the cause by signing the banner.

The concentrated efforts of the multiple organizations conducting and participating in nationwide activities are to show the support for the government's decision of implementing pictorial warnings that they believe would ultimately lead to better awareness regarding the health hazards of tobacco and reduction in tobacco usage.

In conclusion, the use of the mass media is of critical importance in raising mass awareness of the tobacco issue. A great deal of planning is required to use it effectively. A combination of paid advertising, free public service announcements and earned media coverage is the most effective. The press should be used to highlight the harm that tobacco is causing in the country, raise awareness regarding the tobacco control legislation and its implementation, and publicize the interaction between tobacco control advocates and the government, as well as their activities in the courts. Some coverage can be obtained with little cost, but a higher level of resources permits a constant engagement with the media

NOTE-India: Effective utilization of existing legislation

This chapter describes some of the legal actions taken by the NGO, NOTE-India. These include a criminal case for the violation of the COTPA involving a superstar, and legal notices to another superstar shown smoking on television and to owners of kiosks selling tobacco products for putting up culturally objectionable cigarette advertisements.

FILING A CASE IN COURT

Amitabh Bachchan

On 25 December 2005, a huge multi-coloured hoarding for the film Family, showing the film icon, Amitabh Bachchan, smoking a cigar, was put up along National Highway 17 that runs from Margao to Panaji, as one enters the village of Nuvem from Margao. The hoarding was displayed in Panaji and some other places in Goa as well. The depiction of a popular figure smoking a cigar was seen as a violation of Section 5(1) of the COTPA.

Section 5(1) of the Act states, "No person engaged in, or purported to be engaged in the production, supply or distribution of cigarettes or any other tobacco products shall advertise and no person having control over a medium shall cause to be advertised cigarettes or any other tobacco products through that medium and no person shall take part in any advertisement which directly or indirectly suggests or promotes the use or consumption of cigarettes or any other tobacco products."

The Indian public has a great deal of respect for Amitabh Bachchan. The film star is immensely popular and has campaigned effectively for many social causes, such as the eradication of polio and awareness of HIV/AIDS.

Since the display of the hoarding amounted to the promotion of smoking and constituted a violation of the COTPA, NOTE-India wrote to the collectors of South Goa and North Goa and Goa's Director General of Police on 26 and 27 December 2005, seeking immediate action against those responsible for putting it up.

When Amitabh Bachchan was recuperating from a medical problem in Goa,,NOTE-India placed a paid advertisement in the 31 December 2005 edition of the most widely circulated local English newspaper, The Navhind Times. The advertisement ran: When millions of people are praying for your speedy recovery, how can you be responsible for death and misery for the millions? You make a difference. A small copy of the hoarding was carried with this. By 1 January 2006, the hoardings were removed in Goa, but they continued to be displayed in many other states.

On 5 January 2006, Dr Shekhar Salkar, the general secretary of NOTE-India, wrote a personal letter to Amitabh Bachchan. The letter read:

You are a well-informed gentleman, Amitabh-ji, and I need not mention to you that this action of their idol would be imitated by millions of your followers, eventually pushing most of them in the jaws of cancer and a premature, early death. Unmindful of the imminent consequences, the youths would embrace this menace, just because they would want to imitate their icon. Remember, Amitabh-ji, these millions fervently prayed for a speedy recovery during your recent illness. Do you intend to preach death to them? Do you wish to support the cause which would generate thousands of widows and orphans?"

Amitabh Bachchan wrote back apologizing for his inadvertent action and naming the parties involved in the production of the promotional material for the film . Pursuant to this, on 25 January 2006, NOTE-India filed a case against Amitabh Bachchan, Keshu Ramsay, the producer of the film, his company, DMS Films Private Limited, Anchor Daewoo India and AB Corporation Limited in the court of the a class judicial magistrate, Panaji (Goa). The case was filed under the COTPA and the Goa Prohibition of Smoking and Spitting Act of 1997. On 20 November 2006, after hearing Dr Salkar and taking into account the prima facie evidence of the violation, the court ordered the issuing of a summons to Mr Bachchan and the other four respondents named in the case. The judicial magistrate asked Mr Bacchan to appear in court on 29 November 2006 in connection with the alleged violation of the anti-tobacco laws.

Use of the court

On 27 November 2006, Mr Bachchan's lawyers went to the Sessions Court and sought a stay on the issuing of summons. The stay was granted. Subsequently, NOTE-India appealed to the Bombay High Court for vacating the stay. The court said in its order that there was no need to vacate the stay but directed the lower court to dispose of the case as early as possible. On 4 April 2008, the Sessions Court cleared Amitabh Bachchan in the case,on the ground that he was not a party to the designing and displaying of the hoarding.

In the original case filed by NOTE-India in the court of the first class magistrate, the court had issued process against all the accused. All the accused, except Anchor, had challenged the issuance of process before the Sessions Court, which allowed the challenge and quashed the process against all the accused, except Anchor. This order of the Sessions Court was challenged by NOTE-India before the High Court of Mumbai by way of criminal revision. The High Court found a prima facie case against Mr Bachchan and others and admitted the same for revision.

Outcome

This case has received tremendous attention from the media, both electronic and print, in India as well as the world. This, in turn, has raised awareness of India's anti-tobacco laws. The case highlights the benefit of involving courts in the enforcement of tobacco control laws as a means of drawing media attention, especially if the violation involves a famous public figure. It also highlights the possibility of according punishment to the violators despite the fact that the legal process can be lengthy and cumbersome.

Key lessons learnt from this campaign

Filing suits in a court of law is an important strategy in health advocacy, especially in the sphere of implementation of the law.

Monitoring of the implementation of the law and initiating action against violators should become the focus of health advocacy campaigns, as this would help educate the public and caution other violators.

SENDING LEGAL NOTICES

Shahrukh Khan

The 20-twenty cricket match between India and Australia, played in the Brabourne Stadium on 20 October 2007, was broadcast by Doordarshan and other television channels. While focusing on high-profile spectators, Doordarshan and the other channels happened to telecast several images of Shahrukh Khan smoking. Similarly, in the television broadcast of the Hindustan Times Leadership Summit held on 12 and 13 October 2007, Shahrukh Khan was shown sitting on the dais with a cigarette in his hand.

These images of the much-acclaimed actor, who is imitated and adored by millions, may influence many young people to take up smoking. NOTE-India has taken a serious view of these incidents and has sent a legal notice to the actor.

Billboards at point of sale

Recently, objectionable billboards advertising the Four Square brand of cigarettes were put up at several points of sale in some parts of Goa. The billboards put the cigarettes at par with other products that characterize Goa. NOTE-India objected to the cultural insult and sent warnings of legal action to the owners of the kiosks where the billboards were displayed. The billboards were removed within 24 hours of the receipt of the notices. NOTE-India also warned the cigarette company, Godfrey Phillips Private Limited, against putting up such billboards.

Key lessons

The law can be used creatively not only to report violations, but also to raise public awareness. This can be done by filing cases on violations of the COTPA or sending legal notices where well-known celebrities or social icons are involved. Usually a celebrity is a person, but in the case of the billboards promoting cigarettes as a product characteristic of Goa, the state was the famous 'personality'. These actions attack the social acceptability of tobacco use and the tobacco industry's efforts to create such acceptance. Getting the media to report on these actions is a part of the process. Hence, it may be useful to engage the services of a public relations agency to get media coverage.

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