Chapter II

Concept, Historical Perspective and Legal Framework
CHAPTER - 2
CONCEPT, HISTORICAL PERSPECTIVE AND LEGAL FRAME WORK

This chapter attempts to give genesis of tobacco, its history, growth and tobacco control in India from 1975 onwards as it was the year when Government took first step towards the regulation of production and supply of tobacco in India. It also gives an overview of tobacco production and profitability of tobacco in India from the mid 1900s and the legal framework.

2.0. TOBACCO: MEANING AND ETYMOLOGY

Tobacco is an agricultural product processed from fresh leaves of the plant genus Nicotiana. The actual scientific name for the plant is Nicotiana tabacum. There are many species of tobacco, which are all encompassed by the plant genus Nicotiana. Every part of the plant except the seeds contains nicotine. The concentration of nicotine increases with the age of the plant. The distribution of nicotine in the mature plant has wide variation: 64% of the total nicotine exists in the leaves, 18% in the stem, 13% in the root, and 5% in the flowers. It can be consumed in the form of nicotine tartrate or used as an organic pesticide. It is also used in some medicines. The word nicotiana (as well as nicotine) was named after Jean Nicot de Villemain, French ambassador to Portugal, who in 1560 brought tobacco seeds and leaves as a "wonder drug" to the French court and sent it as a medicine to the court of Catherine de Medici (Wilbert, 1975).

It is cultivated similar to other agricultural products and is an annual crop. Seeds are sown in cold frames or hotbeds to prevent attacks from insects, and then transplanted into the fields. After harvest, tobacco is stored for curing, which allows for the slow oxidation and degradation of carotenoids. This allows for the agricultural product to take on properties that are usually attributed to the "smoothness" of the smoke. Following this, tobacco is packed into various forms for consumption which include smoking, chewing, sniffing, and so on (Kenkel & Chen,
2000). The 1988 report of the United States Surgeon General, subtitled Nicotine addiction, concluded that: “The pharmacological and behavioural processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine” (US Department of Health and Human Services, 1988). Some addiction experts have rated tobacco as worse than heroin or cocaine in producing dependency (Barwick, 1995).

2.1. ETYMOLOGY

Nicotine is a drug found in tobacco. It can be described as a recreational drug. In its pure form it is a powerful poison and stimulates the human body. There is some debate over where from the word tobacco came. Some believe it originated in Mexico in the current state of Tabasco. Others believe that it came from a Caribbean island named Tobago. The Mississippi tribes were probably the first to begin using it in North America. In 1612, the first tobacco plantation was established in Virginia and more plantations began to crop up in Maryland and other parts of the south (Levy & Friend, 2001).

The word tobacco was first mentioned (in the form tabaco) by Gonzalo Fernandez de Oviedo y Valdes (1478-1557) who used it as a term for the act of smoking and also, in his later writings, for the leaves of the plant itself. In 1586 the botanist Jaques Dalechamps gave the plant the name of Herba nicotiana, which was also adopted by Linné. It was considered a decorative plant at first, then a panacea, before it became a common snuff and tobacco plant (Laviolette & Van der Kooy, 2004).

Tobacco is certainly a stimulant and in sufficient quantities it can have hallucinogenic properties. Tobacco contains the harmala alkaloids harman and horharman and the closely related harmine and harmaline are also known hallucinogens. The levels of harman and horharman in cigarette smoke are between forty and 100 times greater than in tobacco leaf, showing that the burning of the plant generates this dramatic increase (Laviolette & Van der Kooy, 2004).
2.2. A HISTORICAL PERSPECTIVE

2.2.1 Western Scenario

It is well known that tobacco is an American plant, the use of which, when discovered by the Europeans, was rapidly spread across the globe. However, less well known is the fact that there was another region of the world in which wild tobacco not only grew but was used by humans completely independent of any American influence. That region is the arid interior or 'outback' of Australia. Records from Captain Cook's 1770 expedition indicate that the Aborigines chewed the herb which most likely had reference to tobacco (probably Nicotiana suaveolens) (Kenkel & Chen, 2000).

Before the arrival of the Europeans in the New World, tobacco use seems to have been restricted to ritual use. The toxic effects of tobacco were well understood by the shamans of South America. They believed that, whilst the human hunger is for food, the hunger of the spirits is for tobacco. Thus, by taking tobacco in its various forms, the shaman made direct and intimate contact with the spirits. The Indians of South America were not only the first to domesticate tobacco, they also discovered all the ways of using it, even some which are almost unknown in the West today. As Wilbert says, they 'chew tobacco quids, drink tobacco juice and syrup, lick tobacco paste, snuff, smoke and apply tobacco enemas (Wilbert, 1996).

Tobacco was seen by some as a medicinal plant of great value for example, in the sixteenth century a leading physician of Seville, Nicolas Monardes, reported the medicinal properties of tobacco and identified 25 ailments that tobacco could cure ranging from toothache to cancer. During this period, the European and Asian systems of medicine were based on the notion of balance. According to the European humoral system of medicine, the human body consisted of a combination of four opposing qualities, i.e. hot and cold, moist and dry. All diseases were believed to be caused due to imbalances, e.g. excess heat and excess moisture. Tobacco was attributed to have hot and dry properties and was believed to have the power to expel excess moisture from the body. The Chinese Yang Yin (hot cold) medical system also classified tobacco to be having similar medicinal properties and effects on body. Interesting accounts exist of tobacco users remaining unaffected by malaria, while
non-users succumbed to the illness in the Yuan Province. But contrary to the Chinese and European systems, the Indian system of Ayurveda, also based on the concept of hot and cold, and of balance, never formally recommended the medicinal use of tobacco. During the seventeenth century, one authority advised a pregnant woman to refrain from consuming tobacco, while another strongly recommended it as beneficial for the growth of the foetus (Sudarshan & Mishra, 1999). Tobacco was often used to avert hunger during travel and sustain long hours of work. The belief that smokeless tobacco has a protective effect on teeth and is a pain killer is widely prevalent in many parts of rural India. Thus, due to different groups ascribing special virtues to tobacco, within a short period, it developed firm roots in the socio-cultural milieu of the country. The versatility in the methods of using tobacco made it popular across the globe and enabled its use and acceptability in various socio-cultural contexts around the world (Sanghvi, 1992).

On the other hand describing the effects of tobacco use as drunkenness was widespread in Europe. John Gerard also likened its effects to opium. However, one of its most vociferous opponents was King James I of England, who attacked tobacco smoking in no uncertain terms in his pamphlet *A Counterblast to Tobacco* (1604) describing it as: ‘a custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and the blacked stinking fume thereof, nearest resembling the horrible Stygian smoke of the pit that is bottomless.’ Yet even the sovereign himself was powerless to prevent the spread of the habit and had to console himself by putting taxes on tobacco (Barwick, 1995).

Tobacco smoking was no longer an exotic custom. It had become an integral part of English social life. At the beginning of the seventeenth century it is estimated that there were 7,000 shops and other outlets where tobacco could be bought in the London area alone. Tobacco smoking had by now become such a commonplace habit throughout English society that Joverin de Rochefort, a French visitor, wrote in 1671 that in the town of Worcester children were sent to school with a pipe in their satchel. Even the most famous school in all of England was not immune to propagating the habit. A seventeenth-century English diarist by the name of Hearne wrote that during the Great Plague tobacco was considered such a medicinal boon that ‘Even children
were obliged to smoke, and Tom Rogers, who was a yeoman beadle, said that when he was a schoolboy at Eton that year when the Plague raged, all the boys of that school were obliged to smoke in the school every morning and that he was never whipped so much in his life as he was one morning for not smoking’ (Barwick, 1995).

Berthold Laufer, in 1924, sketched out the three routes by which tobacco diffused through Asia. The first route began in Mexico, from where the Spanish took tobacco (mainly in the form of cigars) to the Philippines in the sixteenth century. Via the Philippines it reached Taiwan, parts of mainland China, Korea, Burma and south India. The beginning of the seventeenth century saw the Portuguese introducing tobacco by way of the maritime routes to many parts of Asia. According to Javanese sources, tobacco had arrived in Java in 1601. By around 1605 it was known in India and eventually filtered through to the more remote tribal areas of the subcontinent, where it was to play an important role in local mythologies. Its arrival in Japan – also around 1605 – was not particularly welcome, according to an account preserved in the diary of Captain Richard Cocks. In an entry dated 7 August 1615, he describes the Emperor ordering the large-scale burning of tobacco. Nevertheless, like James I, the Emperor seems to have been powerless to stop the growth of the habit, as at the same time Kyoto craftsmen were already manufacturing smoking pipes. Interestingly, tobacco chewing did not catch on in Tibet and the Far East (Korea, China and Japan) but was keenly taken up by the Indians and south-east Asians who had long-established traditions of chewing another stimulant, namely betel. Tobacco and betel are often chewed together, a habit which is also popular in New Guinea. The third and mostly northerly route was across Siberia. When the Russians introduced tobacco into Siberia (although the influence of the Chinese use of tobacco had already entered some parts of north Asia) the local shamans were quick to see its shamanic applications and added it to their traditional practices, despite the fact that to their Russian colonizers it was a drug with no religious connotations (Reddy, 2004).

The social standing of tobacco has swung from one extreme to the other throughout European history. Often, even in recent times, smoking has been widely accepted as an innocuous or even positive pastime. During the World Wars tobacco was seen as an indispensable part of the soldier's staple diet, helping him combat the combined
assaults of cold, hunger, fear and boredom. The morale of the troops often depended on the uninterrupted supply of cigarettes to the front line. Smoking provided a solace that food simply could not (Roemer, 1999).

Medical opinion has swung the pendulum firmly (and probably permanently) back towards the negative pole. Tobacco is now seen as one of the most virulent of poisonous plants. The clear-cut liberal argument of the anti-smoking lobby, namely that it is a citizen's own private business if he or she wishes to smoke such a dangerous but licit substance, has collapsed in the wake of the discovery of the phenomenon of passive smoking, which makes the habit interfere with the rights of other citizens. Our secular society, with no recourse to such means, has sought to limit it via medical repudiation: a message that seems slowly to be getting through. Yet the genie of tobacco shows no signs of disappearing overnight in a puff of smoke. With more deaths to its name than all the illicit narcotics put together, there can be no doubt that tobacco is the most dangerous drug in the world (Roemer, 1999).

American Indians smoked tobacco in pipes long before Christopher Columbus sailed to the New World in 1492. Columbus brought some tobacco seeds back to Europe, where farmers began to grow the plant for use as a medicine that supposedly helped people relax. Commercial production of tobacco began in North America in 1612, after an English colonist named John Rolfe brought some tobacco seeds from South Carolina to Virginia. The Virginia soil and climate were excellent for tobacco, and it became an important crop there and in other parts of the South. Most of the tobacco grown in the American Colonies was exported to England until the Revolutionary War began in 1775. Manufacturers in the United States then began to produce smoking tobacco, chewing tobacco, and snuff for domestic use. Cigars were first manufactured in the United States in the early 1800s. Spaniards and some other Europeans began to smoke hand-rolled cigarettes in the 1600s, but few people in the United States used them until the 1850s. Cigarette smoking became increasingly popular after the first practical cigarette-making machine was invented in the early 1880s. Hand-rolled cigarettes achieved limited popularity in the United States between 1855 and 1885 (Wilbert, 1996).
Tobacco arrived in Africa at the beginning of the 17th century. The leaf extract was a popular pest control method up to the beginning of the 20th century. In 1851, the Belgian chemist Jean Stas was the first to prove the use of tobacco extract as a murder poison in the civilized world. The Belgian count Hippolyte Visart de Bocarmé had poisoned his brother-in-law with tobacco leaf extract in order to acquire some urgently needed money. This was the first exact proof of alkaloids in forensic medicine (Charlton & Moyer, 1991). At high doses, tobacco can become hallucinogenic; accordingly, Native Americans never used the drug recreationally. Instead, it was often consumed as an entheogen among some tribes. This was done only by experienced shamans or medicine men. It was believed that tobacco was a gift from the Creator and that the exhaled tobacco smoke was capable of carrying one's thoughts and prayers to heaven. Soon after the arrival of the Europeans, tobacco became increasingly popular as a trade item (US Department of Health and Human Services, 1992).

2.2.2 Indian Scenario

It was the Portuguese sailors, who brought tobacco to India, sometime in the 16th century. Soon they offered this 'uplifting substance' to the ruler Emperor Akbar. There was a heated debate in the court on how the king could inhale this unknown substance. The royal hakim came up with a compromise formula. The king will smoke, he ruled, only if the smoke passes through water. That was how hookka was invented (Chadda & Sengupta, 2002). By 1610, smoking had become extensive, among all socioeconomic and gender groups. Thus, tobacco was smoked by men and women, irrespective of whether they were nobles or commoners (Bhonsle et al., 1992). The addiction to nicotine grew fast and tobacco cultivation spread in India. Akbar’s son Jahangir taxed tobacco and found it to be a fabulous source of state revenue. Since then, all governments have followed Jahangir. The Indian Tobacco Board, backed by the Ministry of Commerce, actively promotes the cultivation of tobacco and provides technical and financial assistance to tobacco farmers. It also promotes the ‘development of the tobacco industry’ and undertakes ‘export promotion to sustain existing markets and explore new markets.’ Rich and varied Indian geographic and agro-climatic conditions foster consistent availability of wide range of products.
tobacco for export all through the year. Indian tobacco, by virtue of its qualities, sheer volumes and diversity, is progressing gracefully to occupy its rightful place in the world tobacco market (Chadda & Sengupta, 2002).

2.3. GROWTH OF TOBACCO INDUSTRIES IN INDIA

Tobacco occupies a prime place in the Indian economy on account of its considerable contribution to the agricultural, industrial and export sectors. India is the second largest tobacco producing country in the world after China. According to the Tobacco Board of India, the country is the sixth largest exporter in the world. The production of tobacco leaf and tobacco products has been increasing over several decades in India. Out of the total tobacco produced in the country, around 48% is in the form of chewing tobacco, 38% as beedis, and only 14% as cigarettes. Thus Beedis, snuff and chewing tobacco (such as gutka, khaini and zarda) form the bulk (86%) of India's total tobacco production. India ranks 14th in the world for manufacturing cigarettes and taking beedi into account India rises to second place after China. Today 10 per cent of the excise revenues and 2 per cent of the government of India's total revenues come from 660 million kilograms of tobacco produced in the country (WHO, 2009).

Tobacco products include home-made and vendor-made products as well as cottage industry (beedi) and industrial products (cigarettes and some beedi). The first Indian cigarette factory was established in 1906, by the Imperial Tobacco Company. Later, Phillip Morris also entered India and several smaller Indian cigarette companies emerged. The Profitability of Tobacco as a cash crop can be the most remunerative, even compared to groundnut, black gram and cotton. Tobacco is a single season crop with a short growing season, allowing farmers to grow other crops during the rest of the year. Tobacco can be grown along with other crops by intercropping and is often grown on a portion of a cultivator’s land. However, the families of tobacco farmers often pay a high price for cultivating tobacco, as it is labour intensive more than any other crop – children drop out from school and mothers neglect their homes because, as described by the farmers, the care required to be given to tobacco during the curing process is like the care being given to a patient in an intensive care unit. Additionally, every tobacco season, workers fall ill during the processing period with an occupational illness known as ‘green tobacco sickness’ and spend money on
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healthcare therefore families are reluctant to continue taking responsibility of tobacco production (Chadda & Sengupta, 2002).

The formal manufacture of beedi in India began in the late 1880s and by 1930 the beedi industry had spread across the country (Chauhan, 2001). Beedi industrialists earn fabulous profits (nearly 25% of the cost), have a net worth of between Rs. 50-100 crore and have strong political clout and have occupied posts of MP and MLA. Some have contributed to philanthropic causes. The money-fed beedi lobby in Madhya Pradesh was once strong enough to prevent entry of any large industry into the area in order to perpetuate the dependence of the region’s poor on beedi making. Now with competition from mini-cigarettes, the beedi industry is declining (Sanghvi, 1992).

The gutkka industry in India has grown from small beginnings twenty years ago to a multi-billion rupee industry with nearly 375 brands, of which, nearly 100 of them are located in Mumbai. One of the largest, the Manikchand Group of industries, began producing gutkka and pan masala in 1991. In an interview (for rediff.com) its Chairman, R.M. Dhariwal, of Pune, estimated that the total industry-wide sale of gutkka, including exports was around Rs.50 billion a year before the ban. Another major player in the gutkka industry is Kothari Products, Ltd., whose net worth doubled between September, 1997 and March, 2001. In the 18-month period ending March, 2000, the pan masala division contributed 96.3% of the total revenue while the packaging division contributed 3.3% of the total revenue of Rs. 3.2 billion and its other products, like zarda, 15 spices, oils, etc., contributed 0.4% of total revenues during the year. The company exports Pan Parag to USA, Australia, Middle East, Europe and other parts of the world. Clearly tobacco has been a major revenue earner for Government of India (Chadda & Sengupta, 2002).

India has witnessed an unexpected increase in its tobacco exports, which had escalated by 55% to reach at $169 million in the first quarter of 2008/09. Many big companies all around the world are showing their interest in purchasing tobacco at higher quantities from India and thanks to which the country’s 2008-09 exports touched the mark of $600 million, which is 19% more than from $503 million of previous year. The biggest player in India tobacco industry is Indian Tobacco
Company (ITC) with a market share of 72%. Although it has been said that cigarette smoking is injurious to health but still, there is an increase in the profit margin of the Indian Tobacco Company. With its wide range of invaluable cigarette brands, it leads from the front in every segment of the market. It's highly popular and highly consumed list of brands include Insignia, India Kings, Classic, Gold Flake, Silk Cut, Navy Cut, Scissors, Capstan, Berkeley, Bristol and Flake. Today India is exporting tobacco to 80 nations in the world. At present the Indian Tobacco Industry is providing livelihood to more than 25 million people in the country. From the total tobacco items exported from India, the unmanufactured tobacco shares around 80% to 85% of the total exports while the manufactured tobacco products hold around nearly 20 to 25 percent (WHO, 2009).

2.3.1 Latest Developments

- India is the second-largest producer of tobacco after China in the World.
- Cigarettes account for 85% of the country’s total tobacco exports.
- Of the total tobacco produced in the country, around 48.5% is consumed in the form of chewing tobacco, 38% as beedis, and 14% as cigarettes.
- The per capita consumption of cigarettes in India is a tenth of the world average.
- In the recent past consumption of tobacco has been reduced by anti-tobacco drives and the ban of consumption in public areas.
- The biggest player in this industry is Indian Tobacco Company with a market share of 72%.

2.4 TOBACCO CONTROL IN INDIA: POLICIES AND LEGISLATIVE PROVISIONS

Tobacco control refers to policy measures as well as preventive measures and strategies for cessation of tobacco use. This section begins with a listing of tobacco control policies emerging since 1975, and proceeds with a description of their development. Efforts are made to briefly describe existing policies made at the Union
and the State level, the preventive measures taken and the strategies adopted for cessation of tobacco use.

2.4.1 Policies

The chief goal of tobacco control policies is to reduce damage to societies. The World Bank has had a formal policy, since 1991, of not lending for tobacco production and of encouraging tobacco control. Evidence shows that countries which undertake concerted and comprehensive actions to address tobacco control can bring about significant reductions in tobacco-related harm. It is important to consider the best mix of specific interventions required. In a broad policy framework, the mix will vary according to each country’s political, social, cultural and economic reality (Sinha, 2004).

Over the past three decades, as the quantity and quality of information about the health consequences of exposure to passive smoking has increased, many governments, especially in high-income countries, have enacted legislation restricting smoking in a variety of public places and private worksites. In addition, increased awareness of the consequences of passive smoke exposure, particularly to children, has led many workplaces and households to adopt voluntary restrictions on smoking. Although the intent of those restrictions is to reduce ‘nonsmokers’ exposure to passive tobacco smoke, the policies also reduce ‘smokers’ opportunities to smoke. Additional reductions in smoking, especially among the youth, will result from changes in the social norms that are introduced by adopting these policies (U.S. DHHS 1994). These restrictions reduce both the prevalence of smoking and cigarette consumption among current smokers. Smoking bans in workplaces generally reduce the quantity of cigarettes smoked by 5 to 25 percent and reduce prevalence rates by up to 20 percent (Levy & Friend, 2001).

However, the question often raised is that when individuals ‘freely’ choose to consume tobacco in-spite of most of them knowing about the risks then why should the governments discourage smoking? The answer is that most smokers start when they are children or adolescents – when they have incomplete information about the risks of tobacco and its addictive nature. By the time they realize and try to stop many
are addicted. Therefore, governments need to adopt policies to correct these information and addiction problems. Furthermore, governments are right in restricting smokers from exposing other people to the risks and nuisance of passive smoking. Thus many factors have cumulatively contributed to the emergence of this national consensus on tobacco control. These include: increasing awareness of health, environmental and developmental damages caused by tobacco; growing global support for tobacco control; catalytic role played by World Health Organization in developing policies and programmes for effective action; vigorous advocacy by civil society groups in India; and decisive interventions by the Indian judiciary (Tobacco Control in India, 2004).

The fact that Indian government took an active and progressive lead in the negotiations of the Framework Convention on Tobacco Control (FCTC) (which concluded in March 2003), and was one of the first eight countries in the world to ratify the treaty was because of the advocacy by non-governmental organisations (NGOs) that have been helpful in preparing the climate for tobacco control, through both community mobilization and advocacy with policy makers and media. This climate also helped in eliciting judicial intervention (e.g. ban on smoking in public places in 1990) (Reddy, 2002). Tobacco control policies have been built by government opinion makers and input from NGOs, based on results from surveys conducted by various medical institutes, epidemiologists and anti tobacco groups. Public interest litigations (PILs) have also been a major input (Kaur & Jain, 2011).

Policy-making and legislations, in India, are made by the Union and the State governments. Tobacco control policy and programmes are the concern of many ministries and state departments and these are: Ministry of Health and Family Welfare, Ministry of Information and Broadcasting, Ministry of Environment, Home Ministry, Ministry of Labour, Ministry of Industry, Ministry of Excise and the Food and Drug Administration which need to work in coordination. Current tobacco control policy at Union level is in the form of Acts, Taxation, and Amendments to Acts, Executive Orders, Codes of Conduct, Judicial Orders and Recommendations.
2.4.2 Legislative Provisions

The Indian Constitution in Article 47 states that “State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and drugs which are injurious to health”. Accordingly, a number of Acts and Ordinances have been enacted and enforced over the years. A number of States also have laws to control tobacco use and protect the rights of the non-smokers. However, the tobacco problem presents a peculiar complexity as it is produced, exported and consumed. The Indian government has since the beginning included controlling and regulating of tobacco as a policy initiative with the Tobacco control legislation which dates back to 1975. Realizing the extent and magnitude of tobacco-related health problems in the country, the Union Government, took the first step by promulgating the Cigarettes (Regulation of Production, Supply and Distribution) Act, 1975. This Act required the display of statutory health warnings on advertisements, cartons, and cigarette packages. The language, style, and type of lettering, and the manner of presentation of the warning were meticulously described. The Act also contained specific restrictions for trading and commercialization practices regarding the production, supply, and distribution of tobacco. The Act set penalties, including the confiscation of tobacco in the event of its provisions being breached. However, the Act had major limitations as it did not include non-cigarette tobacco products, such as beedis, gutkha, cigars, and cheroots. The Act also supported and favoured tobacco production and trade because tobacco was considered a major source of public-revenue.

It was for the first time in 1990 that the scope of the Prevention of Food Adulteration Act, 1954 was expanded to cover chewing tobacco and pan masala. It mandated the tobacco industry to put the statutory warning “chewing of tobacco is injurious to health”, and “Chewing of pan masala may be injurious to health”, respectively on chewing tobacco products. Every package of areca nut is to carry the warning “Chewing of supari is injurious to health”. In 1992, an amendment to the Drugs and Cosmetics Act, 1940 barred manufacturers from using tobacco as one of the ingredients in toothpaste and toothpowder.
The Cable Television Networks (Regulation) Act, 1995 (replaced in 2000 by an amended Act) prohibits advertisements directly or indirectly promoting the production, sale or consumption of cigarettes, tobacco products (or alcoholic beverages, infant milk substitute, infant food or feeding bottles), etc.

The Ministry of Railways in 1999 banned sale of cigarettes and beedis on railway platforms and inside the trains. The blanket ban took effect immediately and is applicable countrywide. In 2001 the Ministry imposed ban on sale of guttka at railway stations, concourses, inside the trains, and reservation centers. Persons caught smoking on railways premises, including railway property, office buildings or railways production units can be prosecuted under the Indian Railways Act, 1989 and fined Rs 100.

In 1995 the Ministry of Health and Family Welfare submitted the first draft on comprehensive tobacco control legislation to the Parliament. The key issues were to: (1) Prohibit advertising and promotion of all tobacco products; (2) Place restrictions on smoking in certain specified public places and (3) Make printing of nicotine and tar content on the packs a mandatory requirement. This bill was withdrawn for various inadequacies and a new Tobacco Control Bill was introduced in Parliament on 7th March, 2001 which was subsequently passed. The Act ‘The Cigarettes and Other Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) (COTPA) Act, 2003’, an amended version of the draft Bill of 2001, completed its passage through Parliament on 30th April, 2003 and was assented to by the President of India on May 18, 2003. This Act applies directly to the whole of India, to all types of tobacco products and primarily involves demand-reduction strategies geared to prevent new entrants to tobacco use. It does not contain any provisions directly regulating tobacco production nor does it ban the sale of any tobacco product, except to minors. The Act aims to protect public health by prohibiting smoking in public places; restricting production, supply and distribution of cigarettes and other tobacco products; ban on direct and indirect advertising of tobacco products and sponsorship of tobacco products; regulating the packaging and labeling of tobacco products and banning the sale of tobacco products to minors below the age of eighteen years within a radius of 100 yards of any educational
institution; prescribing strong health warnings including pictorial depiction on tobacco products and regulating tar and nicotine contents of tobacco products. The Act also provides for entry and search for products (without proper warnings); power to add any tobacco products to the Schedule and punishments for offences.

The Ministry of Health has followed up its commitment of tobacco control by dedicating funds for the states to use them for educational and cessation programmes through the Rural Health Mission. In 2003, the central and state governments acted in a number of areas of concern to strengthen the legislative provisions for tobacco control. These include better quantification of health risks posed by tobacco, increasing knowledge of diseases linked to tobacco use, increased global awareness regarding the harmful effects of tobacco, and increased scientific evidence of tobacco as a cause of mortality.

The Smoke Free Rules (Section 4 of the COTPA) came into effect, prohibiting smoking in all public and work places from October 2, 2008. As a result, public places like offices, airports, hospitals, shopping malls, cinema halls, banks, hotels, restaurants and bars, public transports, educational institutions and libraries are now smoke free across India.

It is unfortunate that since Feb 1, 2007 pictorial warnings in India have been diluted thrice and delayed over half a dozen times. Strong, effective, evidence-based warnings notified by government on Sep 29, 2007 were rejected via a GOM decision and substituted by a set of three images that are softer and un-tested. It remains to be seen how effective pack warnings will prove to be in India. On the whole, it is expected that warnings on tobacco packages will enable the public, including the less literate and vulnerable, like women and children to be informed of the hazards of tobacco use (Tobacco Control in India). It was on May 6, 2009 when the Supreme Court issued an order that pictorial health warnings will be implemented on all tobacco products that pictorial warnings on all tobacco products as specified under Section 7, 8, 9 of the COTPA have become mandatory from 31 May 2009.
Judicial interventions through litigation were initiated by some Non-government organisations (NGO) and individuals also. NGO’s have taken interest in advocacy, initiatives for a smoke-free society, support for the Framework Convention on Tobacco Control (FCTC), research and promotion of alternative crops, alternative uses of tobacco, community interventions, and motivation for cessation. A cessation initiative by one of the private sector companies (Alkalis and Allied Chemicals Ltd.) is one of the most encouraging role models for cessation of tobacco in India. NGOs were successful in community intervention through their innovative models, such as, Youth Parliament Model and communication strategies for rural populations and a tobacco behaviour modification model. Certain NGOs played a key role in following up the process of development of these regulations.

Thus, the latest initiatives taken up by the government are:

- The Ministry of Health and Family Welfare launched the pilot National Tobacco Control Programme in 2007 in 9 states of the country covering 18 districts. In 2008, it was extended to 42 districts across 21 states. It includes setting up of state tobacco control cells, district tobacco control programme, sensitization of stakeholders, training and capacity building of enforcement officials, cessation centers at district levels, establishment of tobacco product testing labs, school health and awareness programmes, development of IEC materials and launching an IEC/media campaign, setting up of National Regulatory Authority (NRA), monitoring and implementation of tobacco control laws, research and training, Adult Tobacco Survey (ATS), national level mass awareness campaigns, etc.

- Most recently, all public and workplaces have been declared smoke free following the rules which came into effect from 2 October 2008. In addition, pictorial health warnings have become mandatory on all tobacco products from 31st May 2009.

- The Ministry of Health and Family Welfare and Ministry of Labour have initiated pilot programmes on alternate cropping and skill-based vocational training of beedi workers to take up alternate livelihoods, in several settings across the country. In addition, other initiatives on tobacco product regulation, surveillance, and monitoring of violations have been taken up at national and state levels.
• The WHO is sponsoring tobacco cessation programs in 12 centres in India, where pharmaceutical aids to tobacco cessation are being made available along with counselling and other therapies. A special feature of this program is the inclusion of smokeless tobacco cessation (apart from smoking), which is a very new topic in tobacco control.

• The Union Government has taken some initiatives in public education. Among them, the National Cancer Control Programme and Radio Dates, 1999, are important ones.

India has outlined an ambitious tobacco control agenda, but will need a substantial group of well-trained professionals for its implementation. Multiple training approaches will be needed to deliver the information to the diverse audiences in a timely manner. Experience throughout the world has shown that tobacco control laws can be difficult to enforce, even with adequate preparedness on the part of the enforcement agencies and civil society groups. Ideally, tobacco control legislation is self-enforcing based on widespread compliance by a population that understands the dangers of tobacco use and the benefits of control. Without greater knowledge about the harms of tobacco use, the majority of Indians are likely to ignore the public policy directives aimed at protecting them from the harms of tobacco and perpetuate existing norms that do not de-normalize tobacco use (Jonathan, Samet & Heather, 2009).

2.4.4. State Efforts

Tobacco control is a comprehensive program relying on the collaborative efforts of both the Central Government and the states. In addition to the central government initiatives some states have also formulated independent legislations to address specific components of tobacco control strategy as outlined below:

The Delhi government was the first to impose a ban on smoking in public places, with the Delhi Prohibition of Smoking and Nonsmokers Health Protection Act, 1996. In addition to prohibiting the sale of cigarettes to minors and prohibiting sale within 100 meters from a school building, this law entrusted the enforcement in public places and public transport to police and medical professionals. A first time offender is fined 100
rupees (US$2.40) on the spot and briefed by the police or medical officer about the law and the negative health consequences of tobacco use. As expected, it has been difficult to enforce this ambitious program, and it has probably had little real impact. The key problem has been lack of manpower to enforce the law.

The Goa and the Delhi Prohibition of Smoking & Spitting Act, 1997 prohibits smoking or spitting in public places; prohibits tobacco advertising; the sale of tobacco products to minors; and prohibits the sale or distribution of tobacco products within 100 meters of educational institutions. In Goa, additionally, this Act makes it mandatory for a "No Smoking/Spitting" board to be prominently displayed at all places of public work. The Goa Act also bans tobacco advertising in the form of writing instruments, stickers, symbols, color logos, trademarks, and prohibits display on T-shirts, shoes, sportswear, caps, carry bags, and telephone booths.

In 1999 the Kerala High Court's judgment and The Kerala Prohibition of Smoking and Protection of Non-Smokers Health Bill, 2002, prohibited smoking in public places, including parks and highways. Smoking in public places is also banned by law in the states of Maharashtra, Andhra Pradesh, Himachal Pradesh, Tamil Nadu, Meghalaya, Jammu and Kashmir, Assam, Rajasthan and Sikkim.

The state of Tamil Nadu had undertaken notable anti-tobacco activities even before the Cigarettes and Other Tobacco Products Act, 2003 was passed. It banned the sale of all forms of chewable tobacco. Following this, the Tamil Nadu Prohibition of Smoking and Spitting Act, 2002, was introduced. The Act had provisions for display of warnings as stated: "Every person in charge of a place of Public work or use shall display and exhibit a board at a conspicuous place in or outside the place prominently stating that the place is a 'No Smoking and No Spitting place' and that 'Smoking or Spitting is an Offence' which shall be displayed both in Tamil and English language and the version in English shall be in the second place below the Tamil version." Further, the Act has provisions for inspections and subsequent actions. "Any authorized officer may enter and inspect at any time if he has reason to believe that any person is in possession of Cigarettes, Beedis, Cigars, Supari with tobacco, Zarda, Snuff or any other smoking or chewing substance or substances for sale or distribution in any premises, which is within an area of 100 meters
around any College, School or any other educational institutions and may search and seize the articles or other substances as per a seizure list specified in Form A." The state has shown great concern for the welfare and well-being of beedi making workers by making provisions for the social security, health insurance and other schemes. The same has been supported by the Central Government through the Ministry of Labour and Employment in the "The Beedi Workers Welfare Fund Act (1976)." The Government has also introduced a number of housing schemes for beedi workers. Ban on the use of smokeless forms of tobacco, such as gutkha and pan masala was also introduced in the states of Andhra Pradesh, Goa, Maharashtra, Kerala, Uttar Pradesh, Madhya Pradesh, Gujarat and Bihar.

2.4.5 Programme Initiatives

The National Tobacco Control Program (NTCP) was launched in the country in 2007 with the following goals:

- Eliminate exposure to environmental tobacco smoke
- Promote quitting tobacco consumption among adults and youth
- Prevent initiation of tobacco among youth
- Identify and eliminate disparities among population groups

The four components of NTCP are:

- Population-based community interventions
- Counter-marketing
- Program policy/regulation
- Surveillance and evaluation

The NTCP framework has been categorized by the Ministry of Health & Family Welfare, Govt. of India into two phases: Pilot Phase-I and Phase-II.

Phase-I was for the years of 2007-08

It was proposed to develop strategies for formulating the National Programme on Tobacco Control as per Govt. of India and WHO Guidelines. Following are the specific steps for implementing.
(1) **State Tobacco Control Cell** - The State Unit is manned by 1 Consultant, 1 Program Assistant, 1 Data Entry Operator supported by a Programme Assistant to build the capacity of the state in effective enforcement of the Anti – tobacco Act and also to coordinate with the district tobacco control programme.

(2) **District Tobacco Control Cell (DTCC)** would implement anti-tobacco laws; create public awareness against ill-effects of tobacco use; conduct school programmes, effective monitoring/ enforcement of anti-tobacco provisions and provide support to tobacco cessation. The personnel for implementing the programme are: 1 Psychologist and 1 Social Worker, engaged on contractual basis selected by the State Unit to carry out the tobacco control activities. Further DTCC will establish and conduct the following:

(i) **Tobacco Cessation Centre** (TCC). These centres will provide counselling and pharmacotherapy to tobacco Users for quitting tobacco addiction besides developing community outreach programmes and training and awareness programme at schools and colleges.

(ii) **Conduct training and capacity building**: Training workshops on tobacco control will be conducted by identified GOI institutions/TCC on tobacco epidemic, tobacco control laws and implementation of the same for School Teachers, Health Workers, Law Enforces, Women Self Help Group, other civil society organization, etc.

(iii) **IEC/ BCC/ Mass media campaign**: The IEC strategies for the year 2011-2012 focus more on making the communication strategies more comprehensive. While the mainstream media from Viz. print, Electronic and radio are included to cater to the general masses, there are new strategies proposed to reach out more effectively to the masses residing in remote areas. State and District level campaigns would be carried out through street corner shows, exhibitions, *mela*, etc. in regional language. Awareness programs on tobacco control proposed to be carried out by the women SHG/NGO in Community, villages, slums, etc. IEC materials will be developed and disseminated in local languages.

(iv) **School health programme**: The school programme is aimed at creating awareness among the school children who will also become the ambassadors for the cause. In the second phase of pilot project at least 50 Government School...
per district per year, would be taken under the coverage of School Programme @Rs.8000/-per school as expected expenditure.

(v) **Monitoring of Tobacco Control Laws:** Effective Monitoring and Evaluation of implementation of the anti-tobacco laws and public awareness against ill-effects of tobacco use. A small team of trained personnel at every level is formed with a view to ensuring implementation of laws to ban smoking in public places and ban on sale of tobacco products to minors. Small teams of trained school teachers, health workers, law enforcers, women SHG, and other civil society organizations would be formed to cover small areas of each district. These groups with local NGOs would report violations for ensuring proper implementation of tobacco control law.

**Phase II for the year 2011-12**

In the second phase Morigaon district and additional 10 districts are proposed to be adopted as pilot districts under NRHM innovative program. The NTCP Plan of Action for the year 2011-12 are:

1. Ensure that the government notify Enforcement agencies and Gazetted Officers as Enforcement Squad as well as mechanism for conducting raids in public places/public transport for violating Tobacco Control Act and ejection of violators of this Act from the public places and imposing penalty.

2. Convergence into all health programmes/ vertical programmes of State Health Society

3. Integrating tobacco control elements into relevant related programmes of Education, Transport, Excise and Customs, Tourism, Labour, etc.

4. Information, Education and Communication (IEC) material to be developed in all forms - print, audio, audio-visual, electronic media, theatre, etc.

5. Training to be imparted to – health professional, teachers, media personnel, police, law enforcers and other stake holders.

6. School programme – sensitization - addressing teachers and students to create a tobacco free environment.
(7) Constant monitoring and implementation of Rules of the Tobacco Control Act.

(8) All District Administrators should order ban on smoking in public places and sale of tobacco products near educational institutions.

(9) Create environment for tobacco control activities and cessation of tobacco use.

(10) Declaration of several tobacco free educational institutions.

(11) Mass scale awareness among all levels on tobacco boycott, ban and cessation.

(12) Mechanism for fining violators to be established.

2.5 CONCLUSION

The general weakness of almost all the organizations is with regard to action, whether it is legal action or mass-based action on the streets. There is poor networking amongst anti-tobacco groups and lack of funds for anti-tobacco activities including counter-advertising. Non-government institutions need to develop expertise in research, planning, designing and implementing of need-based interventions, fund raising and in working with all those sectors needing activation for effective tobacco control (Dhirendra et al., 2004). More and more NGO’s should be involved in tobacco control programme as NGO’s have expertise in advocacy, judicial intervention, youth intervention, community intervention, consumer movement, in developing material for advocacy and in media advocacy. But unfortunately, in India, only a few NGO’s are involved in tobacco control programme. There is need to enhance the involvement of more NGO’s.

It is imperative to impose a ban on oral tobacco products, strengthen enforcement of existing regulations, establish coordinating mechanisms at the levels of center and state and mobilize people to combat the problem. Taxes on tobacco products should be raised and the generated revenue could be spent for strengthening of the tobacco control program. Multipronged approaches should be undertaken for the cessation of use of tobacco. Under the Ministry of Health there is an active Anti-tobacco Cell which has been putting lot of efforts for tobacco control. Since other ministries do not have anti-tobacco cells, such cell should be started in other ministries also. There is need to have joint coordination mechanisms between the Ministries of Health,
Agriculture, Labour, Commerce, Finance as well as Information & Broadcasting for sustainable and definitive results on the tobacco control front in the long run.

India needs to adopt a more holistic and coercive approach to fight the problem of tobacco. Not only the government, but all responsible citizens will need to support the fight against this global epidemic.
2.6 REFERENCES


