CHAPTER – II

REVIEW OF LITERATURE
2.1. Definitions Related to Tobacco Use

The World Health Organization (WHO, 2005) reported that tobacco use is responsible for about 5 million deaths per year worldwide. Furthermore, half of the people who smoke today will die prematurely. Smoking is the single most preventable cause of illness and death in our society and is responsible for almost half a million deaths due to cancer, heart disease, stroke, complications of pregnancy, and respiratory illness (Centers for Disease Control and Prevention [CDC], 2002a, 2002b, 2005b; U.S. Department of Health and Human Services [USDHHS], 2004). Because abstaining from smoking is the single most important preventive health behavior African American women can engage in to significantly reduce their chances of morbidity and premature mortality related to these illnesses (USDHHS, 2000).

The word ‘tobacco’ itself is a plant which contains many toxins and is harmful to humans. It is manufactured in various forms and it can be taken by anyone. Tobacco once taken usually leads to dependency and addiction due to the nicotine and other chemicals present both in the raw and processed tobacco. The use of tobacco is harmful because it contains toxins which have affected the health of the body. According to the World Health Organization, ‘health’ means well-being, sound body and sound mind, not the mere absence of disease or infirmity. ‘Positive health’ includes all the physical, psychological, cultural, social, environment and political conditions.

Nicotine is the ingredient in tobacco that cause changes to the brain and behavior. Tobacco, a broad leafed plant that originated in the Americas is one of the most widely abuse psychoactive or mind altering substance. When it enters the blood stream, either through the lungs, the skin inside the mouth, or the nasal passages, it
moves to the brain. Nicotine causes two sensations: stimulation in the thought process, and general relaxation in the users. It also enhances memory and promotes a feeling of well being. In other words, it stimulates the brain’s reward system and making the users feel good.

‘Dependency’ refers to a condition in which the body requires it or is dependant at certain level for the functioning of the system. **Nicotine dependency** /**Nicotine exposure** is similar in smokeless tobacco users and smokers, often leading to strong physical dependence. As a rule, smokeless tobacco products contain high levels of nitrosamines with carcinogenic potency in experimental animals. Therefore, **tobacco dependence (TD)** is a complex disorder resulting from the interplay of multiple factors beyond cigarette consumption. According to the nicotine sensitivity model, TD is strongly related to individual sensitivity to nicotine. However, current knowledge of risk factors for the onset and maintenance of TD as well as of indicators of increased susceptibility to the effects of tobacco and, in particular, nicotine is lacking, and the etiologic contribution of possible risk factors has not been accurately quantified.

‘Addiction’ is deeper than dependency. In addition, the person and cannot live or stay without it and also the body is ruined by it. In addition, it is like a disease which often may appear after many years of abstinence.

The word ‘addiction’ has been used to describe two very different phenomena, with very different clinical significance and applicability. However, the extent of this dichotomy between psychological and neurobiological views has received scant attention. Partly this is because for some there is no dichotomy – the
mind is seen as simply the result of functions of the rain, as expressed in the maxim: ‘the mind is what the brain does’ (Waldrop, 1992).

The assessment for tobacco dependence is based on the six criteria given in the International Classification of Diseases, 10th revision known as ICD 10 which includes a strong desire or sense of compulsion to take tobacco, difficulties in controlling tobacco taking behavior in terms of its onset, termination, or levels of use, a physiological withdrawal state when tobacco use has ceased or been reduced, the characteristic withdrawal syndrome for tobacco, or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms, evidence of tolerance, such that increased doses of tobacco are required in order to achieve effects originally produced by lower doses; progressive neglect of alternative pleasure or interests because of tobacco use, increased amount of time necessary to obtain or take the substance or to recover from its effects, progressive neglect of alternative pleasure or interests because of tobacco use, increased amount of time necessary to obtain or take the substance or to recover from its effects and persisting with tobacco use despite clear evidence of overtly harmful consequences, such as depressive mood states consequent to periods of heavy substance use, or drug related impairment of cognitive functioning.

The DSM-IV section on ‘Substance-related Disorders’ explains addiction in terms of the presence or absence of physical dependency, of common clinical signs such as unsuccessfully attempting to decrease use, and of effects (not causes) of addiction such as loss of usual social functioning. Neither psychological nor current neurological views factoring in the aetiology of addiction are considered. The significance of physical dependency as a measure of severity which is a major
difference between ‘Dependence’ and ‘Abuse’ is also unwarranted, since physical
dependency can be present only with certain drugs whose use, or not, does not bear on
the diagnosis or the severity of addiction. It is possible to destroy one’s life by use of
hallucinogens that cannot produce physical dependency and to function quite well
with regular use of a benzodiazepine that rapidly induces physical dependence.

Therefore, addiction has been used to describe very different phenomena,
resulting in views of its cause and nature that are also very different. Nearly all
instances of addiction can be shown to be a psychologically based compulsion in the
same group with other psychological compulsions. The unity of these behaviors is
indicated by the fact that they can substitute for each other, and may even be replaced
by other kinds of purely psychological symptomatology such as psychologically-
induced forgetting. Hence, psychological findings, explain addictive activity that is
planned, anticipated, delayed, and intended (not impulsive) although not necessarily
wanted. And such psychologically-based compulsive behaviors are the result of
higher functions of the mind such as emotional defenses, including the ability to
displace actions to substitute activities (which are then called addictions or
compulsions), and the presence of a conscience and the capacity for internal conflict
which leads to inhibition of direct action, thereby requiring a displacement. Finally,
tobacco use or consumption is a nicotine addiction and understanding of tobacco use
as an addiction is based on the psychological compulsive behavior involving
recognition of the pattern, understanding the forms of helplessness, and undoing the
displacement to take actions that are a more direct (and appropriate) expression of the
need to reassert power.
‘Tobacco use’ or ‘tobacco consumption’ means taking of tobacco in any form such as smoking, chewing, and pasting etc. of any types and any kind whether it is local, indigenous or manufactured. The frequency of tobacco use may be varied.

Nicotine is a psychoactive drug that triggers the brain and throughout the body that can, in turn, act in concert to reinforce tobacco use (Markou and Henningfield 2003). While, only a short-term exposure to nicotine has been shown to induce long-lasting changes of the excitatory input into the brain’s reward system, which may be an important early step in the path to addiction (Lavallette and van der Kooy 2004). An individual differs greatly in his or her sensitivity to nicotine dependence; evidence suggests that most adults are susceptible to the biological effects of nicotine and tobacco (Picciotto 2003).

Nicotine dependence has been established as the primary factor responsible for the maintenance of smoking, and dependence severity strongly predicts withdrawal severity and relapse. The recent conceptualizations have emphasized the multidimensional nature of dependence, which encompasses factors such as negative (e.g., smoking to alleviate negative affect) and positive (e.g., smoking to enhance mood) reinforcement, and automaticity (e.g., automatically reaching for a cigarette after quitting and disposing of cigarettes). Degree of mindfulness and level of nicotine dependence are hypothesized to be related because mindfulness reduces both self-report and objective indices of negative affect and stress, and is associated with enhanced positive affect.

Nicotine is taken in several ways. The most common and quick acting manner is smoking. The use of tobacco may be broadly classified into two forms such as ‘smoke’ and ‘smokeless forms’. The term ‘smoked tobacco’ (ST) means tobacco
which is ingested by smoking like cigarette, beedi, Cheroots and others. In addition, the risks of tobacco use include the risks to others known as passive smoking or secondhand smoke.

The term ‘smokeless tobacco’ (SLT) is used to describe the tobacco that is consumed without heating or burning at the time of use. The oral use of smokeless tobacco is widely prevalent in India with different methods of consumption like chewing, sucking and applying tobacco preparation to the teeth and gums.

One of the relevant aspects of tobacco use in the universe is secondhand smoke. The common feature is that they are not burned by consumers at the time of use. The term ‘secondhand smoke’ refers to the smoke inhaled by persons who are not smokers themselves. Second-hand tobacco smoke is the smoke emitted from the burning end of a cigarette (side-stream smoke) or from other tobacco products, usually in combination with the mainstream smoke exhaled by the smoker, and has similar components to inhaled or mainstream smoke. However, it is three to four times more toxic per gram of particulate matter than mainstream tobacco smoke, and the toxicity of side stream smoke is higher than the sum of the toxicities of its constituents. This exposure to smoke is thus indirect and a passive form of inhalation. People in places that allow smoking can be subject to significant levels of toxins, as pollution from tobacco smoke can reach levels that are much higher than levels of other environmental toxins, such as particles found in automobile exhaust.

The other method of tobacco use which is very much popular in the middle east is called ‘Water pipe’ and was apparent during the recent 12th World Conference on Tobacco or Health (Helsinki, February 2003), despite the fact that as many as 100 million people use water pipes daily (Wolfram RM, Chehne F, Oguogho
A, et al. Narghile (water pipe) smoking influences platelet function and (iso-)
eicosanoids, Life). The terminology ‘Water pipe’ can depend upon region, and
includes names such as "shisha", "boory", or "goza" (Egypt, Saudi Arabia;),
"narghile", "nargile", or "arghile" (Israel, Jordan, Lebanon, Syria, "hookah" (Africa
and Indian subcontinent;), and "nubble bubble" (many regions). Besides terminology,
there is also regional variation in shape, size, appearance, and tobacco smoked
is used to refer to tobacco use methods in which smoke passes through water. It
consists of head, body, water bowl, and hose. The most common type of tobacco used
in the water pipe is called Maassei, which is sweetened and flavoured (for example,
apple, mint, and cappuccino). It is used to smoke tobacco in regions of China, India,
and Pakistan, and is often associated with the Eastern Mediterranean Region (EMR).
However, as recently as 1980, its popularity had been declining despite the fact that
today boys and girls of EMR are using water pipes, due to which they view as
fashionable. While, in some societies, gender may play an important role in
maintaining low rates of women's cigarette smoking, but may not have the same
magnitude of effect on water pipe use. The recent study in Syria examined
perceptions for water pipe use and cigarette smoking by sex of the respondent and sex
of the user/smoker. Water pipe use was generally more positively perceived than
cigarette smoking, especially for women. Water pipe users, especially women, were
particular about water pipe's positive aspects, including that it looks traditional,
familiar, social, and attractive. The main attitudes and beliefs among water pipe users
were that they perceived to be less harmful and have less health risks over cigarette
smoking. So, it may be becoming a behavioural norm in the EMR, especially for
women and girls (Israel E, El-Setouhy M, Gadalla S, ef al. Water pipe (Sisha [sic]) smoking in cafes).

The other common practice among the Mizo is the consumption of tobacco instilled water which is tobacco water and is called *tui* *bur*. The method of preparation and the practice is culturally imbedded. The Mizo literature has reflected that the practice was started as a continuation after the stopped of practice in smoking of water pipe tobacco generally by both men and women. The tobacco instilled water is prepared through indigenous system of preparation by soaking the tobacco leaves in water and later consuming the instilled water alone. Historically, the smoking of water pipe tobacco was observed across gender. Infact, this indigenous system of preparation has been modified and innovated and gradually converted into mechanical system with the advancement of technology. The process of preparation requires three big containers which are connected to one another. The first tumbler is connected with water from the nearby stream. This is meant for storage of water that has been taken from the stream. However, the first tumbler, the second tumbler and finally the third tumbler are connected to each other by water pipes with electrical system. The second tumbler contained the tobacco leaves alone. The third tumbler is meant for storage of filtered tobacco water which is ready to be consumed after getting cool. After having required enough water stored in tumbler and first the water is boiled. Then, the boiled water is passed on to the second tumbler mixing with the tobacco leaves. After cooking for 2 hours, then the tobacco water alone travel down to the third tumbler. Finally the quantity of water is decreased and becoming only to one third of water before the preparation. It is found to be too thick and produced little
money for selling. Therefore, additional boiled water is added based on quality preference of the maker (Andrew LR., Khiangte, 2010).

The gentle difference which is observed in the use of tobacco instilled water between the past and the current generation is that it is mostly consumed by the middle aged Mizo women. It is also important to note that beliefs such as mouth refreshment in early morning before brushing teeth, taking tobacco instilled water soon after meal to take away the meat fatty smell or highly flavour smell remaining in the mouth, relieve toothache, regulate bowel movement while having constipation, reducing labour pain while delivery of child and application of tobacco instilled water on a skin where there are rashes are some reasons why it is consumed. This assumption is that entering of the tobacco instilled water inside the pores will kill the germs of the bites and could be disinfectant.

**Environmental Tobacco Smoke (EST):** Globally, we aware and talk about the incidence and consequences of Environmental tobacco smoke (ETS). The EST refers to exposure to tobacco smoke. It has occurred not in the form of smoking, but indirectly from being exposed to someone else's cigarette, cigar, or pipe smoke. The breathing exposure to ETS is also known as passive smoking, second-hand smoke, or involuntary smoking. The important concepts in environmental smoking are the so called ‘mainstream smoke’ (MS) and the ‘Side streams smoke’ (SS). The **mainstream smoke** means the smoke that is inhaled and then exhaled from the smoker's lungs including passing around the smoke to people surrounding. Whereas, the smoke that enters the air directly from the burning ends of a cigarette, cigar, or pipe before inhalation by the smoker is known as the **side streams smoke**. In side streams smoke, the burning end of a cigarette is not usually hot enough for complete combustion of
the tobacco to occur and some chemicals are favoured by this incomplete burning, undiluted side streams smoke which is containing higher concentrations of several chemicals than the mainstream smoke inhaled by the smoker. The smoker is also exposed to mainstream Therefore, ETS is harmful for everyone including both the smokers and the non-smokers i.e passive smoker because they have similar exposure inside a room inspite of majority of ETS in a room comes from side stream smoke. But this exposure is limited to the time it takes to smoke a cigarette. However, exposure to ETS remains constant for the entire time spent in that room.

However, it is difficult to measure the exposure of a passive smoker to environmental tobacco smoke (EST). The exposure varies according to the type of smoke and the number of cigarettes or other tobacco products burned, the number of smokers present at the time of smoke, the rate and manner of smoking, the room volume, the room ventilation rate, and the percentage of fresh air supplied.

In connection to the above, the exposure to ETS has been estimated in terms of "cigarette equivalents". Cigarette equivalents can be measured by determining carboxyhemoglobin levels in blood. Carboxyhemoglobin is formed in the blood when someone inhales carbon monoxide. The hemoglobin in the blood that has oxygen bound to it is called oxyhemoglobin. It is the oxyhemoglobin that carries oxygen to the tissues. However, carbon monoxide has a much stronger attraction to hemoglobin than oxygen. Thus, inhaled carbon monoxide quickly replaces the oxygen in the oxyhemoglobin and binds to the hemoglobin to form carboxyhemoglobin which can be finally measured.
The term ‘psychosocial’ implies a very close relationship between psychological and social factors. Psychological factors include emotion and cognitive development - the capacity to learn, perceive and remember. Social factors are concerned with the capacity to form relationships with other people and to learn and follow culturally appropriate social codes. According to the English Oxford Dictionary the term psychosocial pertains to “the influence of social factors on an individual mind or behavior, and to the interrelationship of behavioral and social factors. The psychological factors that are enquired to in the study are stress, sadness and rebelliousness. Whereas, the social factors such as accessibility of tobacco, value of tobacco use and adolescent autonomy in parent-adolescent relationship with tobacco use are also explored. The study focuses on the psychosocial factors related to tobacco use by Mizo women because it is interesting to explore the area which has not yet been covered and further since it has a bidirectional affected on tobacco users.

The study encounters that the use of tobacco is often as part of coping skills out of stress. Further the use of tobacco also induces stress. Any stress started with a pressure which needed a huge psychological energy. Pressure refers to those features of a situation that may be problematic for the individual and that amount to demands for adaptation of some kind. Stress, refers to a specific set of biochemical conditions within the body conditions that reflect the body's attempt to make an adjustment. So, pressure is in the situation and stress is in the person. The level and limitation of stress could be reduced and controlled by reacting less intensely in a given situation. Therefore, to reduce the intensity or control the extent of behaviour, a person uses tobacco.
In addition, everyone in all walks of life has experiencing stress with different intensity and to certain extent. The stress can have both negative and positive consequences. In the meantime, it is also greatly depending upon the stressors and the stress management level too.

According to Selye, **eustress** is the stress of achievement, triumph, and exhilaration. It is the stress of winning. All of us to some extent, and some of us to a great extent, welcome certain stressful experiences because of the positive feelings obtained from them. The accompanying is a natural part of meeting challenges effectively, such as the challenges in a managerial position or in any other professional job. Conversely, stress becomes **distress** when for any reason that we begin to sense a loss of feeling secure or adequate, helplessness, desperation, and disappointment, which finally turn stress into distress. So, finally a distress is known as stress of losing. The entire continuum of tobacco use by women induces negative consequences that is recognized sooner or later and leads to distress. In connection, stress if not dealt with in a positive way and if it remains unrelieved and unsolved, obviously can affect our bodies to the point that we become more vulnerable to illness. Many of the consequences of chronic stress are manifested in gentle ways, by habits, in transactions with other people, and in general style of coping and marginally deficient in the mental skills. Many people in the United States today seem to suffer from chronic low-grade anxiety about themselves, their lives, and their surroundings. Most seem unaware of their stress because they have had it for so long.

The other determinants of stress is `**burnout**` which describes as `a process that comes about as a consequence of a depletion of energies as well as feelings of being overwhelmed with many issues that may confront an individual’
(Freudenberger, 1986). The depletion of energies cause an inability to handle pressure and leading to burnout. According to Cherniss (1980), *burnout refers to ‘negative changes in work related attitudes and behavior in responses to job stress’*. The symptoms of stress may be associated with impairment of functioning at work, lateness, absenteeism, increased use of sick leave, interpersonal conflict, disengagement from previous levels of responsibility taking and rapid job turnover. There is also an increased risk of addictive behaviors including the misuse of psychoactive substances and gambling.

Lazarus and Folkman (1984) view stress as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and as endangering wellbeing. The two processes that have been identified as critical mediators are stressful person and his relationships with the environment and its outcome. Also any events, both major and minor, which have initiated the process, are referred to as stressors.

Meanwhile, the cognitive appraisal refers stress as a process of evaluating the significance of a stressor to one’s well-being. It is the generalized beliefs about control and situational appraisals of control that have been found to alter the extent to which an encounter is appraised as threatening and/or challenging (Folkman, 1984). Thus, there is a need to evaluate perceived control over stressors as a potentially significant dimension of appraisal in smoking cessation.

The term `stress’ has been applied inconsistently, as a stimulus, as a response or as the experience of an individual (King et al., 1987), as a result of different theoretical models and perspectives: psychological, psychodynamic, organizational, sociological and transactional. A more widely accepted dentition of
stress is the experience of an individual or someone when they perceive that the demands being placed on them as exceeding their ability to cope and a more widely term for stress when presented in this way is `distress’.

While, anxiety is another concept related to stress. The feelings of anxiety are interpreted as a signal that the environment is uncertain and uncontrollable and that feelings of sadness are interpreted as a signal that a source of reward (e.g., pleasure, comfort) has been lost. As a result, while anxiety steers preferences toward options that reduce risk and uncertainty, sadness steers preferences toward those that are more rewarding and this even when the decision is unrelated to the source of anxiety or sadness (Raghunathan and Pham, 1999).

There are different forms of an emotion which is more intense, momentary and associated with determined reasons and cognitive contents, such as joy, success, shame, guilt or fear which can arise in a moral situation. Emotions can attributed directly to a situation and affect overtly a person’s behavior. On the other hand, a mood state is like a general good or bad feeling that is not related to a moral situation and influences a person’s cognitive processes covertly. Since ordinary mood fluctuation is part of our everyday life, an individual could be in a happy or in a sad mood state at the time of facing a moral issue. Mood is defined as a silent, subtle and enduring kind of feeling that has little cognitive content and no obvious reason (Isen, 1984).

The emotions like anxiety, sadness, and anger are explored to understand the psychological aspects that are involving in tobacco use by women. They are the ones most frequently involved in social and interpersonal problems (DSM-IV diagnostic system (American Psychiatric Association, 2000). The descriptions of anger as
externalizing and sadness and anxiety and fear as internalizing emotions (Bradley, 2000) furthermore lead to an expectation that change in behaviour will be rated as greater for anger than for anxiety and sadness. Females have been shown as being more confident in their emotional expression and communication (Fischer, 1993; Wood, 1997), suggesting lower emotional anxiety and lower need for control of emotional arousal, and consequently lower control ratings than males. Among the many anxiety disorders like post-traumatic stress disorder (PSTD), social phobia, agoraphobia, panic disorder, and obsessive-compulsive disorder, the generalized anxiety disorder (GAD) is the most common type of anxiety disorder (Stanley and Novy, 2000).

The classification between major and minor depressive disorder by the American Psychiatric Association (APA), 2000 is that the symptoms of major depressive disorder (MDD) include: depressed mood, loss of interest or pleasure in activities, weight or appetite changes, sleeping disturbances, psychomotor agitation or retardation, low energy level, feelings of worthlessness, difficulty concentrating, and suicidal ideation. Depressed mood and lack of interest are the two core symptoms in late life. One or both of these symptoms and four or more other symptoms must be present for a minimum period of two weeks to meet the diagnostic criteria for MDD. According to Blazer (2003), minor depression in older adults has been associated with impairment similar to that of major depression including impaired physical functioning, disability days, poorer self-rated health, use of psychotropic drugs, perceived low social support, female gender, and being unmarried. However, despite its label, minor depression can be serious for older adults and produce negative outcomes for health and well-being.
Depression, anxiety, and low self-esteem are frequently associated with eating and substance use disorders (SUD). It is relevant to understand the relationship between eating disorders (ED) and substance use disorders (SUD) in the context of tobacco use by women. Co-morbidity among eating disorders and substance use disorders is pervasive, as individuals presenting with ED are up to five times more likely to have substance use problems, and those with substance use problems are 11 times more likely to present with an ED (National Center on Addiction and Substance Abuse, 2003).

The emotions of an individual include awareness, acceptance and understanding of one’s emotions (emotional regulation), and the capacity to utilize and adapt appropriate emotion regulation strategies depending on the situation (Gratz & Roemer, 2004). The association between emotional regulation and eating (or lack thereof) is clearly established (Geliebter & Aversa, 2003; Masheb & Grilo, 2006; Whiteside et al., 2007). Eating as a means to control affect, otherwise known as emotional eating, is an emotional coping strategy associated with overeating and eating disorder, especially binge eating disorder (BED) (Arnow, Kenardy, & Agras, 1995; Courbasson, Rizea, & Weiskopf, 2008; Pinaquy, Chabrol, Simon, Louvey, & Barbe, 2003). Women with eating disorder namely and bulimia, have a diminished capacity for emotion regulation and often use overeating and binge eating to distract themselves or escape from negative or unpleasant emotions (Whiteside et al., 2007; Wiser & Telch, 1999).

It is assumed that individuals would be more likely to lapse in rebellious states than in conformist states because they consider smoking a rebellious activity consistent with the desire to break rules. Smoking during a cessation attempt
constitutes breaking self-imposed rules and can satisfy a desire to feel rebellious in situations in which breaking rules imposed by others might be too costly. Lapsing during rebellious states also might result from an attempt to manage anger, a frequent concomitant of rebellious states. Finally, being in rebellious states makes invoking coping strategies for resisting the urge to smoke unlikely, because doing so would not allow one to act on rebellious impulses.

Several research studies on the social determinants of tobacco use by the youth include parents – adolescent communication on tobacco and alcohol consumption, drugs and substance abuse is limited. It is however assume that the parents - child communication is one of the factors related to tobacco use and substance abuse. In deeper sense it is also a reflection of the parenting style started from child rearing stage. The parent - child communications is presumed fundamental to understanding the influence of parents in children's decisions about tobacco and alcohol use. The verbal communication of the parents is a direct expression of their feelings and concerns about substance use and expectations for behaviors. The presumed importance of parent - child communication about substance use is reflected in family-based approaches to substance use prevention, most of which focus on improving family functioning and parenting skills, including communication (A.shery, Robertson, & Kumpfer, 1998; Grover, 1998).

The communication between the parents and their child is depending upon their relationship and there may be variation depending upon the contents and frequency of talks with their children. The discussion could range from generally talking about negative consequences of tobacco and alcohol use, to helping children recognize social or media pressures to use, to working through how to handle
situations where tobacco and alcohol are present, to encouraging children not to smoke or drink, to laying down explicit family rules (Catalano & Miller, 1992).

Jackson and Henriksen (1997) found that antismoking socialization that included parent-child communication about smoking reduced the onset rate of smoking among children whose parents smoked. In examining the content of parent-child communication and impact on adolescent substance use, an additional important consideration may be the timing of conversations between parents and children. These conversations could occur before or after initiation of tobacco or alcohol use or not occur at all, with potentially different effects. Andrews and colleagues (1993) reported that adolescents whose parents warned them about harmful consequences of alcohol, tobacco, and marijuana were less likely to initiate use; however, for adolescents who had already initiated use, parental warning predicted continued rather than reduced or discontinued use for some sub-groups of adolescents. The parent-adolescent relationship with tobacco use involves the whole process including family environment, social environment, life styles of the family members, parenting styles, orientations on harmful effects of tobacco use. It is also linked to parental supervision of adolescent, role modeling, non-verbal communication, restrictions and the autonomy sanctioned to the child.

The quality and frequency of parents-child communication also connotes the autonomy given to children for any of social disapproved activities. In addition, several studies have shown that adolescents are at greater risk for smoking and drinking when parents smoke or drink (Ennett & Bauman, 1991; Jackson, Henriksen, & Foshee, 1998; Kandel & Andrews, 1987), are more tolerant of tobacco and alcohol use (Andrews et al., 1993), and provide less support and supervision (Barnes &
Farrell, 1992; Biglan, Duncan, Ary, & Smolkowski, 1995; Foshee & Bauman, 1994; Kandel, 1990; Jackson et al., 1998). In addition to these aspects of the family environment, adolescents are at high risk if they have less educated parents (Chassin, Presson, Sherman, & Edwards, 1992), and are White (Bachman et al., 1991; Barnes, Farrell, & Banerjee, 1994).

### 2.2 Critical Issues on Tobacco Use

India's tobacco industry is one of the biggest in the world and is holding third in tobacco production, after China and the United States of America. It is at the intersection of local and global forces fueling a worldwide epidemic of smoking deaths. According to World Bank report: Curbing the Epidemic: Government and the Economics of Tobacco Control, 1999 about 6 million Indian farmers are engaged in growing tobacco and another 20 million people work on tobacco farms, and a large percentage of the population is employed in the retail trade. If the employees' families are counted, it can safely be said that the tobacco industry in India probably supports 100 million people. The industry also generates substantial employment.

The nature of world’s tobacco trade has showed that tobacco consumption is growing dramatically since the beginning of the 21st century. The worldwide consumption which is based on an estimated one billion smokers has more than doubled in the last 20 years and is projected to continue growing over the next 20 years. The transnationalisation of marketing and promotion of harmful commodities, such as tobacco, is one important component of globalised public health threats. Moreover, considering that in 1986, 61% of the world’s tobacco consumption was in
developing countries and by the year 2000 this number is expected to jump to 71%4; that by 2020, 70% of the expected 8.4 million deaths caused by tobacco will be in developing countries; and that at present almost 70% of tobacco is grown in developing countries, tobacco control needs to be a higher priority in development programmes.

The country wise variation in the trends of tobacco consumption reflected that not all countries are experiencing a growth in cigarette consumption. The per capita cigarette consumption has declined steadily in the developing countries in the past several decades, whereas per capita consumption has grown steadily in the less developing countries. This trend is expected to continue and the less develop countries (LDCs) are expected to become the major consumer of the world’s tobacco sometime early in the next century. The international production, manufacture and trafficking of tobacco is dominated by seven trans national companies based in the United States of America and the United Kingdom (MacKay, 1991).

Further, the transnational companies operating in the less develop countries often sell cigarettes without health warnings, great advertisement on television. They also sell cigarettes which are containing higher levels of tar, nicotine and other chemicals than those marketed in the developing countries. Moreover, they also engage actively in promotional activities that target children and women, including the distribution of free cigarettes; the use of images and messages in advertisements that promote smoking as sexy, romantic, slimming, and others. Their activities include sponsorship of sporting, music, fashion and other events; and the use of Western rock stars, actors and athletes. The companies are able to engage in such
activities because there are few restrictions on marketing and containing little information on smoking restrictions.

It is as well important to note the agriculture responsibility that tobacco is one of the most widely grown non-food cash crops in the world; estimates are that 0.3% of the world’s arable land is devoted to tobacco cultivation and an approximate of 72% of the world’s land under tobacco consumption is located in the less developed countries and a majority of the tobacco sold in the world is produced by small farmers belonging in the less developed countries. In fact, they are also controlling the international production and selling of tobacco by arranging loans to the farmers, providing tobacco seed to farmers along with fertilizer and pesticides at minimal and reasonable prices. Also, those farmers are receiving proper instructions on planting and tending the crop, and as well as buy the products back from the farmer. Though it seems to be helpful and has great opportunity for economic promotion and development, the burden of tobacco consumption is tremendously increasing in a less developing country.

The Global Youth Tobacco Survey (GTYS) 1999-2001 has presented results from 75 sites in 43 countries and the Gaza Strip/West Bank region. The self administered consisted of a set of core questions, and are completed by a representative school based sample of students primarily between the ages of 13-15 years. The results shows that the current cigarette smoking ranges from 39.6% to less than 1%, with nearly 25% of students who smoke, having smoked their first cigarette before the age of 10 years. The majority of current smokers want to stop smoking and have already tried to quit, although very few students who currently smoke have ever attended a cessation programme. Exposure to advertising is high (75% of students had
seen pro-tobacco addiction), and exposure to environmental tobacco smoke (ETS) is very high in all countries.

The overall median for the prevalence of ever smoked cigarette among the age group was 33.0% and the highest per cent was found in the Northern Mariana Islands (79.8%), and the lowest in Tamil Nadu, India (3.4%) and four sites belongs in India among the five sites reported ever smoking rates that is less than 10%. In regarding the age of initiation of smoking cigarette, 23.9% smoked their first cigarette before age 10 years and Manipur, India (87.8%) had the highest rate of smoking initiation before age 10, and the lowest was Buenos Aires, Argentina (6.1%). The overall median per cent of current use of any tobacco product (smoked cigarettes or used other tobacco products on one or more days in the 30 days preceding the survey) was 18.7% whereas Nagaland, India has the highest of 62.8% and the lowest is in Goa, India (3.3%). The exposure of home student to environmental tobacco smoke (ETS) was assessed to understand their exposure to secondhand smoke and almost half of the students reported that they were exposed to second hand smoke from others in their home (48.9%) and the highest rate of exposure (79.8%) occurred among the students in Meghalaya, India. Overall, 70% of students were exposed to others smoking in their home in six sites and all of them were in India. To access the inclusion of the harmful effects of tobacco in school curriculum 50.8% students has reported that they were having been taught in school about the dangers of tobacco use. However, it had covered only 2.7% students in Bihar, India.

In addition, the GYTS data reflected the differences among sites i.e states within the country. There is an extremely wide range in responses to virtually all questions on tobacco use. In India, a country of over one billion people, which had
both the highest and lowest rates for current use of any tobacco product as 62.8% in Nagaland, India and 3.3% in Goa, India. These wide variations in responses within a country underscore the importance of sub-national data, and also how nations and states needs the enhancement of tobacco control within the jurisdiction. Moreover, a vast majority of students are exposed to second hand smoke in public places, and substantial proportions are exposed to tobacco in their homes. Generally, the majority of students knew that tobacco smoke from others i.e passive smoking, and secondhand smoking was harmful to them. All these findings reinforce the need for laws which protect children from exposure to second hand smoke. Survey results indicate that a large percentage, generally a majority of current smokers, have purchased their cigarettes from a store. A vast majority of 13-15 year old current smokers who tried purchasing cigarettes from a store were not refused the purchase because of their age. Thus, there is a need for strong laws prohibiting the sale of tobacco products to minors, and these laws must be enforced. In connection to this, it also shows that over two thirds of current smokers want to stop smoking. This strongly suggests the need for effective youth cessation programmes. Therefore, the need for development and effective implementation of tobacco control law in school education programmes is important.

Communities with shared values are now able to work together more easily then before as result of information technologies. The major tobacco control intervention is information. This includes information about health effects, the negative economic impact of tobacco, the benefits of quitting, what policies work and the structure and functioning of the tobacco industry. Therefore, tobacco dependent person’s treatment should be supported remotely through the internet and religious
groups exchanging views on how to strengthen tobacco control within their communities. Many geographically based health promotion entities such as schools and cities have embraced tobacco control as part of health promotion in schools or healthy cities programs. Global networks of local groups allow for exciting local-global synergies.

Hence, the complex process of nicotine addiction involves biological, psychological, behavioral, and cultural factors. Three factors that influence smoking and that are influenced by smoking are performance, stress, and body weight. Stress results in increased smoking, but there is little empirical evidence that smoking reduces stress. **Stress reduction from smoking** is likely the relief of withdrawal reduced negative mood that is experienced between cigarettes.

Smokers weigh on average 3-4 kg less than nonsmokers, and the weight-gain seen after quitting smoking also averages 3-4 kg. The Changes in eating and energy expenditure are responsible for the body weight changes seen during smoking cessation and relapse. It is important to notice the full range of conditions under which nicotine affects behavior.

**Nicotine can function as a reinforcer** to maintain self administration behavior in humans and animals (Rose & Corrigall, 1997), and the mesolimbic dopaminergic system is one brain site mediating the reinforcing effects of nicotine and other drugs of abuse (Corrigall, Franklin, Coen, & Clarke, 1992; Pich et al., 1997). Naturalistic and laboratory studies have shown that stressful situations result in increased desire to smoke and actual smoking (Perkins & Grobe, 1992; Pomerleau & Pomerleau, 1991), but little empirical evidence exists that smoking reduces stress. **If smoking reduced stress, then smokers should be less stressed than nonsmokers, but**
surveys repeatedly indicate that smokers are more stressed than nonsmokers. Further, if smoking reduced stress, then smokers should experience increased stress when they quit, but studies have shown that individuals report feeling less stress after they quit smoking.

The association of stress with tobacco use is another factor frequently reported in many literatures. Almost half of the current smokers (49.3%) in a study of 1,000 randomly selected undergraduates from a major north-eastern university identified stress as a motivation for smoking. The instrument used was adapted from the 1992 National Health Interview Survey and contained multiple-choice questions that assessed smoking status, onset of smoking, and motivations for smoking or not smoking. The smoking environment has also been found to be associated with an increase in tobacco use. A person’s smoking behaviour has been shown to be associated with having parents or friends who smoke and with having a greater perceived prevalence of smoking in the individual’s community of residence.

The World Health Organization (WHO), 1992 reported that anemia in pregnancy is a common clinical problem in many developing countries. It contributes significantly to maternal mortality and to adverse pregnancy outcomes (Brabin, Hakimi, & Pelletier, 2001; Ezzati, Lopez, Dogers, Vander, & Murray, 2002; Malhotra et al., 2002; Ronnenberg et al., 2004). While, estimation of an anemia among pregnant women in India range from 50% to about 85% (International Institute for Population Sciences, 2002 and Indian Council of Medical Research, 1989). Many studies on pregnant women have often associated smoking with decreased hemoglobin levels (Chang, O’Brien, Nathanson, Mancini, & Witter, 2003; Strinic et al., 2005; Wingerd, Christianson, Lovitt, & Schoen, 1976), although not consistently
Smoking during pregnancy also has been associated with other blood parameters that are closely related to blood hemoglobin, such as decreased serum vitamin B12 and maternal red blood cell folate (Casanueva et al., 2003).

The cultural aspects, the traditions and orientation of a person should always be considered as important determinants to tobacco use. The use of smokeless tobacco is a worldwide practice with numerous variations in the nature of the product used as well as in the customs associated with its use. In the United States, smokeless tobacco is used predominantly in the form of chewing tobacco and snuff. Chewing tobacco is chewed or held in the mouth between lip and gum. Smokeless tobacco was used in the American colonies in the early 1600s after snuff made its way from the Jamestown Colony in Virginia in 1611 through the efforts of John Rolfe. Tobacco chewing, however, was not reported until a century later in 1704. In the late 1930s in Sweden, Ahblom observed that more patients with buccal, gingival, and "mandibular" cancers than with other cancers reported the use of snuff or chewing tobacco. In the United States, case reports of oral cancer among users of snuff or chewing tobacco appeared in the early 1940s. The first epidemiologic study of smokeless tobacco was not conducted until the early 1950s. The use of smokeless tobacco products in the United States was widespread until the end of the 19th century. With the advent of anti-spitting laws, loss of social acceptability, and increased popularity of cigarette smoking, its use declined rapidly during much of this century. However, recent data indicate resurgence in smokeless tobacco habits, particularly among teenage and young adult males.
The report of the Global Tobacco Epidemic, WHO, 2009 has highlighted that it is estimated one third of adults are regularly exposed to second-hand tobacco smoke. European Union, 14% of non-smokers are exposed to other people’s tobacco smoke at home, and a third of working adults are exposed to second-hand tobacco smoke at the workplace at least some of the time. Among the estimated 700 million children worldwide about 40% of all children are exposed to second-hand tobacco smoke at home. The global average of children with at least one smoking parent, according to the definition used by the Global Youth Tobacco Survey (GYTS), is estimated to be 43%. The report extended that children and women are the most affected population of second hand tobacco smoke and in all deaths attributable to second-hand tobacco smoke, as high as 31% occur among children and 64% occur among women.

Also, more than half (52%) of adults were exposed regularly to secondhand smoke at home. The SHS exposure at home ranged from the highest of 97% in Mizoram state to the lowest 10% in the state of Tamil Nadu. It also shows the state wise variation of SHS at home. The rate of exposure to secondhand smoke within the roof alone is much higher in rural areas (58%) and another 39% is occurring in urban areas of India (GATS India, 2012).

In developed countries, smoking is estimated to cause over 90% of lung cancer in men and about 70% of lung cancer among women. In these countries, 56% of deaths due to chronic respiratory disease and 22% of cardiovascular deaths are attributable to tobacco. The attributable mortality is greater in males (13.3%) than in females (3.8%). Worldwide, the attributable fractions for mortality due to tobacco smoking were about 12% for vascular disease, 66% for cancer of the trachea,
bronchus and lung cancers. Hence, the disease consequences of tobacco use (smoking) have been more extensively and better documented than perhaps for any comparable risk factor. This is partly due to the fact that for decades, until recently, the tobacco industry kept on challenging the validity of the findings and refused to accept results that were long accepted by all health scientists.

In India, where tobacco is smoked, chewed and applied in a wide variety of ways, and a considerable number of research studies have shown that these forms of tobacco use are causal risk factors for many types of cancers and other specific diseases caused by tobacco use in India are cancer, lung diseases, vascular diseases and acute health problems suffered by tobacco harvesters.

2.3 Theories Explaining Tobacco Use

To examine the theories that are related to tobacco use and dependency, it is important to understand addiction. It shares similarities to other pleasure-orientated desires. Addictions are, however, particularly strong, but addicts do not completely lack autonomy and cognitive control – as is often stated in neurology and psychiatry (Foddy & Savulescu 2010, 2007). This notion does not contradict some of the theories in the field, including Jim Orford’s (2001) psychological theory of excessive appetites, which are seen as rewarding and habit-forming, but involve high costs and various psychological and social conflicts.

The most crucial point expressed is that even though drugs might sometimes alter realities, change the speed of perception and enable creative processes, they also involve the most rigid modes of acting and “drug addicts continually fall back into what they wanted to escape”. Although drug addicts might be considered as
experimenting with life, they end up following the conformist path (Deleuze & Guattari 1980).

**Cognitive-behavioral theories** are best conceptualized as a general category of theories, or a set of related theories, which have evolved from the theoretical writings, clinical experiences, and empirical studies of behavioral and cognitively oriented psychologists. There is no single definition of cognitive-behavioral theory. The individual theories are tied together by common assumptions, techniques and research strategies, but maintain a diversity of views about the role cognitions play in behavior change. The hyphenated term "cognitive-behavioral" reflects the importance of both behavioral and cognitive approaches to understanding and helping human beings. The hyphen brings together behavioral and cognitive theoretical views, each with its own theoretical assumptions and intervention strategies.

**Cognitive-behavioral interventions** target both cognitive and behavioral problems using a full integration of cognitive and behavioral strategies. Cognitive-behavioral research is based on observed changes in behavior and cognition with methodological rigor. Cognitive-behavioral theories provide great flexibility in treatment targets and interventions, sharing a fundamental emphasis on the importance of cognitive workings and private events as mediators of behavior change. Behavioral assessment, operating in the "triple response mode", provides a conceptual model of the functional relationships between thoughts, behaviors, and feelings and provides the necessary background for clinicians and researchers to implement and evaluate intervention strategies. Cognitive-behavioral theories and counseling interventions are currently highly influential. There are many different cognitive-behavioral intervention techniques and the number is likely to grow as the theories
continue to be developed and tested for effectiveness with a variety of psychological problems.

Tobacco use or tobacco consumption has indicated the taking of tobacco in a large quantity. It also means a habit of taking tobacco in any form or pattern. ‘Behavioral theory’ is relevant because it is based on conditioning theories of learning where behavior is learned and unlearned. Another important theory related to the study is ‘Social Learning theory’ which comprises of three major elements such as antecedents’ events, behavior and consequences. This theory is based upon the facts that there are predisposing factors to behavior as well as positive or negative rewards. Therefore it focuses on behavioral analysis and identification of problematic or undesirable behavior that needs to be changed.

The term ‘psychosocial’ implies a very close relationship between psychological and social factors. Psychological factors include emotion and cognitive development—the capacity to learn, perceive and remember. Social factors are concerned with the capacity to form relationships with other people and to learn and follow culturally appropriate social codes. According to the English Oxford Dictionary the term psychosocial pertains to “the influence of social factors on an individual mind or behavior, and to the interrelationship of behavioral and social factors”.

Zbikowski, Klesges, Robinson and Alfano (2000) in their on the smoking status of adolescents ranging between the age of 15-18 years had identified the following psychosocial risk factors – Approval of smoking, Accessibility of cigarettes, Value of smoking, Rebelliousness, Social support, Sadness and Stress. The survey conducted among 5683 female adolescents on smokeless tobacco use,
potential psychosocial risk factors were Perceived negative consequences, Substance use, Modeling and Active lifestyle (William T.R, James T.B, P. Alex Mabe and David R. M).

According to cognitive theory of depression (Beck, 1987), depression is associated with pessimistic expectancies, a negative view of the future comprising one aspect of the negative cognitive triad. Numerous studies have corroborated this prediction, finding that generalized pessimism or hopelessness correlates positively with depressive symptom severity (Haaga, Dyck, & Ernst, 1991).

Among the factors affecting the decision to smoke includes: One’s level of exposure to smokers in the social environment, the degree of parental oversight or adolescent autonomy in the parent - adolescent relationship and adolescent’s level of psychological distress (Chassin, Presson,Rose & Sherman,1996; Tercyak, Goldman, Smith & Audrain, 2002).

2.4 Research Studies on Tobacco Use

The prevalence of tobacco consumption by social class in India have been calculated based on scheduled caste (SC) and scheduled tribe (ST) classifications. The difference in prevalence rates between SC and STs and the general population category is very stark. While, smoking 288, smokeless tobacco 464 and any form of tobacco 664 among ST population and smoking 270, smokeless tobacco 167 and any form of tobacco 400 among SC. The variations among states reflected that consumption of tobacco in any form is highest among the north-eastern states, with Mizoram and Meghalaya topping the list. The main reason for that is a high
prevalence of smoking in those states. The chewing forms of tobacco are more popular in some of the eastern states including states like Bihar and Orissa (NFSH 52nd round, 1995-96.) Therefore, the analysis from NSS 52nd round emerge that the prevalence of smoking as well as smokeless tobacco went up between 1993-94 and 1995-96 with an increase in prevalence among females for both smoking and smokeless tobacco. It also shows the use of smokeless tobacco is higher than smoking among females and teenagers both in rural and urban areas. In addition, smoking is most prevalent among older age groups while, smokeless tobacco use is most prevalent in ages 20 - 44 years. So, the consumption of tobacco in any form is a more serious problem among the economically and socially vulnerable sections of the society.

2.5 Tobacco Use across Population

2.5.1 Gender and Tobacco Use

Many of the studies have reflected that an approximate of one third of female smokers quit once they learn that they are pregnant (Fingerhut, Kleinman, & Kendrick, 1990; Floyd, Rimer, Giovino, Mullen, & Sullivan, 1993; LeClere & Wilson, 1997; Severson, Andrews, Lichtenstein, Wall, & Zoref, 1995), but up to two-thirds of women who stop smoking during pregnancy relapses within 6 months after delivery (Colman & Joyce, 2003; Fingerhut et al., 1990; Martin et al., 2008; McBride & Pirie, 1990; McBride, Pirie, & Curry, 1992; Ratner, Johnson, Bottorff, Dahinten, & Hall, 2000). Women who remain tobacco abstinent after delivery experience health benefits that include protection of infants from secondhand smoke.
exposure, lower risk of poor pregnancy outcomes in subsequent pregnancies, and decreased personal risk of tobacco-related health problems (Mullen, 2004). To increase the proportion of women who maintain tobacco abstinence after delivery, it is necessary to understand the modifiable factors associated with postpartum relapse to smoking.

With an estimated population of 195.5 million in 1996, Indonesia is the fourth most populous nation in the world. Indonesia has a long historical tradition of tobacco growing and trading. Tobacco is a major part of Indonesia's contemporary economic and cultural life. Indonesia is famous for its aromatic kretek cigarettes, which are made from a mixture of tobaccos and cengkih (coves). Although several international brands are manufactured locally under license, kretek brands produced by Indonesian companies dominate the retail market. Traditionally tobacco production has been considered to be women's work. There is almost no public policy on tobacco and health in Indonesia and from 1991, cigarette packets sold in Indonesia have carried the same general health warning and there are no special warnings. It is worthy to mention that since 1990 there has been an annual communications forum on smoking, conducted under the auspices of the directorate-general of food and drug control in the Ministry of Health.7 The annual "No-smoking day", promoted by the World Health Organization, allows for activities such as public meetings and media announcements to raise consciousness about tobacco and health.

Women in general tend to perceive water pipe use more positively than cigarette smoking, with women water pipe users noting its positive attributes of being familiar, looking traditional, and being social (Maziak, Ward, Soweid, et al., 2004). Other studies in the Middle East indicate that women find water pipe smoking to be
attractive (Maziak, Rastam et al., 2004) and an occasion when they can participate with others (Tamim, Terro et al., 2003). The water pipe, also known as *shisha*, *hookah*, *narghile*, *goza*, and *hubble bubble*, has long been used for tobacco consumption in the Middle East, India, and parts of Asia, and more recently has been introduced into the smokeless tobacco market in western nations.

In the general population, depression, anxiety and stress are more common among smokers than nonsmokers; these factors are barriers to smoking cessation and triggers for relapse (Breslau, Kilbey, & Andreski, 1991; Curry & McBride, 1994; Glassman & Covey, 1996; Glassman et al., 1990; Hall, Munoz, Reus, & Sees, 1993; Kendler et al., 1993). Among pregnant women, current and former smokers are more likely to report depressive symptoms than never-smokers (Zhu & Valbo, 2002), and pregnant smokers are more likely than pregnant nonsmokers to have a mood disorder (major depressive disorder, dysthymia, and hypomania) or an anxiety disorder (panic disorder, phobia, and generalized anxiety disorder; Goodwin, Keyes, & Simuro, 2007). Although pregnant women who quit during pregnancy have lower levels of depressive and stress symptoms, compared with women who continue to smoke (Blalock, Robinson, Wetter, & Cinciripini, 2006; Bullock, Mears, Woodcock, & Record, 2001; Ludman et al., 2000), prenatal quitters are at risk for both mood fluctuations and smoking relapse after delivery.

The rise in tobacco use among younger females in high-population countries is one of the most ominous potential developments of the epidemic’s growth. In many countries, women have traditionally not used tobacco: women smoke at about one fourth the rates of men. Most women currently do not use tobacco however, the tobacco industry tap this potential of new market mainly through media - advertising,
promotion and sponsorship, including charitable donations to women's causes, weaken cultural opposition to women using tobacco (Gilmore A et al. American Journal of Public Health, 2004). Further, in most of the European Union countries, teenage girls are as likely to smoke as boys, if not more likely (Global youth tobacco survey, U.S. Centers for Disease Control and Prevention, 2007).

2.5.2 Tobacco and Youth

India has the highest and lowest rates for current use of any tobacco product in the world as 3.3% in Goa and maximum of 62.8% in Nagaland. These wide differences in prevalence within a country underscore the importance of sub national or regional data, for national estimates can obscure important regional differences within the country. Many studies conducted during 1989 and 2004 using different methods have shown that tobacco use among girls of colleges and medical and dental colleges was low relative to boys and adults in the general population and the results of the India GYTS 2000-2004 are consistent with the above studies; however, in some of the states, there is no statistical difference in the use of cigarette and non-cigarette products between boys and girls. This indicates a breakthrough in social norms in India, where tobacco use by girls and women is considered taboo.

The average percentage of ever-smoker students in the GYTS who smoked their first cigarette before the age of 10 years was 54% which is an average for 13 states including 8 northeastern states. Early initiation before 10 years of age was reported to be high in the states where tobacco use prevalence was high. In the northeastern states, ever-tobacco users who first used tobacco before the age of 10
years was more than 65% in all the states except Mizoram which have accounted for 23.9%.

Tobacco consumption often starts in adolescent years. Everyday about 80,000 to 100,000 young people initiate smoking around the world of which most are in the developing countries. Of 1000 teenagers who smoke today, 500 will eventually die of tobacco related diseases 250 in their middle age and 250 in their old age. In India, tobacco use is estimated to cause 800,000 deaths annually. It is estimated that 5,500 adolescents start consuming tobacco every day in India, joining the four million young people under the age of 15, who already consume tobacco regularly.

In 1996, it was estimated that India is having 182 million tobacco users of whom about 83 percent were males. Teenagers (ages 10-19) accounted for anywhere between 8 - 10 million out of which about 57 percent were using smokeless tobacco. While, regarding female tobacco users, almost three-quarters of this group used smokeless tobacco, whereas the rest smoked cigarettes or bidis. In the urban areas, smokeless tobacco consumption seems to be higher among teenagers and young adults. The increasing consumption of smokeless tobacco among the younger generation in urban areas becomes more acutely evident in the 52nd round. Like other developing countries, the most susceptible age for initiating tobacco use in India is during adolescence and early adulthood between the ages of 15 years -24 years. Most tobacco users start consuming tobacco before the age of 18 year, while some start as young as 10 years.

A study on Peer Influence: Use of Alcohol, Tobacco, and Prescription Medications was conducted by Alberto Varela, BS; Mary E. Pritchard among 312 colleges students at Bosh University in 2001 and had found that participants were
most likely to take health risks when accompanied by someone they consider a friend. It also indicated gender differences in risk-taking behaviors, as well as an interaction effect between companion and gender. The result on tobacco use by the colleges students shows that participants were more likely to smoke cigarettes in the presence of someone else, $F(3, 305)=35.03, p<.01$, specifically with their friends. Men were more likely than were women to smoke alone or with friends, but women were more likely than men to smoke with their family members. There was a significant interaction of companion on chewing tobacco, $F(3, 300) = 8.27, p < .01$. We also found an interaction effect between companion and gender, $F(3, 300) = 7.87, p < .01$. Men were more likely to use chewing tobacco with their friends or by themselves, whereas use of chewing tobacco had very little variation across companion for women.

**Peer relations** are an important source of influence on adolescents’ use of substances (Hawkins, Catalano, & Miller, 1992; Kobus, 2003; Wills & Cleary, 1999; Wills, Resko, Ainette, & Mendoza, 2004). The specific processes involved in peers’ encouraging or deterring substance use may include normative or informational social influence, selection, socialization, or network position (Ennett & Bauman, 1993, 1994; Kobus, 2003; Wills & Cleary, 1999; Wills et al., 2004).

**Social network analysis** is a promising approach for examining the complexities of peer interactions and their impact on adolescent behaviors, such as substance use. It also allows for a closer examination of social structure and position than do self-report of peers’ attitudes, relationships, and behaviors (Cairns & Cairns, 1994. Social network analysis requires each respondent to report only on his or her
own behaviors, whereas self-report methods require the respondent to report his or her own behaviors and estimate peer behaviors.

A study on Early Adolescent Social Networks and Substance Use was conducted by David B. Henry Kimberly, Kobus University of Illinois at Chicago to examine the relationships between social network position and the use of tobacco, alcohol, marijuana, and inhalants. Social network analyses of peer nominations were used to categorize youth as members of social groups, liaisons between groups, or social isolates. The isolates students mean having not more than one bidirectional dyadic tie to another student. Group members are the students tied to at least two other students who also identified each other as friends, thus forming a triangular relational tie and liaisons are the students who were connected to at least two other students by bidirectional dyadic ties, neither of whom were connected to the other. Among the 1,119 respondents from 144 classes in 14 public schools studying in the sixth grade the study out found that the liaisons were more likely to use tobacco than members or isolates and were more likely to use alcohol than isolates. It is because that the liaisons may be at increased risk for the use of alcohol and tobacco with explanations on having greater opportunity for association with substance-using youth. Further, individuals who are occupying the liaison position are seen as bridges between multiple peer groups and/or other peers who are not members of groups. As bridges, these individuals are constrained by the multiple and possibly conflicting norms and values of the various groups to which they are connected. So, they may experience stress similar to that experienced by boundary spanners in organizations. (i.e., stress resulting from the conflicting demands and expectations of multiple social groups). If so, liaisons may turn to tobacco or alcohol as a way to cope through self-
medication. The results also reveal a snapshot of a dynamic process whereby substance use promotes group acceptance or rejection. Youth who occupied the position of liaison and used tobacco or alcohol may have been attempting to gain social approval through their substance use and, in so doing, facilitate peer group entry (cf. Luthar & D’Avanzo, 1999; Maggs, Almeida, & Galambos, 1995). This possibility is supported by the research of Michell (1997; Michell & Amos, 1997).

Finally, it is possible that liaisons were in the process of being marginalized by peer groups. The sixth-grade substance users who occupied the liaison position in the study might, in three years as ninth graders, become isolated from peer groups. The general social stigma associated with substance use combined with the increased developmental importance of peers and the emergence of substance use around sixth grade may promote instability and alignment of peer groups based in part on substance use.

The Global Youth Tobacco Survey of Orissa, 1999-2003 shows that, about 30% of the tobacco user consumed tobacco for the first time at the age of ten years or earlier and from rural areas in Gujarat, Tamil Nadu and Karnataka, where one third to one half of children under the age of ten years experimented with tobacco in some form. On the other hand the same study at Patna (Bihar) revealed 29% of grade 3 students reported tobacco initiation at eight years of age.

To assess the prevalence of tobacco use and to address reduction of the impoverishment due to tobacco use in Kerala, India, a study was conducted among school children and youth between the age of 12 years - 19 years by K. R. Thankappan and C. U. Thresia in 2007. The study shows that current use of any form of tobacco was reported by 11 per cent of them. The proportion of school students experimented
with some form of tobacco was 35% which comprised of 24% smoking and 11% using smokeless tobacco. The prevalence of current smoking among these children was 8.1% and use of smokeless tobacco was 3.2%. It was found that tobacco use was four times higher among the students who received pocket money, three times higher among those with lower academic performance and three times higher among those whose friends used tobacco compared to their counterparts. A similar finding was reported in a recent study from Delhi and Chennai schools where tobacco use among students in sixth grade was two to four times higher compared to eighth grade students. The prevalence of current tobacco use among male college students in Kerala was 13.6% and overall prevalence of current smoking was 11.7%. More than 37% of the students experimented with some form of tobacco. The study noted that like many other parts of India, the factors associated with tobacco use in Kerala are closely linked with age, sex, social class, education and professional status. Although limited, some of the available studies indicate a variety of socio-cultural influences attributable to tobacco use. In connection to tobacco use by school going children in Kerala, school going boys, whose fathers were current tobacco users, were two times more likely to use tobacco compared to their counterparts. Also boys having friends who were current tobacco users were 2.9 times more likely to use tobacco compared to those whose friends were not using tobacco. Among the college students, those having a tobacco using household member were three times more likely to use tobacco compared to those who did not have any tobacco user in the household. This was consistent with the findings from the study among the south Indian college students in which ‘for friendship’ was the most common reason cited for smoking.
2.5.3 Children and Tobacco Use

It is well known that in any aspect of life including behavior of tobacco use, family interaction influences children’s behavior, and because family is the social unit primarily responsible for modeling communication behavior and teaching social skills, family interaction might also provide models for competencies related to drug resistance and use (Baumrind, 1991; Noller, 1994; Patterson & Yoerger, 1997; Socha & Stamp, 1995). In fact although peers play a crucial role in levels of current adolescent drug use the attitudes and behaviors of parents, the overall quality of family life, and the relationship between parents and children are what play the most crucial role in adolescent behaviors such as initiation and experimentation with ATOD (Brown, Mounts, Lamborn, & Steinberg, 1993; Hoffman & Su, 1998; Kumpfer & Alvarado, 1995; M.A. Miller et al., 2000). According to Kandel (1996), scholars who view family influences as less important than peer influences are ignorant of the central role family relationships play in influencing adolescents’ values, norms, and behavior. Furthermore, Coombs, Paulson and Richardson (1991) noted, that parental influence may be more important than peer influence in young people’s reasons for nonuse. The quality of family life consistently emerges as a pronounced influence on adolescent substance use behavior (Gullota, Adams, & Montemayor, 1995; Hawkins, Catalano, & Miller, 1992).

The General Social Survey (GSS) using data from the 1977-1994 conducted by National Opinion Research Council has examined the impact of parental divorce on the alcohol and tobacco consumption of adult offspring. Divorce greatly increases the likelihood of being a smoker and, for men, a problem drinker. Parental remarriage completely offsets the effects of parental divorce on men’s
drinking but does not substantially affect cigarette use. The respondent socioeconomic characteristics accounted for a portion of the relationship between parental divorce and smoking but did not affect rates of problem drinking including social control and psychosocial adjustment due to parental divorce. In connection to previous research in the area and having a conclusion that parental divorce can have many lasting effects on the well-being of adult offspring, including marital instability (Amato 1996; Glenn & Kramer 1987; Kulka & Weingarten 1979; Mc Lanahan & Bumpass 1988; Mueller & Pope 1977;) Alcohol and tobacco use may well be two additional forms of maladjustment related to parental divorce. While talking Social control, after a divorce almost every familial routine is disrupted (Wallerstein & Kelly 1980) and divorced mothers often experience considerable emotional distress affecting their parenting skills (Dornbusch et al. 1985; Wallerstein & Kelly 1980). Moreover, single mothers are likely to be working and therefore less able to supervise children (McKeever & Wolfinger 1997).

Kandel and Yamaguchi, have written that adolescents are especially at risk as the chances of initiation into alcohol and tobacco use peaks at about age 18 years. Further, the GSS also mentioned that low levels of education increase the likelihood of divorce (Bumpass, Martin, & Sweet 1991), so divorced parents as a whole comprise a disproportionately uneducated group. Due to their lower average level of education, divorced parents may be relatively permissive about smoking. In contrast, educated parents, even if divorced, are more likely to dissuade their children from smoking through both exhortation and example. Resnick et al. 1997 mentioned that the absence of cigarettes in the house substantially decreases the likelihood that offspring will smoke.
The psychosocial effects of parental divorce often persist into adulthood, including poor mental health (Amato 1991; Amato & Booth 1991; Cherlin et al. 1998; Kuh & Maclean 1990; Roy 1985; Schooler 1972) and difficulty in romantic relationships (Amato 1996; Amato and Rogers 1997; Silvestri 1992; Webster, Orbuch & House 1995). Single-parenting and step-parenting produce almost identical increases in the risk of smoking which is against an evidence of the social control argument: the presence of a step-parent, no matter how ineffectual a disciplinarian, should provide an additional agent of social control and thereby reduce initiation into smoking. Female respondents from step-families report higher rates of problem drinking than women from either intact families or mother only families.

A study on the pattern of tobacco use among school children in thirty government middle schools and senior schools of National Capital Territory (NCT), Delhi, India was conducted by Vinita Singh, Hem Raj Pal, Manju Mehta1, S.N. Dwivedi & Umesh Kapil, 2005. Data were obtained on the use of tobacco, age of initiation, reason of initiation of consumption of tobacco, places of tobacco consumption, money spent on the purchase of tobacco, frequency of consumption among 3,422 consisting 56.5% girls and 43.5% boys school children belonging to the age group of 10 years to 14 years using a pre-tested semi-structured questionnaire. Surprisingly, it was found out that an overall 9.8 per cent of the school children in the study had experimented at least once with any form of tobacco in their lifetime. The proportion of children who were current users of tobacco products were 5.4% having 4.6% boys and 0.8% girls. Among the current users, nearly 70.2% comprising 85.6% boys and 14.4% girls consumed pan masala with tobacco, whereas, 85.5% boys and 14.5% girls consumed tobacco as gutka. Also, as high as 97% boys and 3% girls
smoked tobacco in the form of cigarette followed by 10.1% who smoked \textit{bidi}. Further, a little 31% of the children consumed tobacco in more than one form and nearly 14% of the respondents have reported that they are consuming betel leaf with tobacco out of which 11.1% are consuming “\textit{zarda}”.

The inquiry on the reasons for initiation of tobacco use shows that more than one third of the children (37.8%) reported that tobacco was first introduced to them by their friends and 29.3% were introduced by their family members or relatives. Moreover, nearly a quarter of the children were influenced by tobacco advertisements in various media outlets such as television, videos, movies, newspapers and others. In addition to this, 30.3% of the respondents were started using tobacco out of their enjoyment and another 26.1% used because of their curiosity.

Hence, the accessibility and availability of tobacco products among the respondents shows that the ease availability played a vital role in their consumption. Majority of 80.9% consumed tobacco in public places, 8% in school followed by 6% which was taken place at home. It was found that nearly 84% of the respondents purchased tobacco from the shop and reported that they were never refused by the sellers or/shopkeepers despite being a minors.

A communication on the harmful effects of tobacco by parents and teachers was studied and that the parents of 59% of the respondents discussed the harmful effects of tobacco consumption with their children and only about 25% had given efforts to stop consuming tobacco.

The results on the determinants of tobacco use reveals that family plays a very important role in initiation of tobacco use by a young child or adolescent. \textit{Tobacco}
use by parents or an elder sibling increases the likelihood that a child begins smoking apart from pocket money, amount of pocket money, school environment, satisfaction with teaching, satisfaction with results, hobbies (reading, friends, watching movies), not having friends, age and location of school. Other studies on similar aspects looked into actors that the students not participating in sports, or having user friends to be at a nearly double the risk.

To examine the dependency on tobacco by children was assessing based on the intervals within which tobacco product is needed after getting up in the morning. The same study shows that nearly 22% of current users reported the need of tobacco as first thing in the morning and also the GYTS shows that around three fourths of cigarette smokers and around half of the smokeless tobacco users reported “needing tobacco” first thing in the morning. The same is observed in majority of the North eastern states of the country. This finding shows that children are already developing dependency on tobacco at very young age.

Tobacco, alcohol and drug use is a widespread and increasing problem among young people. Recent trends show a growth in heavy drinking with an associated increase of smoking and illegal drug use. One in four deaths of European men aged 15 years – 29 years is related to alcohol and an UK survey found that 13% of 11 years – 15 year olds smoke regularly and 20% had used illegal drugs in the past year. A number of systematic reviews and meta analyses have shown parenting programmes to be effective in changing children’s behaviour, reducing time in institutions for juvenile delinquents and improving psychosocial health of mothers. However, behavioral problems are not the only aspect of a child’s health that is influenced by their family and home environment. Low parental supervision and monitoring has
been found to be a strong predictor of smoking in girls and increased drinking and problem behavior in boys. So, the expressions of parental disapproval have been demonstrated to be effective deterrents to children smoking.

In the midst of the present worldwide tobacco epidemic, concern is growing regarding the use of a water pipe (referred to in various regions as *shisha, hookah, narghile, and hubble-bubble*) to smoke tobacco, a practice dating back at least 400 years. This early form of smoking is experiencing a global revival, particularly in Middle Eastern countries. (Maziak, Ward, Soweid, & Eissenberg, 2004). Some of this increase in use has been attributed to the popularity of flavored or sweetened tobaccos for use in the water pipe (Rastam, Ward, Eissenberg, & Maziak, 2004). Recent reports indicate that water pipes are commonly used in Egypt, Saudi Arabia, Jordan, Lebanon, Syria, Kuwait, Israel, Africa, India, and certain parts of Asia (Al Mutairi, Shihab-Eldeen, Mojiminiyi, & Anwar, 2006; Maziak, Ward, Soweid, et al., 2004; Singh et al., 2006). Water pipe use has recently grown in popularity and present-day water pipe smokers include trendy youth, university students, and even high-school-aged children (Maziak, Ward, Soweid, et al., 2004). Growing evidence indicates that women are increasingly likely to become water pipe smokers. Some of this trend may be attributable to the introduction of sweetened and flavored water pipe tobacco during the 1990s (Rastam et al., 2004), which may be attracting female teenagers (Hadidi & Mohammed, 2004).

In the developing world, tobacco use rates for adult females remain relatively low, but could rise quickly among teenage females. In South-East Asia, the adult male smoking rate is ten times higher than the adult female rate. Among 13 years -15 year olds, however, the male smoking rate is only about two and a half times higher
(Guindon GE, Boisclair D. Past, current and future trends in tobacco use, World Bank, 2003). Although anyone who uses tobacco can become addicted to nicotine, people who do not start smoking before age 21 are unlikely to ever begin. Adolescent experimentation with a highly addictive product aggressively pushed by the tobacco industry can easily lead to a lifetime of tobacco dependence. The younger children are when they first try smoking, the more likely they are to become regular smokers and the less likely they are to quit.

The Global School Personnel Survey (GSPS) in India conducted simultaneously with the GYTS, has revealed that tobacco policies in schools restricting student smoking and school personnel smoking are rarely adopted and enforced. Tobacco prevention instruction by teachers on six different teaching and training measures was below 35%. A special striking feature was the lack of teaching material and training for teachers regarding tobacco legislation. However, there is evidence that central government schools that adopt tobacco control policies had a low prevalence of current tobacco use among students and school personnel as compared to state schools, which had no policies.

2.5.4 Women and Smoking

Tobacco use plays a pivotal role in perpetuating health inequalities among different socioeconomic groups and between genders. Women tobacco users not only share the same health risks as men, but are also faced with health consequences that are unique to women, including those connected to pregnancy and cervical cancer. However, tobacco use among women is prevalent in all regions of India and
among all sections of society. In India, 2.4% of women smoke and 12% chew tobacco. The prevalence of smoking among women is low in most areas due to social unacceptability, but is somewhat common in parts of the north, east, northeast and Andhra Pradesh.

In India, the limited studies on pregnant women indicated that tobacco use by the pregnant women is not different from that of women in the general population which reflected the absence of specific tobacco use prevention efforts during antenatal care. In a report from a large teaching maternity hospital in Mumbai, 33.4% of women in the reproductive age group were smokeless tobacco users. Women in many rural areas believe that tobacco has many magical and medicinal properties; keeping the mouth clean, getting rid of a foul smell, curing toothache, controlling morning sickness, during labour pains.

A longitudinal analysis of smoking, transitions and occasional tobacco use among young adult women was studied by Liane McDermott, Annette Dobson, Neville Owen to examine the factors associated with these transitions, by comparing socio demographic, lifestyle and psychosocial characteristics of those who changed from occasional smoking to daily smoking, non-daily smoking or non-smoking. The respondents were women between the ages of 18 years - 23 years randomly selected from the Medicare Australia database. The survey was conducted for three times and the self-reported smoking status at survey I (1996), survey II (2000) and survey III (2003), for 7510 participants who took part in all three surveys and who had complete data on smoking at survey I. Data was collected through mailed questionnaires containing 300 items, on general health and well-being; health service use symptoms; stress; smoking and alcohol; weight, exercise and eating; time use; social support;
demographics; and aspirations which was approved by the human research ethics committees of the University of Newcastle and the University of Queensland.

The results shows that among the 7510 participants who has completed surveys 1, 2 and 3, 11% (n = 829) reported were smoking occasionally, 17% (n= 1291) smoked regularly, 15% (n= 1127) were ex-smokers and 57% (n = 4263) reported never smoking. Thus, 39% of all current smokers were occasional smokers. Among the baseline occasional smokers, 40% (n = 331) reported that they had smoked daily for 6 months and 58% (n = 484) reported never smoking daily for 6 months.

The three smoking groups compared in the subsequent analysis of smoking transitions between survey 1 and 2 comprised those 240 daily smokers, 226 non-daily smokers and 361 stopped smoking at survey 2. The groups compared in the analysis of smoking transitions between surveys 1 and 3 comprised 193 daily smokers 177 non-daily smokers and 454 stopped smoking at survey 3.(Daily smoker and non-daily smoker = decreased, quit rate = increased).

It was found that young women who were most susceptible to progressing to daily smoking and had intermediate levels of education. These educational qualifications may place them in occupational groups (eg, hairdresser, clerical and administrative worker, or sales assistant) that have higher smoking rates than the wider population. In connection to this, a recent study among the young, non professional Australian workers found that 50% were current smokers, with smoking rates ranging from 38% among those working in retail or fast food outlets to 71% among hair dressers.
It was further found out that marriage and parenthood modify smoking behavior and in the multivariate analysis, marriage was statistically significantly associated with not smoking at both points of time, whereas the relationship between not smoking and becoming a parent was evident only for surveys 1 and 2. This can be because of a strong association between parenthood and marriage which concerned more with lifestyle and health, increased personal commitment to a spouse, as well as to preparation for parenthood. Also a qualitative research on life transitions and young women's smoking behaviour suggested that around their mid-20s, young women become more concerned about the addictive nature of cigarettes and their capacity to quit, as they consider their future health and plans for having children.

The associations between tobacco, alcohol and illicit drug use was examined and was found that the use of one or more of these substances is associated with subsequent use of the others. As young adulthood is a stage of life that includes going out with friends, drinking and experimenting with drugs in settings such as private parties, raves, pubs and clubs. Young women regard smoking as a normative behavior in these social settings, and as a means to meet and bond with others. Some of them only smoke in these circumstances, regarding themselves as "social smokers" and may quit smoking as they mature out of this "single, partying" stage of life towards marriage and parenthood.

2.6 Second Hand Smoke (SHS)

Tobacco use and exposure to secondhand smoke (SHS) are widely viewed as serious threats to the health of pregnant women, infants, and children around the
world. In fact, it has been a leading preventable cause of morbidity and mortality for women and men, and a leading preventable cause of poor pregnancy and infant outcomes, such as low birth weight (LBW), preterm delivery, placental abruption, and sudden infant death syndrome (SIDS) for many years.

In many low and middle-income countries (LMICs) the prevalence of tobacco use by women, including pregnant women, is low and recent surveys confirmed that there is a changing situation in using tobacco during pregnancy. Increased tobacco use and exposure to SHS among pregnant women in LMICs, where poor pregnancy outcomes are already common, threatens to undermine improvements in maternal and child health in these countries. The reduction of active smoking among pregnant women and eliminating SHS exposure of pregnant women and infants are directly relevant to Millennium Development Goals- number 4 emphasis on reduction of mortality and morbidity by improving maternal health.

In many countries tobacco use has long been considered a culturally inappropriate behavior for women and girls, and the stigma associated with tobacco use has inhibited tobacco use initiation among women and girls. However, globalization, modernization and efforts to improve the status of women are eroding traditional cultural constraints on women’s behavior, including women’s tobacco use behaviors. In this regards, there are the dual challenges of maintaining and even reducing the generally low prevalence of cigarette smoking in women, while also reducing the high prevalence of their exposure to SHS, reflective of the high rates of smoking among men in many countries.

However, tobacco use by men and women in high-income countries continues to decrease, the multi-national companies and many national tobacco industries have
targeted women and girls in LMICs as an untapped and potentially vast market. Western style tobacco marketing frequently associates women’s cigarette smoking with independence, sophistication, sex appeal, slimness, and fashion. Additionally, exposures to images of tobacco use in movies and other entertainment media are likely to contribute to a view of cigarette smoking as ‘normal’ in LMICs.

Tobacco use by women at the individual level comprises of women’s knowledge of health hazards of tobacco use, including use during pregnancy and postpartum; perceived ‘benefits’ of tobacco use; perceived social acceptability of tobacco use for women and girls; perceived ability to ask family members not to smoke in the home; awareness and perceptions of cigarette brands and tobacco marketing strategies targeting women; perceived social support for quitting.

In addition, pregnant women’s exposure to SHS inside the house and in workplaces is widely prevalent. The local understanding and concerns about tobacco use and SHS is best mechanized by rising awareness on the harms of tobacco use and SHS exposure; industry targeted marketing strategies in place in individual communities; community implementation of evidence-based tobacco control strategies. Towards the health care of the pregnant women tobacco use and exposure to SHS, knowledge of health risks, including pregnancy-specific health risks, training and perceived ability to deliver cessation interventions, prohibitions on tobacco use in healthcare settings, barriers to providers’ assessing and assisting pregnant women to quit tobacco use.
2.7 Legislation and Regulation on Tobacco

Legislation is at the core of the effectiveness and success of tobacco control program and regulation. It is known that the impact of tobacco has been in several ways entering all populations and age group. The WHO adopted Framework Convention on Tobacco Control (FCTC) in May 2003 at its 56th session and the convention was to take effect after a minimum of 40 countries had ratified to it. India is the largest democratic country as well as the 8th nation that has ratified FCTC on the 8th February, 2004.

A framework convention (FCTC) is an international legal instrument by establishing a general system of governance for tobacco control. It lays down the general requirements for those countries rectified to it in respect of the measures that need to be taken in the area of tobacco control. The countries could modify the existing laws or develop new laws which could reflect the commitments.

The main objectives and key provisions of FCTC is ‘to protect present and future generations from the devastating health, social, environment and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the parties at the national, regional and International levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke’.

The WHO has a constitutional mandate and FCTC recommends initiatives at the national and international level. The main provisions of the FCTC on The Cigarettes and Other Tobacco Products Act, 2003 are:

a. Tax policies - Ministry of Finance to increase taxes on tobacco products.
b. Protection from secondhand smoke - Strict prohibition of smoking in a defined public places.


d. Packaging and Labeling – Information on nicotine and tar contents along with permissible limits to be indicated on every package of cigarettes and tobacco products.

e. HealthWarnings – Prominent warning, including pictorial warnings depiction of skull and cross bones and any other such warnings that is to be notified.

f. Education, Communication, Training and Public awareness – It is not a legislative measures in the Indian Act and require administrative actions to mobilize multiple stakeholders, engage civil society and utilized public-private partnership.

g. Advertising, Promotion and Sponsorship – The Indian Act imposes a total ban on direct and indirect advertisements on cigarettes and other tobacco products and also prohibits sponsorship of sports and cultural events. This is extent to producers, suppliers and distributors and control of media.

h. Tobacco Dependence and Cessation – It is not a legislative measure and administrative action by the Ministry of Health and allied agencies to expand and strengthen existing tobacco cessation programmes.

i. Smugglings- The measure to curb illicit trade on tobacco under the Indian Custom Act 1962, which need review and amendment to incorporate the recommendations of FCTC.
j. Sales to and by minors – Prohibition of sale to minors by limiting accessibility by minor and ban within 100 yards of educational institutes. However, the FCTC has no provisions on prohibition of sales of cigarette and tobacco products by a minor.

2.7. 1 Tobacco Control in India

In India, the legislation on tobacco control started evolving in the mid 1970s mainly due to increasing scientific evidence of tobacco being a major cause of mortality and morbidity in the world. The growing awareness on the adverse health effects of tobacco consumption in India, the government of India enacted The Cigarette (Regulation of production, Supply and Distribution) Act 1975, which made mandatory to display a statutory health warning on all packages and advertisements of cigarettes. The Act was passed to regulate the restriction of productions, supply and distribution of cigarettes and clearly state that “Smoking of Cigarette is harmful habit, and in the course of time, can lead to grave health hazards….”(Battle for tobacco control-The Indian experience, Legislation and Enforcement, Report on tobacco Control, GoI, 2004). The main highlights of the Act relevant to the study are that it requires the manufacturers to display a statutory warning’ to inform citizens on the harmful effects of smoking as ‘cigarette smoking is injurious to health’ it also made an obligation that manufacturing, distribution and supply of cigarette should bear specific health warnings and clearly visible to the buyers.

During the 1980s and 1990s, the states and central government imposed further restrictions on tobacco trades and efforts and initiated to bring forth a
comprehensive legislation on tobacco control. There was national consultation on ‘Tobacco or Health’ in 1991 and the proposal was deferred to evaluate the revenue and economic impact of tobacco control.

Further, the issue of tobacco use and its health effects increasing received international and national concern. There was a tremendous pressure from the civil society and the National Commission for Human Right, India also stepped out advocating tobacco control is essential measures to promotes human rights and convened a South East Asia Regional Consultation on ‘Public Health and Human Rights’. Later, the high court of Kerala and the Supreme Court of India called for effective bans on smoking in public places and affirmed the rights of non-smokers to breathe air free from tobacco smoke.

The critical analysis of The Cigarette Act, 1975 indicated the inadequate accomplishment due to incomprehensive coverage and was feeble in its provisions. Also the health warning is too mild to be effective deterrent. The main criticism of the Act is that in its purview did not include the non-cigarette products like beedi, cheroots, gutkha and cigars and these are hugely consumed tobacco products in India.

Finally, the Indian parliament has passed the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Bill, in April 2003 and became an Act on 18th May, 2003 and was enforced on 1st May, 2004.