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A Thing to Chew On

Manufacturers protest an imminent ban on chewing tobacco

If a government committee has its way, your favourite pan masala pouch could soon disappear from your neighbourhood pan shop. It has recommended a blanket ban on the manufacture, distribution, stocking and sale of all forms of chewing tobacco including pan masala, gutka and plain and zafrani zarda.

The proposal was mooted by the expert committee appointed by the UF government, in its meeting of September 1997. Last month, it was decided, in principle, to ban these products on health grounds. It is expected to be ratified when the Central Committee on Food Standards under the Directorate General of Health Services (DGHS) meets in New Delhi on April 13, after which a public announcement will be made.

The ban's triggered by the government accumulating substantial evidence that non-smoking tobacco causes cancer of oral cavities, pharynx and oesophagus and also leads to coronary artery diseases. The committee also says it has data to prove that consumption of chewing tobacco has increased the incidence of oral cancer in the country. According to official statistics, consumption has increased tremendously over the last decade or so. The industry has grown six-fold in five years to reach around Rs 1,200 crore in turnover in 1997.

Among the studies referred to by the committee is one by the National Institute of Nutrition, Hyderabad, which states that pan masala with chewing tobacco, if consumed for five to seven years, led to oral fibrosis. Another study by the Regional Cancer Centre, Thiruvananthapuram, in collaboration with Johns Hopkins University of the US, showed mutagenic activities—which could lead to genetic deformities—amongst users of pan masala, with or without tobacco. Yet another study by Chittaranjan National Cancer Institute, Calcutta, revealed that 31 per cent of malignant cancer cases were attributable to tobacco.

The prospect of this ban has left manufacturers of flavoured chewing tobacco fuming. The domestic industry, with close to 300 companies and a Rs 1,200 crore turnover in the organised sector, says the government is acting in haste and under the influence of MNC cigarette companies who have been the direct sufferers of the pan masala and gutka revolution in India. They claim the cigarette industry has lost 25 to 30 per cent of their market since the beginning of organised chewing tobacco manufacture in India 12 to 15 years ago. "It's funny that a cigarette, which has 100 per cent tobacco content, is allowed to survive and pan masala and gutka, with 20 per cent tobacco, is being banned," says Shree Gopalji Gupta, MD, Gopal Industries of Gopal zarda. Says M.M. Kothari, proprietor, Kothari Products, makers of the popular Pan Parag pan masala and gutka: "Cigarettes have been proven to be harmful. When doctors and researchers in the US and Europe are asking people to switch to chewing tobacco, in India, the government is going the other way round."

TRIBHUVAN TIWARI

Manufacturers find it funny that pan masala, which has 20 per cent tobacco content, is being banned and not cigarettes which have 100 per cent tobacco.

Manufacturers argue that studies show chewing tobacco is 98 per cent safer than cigarette smoking. A study by the Central Tobacco Research Institute, a government agency, said "chewing of tobacco or its presence in gutka and pan masala is far less harmful, *if at all*, in comparison to direct smoking of tobacco, cigarettes and cigars."

The manufacturers also point out that the committee in its report has admitted that epidemiological studies linking oral cancer to the use of pan masala and other forms of chewing tobacco, were unavailable and the government had based its report on unsubstantiated theories. "The government has no concrete evidence to prove this sector is directly responsible for the incidence of oral cancer. Its decision is arbitrary," says Ashok Agarwal of Dharampal Satyapal Group, makers of Rajnigandha pan masala and Tulsi zarda.

But DGHS officials say that since pan masala in India is of recent origin and oral cancer has a long incubation period of 15 to 20 years, any epidemiological study now would be useless. Their theory: "Sufficient information is available on the carcinogenicity or cancerous nature of two mixtures similar in composition with pan masala containing tobacco—Mainpuri tobacco and *mawa*, a tobacco mix. If these can have a harmful effect on human beings...pan masala containing tobacco would have the same harmful effects."

The other aspect is that the industry employs over 50 million people in its manufacture and raw material supply and many more in its distribution networks. That could be too large a number for a bare-majority Union government to offend. If it follows the committee's recommendations, there could be serious political repercussions. The question now is of priorities. ■

Arindam Mukherjee

This photo copy is being supplied ... and study

BUSINESS STANDARD
(CALCUTTA)

12 SEP 1997

CHC

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Production-linked excise levy for pan masala units soon

12/9/97 D75 BS M105

Our Economic Bureau
NEW DELHI

After mini-steel rolling mills, the revenue department is proposing to target pan masala manufacturers to check excise evasion by bringing them under the purview of production linked method of excise assessment.

Targeting sectors where units are suspected to be evading excise duty payment, through suppression of their production by under invoicing, is part of the revenue department's game plan to mop up additional revenue for the current financial year.

Production linked assessment of excise is based on the premise that the excise paid by the manufacturer at the gate should broadly match the installed capacity of the unit multiplied by the value of the product.

If the company has either under invoiced or suppressed production, the revenue department believes that it would be reflected when excise inspectors resort to this rough calculation.

The pan masala is an unorganised industry and only a few reliable estimates are available about its size, production or turnover. Even Pan Parag, the best known pan masala brand in not listed.

However, the pan masala business is roughly estimated to be a Rs 500 crore industry, localised to the Uttar Pradesh belt, with a large number of units operating in this sector estimated to be evading tax payments.

Mini-steel mill and ingot manufacturing units were the first sector to be brought under the purview of production linked mode of value assessment of excise duty payment.

The industry is also localised and is concentrated around the Delhi belt. Here too, the revenue department suspects that the manufacturers have been suppressing production by under invoicing to evade excise duty payment.

The revenue department is looking at various alternatives to raise duty collections primarily on account of the across the board rate cuts effected by the 1997-98 budget, combined with an industrial deceleration which is not expected to clear before the second quarter of the current financial year.

"We are now looking microscopically at excise evasion," revenue department sources said.

The MRP is the other mode of assessment being implemented by the revenue department to check excise evasion.

The revenue department has notified a number of sectors, including cosmetics and toiletries, footwear, aerated water and television manufacture under MRP.

THE TIMES OF INDIA (BOMBAY)
3 MAY 1998

D75

Should gutka be banned? Yes, says a majority

Chewing tobacco and pan masala have been linked with OSF, a mouth disease that could lead to oral cancer. Till recently the condition was restricted to the elderly. Today, eight out of 10 new cases involve people under 35, many of them still teenagers. An expert committee has called for a ban; the government is reportedly working on a notification. Clearly, the dangers cannot be ignored.

Beginning a series of surveys on issues of compelling national interest, the *Sunday Times* initiated a wide-ranging, scientific opinion poll to gauge public feelings on whether the ban is necessary, fair or even feasible. Adding the full health picture to the findings, we present a comprehensive Special Report on a serious matter to chew on

By K. Balakrishnan and G. V. L. Narasimha Rao

THE consumption of pan masala and gutka (flavoured mixtures of *supari*, lime, chewing tobacco and spices) has increased phenomenally in the country over the last decade or so — particularly after these products were made available in small 5ml pouches. And, concomitantly, there has been growing concern over the accumulating scientific evidence that these products are highly carcinogenic, and are responsible for the increasing incidence of oral submucous fibrosis (OSF) and oral cancer.

Pan masala by itself (without chewing tobacco) has been shown to have 'high mutageneity', and gutka (pan masala with tobacco) even more so. And clinical studies suggest that use of these products leads more readily to OSF and oral cancer than the traditional betel quid with tobacco.

So much so that an expert committee appointed by the central government (headed by Dr S P Agarwal, Director General of Health Services) has recommended a comprehensive ban on the manufacture and sale of these products and, reportedly, the government has readied a notification.

The imminence of a ban has had manufacturers of pan masala and gutka crying foul. They cite the distress that will be caused to the millions of farmers and workers dependent on this industry for their livelihood and they also see the hand of the powerful MNC-dominated cigarette industry behind this move since the growth of the "smokeless" chewing tobacco products has cut into the marketshare of cigarettes.

What do the consumers and the public at large feel about this issue? An opinion poll conducted for *The Times of India* in eight metropolitan cities across the country brings up some very interesting results.

The survey shows that 36 per cent of the respondents (48 per cent of the men and 18 per cent of the women) have at some time consumed pan masala or gutka.

More significantly, in 46 per cent of the households someone is a regular consumer of these products. This proportion, of captive consumer households, is highest in Ahmedabad (at 85 per cent), is 65 per cent in Patna, 62 per cent in Lucknow and is the lowest in Delhi where it is 31 per cent.

The poll clearly brings out the high level of awareness and concern among the metro population of the health hazard posed by these products. A large majority (69 per cent) of the respondents favour a complete ban on them.

The sentiment favouring a ban is highest in Bangalore (86 per cent) where the consumption level is relatively low but, significantly, even in high-consumption cities a large majority are in favour of a ban: 82 per cent in Lucknow, 78 per cent in Patna and 69 per cent in Ahmedabad. In Calcutta, only 51 per cent favour a ban while 36 per cent are against it.

The adverse impact a ban is likely to have on the livelihood of lakhs of people (tobacco and arecanut farmers, workers in manufacturing units, distributors and *panwalas*) was brought to the attention of the respondents. Despite this, 52 per cent of the respondents are firm in their opinion that an immediate ban is desirable, while 19 per cent feel the ban can be phased out over a period of two to three years to enable farmers to switch to other crops and for manufacturers and workers to shift to other occupations. There is a great measure of support for incentive schemes for farmers, manufacturers and workers to enable them to switch to other crops and occupations smoothly.

In case a ban is not imposed, 55 per cent of those polled would favour discouraging consumption of pan masala/gutka through mandating prominent statutory warnings, ban on advertising and heavy taxes — just as in the case of cigarettes.

Are pan masala and gutka more harmful than cigarettes and *bidis*, and is a differential treatment between them justified? A clear majority feel they are equally harmful and that a ban, if imposed, should extend to cigarettes and *bidis* too.

A significant finding of the study: Women are much stronger votaries of a ban on pan masala/gutka along with cigarettes and *bidis* — about 75 per cent of the women favour a comprehensive ban compared to 55 per cent of the men.

The survey was carried out for *The Times of India* by Development & Research Services, the Delhi-based public opinion polling agency, in the eight metropolitan cities of Delhi, Mumbai, Calcutta, Chennai, Bangalore, Ahmedabad, Lucknow and Patna. In each city, 200 to 300 adult respondents were interviewed following a stratified random sampling procedure. In all, 2,062 respondents were interviewed in households with the help of a structured questionnaire on April 25 and 26. The findings are subject to an error margin of plus or minus 3 per cent.

(This is the first of a series of opinion polls that have been planned on important national issues. The opinions expressed in this survey are entirely those of the respondents in metro cities who were carefully selected according to a scientific sampling procedure. They are not to be attributed to this newspaper or to the sponsor)

THE T... ... INDIA
(BOMBAY)

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State asked to clarify stand on 'gutka' trade

By A Staff Reporter

MUMBAI: The Mumbai Bidi Tambakhu Vyapari Sangh has demanded that the state government clarify its position on the proposal to ban the sale of *gutka* in Maharashtra.

Although state health minister Daulatrao Aher has made several announcements about the proposed ban, no legislation has been introduced so far. As a result, retail traders were often harassed for selling the item, the Sangh said.

"We do not oppose the ban. But we have continued to sell *gutka* because the state government's position is unclear. However, several people have demanded money from retail traders by threatening to report them for continuing to sell *gutka*," said Sangh president Sharad Rao. He said the state had banned only three *gutka* brands so far but the public believed there was a blanket ban on *gutka*.

The Sangh will hold a demonstration in the city on Thursday to press its demand. A delegation will meet deputy chief minister Gopinath Munde. If their demands are not attended to, around 20,000 retail traders in the city start boycotting Goa *gutka*, Mr Rao said. There are around 35,000 *gutka* outlets in the city, he said.

Mr Rao also demanded that *gutka* manufacturers provide bills to the retailers. He claimed that when adulterated *gutka* packets were detected, the government lodged proceedings against retailers. "Since they have no bills to pin the blame on manufacturers, the retailers are made scapegoats," said Mr Rao.

When asked how many cases had been lodged against retailers so far, Mr Rao said that only around eight cases had been lodged so far and that too by the weights and measures department.

Mr Rao also said that workers from the Brihanmumbai Electric Supply and Transport Undertaking (BEST) would hold a dharna on Wednesday to press for Diwali bonus.

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Control of Tobacco-related Cancers and Other Diseases
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Carcinogenic potential of some Indian tobacco products

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Although there is epidemiological evidence to link tobacco use with oral cancer in India, the carcinogenic potential of tobacco products has not yet been established in long-term bioassays. In a study conducted in animal systems with tobacco products commonly used in India, we conclude that (i) certain tobacco products used in India are carcinogenic to animal systems; (ii) the carcinogenicity is enhanced by a commonly used herbicide and by chillie extract; (iii) betel quid containing tobacco extract is less harmful than an extract of tobacco alone; and (iv) *bidi* smoke condensate is also carcinogenic. It is suggested that various modulatory factors may be involved in oral carcinogenesis, and the identification of such factors constitutes an important means of reducing the risk from tobacco.

INTRODUCTION

Tobacco habits are prevalent in all sections of Indian society, and most consumers begin use at an early age and continue for several decades. The dynamics of tobacco use in the population is described in an earlier paper (see Bhonsle *et al.*, this volume). Tobacco habits in India include smoking of cigarettes, *bidis, chuttas, chilum* and *hookli*. Tobacco is also chewed, generally with slaked lime or in a betel quid. In rural areas, tobacco is also used as a toothpaste in the form of *gudhaku* and *mishri*. The latter is a pyrolysed product used initially for cleaning teeth but which becomes a habit, especially among women in Maharashtra (1). Several tobacco-containing toothpastes (creamy snuff) have become available commercially and are becoming increasingly popular. Tobacco is also used for inhalation as snuff by a small minority of older people.

A link between tobacco chewing (in betel quid) and oral cancer was suspected as early as 1902 (2), and this was subsequently confirmed (3); however, the carcinogenic potential of such tobacco products has not yet been established in long-term bioassays. We report here on the carcinogenic potential of some Indian tobacco products in mice, rats and hamsters.

MATERIAL AND METHODS

Experimental animals: Eight-week-old male Swiss mice, 8-week-old male Wistar rats and 8-week-old, male Syrian golden hamsters were treated with various extracts, as described below. Animals were maintained at 20 ± 1°C and fed standard laboratory diet (4). They were treated with the preparations described below.

Preparation of products and extracts

Tobacco extract: *Pandharpuri* brand of chewing tobacco *(Nicotiana rustica)* was purchased from a local market and an ethanol extract was prepared by the method of Shah *et al.* (4).

Betel quid with tobacco: A water extract of a quid containing two *Piper betle* leaves, 1 g areca nut, a pinch of catechu, slaked lime and 4 g tobacco was prepared by the method of Shirname *et al.* (5).

Tobacco plus benzene hexachloride: In order to simulate the human situation, 50 g tobacco were mixed with 100 ml saliva obtained from normal, healthy subjects with nò tobacco habit. The mixture was diluted in distilled water and flash-evaporated to obtain a viscous fluid, which was mixed with mouse diet and with 0.625 g benzene hexachloride, a common herbicide, to a final concentration of 125 ppm.

Chillie extract: Chillies, (*Capsicum annum* and *C. frutescence*), often used in the Indian diet, were extracted by the method of Nagabhushan and Bhide (6).

Mishri: *Mishri* was prepared as described previously (see paper by Bhonsle *et al.*, this volume). An extract was prepared by the method of Kulkarni et al. (7) and evaporated to dryness. The residue was dissolved in acetone to give a total of 1 or 2.5 g *mishri* in 20 µl of acetone.

Bidi smoke condensate: A solution of *bidi* smoke condensate in dimethyl sulfoxide was prepared as described by Shirname *et al.* (8).

Snuff: One popular brand of crude nasal snuff and one of scented nasal snuff were suspended in liquid paraffin for topical application.

Treatments: Eight independent experiments were carried out using the products described above.

(i) In the first experiment, 20 male Swiss mice were fed extracts of tobacco or betel quid with tobacco by gavage, five days per week for 16 months. At the end of this period, animals received only a normal diet and were observed until death. Controls received distilled water by gavage and a normal diet. (ii) In the second experiment, 20 Swiss mice received a diet containing 50 g tobacco per kg diet until they were 20 months old. Both the diet and drinking-water were given *ad libitum*. At the end of treatment, they were returned to a normal diet and observed until death. Controls received a normal diet only. (iii) A further group of 40 Swiss mice received the diet containing tobacco/saliva extract and benzene hexachloride *ad libitum* to the age of 18 months. At the end of treatment, they were returned to a normal diet and observed for life. Groups of 40 mice receiving only 125 ppm benzene hexachloride or only the tobacco/saliva extract or normal diet were used as controls. (iv) A group of 25 BALB/c mice received tobacco extract in the diet and chillie extract in drinking-water (1 mg capsaicin/ml) *ad libitum* until the age of 18 months, after which time they were observed until death. Control groups of 25 mice received only tobacco extract or only chillie extract. (v) Groups of Swiss mice, Wistar rats and Syrian hamsters consisting of 30 animals in each group were fed diets containing 10% *mishri* for 20 months, after which time they were returned to a normal diet and observed until death. (vi) Groups of 30 Swiss mice and Swiss nude mice, a mutant strain that is highly sensitive to skin carcinogenesis (9), were painted on the back skin with 2.5 mg *mishri* extract once a day for five days per week until they were 20 months old and were observed until death. Mice receiving acetone or no treatment served as controls. (vii) 20 Swiss mice were given 1 mg *bidi* smoke condensate by gavage once a day on five days per week for 35 weeks, then observed until death. Controls received either 0.1 ml dimethyl sulfoxide or no treatment. (viii) Groups of 20 hamsters were treated topically on the cheek pouch epithelium with 20 mg crude or scented snuff on five days per week for a period of 21 weeks, at which time they were sacrificed. A positive control group of 20 hamsters received 7,12-di-methylbenz[*a*]anthracene (DMBA), a standard carcinogen, and a further control group received no treatment.

Histological methods: All the control and treated animals from different groups were killed by cervical dislocation and dissected carefully. Lung, liver, kidney and other grossly abnormal tissues were fixed in 10% formalin.

processed by routine histological techniques and embedded in paraffin. Paraffin sections, 6 µm thick, were cut and stained with haematoxylin and eosin for microscopic examination.

RESULTS

Tobacco extract administered to Swiss mice by gavage or in the diet induced lung and liver carcinomas in 10/20 and 8/18 treated animals, respectively (Table 1). Only one mouse in the control group developed a lung tumour. The extract of betel quid with tobacco was less tumorigenic; however, simultaneous treatment with benzene hexachloride or with chillie enhanced the tumorigenic effect of tobacco. In animals treated with tobacco extract + BHC,

Table 1

Tumour incidence in Swiss and BALB/c male mice treated with betel quid and tobacco (BQT), tobacco (T) alone or in combination with benzyl hexachloride (BHC) or with chillie

Group	Effective no. of mice[a]	Route	Tumour incidence (months)			Total tumour incidence
			9-14	15-20	21-25	
Swiss						
Untreated	20			0/6	1/14	1/20 (5%)
BQT	18	Gavage		1/10	3/8	4/18 (22%)
T	20	Gavage		8/15	2/5	10/20 (50%)
T	18	Diet			8/18	8/18 (44%)
T+BHC	40	Diet	14/20	20/20	—	34/40 (85%)
BHC	35	Diet	0/10	7/9	14/16	21/35 (60%)
BALB/c						
T	15	Diet	0/6	2/9	—	2/15 (13%)
T+chillie	15	Diet Drinking-water	0/3	4/12	—	4/15 (27%)
Untreated	20	—	0/6	1/10	—	1/20 (5%)
Chillie	23	Drinking-water	2/14	0/9	—	2/23 (9%)

[a]Number of mice that survived beyond eight months

Table 2

Lung and stomach papilloma incidences in mice, rats and hamsters kept on 10% mishri *diet*

Species	Treatment	Age group (months)		Total tumour incidence
		12-18	19-25	
Mice	Untreated		1 lung 2 stomach	3/27 (11%)
	Mishri		2 lung 12 stomach	14/26 (54%)
Rats	Untreated	0/6	0/19	0/25
	Mishri	2/6	8/21 stomach	10/27 (37%)
Hamsters	Untreated	0/6	2/20 stomach	2/23 (9%)
	Mishri	3/10	9/18 stomach	12/28 (43%)

Table 3

Skin lesions induced by daily painting of mishri *extract on the back skin of Swiss and Swiss nude mice*

Strain	Treatment	Incidence of lesions			Total tumour incidence
		Hyperplasia	Papilloma	Carcinoma	
Swiss	Acetone (20 μl)	8/30 (27%)	0	0	0
	Mishri (2.5 mg/day)	14/30 (47%)	0	0	0
Swiss nude	Acetone (20 μl)	19/23 (83%)	0	0	0
	Mishri (1 mg/day)	13/21 (61%)	6	1	7/21 (33%)
	Mishri (2.5 mg/day)	9/17 (53%)	6	0	6/17 (35%)

Table 4

Tumour incidence in Syrian golden hamsters treated with snuff inhalation

Group of animals	No.	Papilloma		Papillomas per hamster			
		Cheek pouch	Stomach	0.5-1.0 mm	1-1.5 mm	2-4 mm	Total
Untreated	15	—	—	—	—	—	—
DMBA	20	10/15 (66%)	15/15 (100%)	9.9	6.8	—	16.7
Crude snuff	20	0/20	17/20 (85%)	12.7	1.0	—	13.7
Scented snuff	20	0/20	15/20 (75%)	6.7	1.5	1.0	9.2

hepatocarcinomas were observed, and the increase in tumour incidence was significant ($p<0.05$). In the tobacco + chillie group, an increased incidence of lung adenocarcinomas was observed ($p<0.1$).

Feeding of 10% *mishri* in the diet to mice, rats and hamsters increased the incidence of papillomas in the lung and stomach in all the three species over those in controls (Table 2). *Mishri* extract induced skin papillomas in Swiss nude mice but not in Swiss mice, although hyperplasia was seen in 14/30 animals (Table 3).

Neither type of snuff induced cheek-pouch papillomas in treated hamsters, but forestomach papillomas were observed in 17/20 and 15/20 animals (Table 4).

Among BALB/c mice treated with *bidi* smoke condensate, 7/15 developed tumours, two of which were carcinomas (one of the stomach and one of the oesophagus). The other tumours were four liver haemangiomas and a papilloma of the stomach. No tumour was seen in controls.

DISCUSSION

We have demonstrated the carcinogenicity to experimental animals of an extract of the tobacco commonly used for chewing in India, and have shown that the carcinogenicity is enhanced by a commonly used herbicide (benzene hexachloride) and by chillie (a common component of the Indian diet). The finding that the extract of betel quid containing tobacco was less carcinogenic to mice after gavage than tobacco extract may be attributed to a chemopreventive effect of betel leaf and *catechu*, two important constituents of betel quid, which are proven antimutagens (10,11). Betel leaf has been shown to be anticarcinogenic as well (12). *Mishri* appears to be a weak carcinogen, since it induced only benign tumours in the skin of mice and in the forestomach of mice, rats and hamsters. We further found hamster cheek-pouch mucosa to be more resistant than forestomach mucosa. *Bidi* smoke condensate induced two carcinomas, one of which was in the oesophagus. These data indicate the carcinogenicity of many of the tobacco products used by the Indian people.

The carcinogenicity of cigarette smoke, which contains two major classes of carcinogens, namely polycyclic aromatic hydrocarbons and tobacco-specific *N*-nitrosamines (TSNA), has been adequately proven (13-15); we report here on the carcinogenicity of *bidi* smoke condensate. *Bidi* smoke is reported to contain both polycyclic aromatic compounds as well as TSNA (16,17). The carcinogenicity in experimental animals of smokeless tobacco products used in the USA and Europe has also been reported in recent years (13,18), and we reported earlier on the carcinogenicity of chewing tobacco in mice (4) and the presence of polycyclic aromatic hydrocarbons and TSNA in snuff, which are initiator and promoter types of compounds, respectively (16,17). Tobacco used for chewing, in the crude or in processed form, contains considerable quantities of TSNA (19,20), two of which, *N*-nitrosonornicotine and 4-(methyl-nitrosamino)-1-(3-pyridyl)-1-butanone (NNK), are potent carcinogens in mice, rats and hamsters (18,21). These two compounds induce tumours in lung, liver and stomach; however, relatively few tumours are observed in the oral mucosa. Recently, we succeeded in inducing cheek-pouch tumours in hamsters by adding hydrogen peroxide simultaneously with NNK; *in vitro*, peroxide radicals appear to be formed transiently in the oral cavity during the chewing of tobacco (22).

Although the oral mucosa of tobacco chewers is bathed in saliva containing TSNA (74-440 μg/day), other modulatory factors, such as spices, nutritional status and concurrent exposure to other carcinogens (through air, water and occupation) may influence transformation of the normal oral mucosa to malignant tissue. The identification of such modulators is an important aspect of reducing the cancer risk of tobacco users.

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PH-9

The Public Health Importance of Tobacco Control
The Case of Chewed Tobacco (Gutkha, Pan Masala, Zarda etc.)

A Review of events in India *

I. **Health Impact:**

Regular habitual tobacco chewing of 4-5 packets per day, over several years, results in gingivitis, leukoplakia, erythroplakia, and oral submucuous fibrosis (OSMF). These effects occur even within 3-5 years with later progression in 5-8% of cases to oral and throat cancer.

These cause-effect relationships have been extensively studied and substantiated by credible institutions, such as the Mumbai Preventive Oncology Dept. of the Tata Memorial Hospital; the Tata Institute of Fundamental Research, Mumbai which studied over 300,000 oral cancer patients country wide, over a 30 year period; Nanavati Hospital, Mumbai; Regional Cancer Institute, Trivandrum; Chittaranjan National Cancer Institute, Calcutta; Cancer Research Hospital, Kancheepuram; Chennai Government Dental College; among others.

II. **Public Health Dimensions:**

The production, sale and use of chewed tobacco in India has increased, particularly during the past two to three decades. There is no stigma, but in fact positive social sanction, for the use of chewed tobacco. It is popular among women and men, and even used by children.

Epidemiological studies reveal a shift in the age group affected by oral submucous fibrosis over two decades, from those above 40 years progressively to younger persons between 25-35 years. This disabling disease, that is incurable, results from a thickening of the inner lining of the mouth. A ten-fold increase in incidence is noted, over the past 30 years, and is described as an epidemic growing in front of our eyes.

Oral cancers açcount for 18-20% of cancers in India and are mainly tobacco induced. India has the second highest incidence of oral cancer.

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* by Dr. Thelma Narayan, Community Health Cell, Bangalore.
Sources of information include newspaper reports during the concerned periods.

CHC.
Bidi/Gutka file
24/10/2000

III. Legal Action :

1. Following public debate and representations from consumer and citizen's groups etc., a statutory Central Committee for Food Standards (CCFS) was constituted in 1994, under the Prevention of Food Adulteration Act (1954)*, during the Prime Ministership of Sri P.V. Narasimha Rao, to go into "the use of chewing tobacco in pan masala and gutka and its effects on public health". At its fourth meeting on November 26-27, 1997, based on a comprehensive review paper prepared by the Indian Council of Medical Research (ICMR), and on scientific evidence from other research institutions, the Committee recommended a ban on the manufacture, sale, distribution and storage of chewed tobacco (gutka, pan parag etc.).

2. The Director General of Health Services, who had chaired the expert committee, sent a communication to the State and Union Territories for a massive educational and public awareness campaign. There is not much evidence that this has trickled down to the field.

3. Based on the CCFS Report, the Government of India initiated work towards amending the PFA Act 1954. This was not taken to "fruition", as there was a change in the government.

4. It is useful to remember that the earlier ban on tobacco toothpaste was legally challenged. Despite the Supreme Court upholding the ban in 1997, tobacco toothpaste was reportedly still available in December 1997.

5. Rulings by the Rajasthan High Court (in early 1997), and by the Aurangabad Court in May 1997 (following a PIL by a consumer activist), have also asked for a total ban on gutka.

6. Kerala State had a different process. Following a campaign and social ban called for by NGOs, a particular Gram Panchayat of Pallipuram exercised its power and banned the sale of gutka, pan parag, etc. on 4.2.1997. North Paravoor Municipality in Ernakulam District also banned the sale of chewed tobacco products. This was followed by Kalamasseri Municipality in Ernakulam district. The above 3 instances were preceded 2 years earlier (1995) by Koolimad Village Panchayat of Kozhikode which banned sale of all tobacco based products.

   Later in 1997 the larger Kochi Municipal Corporation banned the sale of pan masala and gutka, followed by the checking of shops/ kiosks/ outlets by health inspectors and food inspectors. Under the ban, cancellation of trade licences and seizure of goods are to be undertaken.

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* Under the prevention of Food Adulteration (PFA) Act; 1954, the government is empowered to ban the sale of substances injurious to health, when used as food or as an ingredient of food.

In Kerala, the apex body of the merchant community, the Kerala Vyapari Vyavasai Ekopana Samiti was reportedly supportive of the move even at the cost of a loss of profit, because of a sense of "social responsibility".

This public debate, public action and action by local bodies, concerning tobacco use, has been taking place for more than five years, setting the societal context for the Kerala High Court Judgement of 1999 banning smoking in public places, which is to be implemented on a State wide level.

7. The chewed tobacco industry has challenged and opposed the proposed measures for control, through the All India Pan Masala and Tobacco Manufacturer's Association, the Zafrani Zarda Manufacturer's Association and by farmers' lobbies. They ask for further evidence or proof of direct link between use of the product with cancer through a countrywide survey. Issues concerning employment, revenue and appeals to swadeshi sentiments are raised. Proposed actions against chewed tobacco are attributed to be instigated by the smoked tobacco lobby as an internal competition, and also by MNCs in an attempt to "snuff out" domestic industry.

In mid 1998, the organised and unorganized sector of the Gutka Trade reportedly accounted for an annual turnover of Rs 2000 and Rs 3000 crores respectively. Imposition of a country wide ban would potentially effect 400 manufacturers of branded gutka and pan masala, who are estimated to control 65% of the market, and to employ 10,000 persons in India. Instances of different companies cited in Maharashtra show that the revenue generated to government is low, with most of the income being undeclared. The number rendered jobless was also small, who could be accommodated elsewhere, e.g.

Rahul Fine Products,	Rs 2 lakhs revenue,	74 employees
Johnny Walker Tobacco,	Rs 20 lakhs "	65 "
Sanket Food Products,	Rs 7 lakhs "	46 "

(Source-Indian Express 12/10/97)

The Maharashtra FDA Commissioner had recommended a ban on gutka and the Govt. of Maharashtra had written to the Central Govt. in July 1997 recommending a ban on gutka.

Conclusion

A cost benefit analysis is often used in decision making. While the costs to the industry are often mentioned in news items, the direct and indirect costs of illness to persons, households and health institutions need to be considered. Intangible costs of suffering are important components that we as informed citizens and concerned policy makers also need to consider. Would we like to subject our loved ones to these risks?

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PH-9
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Review Article

Is *pan masala*-containing tobacco carcinogenic?

KISHORE CHAUDHRY

ABSTRACT

Background. *Pan masala-containing tobacco (PM-T) was introduced in the Indian market during the 1970s. It is a mixture of areca nut, tobacco, lime, catechu and spices. Despite mounting evidence of health hazards of tobacco, tobacco manufacturers as well as policy-makers often seek evidence regarding the carcinogenicity of newer tobacco mixtures such as PM-T.*

Methods. *All the studies on pan masala (with or without tobacco) listed on MEDLARS, and the studies known to the expert committee on the subject constituted by the Directorate General of Health Services, were reviewed. The studies on individual components and PM-T like substances were also reviewed. The interpretation of carcinogenicity of PM-T has been made, based on studies on (i) PM-T; (ii) PM-T like mixtures; and (iii) the effect of individual ingredients of PM-T and the likely effect of their combination.*

Results. *Studies on Chinese hamster ovary cells and Ames test indicate that PM-T is mutagenic. There is limited evidence that it may be carcinogenic to animals. The proportion of areca nut and tobacco in PM-T is in between the proportion of these substances in two known tobacco–areca nut mixtures of India (Mainpuri tobacco and mawa). Studies on Mainpuri tobacco indicate that it is carcinogenic, while literature suggests an association between mawa use and oral submucous fibrosis.*

Conclusion. *Human studies on PM-T like mixtures and the limited studies on PM-T suggest that PM-T is likely to be carcinogenic.*

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INTRODUCTION

Betel quid chewing is an ancient, socially acceptable habit in India. This has helped in popularizing tobacco chewing practices. The introduction of *pan masala* in 1975 offered an easy way to carry the mixture which removed the inconvenience of its preparation. The increasing popularity of *pan masala* helped in introducing *pan masala*-containing tobacco (PM-T). In 1994, in Agra and Mainpuri regions, 52 brands of *pan masala* and 47 brands of PM-T were available. Thirty-five brands of *pan masala* were found to be popular among children. Twelve companies sold *pan masala* without a brand name. *Pan masala* (with or without tobacco) is available in tins as well as in small sachets. The sachets generally contain 3–5 g of the mixture. However, some brands have 2 g and 10 g packs as well. The price of these sachets varied from Re 0.25 to Rs 2.25 in Agra in 1994 (Lahiri VL, unpublished data, 1994).

Despite mounting evidence of the health hazards of smokeless tobacco, evidence is sought (especially by tobacco manufacturers and policy-makers) regarding the carcinogenicity of newer mixtures of tobacco. Human studies are the most important evidence for deciding the carcinogenicity of any substance, which means that to prove such an association one would have to follow up the users for a long time after introduction of these substances, or wait for 15–20 years to initiate case–control studies. Such an approach is against the principles of prevention. Therefore, it is important that the existing data are analysed for the possible health hazards of newer formulations of tobacco.

METHODS

This paper was prepared to help an expert committee of the Directorate General of Health Services, New Delhi, to decide on the health hazards of PM-T. All the studies on *pan masala* (with or without tobacco) listed on MEDLARS, and the studies known to the members of the expert committee were reviewed. The studies on individual components of PM-T and PM-T like substances were also reviewed.

CONTENTS OF *PAN MASALA*

The contents of *pan masala* vary from brand to brand and the exact details about their contents are closely guarded secrets. Three types of *pan masala* are available in the Indian market—plain *pan masala*; sweet *pan masala*; and PM-T. The constituents listed on the packets of various *pan masalas* include areca nut, catechu, lime, sandal oil, menthol, cardamom, flavours, spices, aniseed, sugar, waxes, oil seeds, colours, etc. Thus, *pan masala* has all the ingredients of betel quid except the betel leaf and some additives which are occasionally used in betel quid. Dry dates replace most of the areca nut in sweet *pan masala*. PM-T contains tobacco in addition to varying proportions of substances found in *pan masala*. On washing, *pan masala* has been found to have soft wooden particles other than areca nut (Lahiri VL, unpublished data, 1994). Areca nut forms about 80% of *pan masala*; catechu about 10%; lime about 1% of weight; and the remaining 9% includes various spices.[1] Areca nut also accounts for about 70%–80% of the weight of PM-T.[2]

The long shelf-life of *pan masala* is achieved by keeping the mixture free of moisture. The manufacturing process of *pan masala* involves cutting the areca nut into small pieces and drying it in ovens, till all the moisture evaporates. All the ingredients are then mixed manually or with the help of mixers. The mixture is immediately packed and sealed.

Other mixtures of tobacco, areca nut and slaked lime

Although PM-T was introduced in the 1980s, mixtures of areca

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nut, lime and tobacco (with or without additives) have been popular for a long time in different parts of India. Mainpuri tobacco is a mixture of mainly tobacco with finely cut areca nut, slaked lime, camphor and cloves.[3] However, the shelf-life of this mixture is about 10–15 days, after which it is not used, due to a change in colour, even though the manufacturers believe that it has the same effect. For this reason, the consumption of Mainpuri tobacco is limited to the Mainpuri district of Uttar Pradesh and areas around it.

Mawa is a mixture of 5–6 g of areca nut shavings, 0.3 g of tobacco and a few drops of watery slaked lime. The mixture is placed on cellophane and tied with a thread into a ball. Just prior to its use, the packet is rubbed vigorously to homogenize the contents, and a portion is rubbed on the palm and then chewed.[4] The use of *mawa* is popular in Gujarat, but it is also prevalent in other regions of India.

Chemical analysis of pan masala

Chemical analysis of five common popular brands of *pan masala* showed the presence of polyaromatic hydrocarbons, nitrosamines, and toxic metals such as lead, cadmium and nickel.[5] Another analysis of four brands of *pan masala* and three brands of PM-T showed the presence of polyaromatic hydrocarbons and residual pesticides, with wide variation between different brands. In this limited experiment, the variations did not seem to be due to the presence or absence of tobacco (National Institute of Occupational Health, Indian Council of Medical Research, Ahmedabad, unpublished data, 1989).

HEALTH HAZARDS OF *PAN MASALA* WITH TOBACCO

Human observations of the health hazards of *pan masala* (with or without tobacco) are not available. Some studies on its *in vitro* mutagenic and genotoxic potential, and a few animal studies have been reported. PM-T contains a known carcinogen—tobacco. Areca nut, the major ingredient, is suspected to be associated with oral cancer and submucous fibrosis (a pre-cancerous condition).

Information on the use of PM-T in the community is not available. As the consumption of PM-T increased during the late 1980s, it is possible that the proportion of persons currently using PM-T alone, for a period longer than the incubation period of oral cancer, may be small. Due to the long incubation period of oral cancer, epidemiological studies may not show any association between PM-T and oral cancer (even if it exists), unless the incubation period of the mixture is shorter than betel quid containing tobacco.

The main ingredients of *pan masala*, *mawa* and Mainpuri tobacco are areca nut and tobacco, though their relative proportions may vary in these mixtures. The proportion of areca nut and tobacco in PM-T is somewhere between that of *mawa* and Mainpuri tobacco. Lime is added to all the three mixtures. Presence of catechu in PM-T is a variation. Catechu is known to liberate tannins and polyphenols.[6] Since PM-T is likely to encompass the health hazards which are present in both *mawa* and Mainpuri tobacco, a comparative study of all these substances would be in order to determine the health hazards of PM-T. Thus, the likely health hazards of PM-T to human beings in this review have been based upon studies on (i) PM-T; (ii) PM-T like mixtures; and (iii) the effects of individual constituents of PM-T and the likely effect of their combination.

ANIMAL STUDIES

Very few studies[7,8] have been reported on the effects of *pan masala* (with or without tobacco) in animals, and there is only one study on PM-T and carcinogenesis.

Sinha[7] applied 0.5 g of PM-T in paste form on alternate days for six months on the entire buccal mucosa of 21 albino rats weighing 150–200 g, excluding two periods of two weeks each following the biopsy. Biopsies of the buccal mucosa were taken from both cheeks (by microlaryngeal biopsy forceps on one side and punch biopsy forceps on the other side) at the beginning of the study and every 2 months thereafter. The histological findings were compared with a control group of 14 albino rats. Fibronectin levels in serum and biopsied tissue (by combining 3 samples due to small amount) were also measured in both the groups. The proportion of animals with hyperkeratosis, oedema and increased vascularity in both the groups was not significantly different at any time during the study. Papillomatous changes were observed in 4 rats in the experimental group after 2 months, and in only 1 rat after 6 months. Such changes were not observed in the control group. Dysplasia was seen in 7 (3 moderate and 4 mild) of the 18 slides examined after 2 months. The number of animals with dysplasia gradually increased, and by the end of the study, 20 out of 21 animals showed dysplasia (6 severe, 9 moderate, and 5 mild). In contrast, 2 out of 14 controls showed mild dysplasia. Compared to controls, there was a significant decrease in the tissue levels and increase in serum levels of fibronectin in the experimental group. A previous study[8] had shown that the development of carcinoma in the hamster buccal mucosa pouch model was preceded by hyperkeratotic, dysplastic lesions which were similar to the dysplastic leukoplakia of humans.

Painting 1 g of *pan masala* in the oral cavity of albino rats on alternate days for 6 months also resulted in a mild-to-moderate loss of nuclear polarity, and increase in keratoses, parakeratoses, inflammatory cell infiltration and vascularity, as compared to controls.[9] The increase in mitotic figures was statistically not significant and no definite changes in the pigmentation of atypical cells were seen. Submucosal collagen increased steeply and steadily throughout the study period and at the end of 6 months, 88% of biopsies showed thickened and condensed submucosal collagen, suggesting submucous fibrosis. Although the comparison at the end of six months of intervention was statistically significant, the trend of increasing percentage positivity with time was observed only for submucosal collagen and vascularity. In this study, the effect of local injury as a confounder on these two parameters cannot be ruled out, as the biopsy quantum was more and the duration between the biopsies was less than that in the experimental group.

Earlier studies have suggested that the combined effect of an extract of tobacco and areca nut mixture on hamster cheek pouch is likely to be more than their individual effects. Suri *et al.*[10] showed that the development of leukoplakia and tumours in the buccal pouch mucosa of male golden Syrian hamsters was faster after the application of a dimethyl sulphoxide (DMSO) extract of a 2:1 mixture of tobacco and areca nut, compared to the extract of the individual substances. The extent of growth of tumours was also greater after application of the extract of mixture. Ranadive *et al.*[11] reported cheek pouch malignancy in male Syrian hamsters after application of DMSO extract of tobacco and areca nut, but not after application of extracts of the individual components. In another experiment, the proportion of Syrian hamsters developing buccal pouch malignancy was more with an aqueous extract of tobacco and areca nut (with and without lime) compared to an extract of areca nut, while an aqueous extract of tobacco or betel quid (with or without tobacco) did not result in malignancy.[12]

Chronic gavage feeding of *pan masala* in rats has been reported to result in impaired liver function (indicated by elevated serum glutamic oxaloacetic transaminase, glutamic pyruvate transaminase, and alkaline phosphatase), decrease in relative weights of the gonads and brain,[13] increase in sperm head abnormalities, and increase in the frequency of X–Y univalents and breaks.[14] A dose-dependent increase in sperm head abnormalities, sister chromatid exchange and cell cycle delay has been reported by intraperitoneal injection of *pan masala* in mice.[15] The same study reported a dose-dependent increase in chromosomal aberrations in the bone marrow after one month of feeding mice *pan masala* or PM-T. A significant dose-dependent increase in sperm head abnormalities was noted, but no significant changes in the weight of testes and total sperm count was seen.

MUTAGENICITY

Mutations in Salmonella typhimurium (Ames test)

Two reports on the mutagenicity of *pan masala* using *Salmonella typhimurium* are available.[16,17] Both the studies did not specify if the *pan masala* used in the experiment contained tobacco. Using the tester strain TA98 and TA100, Polasa *et al.*[16] tested aqueous extracts of 8 varieties of *pan masala*, 6 varieties of scented *supari* and areca nut. Three tested concentrations of dry extracted material (100, 200 and 300 µg/plate) showed statistically significant higher frequency of revertants, as compared to controls, except for one variety at 100 µg extract/plate with TA98. An enhancement of the effect was seen by activation with S9 mix. A dose–response relationship was also observed. All the 6 samples of scented *supari* (200 µg of extract) showed significantly higher revertants in both TA98 and TA100. Metabolic activation generally enhanced the effect. The effect was the same after addition of 500 ppm of saccharin to 2 samples of scented *supari*. The TA100 strain showed statistically significant results more often than TA98, and after S9 activation all the values with scented *supari* in TA100 were significantly higher than those in controls. The mutagenic effects of *pan masala* and scented *supari* extracts were similar to those produced by areca nut extract.

Bagwe *et al.*[17] tested polar and non-polar extracts of a popular brand of *pan masala* on Ames test using TA98 and TA100 tester strains of *Salmonella typhimurium*. No mutagenic response was seen in aqueous extracts, aqueous:ethanolic extracts and chloroform extracts. Pre-treatment with 300 µg of sodium nitrite at an acidic pH or metabolic activation did not change the results. However, the ethanolic extracts elicited a weak mutagenic response in strain TA98 without metabolic activation, suggesting the presence of direct-acting frameshift mutagens in *pan masala*. A dose-dependent increase in the number of revertants was seen up to a dose of 25 mg, after which there was a negation of the mutagenic response. The reason for the difference in these two studies is not clear.

Bhide *et al.*[18] found that only ethanolic extract of *Nicotiana tobaccum* induced mutations in *Salmonella typhimurium* TA98 but not in TA100, TA1535 and TA1538. However, Shirname *et al.*[19] reported a dose-dependent increase in revertants in *Salmonella typhimurium* TA1535 and TA100 (but not in TA98 and TA1538) by aqueous extracts of betel quid (with or without tobacco) and areca nut. An aqueous extract of betel leaf was not mutagenic in all the four strains, and in fact reduced the mutagenicity of areca nut in TA100 strain in the presence of S9 mix. Arecoline induced mutagenicity of areca nut in all the four systems in the absence as well as presence of S9, while arecaidine required S9 for inducing mutations in all these systems.

The addition of S9 mix in different studies has shown variable effect—no effect to potentiation of mutagenicity. The reasons for these variations need to be studied. Some probable factors are a batch-to-batch variation in the raw product, processing of the raw product, proportions of various ingredients in the mixture, storage conditions and ageing of the raw product or the mixture. Also, procedural differences in the conditions under which these experiments were conducted may have been different.

Even though there is no study on the mutagenicity of PM-T on Ames test, the existing literature suggests that PM-T is likely to be mutagenic on Ames test, at least on one of the four strains used (two studies reporting the mutagenesis of *pan masala* on Ames test did not specify the presence or absence of tobacco in the samples). This impression is based on the fact that studies have found aqueous extracts of betel quid (with as well as without tobacco), areca nut and areca nut alkaloids to be mutagenic. Ethanolic extracts of tobacco have also been found to be mutagenic. However, aqueous extracts of betel leaf have been found to protect against the effect of areca nut in the TA100 system. Neutralization of the mutagenic effect in a PM-T mixture is unlikely as all the ingredients have individually been found to be mutagenic.

Studies using Chinese hamster ovary (CHO) cells

The mutagenicity of *pan masala* and PM-T on CHO cells has been studied using their aqueous, ethanolic and DMSO extracts. Similar studies have also been carried out on betel quid (with and without tobacco), as well as on individual ingredients of betel quid and *pan masala*. Application of aqueous extracts of *pan masala* to CHO cells for 3 hours followed by recovery for 17 hours, resulted in a dose-dependent and statistically significant elevation in sister chromatid exchange (SCE).[20] A dose-dependent increase was also seen in the M1 fraction (with a corresponding decrease in the M3 fraction), average generation time, number of chromosomal aberrations (CA) per cell, and the proportion of aberrant metaphases. However, the increase was statistically significant only for aberrations per cell for cultures treated with the highest dose of the extract.

Another similar study showed significant elevation of CA, SCE, and micronucleated cells (MNC) in a dose-dependent manner in cultures without metabolic activation.[21] Addition of the S9 activation system generally resulted in suppression of chromosomal damage, suggesting that *pan masala* and PM-T contain water-soluble direct-acting mutagens. A DMSO extract of *pan masala* or PM-T was also found to significantly increase the frequency of CA, SCE and MNC in CHO cells, with the S9 mix resulting in suppression of CAs and MNC formation. However, there was no significant change in SCE counts.[22] The cytogenetic damage was greater with the DMSO extract than the aqueous extract.

A study of the combined effect of aqueous extracts of 1.11 mg of *pan masala* or PM-T and alcohol (in varying strengths) for 3 hours on CHO cells showed that alcohol alone, *pan masala*/ PM-T alone, as well as their combinations (irrespective of the sequence of exposure) increased CAs in a dose-dependent manner.[23] Simultaneous exposure to alcohol and *pan masala*/ PM-T showed a higher increase than sequential exposure. Exposure to 4% alcohol with *pan masala*/PM-T resulted in necrotic cells. A 20-hour treatment of CHO cells with alcohol (0.25% and 0.5%) and combinations of 0.22 and 0.55 mg of *pan masala*/PM-T also showed a similar increase in CAs. However, significant changes were not noticed by the application of individual substances. The

proportion of chromatid type aberrations was higher with PM-T extract, while it was about the same with *pan masala* extract (with or without alcohol). Ethanol alone as well as a combination of ethanol with PM-T extract resulted in a sharper increase in chromosomal type of aberrations.

Similar studies conducted on CHO cells showed significant increase in CAs and SCEs, using aqueous extract of *Nicotiana tobaccum*,[24] aqueous extract of areca nut,[25,26] nicotine,[27,28] arecoline,[25,29] and combinations of nicotine and arecoline.[30] A dose–response increase in CAs and SCEs was seen in all these experiments. A combination of nicotine and arecoline produced significantly higher cytogenetic damage than the corresponding concentration of either substance alone.[30] Betel leaf extract was not mutagenic, and resulted in decrease in CA and SCE frequencies due to *pan masala*/PM-T.[31]

Chinese hamster V79 cells

Shirname *et al.*[32] noticed that only ethanol extract of tobacco produced mutations in Chinese hamster V79 cells with S9 mix enhancing the effect. This extract also induced micronuclei in bone marrow cells of Swiss mice.

EFFECT ON HUMAN LYMPHOCYTES AND BUCCAL MUCOSA

Dave *et al.*[2] measured the CA and SCE frequency in peripheral lymphocytes and frequency of MNCs in the buccal mucosa in 30 healthy vegetarian teetotallers, with no history of viral infection or antibiotic therapy during the last six months, and who were not engaged in any hazardous occupation. The 10 *pan masala* and 5 PM-T chewers used the same brand as studied by the team for its effect on CHO cells,[22] and had no other concomitant tobacco, areca nut or betel quid habit for at least one year. Fifteen controls did not take tobacco, *pan masala* or areca nut. The habitues had no clinically detectable changes in the oral mucosa, but showed significantly higher frequency of MNC in buccal mucosal cells, and CA and SCE in peripheral blood lymphocytes. The mean values of SCE, CA and MNC did not differ among *pan masala* and PM-T chewers.

The effect of *mawa* chewing on human peripheral lymphocytes and buccal mucosal cells has been found to be similar to that of *pan masala* and PM-T. A study on three groups of non-smoking teetotaller *mawa* chewers (with oral cancer, oral submucous fibrosis and without oral lesions) found statistically significant elevation of per cell values of SCE and CA in peripheral blood lymphocytes, as compared to controls.[33] The number of CA and SCEs per metaphase showed a gradual increase from controls to healthy chewers to submucous fibrosis to oral cancer patients. Chromatid aberrations (majority being gaps) were more frequent than chromosome type aberrations. The MNC frequency in buccal mucosal cells was significantly higher among healthy *mawa* chewers and patients with oral submucous fibrosis (OSMF) compared to controls.

The CA and SCE frequencies in CHO cells were found to be significantly elevated following treatment with urine concentrates of tobacco with areca nut chewers (type not specified) compared to the urine concentrates of non-chewers.[34] Urine creatinine levels were comparable between controls and T/AN chewers. The saliva of *pan masala* chewers has also been found to be clastogenic to CHO cells.[35]

Kayal *et al.*[36] studied the frequency of MNCs in the exfoliated buccal mucosa of normal healthy individuals from different parts of India who were regularly using either areca nut alone, *mawa*, *tamol*, tobacco with lime, dry snuff, or *masheri*. The analyses were also carried out among OSMF patients who chewed either *mawa* or areca nut. Compared with healthy individuals with no habit, all the chewer groups irrespective of their type of habit, had significantly higher frequency of MNCs. However, no difference in frequency of MNCs was observed according to type of chewing habit, presence or absence of tobacco, type of areca nut used for chewing, and the presence or absence of OSMF.

Chromosomal aberrations were found in 6 out of 9 chewers of betel quid with tobacco, and *masheri* users, gaps and chromatid breaks being the commonest aberrations.[37] SCE frequency was also significantly higher in tobacco chewers than that in controls. Tobacco chewers and oral cancer patients exhibited significantly higher frequency of MNCs than the controls. Urine samples from female habitues exhibited higher levels of cotinine, and direct mutagenicity to TA100, while control samples were non-mutagenic. Treatment with β-glucuronidase decreased the mutagenic potency of urine of tobacco habitues, but increased the potency of urine of controls. Nitrosation of samples increased the mutagenicity to TA100, but the increase was higher in controls.

Higher values of CAs and SCEs per cell have also been detected among vegetarian and teetotaller areca nut chewers with or without oral cancer or oral submucous fibrosis,[38] dry snuff users,[39] and chewers of tobacco with lime.[39]

STUDY OF PRECANCEROUS LESIONS IN HUMANS

Oral leukoplakia

There have been no studies on the association of PM-T and oral leukoplakia. However, chewing of Mainpuri tobacco has been shown to be associated with a higher prevalence of oral leukoplakia as compared to no chewing.[40] Association of leukoplakia and tobacco chewing (generally as a component of betel quid) has been demonstrated in prospective studies,[41–43] as well as in case–control studies.[44,45] These prospective studies have also shown malignant transformation of oral leukoplakia to oral cancer.

Oral submucous fibrosis (OSMF)

Oral submucous fibrosis (OSMF) has long been suspected to be associated with areca nut chewing.The precancerous nature of submucous fibrosis was first mentioned by Paymaster in 1956,[46] who observed the development of a slow-growing, squamous cell carcinoma in one-third of patients with submucous fibrosis. On examination of 220 biopsies of OSMF, Pindborg[47] found atypia in 13.2% of biopsies, suggesting that it is a precancerous condition. Histopathological studies of the silver-staining nucleolar organizer region in mucosal biopsy samples of normal, leukoplakic, neoplastic and submucous fibrosis tissues showed the highest count in carcinoma followed by submucous fibrosis tissues.[48] Prospective studies on malignant transformation of oral submucous fibrosis proved that it is a precancerous condition.[43,48–50]

In a study of 36 patients with OSMF—12 each in grade I to III—and 12 healthy volunteers, attending two dental colleges in Chennai (Madras), it was noted that all patients had the habit of chewing betel nut, *pan masala* or the traditional betel quid.[51] Eighteen patients (9 with grade I, 7 with grade II, and 2 with grade III OSMF) consumed *pan masala*, 6 (3 each with grade I and II OSMF) chewed betel nut alone, and 12 (2 with grade II and 10 with grade III OSMF) chewed a mixture containing betel nut, betel leaf and lime. Ten of the 12 patients with grade III OSMF chewed tobacco along with the mixture. Patients who chewed *pan masala* were below 30 years of age and they had started the chewing habit 2–3 years prior to the diagnosis; whereas the patients chewing

traditional mixtures developed OSMF 20–25 years after starting the habit. Thirteen patients (5 with grade I, 7 with grade II, and 1 with grade III OSMF) were smokers. The much shorter history of chewing habit among *pan masala* users (addition of tobacco or smoking unknown) is alarming.

Another comparison of the chewing habits of 50 OSMF patients attending a dental department showed that chewers of *pan masala*/PM-T were younger in age and had a shorter history of the habit of chewing compared to betel quid chewers (2.7 years *v.* 8.6 years, respectively).[52] Patients who were smokers were not included in the study. Even though the duration of presence of OSMF was not indicated, the similar interincisal distance between these categories suggests a shorter incubation period of the disease among users of *pan masala.*

A study on 60 OSMF patients and age, sex, religion and socio-economic status-matched healthy controls showed that 98% of patients chewed areca nut regularly in one form or the other, whereas among controls 35% chewed areca nut, giving an overall relative risk of 109.6.[53] Areca nut chewing was practised most commonly in the form of *mawa. Mawa* chewers and those who chewed *mawa* along with other substances showed very high relative risk. The relative risk increased with increase in frequency as well as duration of the chewing habit. In a bivariate analysis, the effect of frequency and duration of chewing appeared to be multiplicative.

Bhargava *et al.*[42] in a two-year follow-up study of 43 654 industrial workers in Gujarat reported the incidence of new cases of OSMF to be 7/2105 (0.3%) among persons chewing betel quid with areca nut; 6/9506 (0.1%) among chewers and smokers; 3/1161 (0.3%) among tobacco chewers alone; and 10/7065 (0.1%) among those with no such habit. In the 10-year follow-up survey,[43] all 11 new cases (out of 39 828 villagers) of OSMF in Ernakulum occurred among chewers of tobacco or betel quid or those with a mixed habit (including smoking); in Bhavnagar, of the 4 new cases seen among 38 818 persons, 2 had no tobacco habit, while 1 chewed tobacco and 1 smoked it. Some well conducted case–control studies have demonstrated an association between chewing of areca nut and development of OSMF.[43,45,54]

EPIDEMIOLOGICAL STUDIES

No epidemiological studies have been reported on the association of consumption of *pan masala* (with or without tobacco) and oral cancer. However, a high risk of developing oral cancer due to the use of a mixture of tobacco, areca nut and lime has been reported in a large, community-based, prospective study. This mixture (Mainpuri tobacco) amounts to PM-T without catechu (although the proportion of areca nut is much lower than *pan masala*). After analysing the cancer occurrence data for 31 months in a population of over 1 million, Wahi[3] reported that chewing of Mainpuri tobacco was the most important factor identified in the causation of oral cancer, the prevalence rate being 4.51 per 1000, as compared to 0.8 among those using other kinds of tobacco, and 0.18 per 1000 among those with no habit of smoking or chewing. Smoking and drinking alcohol showed an additive effect with Mainpuri tobacco, although smoking and drinking also increased the risk of chewing other tobacco mixtures (as also among persons with no chewing habit). The prevalence of oral cancer was cross-tabulated according to various combinations of tobacco usage habits and other factors such as sex, age, education, residence, religion, food, smoking, drinking, income and occupation. A consistently higher rate was observed among those who chewed Mainpuri tobacco than among those who chewed other kinds of tobacco, which in turn was higher than that for persons without the habit.

Some case–control studies have concluded that chewing of betel quid with tobacco has an association with cancers of the oral cavity and/or pharynx.[55–61] Cross-sectional surveys and prospective studies also showed an association between chewing of betel quid with tobacco or tobacco chewing (with or without smoking) and development of oral cancer.[41–44,62] Many case–control studies have reported an increased relative risk of developing cancers of the oral cavity and/or pharynx and oesophagus due to use of betel quid with or without tobacco.[63–69] *Khaini* (a mixture of tobacco and lime) use has also been implicated in the aetiology of oral cancer.[70]

DISCUSSION

In 1985, an IARC (International Agency for Research on Cancer) expert group[6] concluded that chewing of betel quid with tobacco is carcinogenic to humans. However, there was inadequate evidence to implicate chewing of betel quid without tobacco. The study on chewing of Mainpuri tobacco was considered as evidence for association of oral cancer with chewing of betel quid containing tobacco. This probably was due to the fact that the habit of chewing PM-T had not gained popularity till then. However, it would be more appropriate to group this study separately, as the habit of chewing Mainpuri tobacco (as well as *mawa*) would be equivalent to chewing PM-T without catechu. The relative proportions of areca nut and tobacco in *pan masala* is between their relative proportions in Mainpuri tobacco and *mawa*. Thus, if Mainpuri tobacco and *mawa* chewing are found to have the same harmful effects on humans, it can be safely concluded that PM-T would also have these. It would be necessary, however, to examine the effect of adding catechu to mixtures such as Mainpuri tobacco and *mawa*.

Epidemiological studies from India suggest that chewing of tobacco and lime has a higher risk for cancer than chewing of betel quid with tobacco.[71,72] The addition of tobacco leaf extract in the drinking water of Swiss male mice has been observed to reduce the occurrence of tumours by two tobacco-specific nitrosamines, N-nitrosonornicotine and 4-(methylnitrosoamino)-1-(3-pyridyl)-1-butanone.[73] The individual anti-carcinogenic components of betel leaf extract (eugenol and hydroxychavicol) and catechu–catechin, have been observed to inhibit the interaction of 3(H)benzo(a)pyrene with DNA, in the presence of both rat and mouse liver S9 fraction.[74] Of the other two studied components of betel leaf extract, β-carotene was effective in the presence of mouse S9 mix only, but α-tocopherol was not effective at all. Another study showed that hydroxychavicol, catechu–catechin, β-carotene and α-tocopherol (but not eugenol) inhibited the interaction between 7,12 dimethylbenzanthracene and DNA in the presence of mouse skin S9.[75] Aqueous extract of betel leaf reduced the mutagenicity of an aqueous extract of areca nut in *Salmonella typhimurium* TA100 in the presence of S9 mix.[19] A three-hour application of aqueous extract of betel leaf along with *pan masala* or PM-T resulted in a smaller increase of CAs and SCEs in CHO cells, as compared to the action of *pan masala* alone or PM-T alone, respectively.[31]

Thus, the existing literature suggests that betel leaf may provide partial protection against the carcinogenic effect of tobacco, areca nut and lime mixture. There is also a suggestion that catechu may be anti-carcinogenic. However, the presence of both these substances in betel quid-containing tobacco is not enough to negate the carcinogenic effect of areca nut, tobacco and lime. If

the betel leaf is removed from betel quid-containing tobacco (PM-T has such a composition), catechu alone is not enough to negate the carcinogenic effect of the areca nut, tobacco and lime mixture. On the other hand, a recent study observed that of the various betel quid components, catechu in the presence of lime at alkaline pH is the most active producer of reactive oxygen species.[76] Reactive oxygen species are considered to be important in the process of mutagenesis.

The pH of saliva of 20 children and 25 adult users of *pan masala* at Agra was measured, ten minutes after its consumption. The pH varied between 7.5 and 8.5 (Lahiri VL, unpublished data, 1995). This finding suggests that the environment of the oral cavity after consumption of PM-T is suitable for generation of reactive oxygen species as well as nitrosamines specific for tobacco and/or areca nut.

Recent studies suggest that processing of areca nut prior to use may be important in determining its carcinogenicity. Measurement of active components of areca nut, arecoline and polyphenols showed their presence to be the maximum in the unprocessed nut, followed by sun-dried or roasted nut, and the minimum levels were detected in nuts processed by soaking and boiling.[77] Weak carcinogenicity in mice fed areca nut alone was noticed only with unprocessed areca nut.[78] The findings point towards a higher carcinogenic potential of PM-T (which contains roasted areca nut) than betel quid mixtures using soaked or boiled areca nut.

The existing literature does suggest that if betel leaf is removed from the traditional betel quid-containing tobacco (PM-T), the carcinogenicity of the mixture would still remain. The finding that pH of the saliva is alkaline after chewing PM-T would hasten the process of carcinogenesis, especially for a mixture of areca nut, tobacco and lime. Experimental studies indicate that a mixture of tobacco and areca nut results in a higher degree of clastogenicity, as compared to the independent action of the same dose of individual components. Animal studies also suggest that a combination of areca nut and tobacco results in a shorter incubation period of cancer.

Experimental studies have shown that *pan masala* (addition of tobacco not known) is mutagenic in the *Salmonella typhimurium* test system; PM-T as well as *pan masala* induces cytogenetic damage in Chinese hamster ovary cells; intraperitoneal injection of *pan masala* results in increased SCE and delays in cell cycle; *pan masala* as well as PM-T induces significant increase in CAs and SCEs in peripheral blood lymphocytes and increase in MNCs in buccal mucosa in humans. Thus, there is enough evidence to label PM-T as mutagenic.

Animal experiments provide only a suggestion that PM-T may be carcinogenic. Based on the then available information, an IARC expert group in 1985[6] concluded that there was limited evidence that areca nut with tobacco (and without tobacco) is carcinogenic to experimental animals. One of the experiments considered by them included application of areca nut, tobacco and lime to the buccal pouch of hamster.[12] Considering that the effect of PM-T is likely to be similar to that of areca nut, tobacco and lime mixture, the same conclusion can be made about PM-T, i.e. there is limited evidence that PM-T is carcinogenic to animals.

There is no study reported on carcinogenicity of PM-T. For the reasons mentioned earlier, conducting such a study at this time may show an association only if PM-T shortens the incubation period of oral cancer. Recent studies point towards this possibility, by showing that 50% of OSMF cases had a two- to three-year-old habit of chewing *pan masala* (addition of tobacco not specified for individual groups). Combined with the earlier knowledge of a shortened incubation period with a mixture of areca nut and tobacco, this may be an important area for investigation. Mainpuri tobacco, which is a PM-T-like mixture, has been shown to be carcinogenic to human beings in a prospective study.[3] Although no study on carcinogenicity of *mawa* has been carried out, the fact that 15 patients of histologically confirmed oral cancer habituated to *mawa* chewing (with no other habit of chewing, vegetarians, teetotallers, and not engaged in any hazardous occupation) could be enrolled in a study[33] suggests a strong association of *mawa* chewing with oral cancer. Association of Mainpuri tobacco[3] as well as *mawa* chewing[53] with OSMF has been demonstrated. As pointed out earlier, if a mixture of areca nut (95%) with tobacco and lime (*mawa*), and a mixture of areca nut with tobacco (major constituent) and lime (Mainpuri tobacco), are found to be carcinogenic in human beings, it is only logical that a mixture of areca nut (70%–80% by weight) with tobacco and lime (PM-T), would be carcinogenic to human beings. Thus, there is sufficient evidence to suspect that PM-T is carcinogenic to human beings.

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Internet Documents on Gutka

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OPINION

Government lowers duty on pan masala

(Tuesday, July 6, 1999)
Anjan Mitra in New Delhi

In a quiet move , the government has reduced the excise duty on certain categories of `pan masala' from 40 per cent to 16 percent which has raised the hackles of other industries, specially the soft drinks industry.

The brands of `pan masala' which are likely to benefit from this government move include `Chutki', `Pan Pasand', `Pan Parag' and `Rajnigandha'

In a notification, issued on June 8 by the finance ministry, the government has said "all goods containg not more than 10 per cent betel nut by weight and not containing tobacco in any portion" would attract an excise duty of 16 per cent --- down by a whopping 40 per cent.

What's more surprising, the June 8 government notification states: "The Central government being satisfied that it is necessary in the public interest to do so..."

Earlier on `pan masala', the government levied an excise of 40 per cent, which included 24 per cent basic and 16 per cent in the form of SAD.

However, the `pan masala' and `gutka' industry is not very happy with this reduction. "Not very many companies would benefit by this reduction in excise duty as we have been demanding for a uniform policy," All-India Pan Masala & Tobacco Manufacturers Association (AIPMTMA)spokesperson, Bharat Thakkar, said.

According to Thakkar, critics do say that such products cause cancer, but "the government cannot have a stick and carrot policy policy towards us."

Thakkar said if there is a uniform excise duty on `pan masala' and `gutka', then standards and quality of the products can be also raised which would reduce spurious goods flooding the market.

The government move has been resented in many other industries. For example, the soft drinks industry feels instead of harmful products their industry should have got some excise relief.

According to soft drink industry sources, soft drinks are being taxed at the highest rate of excise duty (40 per cent), while no other consumer goods industry is taxed at this level.

Reacting to the government notification, soft drinks industry sources said the excise duty rate is highest in India even among developing countries where soft drinks are concerned. While India has levied 40 per cent duty on soft drinks, in Pakistan the corresponding figure is 25 per cent, in Thailand it is 18 per cent and in Bangladesh it is just 10 per cent.

According to AIPMTMA's Thakkar, they have given several representation to the government earlier on the high excise duty`pan masalas' and `gutkas', but to no avail.

(ENDS)/ 7 p.m.

Your Deadly Friend: Paan - Masala
by Dr. Anil Nirale, M.Ch. Plastic Surgeon

Do you want to make friends with Mr. DEATH ? Are you ready to die a slow, lingering and painful death?

I think yes ! Yes, some of you are ready to die from an irreversible disease wherein death is guaranted. So here is the easiest way. Just develop the habit of chewing Paan Masala or Gutka regularly and you will succeed in meeting Mr. DEATH easily. This is indeed the truth. The other side of your habit of eating "Paan Masala" is very dark and unbelievable.

What is Paan Masala, Gutka ?

Paan Masala = Powdery mixture of betel nut, lime, arecanut (Supari) in various proportions.

Which class of people eat paan masala? Who are the persons affected by this habit?

Nowadays eating paan masala has become a "Status Symbol". This habit is common in all socio-economic class. A labourer eats it to take rest from his work and to freshen up. A high class executive eats it to show how "modern and advanced" he is ! A school-going kid eats it as an experiment, or just to copy his parents. The house wife eat it after a day's cooking and after food. College boys eats it to make a time-pass at "nukkad". So in the end, everybody falls prey to this temptation of so called "freshening" his/her mouth with this "slow poison".

Is paan masala a real "Slow poison"?

Yes, According to various studies carried out at national and international levels, it has been proved beyond doubt that paan contains "Mutagens" which can change our normal tissues into cancer tissues, and can cause a progressive disease called, "Sub Mucous Fibrosis" (SMF).

What is SMF? How does it happen?

SMF means Sub Mucous Fibrosis... i.e. a permanent thickening and hardening of the inner lining of the mouths. The various materials used in paan masala causes irritation to our mouth, which gradually leads to thickening and hardening. Then gradually the mouth opening decreases and a day comes when the victim will not be able to open his mouth at all.

The tongue will lose its roughness and will becomes smooth and white. Taste sensation will be lost. You will not be able to tolerate spicy foods. All these things happen slowly but progressively and are guarranted to happen.

What is more dangerous then SMF?

Oral Cancer. The person who is a habitual chewer has a 400 times greater risk of getting oral cancer because SMF is a precursor to oral cancer. And all of you are aware of the fatality of oral cancer.

Can we prevent SMF?

Yes, stop the chewing habit and SMF will leave you (only in its early stages).

How can "Plastic Surgery" help patients with Sub Mucous Fibrosis?

In patients with established SMF, the mouth opening is restricted and the inner lining is permanently damaged. These problems can be treated by the various plastic surgical techniques listed below.

a. The hardened bands can be removed surgically.
b.The wider area of thickened tissue can be removed and new skin can be placed there by a plastic surgical technique called "Excision and Skin Grafting".
c.Whenever surgeons want to give the patient, a soft, moist, pliable cover, then a special procedure of making use of a portion of the tongue to cover the cheek has to be done - a "tongue in cheek" or a "Tongue Flap" operation.
d.Similarly, the excess skin from the outside of the cheek can be placed inside the oral cavity by a operation called - "Nasolabial Flap" surgery.
e.Injections of steroids into the hard tissues are also helpful.
f.Creams and jelly for local application and massage are of a temporary nature.

All these operations are to treat the complications caused by paan masala. To prevent recurrence of SMF you have to give up this habit permanently and immediately.

What about tobacco content?
what is the difference between
gutha and paan masala?
Does gutha contain tobacco?

Fertility | Pregnancy | Health | Stages | Family | Work | Fun | iBaby.com | iMaternity.com | Experts | Tools | Chat | Boards

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Complications
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Postpartum Recovery
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Pregnancy Loss
Breastfeeding
Maternity Leave
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Pregnancy Newsletter
Baby Name Finder
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Pregnancy Boards

Find It

Pregnancy: EXPOSURE CONCERNS

Dangers of chewing tobacco

Answered by Kim Loos, DDS

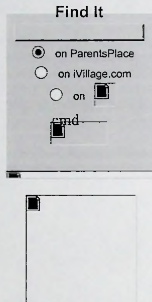
SPONSORS

DON'T MISS

Q: Do you have any information about the dangers of chewing tobacco? How do I teach my sons that chewing tobacco is harmful when their favorite baseball players chew?

A: Numerous studies have shown that dipping snuff or chewing tobacco can lead to oral cancer. Oral cancer, if left unchecked, can be fatal. This is why oral cancer screenings should be part of every routine dental examination. An oral cancer screening is quick, easy, and painless.

It is estimated that about 40% of all major league baseball players and about 30% of all minor league baseball players chew tobacco or dip snuff. One study found that about 59% (83/141) of major league baseball players that use smokeless tobacco already have lesions that may develop into cancer. This is very alarming news! Dr. John Greene, a former dean at University of California at San Francisco Dental School, examined 141 professional baseball players during spring training. According to the April 9, 1998 edition of the San Francisco Chronicle newspaper, fifteen players had serious lesions that required biopsies. It was reported that Curt Schilling, an excellent pitcher, quit using snuff after a dangerous lesion was detected in his mouth.



dangerous lesion was detected in his mouth.

During a biopsy, a sample of the lesion is removed to determine if the cells are cancerous. Cancerous lesions may be treated using a combination of surgery, chemotherapy, and radiation. Oral cancer can spread to the lymphatic system. However, oral cancer can also be successfully treated if it is detected early.

Some players claim that chew enhances their athletic performance. However, Robertson et al. (1995) reports that "the use of snuff and chewing tobacco is unrelated to whether or not a baseball player makes it to the major leagues, or how he hits a ball, fields a hit or throws a pitch." However, they did determine that the use of smokeless tobacco is correlated with the presence of oral lesions.

Smokeless tobacco has been banned by all youth baseball leagues, the National Collegiate Athletic Association and all of Major League Baseball's minor league clubs. The Professional Baseball Athletic Trainers Association also discourages the use of smokeless tobacco (Connolly et al. 1995). Unfortunately, smokeless tobacco has not yet been banned from the American or National Baseball Leagues. The leagues do cooperate with the National Spit Tobacco Education Program to discourage children from using tobacco. When people team up with tobacco, they lose.

Additional information

- Oral Cancer: Prevention and Detection
- Chewing Tobacco and Cancer
- Smokeless Tobacco and Oral Cancer
- Teenager Has White Spots In Mouth
- Detecting Oral Cancer / Extraoral Examination
- Oral Cancer Information Center
- Spit Tobacco Prevention Network
- Spit Tobacco
- Tobacco Intervention Network
- Facts About Oral Cancers

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VALUE OF TAKING HISTORY OF TOBACCO CONSUMPTION IN PRIVATE PRACTICE

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Many G. Ps do not have any idea about the ways in which tobacco could be absorbed by the body. One of the methods is:

I.Smoking
- a.smoking cigarettes
- b.smoking bidis
- c.smoking hukka (Arabic countries call it shisha)
- d.chilam

II.The tobacco can be consumed through the mouth in the following ways:
- a.Applying tobacco paste couple of times a day, popularly known as kudaku.
- b.To put raw tobacco in the mouth with or without supari which could start from a "saada tobacco" and going upto 120-160-300 and about 600 strength. This tobacco could also be put in the pan. Khainee is the commonest tobacco used in Maharashtra.
- c.Very often Pan Parag contains tobacco in various forms.
- d.There is a preparation known as Gutka which contains a very heavy dose of tobacco and supari and many other ingredients which the Indian patients keep in the mouth and consume 5-10 times a day. The most costly and strongest gutka is Manekchand Gutka.
- e.Tobacco is often used in pan as "Kemam".

III.Tobacco could be consumed in the form of snuff as is done by Pathans and many Maharashtrians.

IV.Finally, the Yemenese patients consume tobacco in the form of "qat".

All the above oral methods can lead to oesophagitis, gastritis, stomach ulcer, duodenal ulcer, cancer of the oral cavity, severe stomatitis and leucoplakia. Also tobacco increases hypertension and the symptoms of coronary artery disease.

Finally, smoking in any form is the commonest cause of cancer of the lungs. In addition, it causes ischaemic heart disease, COPD and duodenal ulcer.

Every doctor practising in India should be aware of consumption of tobacco and the history should be elicited
in detail and not by a casual question - do you smoke?

To Section TOC

Maharashtra bans gutka
100 m around educational
institutions & government offices

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CHEWING HABITS AMONG RURAL WOMEN IN PONDICHERRY

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Abstract:

Research question. 1. What is the prevalence of chewing habits among rural women?

2. What are the factors associated with their use?

Objectives: To find out the prevalence of chewing habits and correlates of chewing habits.

Design: Cross-sectional descriptive study.

Participants: Females aged 15 years and above.

Study variables: Age, educational status, marital status, occupation, income, type of family, age of starting habitual chewing, persons influencing chewing habits and reasons for continuing the habit.

Outcome variable: Chewing habits.

Statistical analysis: Chi-square test, Analysis of variance, Odds ratio and Logistic regression.

Results: The prevalence of chewing betel quid was 24.6%, betel quid with tobacco 13.7% and betel nut 0.2%. Mean age of starting betel quid was 22.7 years and betel quid with tobacco, 16.5 years. Friends were the most influencing persons for starting the habit. The most common reasons for continuing was craving for the substances. There was direct relationship of chewing habits with age and inverse relationship with educational status. The chewing habits were more prevalent among married women and women engaged as agricultural labourers.

Conclusion: Chewing betel quid with or without tobacco is a common practice among rural women. It is influenced by socio-cultural factors.

Key words: Rural women, betel quid, tobacco, chewing habits

Introduction:

India has a very long tradition in the usage of betel quid and betel quid with tobacco. It is a part of Indian culture, perhaps there is no person in India who has not chewed betel quid some time or the other[1]. Different studies have given different prevalence rates in the country on the usage of betel quid. In 1994 Mehta et al have estimated that there were about 400 million betel quid chewers all over the world[2].

India is third among the world's nations leading in tobacco use[3]. WHO (1988) has estimated that there were around 100 million tobacco users in India and Pakistan alone[4]. In the world, tobacco use is increasing by 2% per annum, in developing countries it is increasing by 3.4% and in developed countries it is decreasing by 0.2%[5].

The effects of tobacco and chewing substance are well known. Several studies have been conducted in India on tobacco use. Most of them have concentrated on tobacco and its effects. Very few studies have reported about tobacco use and its correlates. In order to reverse the rising trend of chewing substances studies are required to quantify the problem and to identify the determinants and their distribution. The available information is limited to a few studies. Moreover, this information has to be area-specific because variations are known to exist between areas. Hence this study was conducted to find out the prevalence of chewing habits and to describe the characteristics of women with chewing habits.

Material and Methods:

The study was conducted in the service area of Jawaharlal Institute Rural Health Central (JIRHC), Ramanathapuram, Pondicherry, which is the rural field practice area of the Department of Preventive and Social Medicine, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Pondicherry.

The total women in the age group of 15 years and above were 2370 and it was decided to study 1000 women. To compensate for loss due to exclusion 1100 were selected. Since the study population was almost half of the total population so systematic random sampling was used taking alternate houses. In the sampled houses all the females of age 15 years & above were included. Chewers were defined as chewing either regularly or intermittently for at least six months. The information was collected by an interview and observation of substances used for chewing. Women not available during three consecutive visits in a month were excluded from the study. The data was tabulated with the help of Foxbase and Epi info-6 softwares. Chi-square test, analysis of variance (ANOVA), odds ratio and logistic regression were used for analysis.

Results:

The percentage of women chewing betel quid was 26.6%, those chewing betel with tobacco was 13.4%, while the remaining 60% were non-chewers.

Majority in betel quid group started their habit when they were between 11 and 20 years of age (45.7%). In betel quid with tobacco group majority of them started before the age of 11 years (41.8%). The mean age of those who started with betel quid was 22.7 years, whereas for the betel quid with tobacco it was 16.5 years. This difference was statistically significant ($p<0.01$) (Table-1).

Table 1: Age of starting chewing habit

Age group (in years)	Betal quid (n=243)	Betel quid + tobacco (n=122)	Total
Upto 10 years	6.5	41.8	71
11 to 15	21.0	16.5	78
16 to 20	24.6	14.8	64
21 to 25	19.3	13.9	53
26 to 30	16.9	9.8	17
31 to 35	6.2	1.6	15
36 & above	5.5	1.6	67
Total	100.0	100.0	365

Mean age for starting in Betel quid group = 22.7 years

All figures are percentages.

Mean age for starting in Betel quid with tobacco group= 16.5 years

Variance between samples= 3126.20

Residual variance= 82.52

F statistic= 37.88

P value <0.01

Around 50% of the chewers of both categories were influenced by their peers. About one-fourth of the betel quid chewers and a few (2.3%) of betel quid with tobacco chewers started on their own. The other influences were from parents (only mother or both) and other relatives in the house. These differences in the persons influencing the onset of chewing habits were statistically significant ($p<0.01$) (Table-II).

Table II: Persons influencing onset of chewing habits

Persons	Betel quid (n=243)	Betel quid +tobacco (n=122)
Peer	59.5	53.3
Self	23.8	2.3
Both Parents	5.9	11.5
Mother alone	3.3	22.7
Others	7.5	10.2
Total	100.0	100.0

Figures shown are percentages.

Table III shows the reasons for continuing the chewing habits. There were multiple responses. Among betel quid chewers more than half (64.1%) used it on special occasions, to prevent wastage or for fun. Craving was a reason for continuance by most of the betel quid and tobacco chewers (90.6%) and among 27.3% in betel quid group. The other reasons quoted were: to prevent sleeplessness, oral odour, tooth ache, dullness, salivation, to suppress appetite and to relieve soreness of throat

Table III: Reasons for continuing the habit

Reasons	Betel quid (n=243)	Betel quid+tobacco (n=122)
On special occasions	31.6	0.0
Craving	27.3	90.6
To prevent wastage	18.5	0.0
For fun	14.0	1.6
Sleeplessness	13.2	0.0
Oral odour	11.5	23.7
After meals	6.7	0.0
Tooth ache	6.1	13.1
Dullness	4.9	13.9
Soreness of throat	4.9	4.0
Salivation	4.5	13.9
Suppression of appetite	2.4	13.1
Others	2.0	4.0

There were multiple responses.

Discussion:

In this study it was found that there were mainly three types of substances which were used for chewing. They were 1) betel nut alone, 2) betel quid and 3) betel quid with tobacco. Since the number of betel nut users was very small (19), they were clubbed with betel quid chewers group for further analysis.

The present study showed a prevalence of 26.6% for betel quid chewing. Other studies have found that prevalence of betel quid chewing was 9.5% among Bangladeshi women[6] and 42% among Aborigines in China[7].

The prevalence of chewing betel quid with tobacco was 13.4%. Various surveys conducted in India between 1960 to 1970 have revealed prevalences among women varying from 3% in Srikakulam[1] to 49% in Pune. A survey report of ICMR published in 1993 showed a prevalence of 12% all over India[8]. George et al have reported a prevalence of 29% in coastal areas of Kerala[9]. Reports from other parts of the world showed the prevalence as 4% in American natives[10] and 0 to 49% in various parts of Kenya[11].

The women studied could recall the age at which they started chewing even though long periods of recall were involved. The youngest age for starting chewing was 5 years. As children, they used to take the substance from the bags of their mothers who were chewing. Such women found the habit interesting and continued to do so. Those who started the habit at a later age were influenced mostly by their friends. In the present study the mean age of starting betel quid was 22.7 years whereas it was 17 years among Bangladeshi women in U.K.[6]. The proportion of betel quid chewers who started before the age of 10 was 6.6% as compared to 18% as reported by Summers et al[6]. Summers et al have also reported that betel quid chewers started the habit earlier than tobacco chewers[6]. However, in the present study, it was the reverse. The proportion of women who started tobacco before the age of 10 was 41.8% in this study. Other workers have reported higher proportions: 89% by Schaefer et al[12] and 57% by Hall et al[10].

Betel quid chewers were influenced mostly by their friends followed by their parents. These results are similar to those in the studies conducted by Rinchuse et al[13] and Lu et al[14]. Among the women who chew betel quid with tobacco, this study has shown that majority were influenced by friends followed by parents. This was similar to the findings of Schaefer et al[12], Marty et al[15], Hall et al[10], Cohen et al[16], Colborn et al[17], Claire[5] and Rinchuse et al[13]. Other studies have showed that they were influenced by negative perceptions[18], image, low self esteem, increase in disposable income, lack of knowledge, advertisement etc.[5].

The women under study mentioned some reasons for the continuation of the habit. The results indicated that the majority of the betel quid chewers were occasional chewers. In South India there is a tradition to offer betel quid on special occasions and similarly there is a ritual to offer betel quid to Gods on auspicious days and festivals. Most of the women who observed / attended these festivals / special occasions were tempted to chew these substances. The betel quid offered to god was either distributed to some one who chewed it or they themselves consumed it to prevent wastage. Some women used it for fun. There were some women who were dependent on betel quid. These women had a craving for it when they did not have it, they would get sleeplessness, bad oral odour, tooth ache, dullness, salivation and sore throat. Summers et al[6] have listed the reasons for chewing - just as a habit, pleasant/ refreshing, good for oral cavity and relief of pain. In the present study most of the tobacco users continued because they had a craving for it when they were not getting it. This might denote addiction to a certain extent. In other studies it was found that the usage was due to tooth related complaints[2] which was much less in the present study. The present study results were similar to those reported by Huges and Hatsukami[19] and Prabhu[20].

Analysing the factors associated with the chewing habits showed the following results. Age is a significant factor related to chewing habits but it has not been studied in great details in earlier studies.

The present study revealed that below the age of 29 years betel quid chewing was practised by only 7-16% of women. Beyond 29 years of age it was in the range of 31-47%. Similarly the proportion of women chewing tobacco was negligible between 15 and 24 years. Thereafter it ranged between 5% in the 25-29 years age group to 44% in the age group of 60 years and above.

The influence of marital status and type of family on chewing habits have not been reported in the other studies reviewed. The present study has shown that married women and widows indulged more in chewing compared to the unmarried. The type of family was not a significant factor. Further studies are required to assess the role of these factors.

The prevalence of chewing habits decreased with increasing level of education. As the educational level advanced, women came to know more and more about the ill effects of tobacco and other chewing habits e.g. the causation of cancer and other morbidities like heart diseases etc. Generally there was a feeling that chewing tobacco was a habit of older generation[21]. This significant result was comparable with those reported by George et al among fishermen community in coastal areas of Kerala[9].

Majority of the study population were agricultural labourers. They were using the substances while at work in the fields. It helped them delay their meals, made them feel pleasant and it gave a good odour from mouth. Many of them were craving for these substances. This finding was similar to that reported in studies conducted by ICMR[8,22]. The next major occupational group was of housewives. Ko et al have reported that chewing habits were more common among blue collar workers[7].

In the present study the income-wise distribution of chewing habits was not statistically significant. Studies conducted by ICMR[8,22] in 1993 and 1994 and Ko et al[7] have reported that chewing habits were more common among the lower income groups.

Conclusions:

The present study has shown that about 40% of rural women had chewing habits out of whom 13% were chewing tobacco. It also gives information on mean age of starting and the reason for onset and continuing besides the influence of age, educational status, occupation and marital status. Such information may help the health authorities to evolve strategies to reduce the problem.

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THE HINDU
(MADRAS)

D 75

16 AUG 1998

Ministries divided over ban on pan masala

D75
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16/8/98
M202

By Our Special Correspondent

CHENNAI, Aug. 15.

Conflicting views of the Ministries appear to stand in the way of the Centre imposing a ban on pan masala/gutka etc.

The Government of India appears to be in a dilemma with the Ministry of Food Processing Industries as well as the Department of Small Scale Industries and Department of Consumer Affairs favouring the ban and the Ministries of Labour, Agriculture and Commerce voicing rservations over the move.

It may be recalled that the Central Committee for Food Standards (CCFS), a statutory committee constituted under the Prevention of Food Adulteration Act (PFA) recommended the ban following a report of an expert technical committee which held that consumption of gutka and chewing tobacco are hazardous to health causing oral submucous fibrosis (OSF) and oral cancers.

Meanwhile, the Directorate of General Health Services, in a communication to the States and Union Territories, has called for a massive education and public awareness campaign in highlighting the horrifying health effects caused by gutka.

It has suggested preparation and screening of video materials in schools and colleges with the help of the teaching fraternity to drive home the message to the public through members of local bodies and NGOs besides organising lectures, exhibitions and hoardings.

An inter-departmental committee under the chairmanship of Dr.H.Narasimhaiah, former Vice-Chancellor, Bangalore University, constituted by the Karnataka government in April last year, has among other things, recommended a ban on the manufacture and sale of gutka, prohibition of advertisements in print and electronic media that encourage the consumption of tobacco products and use of services of NSS, NGOs and autonomous institutions to highlight the evil consequences of gutka consumption.

The committee was also in favour of imposing a heavy tax on tobacco products and to make use of the revenue therefrom to educate the general public on the harmful effects of consumption of tobacco products. The Karnataka Government intimated the Union Health Ministry that the recommendations of the Narasimhaiah committee were under its consideration. The State Government had also mentioned that Dr.Narasimhaiah had not recommended substitution of ingredients which were proved injurious to health by other ingredients.

The Union Ministry of Food Processing Industries as well as the Department of Small Scale Industries and Department of Consumer Affairs are in favour of the ban. These Ministries along with the Ministry of Education and Ministry of Information and Broadcasting have suggested vigorous campaign propagating the adverse health effects of pan masala and gutka.

On the other hand, the Ministries of Labour, Agriculture and Commerce have voiced strong reservations against the ban, citing unemployment problem of labourers engaged in the gutka industry, adverse effect on the interest of tobacco growing farmers and their unwillingness to grow alternative crops considering the high price of tobacco and its products.

The ban suggested by the expert committee comprising leading cancer experts and other scientists was on the strength of a comprehensive review paper prepared by the Indian Council of Medical Research and other scientific evidences produced by research institutions.

The committee, after careful deliberations at four meetings held in October 1994, February 95, March 96 and September 97, concluded that consumption of gutka and chewing tobacco are hazardous to health causing oral sybmucous fibroris (OSF) and oral cancers.

The recommendations of the committee were considered by the CCFS which, at its meeting held on November 26 and 27 last year, strongly recommended a total ban on use of tobacco in pan masala/gutka by itself or as an ingredient in any food item.

As for the gutka trade, organised sector and unorganised sector accounted for an annual turnover of Rs.2000 and Rs.3000 crores respectively, in respect of pan masala, chewing tobacco and gutka, according to figures made available to the Centre.

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THE TIMES OF INDIA
(BOMBAY)

13 AUG 1997

Ban on gutkha ads at Ganesh mandals

Hema Gobindram Lobo

THE Thane assistant commissioner of the FDA, R V Yadav, has announced that the display of gutkha and paan masala advertisements will be banned at Ganpati mandals in Kalyan, Thane, Navi Mumbai, Bhiwandi and Ulhasnagar as well as the talukas of Thane district such as Palghar, Dahanu Road and Talasari.

Penalties for violating these instructions of the FDA will have to be determined by the civic authorities, said an FDA official, stating that the FDA did not have the manpower necessary for strict monitoring.

Meanwhile, paan shops which have been doing roaring business, selling gutkha— mainly to teenagers and college students— are in for a lean season. In the wake of the Income Tax raids on the 'gutkha king' and widespread reports that plans are afoot to ban the sale of gutkha, several paanwallahs say that their source of maximum profits is drying up. Fresh paan is not their main business anymore because it is becoming more expensive by the day.

"A ban on the sale of gutkha will mean a loss of at least Rs 100 a day," said Laloo Bagher, a paan shop owner in Vashi. But right now it's a case of making hay when it's possible by selling Manekchand gutkha at a premium.

"The supply of Manekchand brand gutkha has actually been sealed for the moment," a supplier said, adding "this has resulted in a hike in supply price from Rs 175 for a box of 50 sachets to Rs 225. Naturally, we have to charge our customers more, but they don't mind paying a rupee or so extra."

"But even at an increased price, there is no regular supply," said another paan-seller at CST station, adding that, thankfully, at least six other brands of gutkha were easily available in the wholesale market.

Whatever the problems of supply it is clear that as long as there is a strong demand for gutkha, a ban on its sale will not have much effect. A ban on production is a must, insist social activists who say that there has to be constant vigilance to ensure that small cottage industries do not produce the addictive masala and counter the crackdown on the big manufacturers.

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THE TIMES OF INDIA (BOMBAY)
10 JUL 1997

'Gutka' addiction on the rise in Kerala

By P.K. Surendran
The Times of India News Service

THIRUVANANTHAPURAM: Pan masala or "gutka" which comes in an attractive aluminium sachet is catching on with teenagers in Kerala. This addictive-looking stuff, which comes from North India, has become a new challenge to the state's grim fight against tobacco-related cancer.

The studies by the Regional Cancer Centre (RCC) have brought out the startling fact that 10.2 per cent of the 420 students in a prominent women's college have used pan masala many times while three per cent had been habituated to it. The corresponding figure in the boys' college was 12 per cent and four per cent respectively. Sample surveys in other colleges in the state brought out that some 12 per cent of college-going students are becoming addicted to pan masala.

Babu Mathew, chief of the cancer centre's community oncology division told this newspaper on Wednesday that between 40 to 50 per cent of Kerala men suffer from tobacco-related cancer. The smoking habit in women is far less due to social stigma attached to it. However tobacco-related cancer (pan and masala chewing) in women was found to be 16 per cent.

The RCC plans to relaunch a "tobacco-free home" which it had successfully did in 1993-94 to relieve one lakh homes free from tobacco. The school-going children are first given simple fact-based booklets or bills to be handed over to parents who smoke. This would be followed by the visit of a group of school children who will extract a promise from the smoker not to smoke at least in the children's presence.

This would eventually result in reducing the intake of smoke far less than usual, and infuse in the elders' a sense of guilt that will help them fight the urge for smoking. The children are then given a sticker to place on their front-door proclaiming, "This is a smoke-free home. Please co-operate."

The RCC would then contact the elders who quit the smoking and inquire if any help was required to fight back the withdrawal symptom. "We found in the follow-up that 82 per cent who promised to the children never to smoke again stuck to the pledge," Dr Mathew said.

The centre now plans to enlarge the scheme to cover a larger target, the doctor said.

Alarmed at the widespread prevalence of smoking among government employees, the state government had, in July 1995, issued orders to ban smoking in public offices. This has at least prevented people smoking while working. The confirmed smokers would go out of the office to puff, but it also had the risk of earning the wrath of the boss who may find the person unavailable on the seat when required.

Chief minister E.K. Nayanar, ironically a confirmed beedi-smoker from his "revolutionary days," has told the assembly on Wednesday that the government was concerned at the growing use of tobacco among the youths. According to Mr Nayanar, 43 per cent of 30 million population of Kerala are using tobacco in one form or another. The saving grace is that the women addicted to smoking are only 0.67 per cent.

A new difficulty, says the anti-tobacco league, is that many people are found to be smoking and chewing pan together. This makes the battle against tobacco a more long-drawn affair.

The chief minister, while answering questions in the house, said 1.86 lakh people become sick of tobacco-related ills every year in the state. They suffer from oral, lung and throat cancers.

Mr Nayanar, however, said the government had not yet proposed to ban pan masala. Nevertheless, some curbs are being contemplated, he added.

D 75

BUSINESS STANDARD
(CALCUTTA)

31 JUL 1997

Govt wants impact of exposure to gutka assessed

M Ahmed
NEW DELHI

M124

The health ministry has decided to order a comprehensive study into the ill effects or otherwise of 'Gutka' Pan Masala and other tobacco-based chewing substances. This follows demands from anti-tobacco activists to ban Gutka sales.

The Rs 200 crore Gutka and pan additives industry has had to constantly face the ire of the anti-tobacco lobby, which has come up with various statistics to "show" that these substances are carcinogenic.

Government sources say various representations had poured in from the states seeking a ban on Gutka and the health ministry did not want to take a decision on it without first making sure that Gutka imperilled public health.

The job of conducting the study will be given to a public or private agency, say sources. At present, there is no clinical research or data on this subject, which makes it difficult for the government to accept the anti-pan masala lobby's contention.

While there are sufficient pointers that prolonged exposure to cigarette and beedis causes cancer, no such medical evidence has been collected in the case of Gutka.

Nevertheless, producers have to carry a notice that Gutka consumption is harmful, as in the case of cigarettes, since Gutka, too, is tobacco-based.

Sources said the study would take a few years to do a comprehensive analysis of long-term exposure to Gutka.

In the meantime, no action is planned against Gutka and Pan Masala manufacturers.

Some states like Andhra Pradesh have declared Gutka harmful and imposed heavy excise duty and sales tax to discourage its use. Andhra this year raised duties from 10 per cent to 50 per cent.

While the anti-Gutka lobby is are trying to discourage its use, the industry is growing.

Most of the players are in the small sector, except the Kotharis who have a Rs 50 crore operation in the pan masala area. The industry is growing at over 10 per cent a year with an annual production of 50 tonnes, according to unofficial estimates.

Government source said the heavy expenditure incurred on advertisement by this industry indicated the high level of profits. While the manufacturing facilities required are relatively modest, the major outgo of funds iexpenditure is on packaging, distribution and advertising.

Some state governments have banned certain additives in Pan Masala. The Food and Drug Administrations (FDA) in Maharashtra, West Bengal, Andhra Pradesh and Karnataka have initiated action against manufacturers for use of certain banned additives in Gutka and Pan Masala.

However, analysis by the Food and Drug Administrations has not found the full Gutka compound as being harmful.

All want ban, but few ready to give up gutka

By Sameera Khan

MUMBAI: The city's paan-beedi shops will wear a deserted look on Friday when the BMC initiates 'No Gutka Day'. Following soon after 'World No Tobacco Day', which was observed on May 31, 'No Gutka Day' will high-light the ill-effects of gutka and pan masala.

"We want to make people of this city aware of the dangers posed by gutka to their health," says deputy mayor Dr Ram Barot, who has taken the lead on this issue. "Increasingly, we find young students falling prey to gutka — a mixture of tobacco, arecanut and other additives — and that is quite worrying for us."

Support has been extended to the BMC by the 10,000 members of the Mumbai Beedi Tambaku Vyapari Sangh who will not sell gutka on this day.

According to the Sangh, gutka sales in the city have surpassed even cigarettes and beedis. "It's a big fad among blue and white collar workers as well as among young people in Mumbai," says Jagannath Khanvilkar, general secretary of the Mumbai Beedi Tambaku Vyapari Sangh. "Almost 70 per cent of those who used to chew paan (betel quid) and other traditional forms of tobacco have switched to gutka."

And the results are there for all to see. Till 1996, no one under the age of 20 was seen with Oral Submucous Fibrosis (OSF) — precancerous lesions in the mouth which are a direct result of consuming gutka — in the preventive oncology department of Tata Memorial Hospital (TMH). Now, there is a case almost every other week. "We are especially seeing young adults in the age group between 25 and 35 — many of them began consuming gutka when they were as young as 13," says Dr Surendra Shastri, head of the preventive oncology department at TMH.

Five years down the line, Dr Shastri expects to see many more cases of OSF, which if not treated in time can cause cancer of the oral cavity. Gutka also puts a person at risk for gingivitis (inflammation and recession of the gums) and precancerous lesions such as leukoplakia (white patch) and erythroplakia (reddish patch) on the inner lining of the cheek.

NO GUTKA DAY

"Over a period of time tobacco deteriorates health in many different ways," says Colaba-based family practitioner Dr Virsen Ruparel. "Tobacco users are more likely to suffer from high blood pressure, cardiac problems, as well as cramps caused by hampered blood circulation."

In such a scenario, why can't we simply say no to gutka every day of the year?

"It's not that we earnestly want to sell gutka, especially to school children. In fact, it's a sin to sell something so destructive," says Mr Khanvilkar of the Mumbai Beedi Tambaku Vyapari Sangh. "But rather than armtwist us into not selling it, we want the government to ban the manufacture of gutka itself."

There have been other demands for a ban of manufacture and sale of gutka. The Maharashtra Food and Drug Administration made a request to the central government for a ban on 62 brands of gutka, found to be contaminated with magnesium carbonate, in July 1997. The request is still pending, according to Madhu Shinde, joint commissioner (vigilance), Maharashtra FDA. The Indian Medical Association has also supported such a ban.

But then, India remains least regulated with regard to sale and promotion of tobacco products in general. In most states — except for Delhi, Assam, Meghalaya, Sikkim, Goa and soon Madhya Pradesh — it is legal to promote and advertise tobacco products openly (except on Doordarshan and All India Radio) as well as to sell cigarettes and gutka to people under 18.

"A ban is not the only thing that works. Sometimes self-regulation and awareness works better," says Dr Barot. "Maybe awareness can create the social and political will that is necessary for future action."

TIMES OF INDIA (BOMBAY) 4 JUN 1999

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TIMES OF INDIA (BOMBAY)

6 MAY 1999

D75|TOI Lethal Masala 6|5|99

According to a study conducted by the Indian Council of Medical Research, paan masala and its variations like gutkha are potential death-traps with just two to three years of habitual consumption leading to oral cancer. Mouth and throat cancer account for 18 to 20 per cent of cancer cases in India, mostly induced by tobacco-based products. We have the world's second highest incidence of oral cancer. Paan masala is a deadly pot-pourri of tobacco, arecanut and synthetic *katha* (lime), besides also containing lead, arsenic and magnesium carbonate. Some leading brands have even been found to contain cadmium and nickel. Habitual and regular chewing of this aromatic and addictive masala corrodes the delicate inner lining of the mouth and throat, weakening the protective cell layer, making it fertile ground for cancer. While cigarettes and bidis are traditionally the mainstay of the male population, paan masala is popular among women, possibly because the social stigma associated with smoking tobacco is absent. Many view it as a harmless mouth freshener and even college and school students have acquired the habit. Most habitual chewers are unaware of its harmful effects. The Tata Institute of Fundamental Research screened over 300,000 oral cancer patients throughout the country and has established beyond doubt that tobacco, betelnut and paan masala chewing lead to mouth and throat cancers and can adversely affect other organs too.

A public interest litigation filed in the Delhi high court in March this year submitted a plea to ban the production, distribution, storage, sale, advertisement and consumption of this product, quoting the shocking case of four college students whose tongues had surgically to be removed as the boys were afflicted with oral cancer induced by chewing paan masala and gutkha regularly for just two years; it seems failure to remove their tongues would have proved fatal. Two decades ago, when commercially produced paan masala changed the profile of paan shops throughout the country, it was trendy for Members of Parliament to pass around their tin *dabbas* filled with heady granules of buff-coloured masala. The product's success led several manufacturers to enter the market with their own recipes and brands. Paan shops were recognisable from a distance, decorated with garishly coloured paan masala pouches. Today our parliamentarians should take the lead in limiting the damage being caused by this product. Kerala has already banned paan masala from the state. Public awareness is the key to public health; the government should, therefore, step up measures to create this awareness as a blanket ban may prove impractical in the near future. The consequent decline in excise revenue and displacement of the labour involved in production will have to be taken into account while framing an appropriate policy. Some pouches already carry a statutory health warning that chewing the product is injurious to health; this should be made mandatory and its sale to minors should be prohibited.

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TIMES OF INDIA (BOMBAY)

14 MAR 1999

Spurt in tongue cancer in young people

14/3/99 D75 TOI

By Kalpana Jain
The Times of India News Service

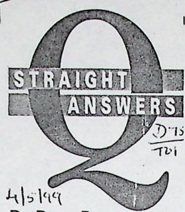
NEW DELHI: Four college friends, aged 20 to 24, recently had to lose a part of their tongues. The reason—all of them were addicted to pan masala.

One after another, all of them developed symptoms of cancer on their tongues, explains Dr S. Khanna, director of the Dharamshila Cancer Hospital and Research Centre, Delhi. The four friends, who had been together since school days, had formed a habit of excessive eating of pan masala, she said. To avoid the cancer from spreading further a part of their tongues had to be removed. Dr Khanna is one of the experts attending the eighth national conference of the Indian Society of Oncology.

Concern over the continued use of 'gutka,' pan masala and tobacco use in various forms has been voiced by experts from time to time. But the increasing use of these products by younger people calls for more than mere concern, they say. It needs urgent government policies to ban the use of some of these items. Head of the department of oncology at B. Nanavati Hospital, Mumbai, Dr Ashok R. Mehta, said that tongue cancers are being seen more and more in young people. And this may well be very early signs of a much larger increase in tongue cancers in young adults.

It takes several years for the effects of life-style related cancers to appear. For instance, says Dr Mehta, women started smoking only after World War II, but the effects of it were seen much later.

These experts also criticised the advertisement of cigarette companies by cricket stars, who are role models for millions of youngsters.



- 4 MAY 1999

TIMES OF INDIA (BOMBAY)

Dr Ram Barot
Deputy mayor
On his campaign against gutka

How do you propose to create awareness among people about harmful effects of gutka?
I am trying to persuade the members of the paan and beedi association to observe June 4 as anti-gutka day. On that day, no paan-beedi shop in the city would sell gutka and negotiations are currently on with their president Sharad Rao. The campaign against gutka is a long one. Even as the chairman of the health committee, I tried to create awareness among citizens to abstain from gutka. But a larger effort is required from the sellers as well.

How many people in Mumbai consume gutka?
The statistics show that in Maharashtra, 72 per cent of the

people use tobacco, of which 16 per cent take it in the smokeless form, that is gutka. It is important that we curb this addiction, especially among teenagers, as it brings a lot of problems along with it.

Isn't the lobby of gutka owners and sellers very powerful?
We had two meetings with the owners of various tobacco giants in the country at the Food and Drug Administration office. It was agreed upon that just like cigarettes, gutka packets should also carry statutory warning at the bottom. Some regulations were also worked out. It was pointed out that no tobacco should be sold within 500 metres of a school or temple. The ground work is ready and now in my capacity I plan to execute it.

But banning might be difficult as the government earns huge revenue from them.
This is a hitch, but steps need to be taken. I have written to Parliament to consider this proposal. Till that comes through, I will create awareness in the city on the harmful effects of gutka. The Tata Memorial hospital and various NGOs are helping this process.

Kaniza Lokhandwala

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TIMES OF INDIA (BOMBAY)

2 MAR 1999

D75/TOI 2/3/99

THE TIMES OF INDIA, MUMBAI

Students fight gutkha menace

By Somit Sen

MUMBAI: Twelve-year-old Nalin (not his real name) loves to play cricket and admires the batting style of Sachin Tendulkar. But now, chewing gutkha after school has become more important to him than playing a game of cricket.

Nalin, a slum resident, was introduced to gutkha by a close friend a few years ago. He now suffers from oral cancer and can barely open his mouth.

"There are several more children like Nalin who need to be educated about the consequences of chewing gutkha," said Ms Himanshi Dhawan, who along with a team of 10 other students of social communications media department of Sophia Polytechnic presented an audio-visual programme, 'Gutkha and Oral Cancer', at the college premises recently.

"The public should be made aware of the dangers of chewing gutkha. Prolonged chewing can sometimes lead to oral cancer," Ms Dhawan said. The team of 11 students researched the subject by referring to books, newspaper articles, and meeting doctors at Tata Memorial hospital, Mumbai, and other health centres in Delhi and Pune. They took nearly five months to complete the project.

"Children are tempted to consume gutkha either by friends or the local *panwalla*, who might offer the first few sachets free of cost," said another student, Ms Mridula Palat. "Nowadays, gutkha sachets are available for as cheap as 50 paise— which is the price of a toffee. This tempts children to buy more. It may later develop into a habit. Although children know that consuming gutkha might be detrimental to their health, they are not aware of the symptoms and dangers of oral cancer."

The 15-minute audio-visual programme dealt with real life incidents. It narrated the horrendous tale of city resident Manoj Thaker, whose addiction to gutkha left him with a disfigured face. After being operated for oral submucous fibrosis (OSF) on three occasions, Mr Thaker resolved to quit the habit. He has now succeeded in persuading over 40 other residents to 'say no to gutkha'.

"Through the audio-visual presentation, we want to alert citizens about the symptoms of oral cancer and the preventive steps that could be undertaken," Ms Tinaz Nooshian stated. Some of the symptoms of oral cancer were : white, red or black patches inside the mouth (oral submucous fibrosis); soreness in the mouth; difficulty in chewing and swallowing; persistent change in voice and lump in the throat and neck. Persons found with such symptoms should be immediately taken to a doctor, Ms Nooshian added.

"We want to reach out to as many people as possible," Sophia Communications Media department head Jeroo Mulla said. "Besides television, we will also target residents in slums and villages of Maharashtra. We are expecting a few non-governmental organisations and schools to assist us in this project," she added.

INDIAN EXPRESS (BOMBAY)
19 JAN 1999

State Govt to seek ban on gutkha

■ 82 samples of gutkha found substandard by FDA; up to 2.36 % of nicotine found in it

PRAFULLA MARPAKWAR
MUMBAI, JAN 18

MAHARASHTRA has decided to move the Centre to amend the Food Adulteration (Prevention) Act, seeking immediate ban on consumption and sale of gutkha in the entire state.

"No doubt, following the ban, we will lose quite a large amount of revenue as sales tax, but it was essential to take a drastic step for protecting the health of the society and also from preventing the younger generation from becoming gutkha addicts," Health Minister Daulatrao Aher told *The Indian Express*.

Aher said the government has drafted a comprehensive amendment to the Food Adulteration (Prevention) Act, 1954, and Maharashtra Food Adulteration (Prevention) Rules, 1962, which will be forwarded to the Central Committee for Food Standards.

"Since the original law is a Central legislation, it is necessary to take a permission from the Centre. In view of the ill-effects of consumption of gutkha, I think the Centre will concede our proposal," Aher said.

Aher said following in-depth analysis of the samples of gutkha by Food and Drug Administration (FDA), it was revealed that they contained magnesium carbonate, used as anti-caking agent and nicotine (0.67 to 2.36 per cent). The Food and Drug Administration also found that 82 samples of gutkha were substandard.

"The consumption of these two items is injurious to health. Besides, studies conducted by leading organisations have revealed that in 90 per cent of the cases, cancer was caused by consumption of gutkha or tobacco," Aher, who is also a qualified surgeon, said. The Health Minister said when the proposal for imposing a ban on consumption and sale of gutkha was being discussed, the question of loss of revenue also figured prominently.

According to records, if the ban is imposed, the loss of revenue will be to the extent of Rs 18.16 crore for the State and Rs 49.91 crore to the Centre towards the excise duty.

"Out of the 400 gutkha manufacturers in the country, 20 are in Maharashtra and their turnover is estimated at Rs 179 crore, while 1050 persons are involved in manufacture and distribution of gutkha," the Health Minister pointed out. "Since it is adversely affects the health of persons consuming gutkha, we should ignore the loss of revenue, which can be recovered from other avenues," Aher added. The Health Minister said there was no sales tax on tobacco-based gutkha as of now.

"We are charging five per cent luxury-tax on gutkha, while we are levying 13 per cent sales tax on pan masala. Studies by leading research institutions have revealed consumption of both can cause oral cancer," he said. Replying to a question, Aher said mere banning the sale of gutkha will not serve the purpose as there is no agency to implement such a prohibitory order effectively.

"Under such circumstances, consumption as well as sale of gutkha should be banned," he observed.

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THE ASIAN AGE
BOMBAY
15 JUN 1998

D 75

Gutka is pre-cancerous, no cure in sight: TIFR study

15/6/98 M145 D 75/AA

By Preeti Deshpande

Mumbai, June 14: Studies conducted independently by the Tata Institute of Fundamental Research and the Tata Memorial Hospital has concluded that regular and prolonged consumption of *gutka* causes sub-mucous fibrosis, a pre-cancerous condition. The studies, conducted independently by Dr Surendra Shastri at TMH and Dr P.C. Gupta at TIFR, researched data collected over 30 years and established that the incidence of SMF had increased ten-fold in India. Dr. P.C Gupta, head, department of epidemiology, TIFR, says, "In front of our eyes, we have seen the disorder change from a little known enigmatic disease to a virtual epidemic." Dr Gupta's study included randomly examining the mouths of commuters outside CST station on Tobacco Day, to check for the incidence of SMF. Dr Gupta concluded that the affected age group was between 25 and 35 years of age, a huge shift from earlier studies, where the disease was restricted to people over forty years of age. Even more alarming is the fact that there is no known or accepted cure for SMF.

SPOTLIGHT

SMF is a condition found only among Indians, or people of Indian origin. Dr. P.C Gupta says, "Since it was confined to the Indian population, its cause had something to do with Indian habits. As the symptoms included a burning sensation in the mouth, it was initially thought to be caused by chillies."

Explaining the effects of SMF, Dr Shastri, head, department of preventive oncology, TMH, says, "Regular and prolonged use of *gutka*, say about four to five packets a day, over eight or nine months, will cause SMF, a pre-cancerous condition that causes the tissues in the mouth to harden. Eventually the patient cannot open his mouth, as the mucous membrane lining the mouth cavity becomes inelastic and cannot stretch. In such case the patient may not be able to speak, or eat without a straw."

"Since the disease is highly pre cancerous, an afflicted person is 400 times more likely to get oral cancer than one not afflicted. In other words since *gutka* contains about 60 per cent tobacco it is already highly carcinogenic. As *gutka* has a high probability of causing sub mucous fibrosis, the chances of a *gutka* user getting cancer are that much higher."

Gutka comprises roughly of 50 per cent areca nut, 50 per cent tobacco, sandal wood powder,

Turn to Page 11

Gutka is pre-cancerous, no cure in sight

Continued from page 9

[illegible]sium carbonate, and flavouring agents and additives.

Says Dr Shastri, "Many of these ingredients irritate the sensitive mucous membrane and fibrous tissues in the mouth, which over time harden and become inelastic, so that patients cannot open their mouths, causing sub mucous fibrosis. Tell tale symptoms are discoloured patches on the palate and the inside of the cheek. These may be white or dark coloured. Other signs are non healing ulcers or legions in the mouth. Since only 20 per cent of the tobacco consumed in India is in the form of cigarettes, a ban on cigarette smoking is ineffective unless you curb other forms like gutka or pan masala. As these are more socially acceptable than cigarettes, their use is harder to curb."

Research on the disease started in the early sixties, when one-in-thirty individuals showed symptoms.

Then it was mainly a disease of the older generation. A sixties study put its highest incidence at 0.3 per cent in parts of Kerala. In '94 its incidence had jumped to one in three individuals. Dr Gupta adds a study done in rural Gujarat still under publication, revealed that eighty per cent of those afflicted were below 45 years of age, 45 per cent below thirty five.

Estimates say that 65 per cent of Indian men use tobacco in some form, the most common being beedis, gutka, and masheri. Contrary to public opinion, cigarette smoking is restricted to a minuscule percentage of the population. 90 per cent of oral cancer patients are tobacco chewers, who use tobacco in either pan or gutka or other variants. Moreover, 55 per cent of all cancer cases in India are preventable, and arise largely due to tobacco use in its desi forms.

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INDIAN EXPRESS (BOMBAY)
9 MAY 1998

Health Ministry isolated on gutka ban

NIRMALA GEORGE
NEW DELHI, MAY 8

THE Health Ministry seems to have bitten off more than it can chew on the issue of banning gutka with a host of ministries opposing the move.

An inter-ministerial meeting held last week revealed the kind of pressures that have come to bear on the Ministry ever since an expert committee ruled that chewing tobacco and pan masala flavoured gutka are carcinogenic and recommended a ban on its production.

Opposition to the move has mainly come from the Labour, Agriculture, Commerce and Industry ministries.

According to Health ministry officials, ultimately the decision on the ban will be a political one. The government will have to decide whether it can afford to face the outcry that would ensue.

The gutka industry which is aggressively campaigning against the move is appealing to the *'swadeshi'* sentiments held dear by the BJP. They feel that since gutka is a one-hundred per cent *'swadeshi'* industry, the BJP would not let it down.

At the meeting, Labour ministry officials did some plain-speaking about the more than 4 lakh workers employed in the gutka and related industries who will be rendered jobless. The Agriculture ministry was no less vehement about the plight of thousands of farmers currently growing areca nut and spices for the pan masala industry.

Any decision on the planned gutka ban threatens to be a political one as the gutka lobby quotes *swadeshi* backed by many ministries including Labour

Not to be left behind, Finance ministry mandarins fretted about the loss in excise revenues. Commerce and Industry ministries wrung their hands about the effect on the Rs 6,000 crore pan masala industry and other related sectors.

And this is quite apart from the numerous state farmers' delegations and gutka and pan masala manufacturers, who have taken their protests on the move to ban gutka to no less than the Prime Minister.

The Health ministry has bought itself some time by seeking expert views on steps to curb the consumption of chewing tobacco and the socio-economic pros and cons of ordering a ban on the sale of such products.

But a way out of the current 'to ban or not to ban' dilemma that the Health ministry finds itself in, may come from an unexpected quarter. There are two public interest litigations (PIL) seeking a ban on gutka pending before the Madhya Pradesh and Maharashtra high courts respectively.

In the light of the activist role taken on by the courts, should either of these courts decide to go by the findings of the earlier expert committee and ban the sale of chewing tobacco, then the Health ministry will have a way out of the problem.

Groups like the All India Pan Masala and Tobacco Manufacturers Association feel that the government should not impose a ban till it finds conclusive evidence about the carcinogenic nature of pan masala containing tobacco. And as proof they cite historical evidence that tobacco chewing has been common in India and large parts of the world since thousands of years.

The Association recently met Prime Minister Atal Behari Vajpayee to plead their case and to press for an in-depth study before any decisions are taken.

For the numerous farmers' delegations that have been entreating Union Health Minister Dalit Ezhilmalai, a ban on gutka could be a matter of life and death.In some states like Karnataka, especially the Shimoga and North and South Kanara areas, farmers have in recent years turned to areca nut farming ever since the popularity of pan masala and gutka, caught on.

Health experts say the government is well within its rights under the Prevention of Food Adulteration Act, 1954, which empowers it to prohibit the sale of any substance which may be injurious to health. But gutka manufacturers feel the law should be applied equally and a ban on gutka should be matched by similar action against known carcinogens like, cigarettes, bidis and even alcohol.

THE TELEGRAPH
CALCUTTA

Tobacco lobby suffers setback

Govt mulls ban on *gutkha*

FROM OUR SPECIAL CORRESPONDENT

New Delhi, May 5: The government will soon mount a massive radio and television campaign against tobacco-chewing as a first step towards a ban on the manufacture and sale of *zarda*, *gutkha* and similar products.

The Union health ministry decided to ban chewing-tobacco about a couple of months ago. The ban was proposed during the United Front government's term and was in the last stages of processing when the BJP government was sworn in.

The BJP government was hesitant about an instant and blanket ban due to pressure from the tobacco lobby and worried about its repercussion on millions of addicts across the country.

Last evening, the health ministry convened a meeting which was attended by officials from several other ministries. All participants, including those from the departments of labour, industries and finance, agreed on the need to discontinue sale of these products, but they were unsure of the wisdom of an immediate ban on their manufacture.

An inter-ministerial committee was formed at yesterday's meeting to decide the issue. The participants met to come up with a policy statement, which the health ministry will place before the Union Cabinet for further action.

But it is the data provided by the labour ministry that is worrying the officials. If the *gutkha* trade is put under a blanket ban, it will create serious problems for nearly four lakh workers in the organised and the unorganised sectors, an official said.

Health ministry officials, however, reminded their counterparts in other ministries that some measure had be taken to curb the trade, in view of the recent court judgments in a number of public interest litigations relating to *gutkha*.

Health ministry sources said that it was the PILs that had prompted the government to consider the ban.

Meanwhile, the All-India Pan Masala and Tobacco Manufacturers' Association has demanded a countrywide survey of oral cancer patients to find out if chewing of tobacco is behind the growing incidence of such cases of cancer.

A ban, the association insisted, could only follow such a comprehensive, countrywide survey.

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THE HINDU (MADRAS) 13 APR 1998

Ban on pan masala not now: Ministry

D75 13/4/98 M156

By Our Staff Reporter

NEW DELHI, April 12.

The Central Government is actively considering a move to ban the use of chewing tobacco in pan masalas and gutkas. The ban, if imposed, will have far-reaching social and political implications as nearly 10 crore people dependent on the industry, directly or indirectly, stand to lose their livelihood.

The inter-ministerial committee is scheduled to meet to consider the matter. The approval by the committee is being regarded as a mere formality. However, while confirming that the matter was under the consideration of the Health Ministry, a senior official said there was no question of such a ban being imposed in the near future. The meeting, scheduled for tomorrow, is part of the consultative process. A proper procedure, which includes inviting and disposing of objections would have to be followed as part of the consultative exercise before a notification imposing such a ban was issued, the official said.

A committee of experts appointed in 1994 has already recommended a ban on chewing tobacco taking the view that it is not only harmful for health but is a causative factor for cancer. The committee's recommendations have already been endorsed by the Central Committee of Food Substances (CCFS). On the other hand, the committee itself states that the pan masala industry was likely to touch the Rs. 1,000 crore-mark in 1997. However, the committee makes no mention of the more harmful effects of smoking tobacco nor has it taken into account the consequences of such a ban.

The expert committee has favoured a ban on chewing tobacco labelling it totally bad for health. Interestingly, it states that epidemiological studies linking oral cancer with the use of pan masala are currently not available. It goes on to explain that the habit of chewing pan masala containing tobacco is of recent origin and the suspected disease (oral cancer) has a long incubation period and any epidemiological study carried out at this time will not be useful.

Similarly, it goes on to equate the Mainpuri tobacco and the 'mawa' habit as having the same harmful effects and has put the pan masala and gutka brands in the same category.

Pan masala and gutka manufacturers have opposed the move of the Centre, saying it will adversely affect crores of people connected with the trade. The worst-hit will be the agriculturists from Gujarat, Karnataka and Assam.

Arguing their case, the Zafrani Zarda Manufacturers Association's organising secretary, Mr. Ashok Aggarwal, said around two crore individuals comprising of panwalas, vendors, hawkers and distributors, whose livelihood depended on this industry would be out of work. The tobacco industry provided employment to over 50 million people, including tobacco and arecnut growers, processors, transporters, silverbeaters, perfumeries, packers and sellers. It contributed nearly Rs. 700 crores last year in the shape of excise duties. The States collected more than Rs. 300 crores in the shape of sales tax.

For its part, the Association pointed out that since smoking was more harmful than chewing tobacco it should be banned first. The experts, they felt, had "conveniently overlooked" the harmful repercussions of smoking tobacco for reasons best known to them.

Quoting from the study in the *American Journal of Medical Sciences*, he claimed it had suggested that, in fact, chewing tobacco could be used as a way to wean away people from the harmful addiction of smoking. The detrimental health effects of cigarette smoking including the increased risk of cancer, heart and circulatory disorders and respiratory diseases are well established.

The study states that a public heath policy that recognises smokeless tobacco as an alternative would benefit individuals confronted with the unsatisfactory option of abstinence or continuing to smoke.

Mr. Aggarwal said scientists in the Central Tobacco Research Institute, Rajamundry, Andhra Pradesh, Mr. Murty Rao and Mr. Gopalchari, have stated that " such chewing of tobacco or its presence in gutka is far less harmful, if at all, in comparison to the direct smoking of tobacco such as cigarettes, cigars and bidis". Figures with the association point out that 1,51,000 smokers developed cancer compared to 6,000 in the case of smokeless tobacco users. Similarly, heart and circulatory problems occurred in 1,80,000 people and respiratory complications in another 85,000 whereas no such diseases affected users of smokeless tobacco.

He felt the ban was being imposed at the behest of multinational companies to wipe out the domestic chewing tobacco industry and provide an open field to the MNCs which are planning to market their cigarette products. He asked why only the smokeless tobacco industry was being meted out this step-motherly treatment and the tobacco industry, with a strong lobby, had been left out.

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INDIAN EXPRESS
(BOMBAY)

1 2 APR 1998

Govt likely to ban gutkha and chewing tobacco

D75
IE
M157
12/4/98

AJAY SURI
NEW DELHI, APRIL 11

COURTING controversy, the Union Health Ministry is working on a proposal to ban the manufacture and sale of chewing tobacco and *Gutkha* across the country. A draft notification is ready and is expected to be soon presented to the Cabinet for its approval.

But before that, an inter-ministerial meeting has been called. Slated for next week, the meeting, to be chaired by Health Secretary K B Saxena, will seek the opinion of the Agriculture, Commerce, and Finance Ministries.

This is being done in view of the far-reaching consequences the proposed ban will have - affecting the livelihood of millions of farmers as well as *paan* and *Gutkha* sellers, and countless consumers across the country.

The decision also threatens to pose a political fallout given that most of the estimated 1,000 tobacco and *Gutkha* companies operate from Uttar Pradesh, Maharashtra, Gujarat and Rajasthan - all BJP-ruled states.

The basis of the Health Ministry's move is a report of an expert committee set up in 1994 during the tenure of then Prime Minister P V Narasimha Rao. This committee which is now headed by Director General of Health Services (DGHS), S P Aggarwal, recently submitted the report to the government recommending a blanket ban on all chewing tobacco products. Incidentally, this committee has met only four times in the last four years.

The committee, ironically, has admitted it doesn't have conclusive evidence to link chewing tobacco with oral cancer.

According to the minutes of its last meeting in September '97 made available to *The Indian Express*: "It was brought out that epidemiological studies linking oral cancer with the use of *paan masala* containing tobacco are currently not available...since the habit of chewing *paan masala* containing tobacco is of recent origin and the suspected oral cancer has a long incubation period, of 15 to 20 years, any epidemiological study carried out at this time would not be useful."

The chewing tobacco lobby — it recently formed an umbrella association called Zafrani Zarda Manufacturers Association — debunks this. Tobacco chewing, points out association secretary Ashok Aggarwal, is not of recent origin but has been "on since the Mughal times, and even before. Certainly, tests could have been carried out long ago."

Aggarwal alleges that the government's move is at the behest of the cigarette manufacturers' lobby who want to capture new markets. "There is evidence to show that cigarettes cause cancer. But the cigarette lobby is more powerful, they are untouched."

The committee's report has drawn its conclusions on the adverse affects of consumption of chewing tobacco and *Gutkha* based on studies conducted by three institutions : National Institute of Nutrition, Hyderabad; Regional Cancer Institute, Trivandrum in collaboration with Johns Hopkins University, USA; Chittaranjan National Cancer Institute, Calcutta.

The committee, constituted to go into the 'use of chewing tobacco in *paan* masala and *Gutkha* and its effect on public health', reports there has been a "tremendous growth" in the chewing tobacco industry from Rs 200 crore revenue in 1992 to well over Rs 1,000 crore in 1997.

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Members seek ban on pan parag

By Our Special Correspondent

CHENNAI, April 1.

A ban on pan parag was demanded in the Assembly today by the DMK, CPI and CPI(M) members who expressed their deep concern over the alarming speed at which the chewing habit spread, especially among the student population. Mr. K. Subbarayan (CPI) asserted that no one had the right to play with the lives of the people as pan parag promoted cancer.

The Health Minister, Mr. Arcot N. Veerasamy, expressed the Government's inability to impose the ban as there was no such ban on liquor and cigarettes. The Minister said that pan parag promoted the disease "sub mucous fibrosis" which was a prelude to the onset of cancer.

The Cancer Research Hospital at Kancheepuram and the Chennai Government Dental College had done extensive research on the disease promoting qualities of pan parag and cautioned the people through the Government-sponsored dental camps.

Mr. Chengai Sivam (DMK) insisting on a ban cited the opinion of world health experts which, he said, testified to the fact that pan parag promoted cancer more than liquor or cigarettes.

The CPI(M) member, Mr. D. Mony said that another product Manikchand was also catching up with the people and it was being sold, particularly in front of schools and colleges to lure the youth. He said the Government should create awareness among the people and the youth about the harmful effects of these products.

Mr. Veerasamy said constant use of these stimulants would result in the shrinking of the muscles controlling the mouth resulting in difficulty in swallowing food. This would be before the onset of regular cancer.

The Minister said the Government would examine whether it could get funds from World Bank and Central Government for launching a campaign for creating awareness about the harmful effects of pan parag as it did in the case of AIDS prevention.

THE HINDU (Madras)
2 APR 1998
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THE ASIAN AGE
BOMBAY

21 MAR 1998

State bans *gutkha* sale near schools

21/3/98

Vajpayee government will bring in tobacco ban: Aher

M154.

BY OUR SPECIAL CORRESPONDENT

D75 A

Mumbai, March 20: *Gutkha* pouches of less than half a kilo will be banned and so will the sale of *gutkha* within 100 metres of educational institutions, state health minister Dr Daulatrao Aher assured legislative Assembly members on Friday. With the new Atal Behari Vajpayee government in New Delhi, Dr Aher was confident that the state proposal for a complete ban on *gutkha* and tobacco will be accepted.

The matter came up during a non-government motion moved by Bharatiya Janata Party MLA from Chandrapur Sudhir Mungantiwar, who has raised the demand for ban on *gutkha* in almost every session of the legislature. Dr Aher, in his reply, said the state was determined to ban *gutkha*, which is responsible for oral cancer and general ill-effects on health, especially of youth. The minister was so carried away with his support to the cause, that he announced his willingness to accept the motion. Traditionally, non-government resolutions are withdrawn by the mover. The government at best takes notice of the issue raised and assures appropriate action. Dr Aher had to be prompted by Mr Pramod Navalkar to urge Mr Mungantiwar to withdraw the motion.

Considerations like handsome revenue from the sale of such pouches will not come in the government's determination to stop sale of *gutkha*, he added. "Maharashtra is capable of collecting enough revenue through other sources," he said when a member pointed out that public-welfare schemes of prohibition in other states like Haryana and Andhra Pradesh had collapsed under revenue considerations from such sales.

Making a strong plea for stopping *gutkha* sale, Mr Mungantiwar said, "Tobacco sells at Rs 1,600 a kilo while the best of dry fruit is priced at Rs 450 a kilo. It is a shame that money is wasted on such harmful habits."

Members from all political parties made a strong plea to ban advertisements of *gutkha* and even its consumption in public buildings like Mantralaya.

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THE ECONOMIC TIMES 12 FEB 1998

Ban on gutka, chewing tobacco on the way

Varsha Gupta
MUMBAI 11 FEBRUARY

THE UNION health ministry's Central Committee on Food Standards (CCFS) has passed a resolution to ban the manufacture, sale, distribution and storage of chewing tobacco and gutka. The resolution is expected to become legally effective after the new government is in place at the Centre.

The health ministry's move follows hectic lobbying by consumer societies and the Food and Drug Administration (FDA) and a prolonged public debate.

The resolution is backed by the Prevention of Food Adulteration Act, 1954, which empowers the Union government to prohibit the sale of any substance which may be injurious to health when used as food or as an ingredient of food.

Speaking to *The Economic Times*, Maharashtra FDA commissioner Anil Lakhina said that a countrywide ban would affect 400 manufacturers of branded gutka and pan masala who control 65 per cent of the market that branded products account for. In addition, it will lead to a revenue loss of about Rs 300 crore for the exchequer.

Weeding Out Health Hazards

- CCFS has passed a resolution to ban gutka, chewing tobacco
- Will become legally effective after the new govt is in place
- Resolution is backed by the PFA Act 1954
- Countrywide ban will affect 400 manufacturers of branded gutka
- It will lead to a revenue loss of Rs 300 cr

There are some 80 brands of gutka, accounting for sales of a staggering Rs 1,500 crore in Maharashtra alone. Gutka manufacturers are expected to seek legal redress.

It all started in early 1997, when the Rajasthan High Court issued directives to the central government to appoint a committee to examine the use of tobacco in pan masala and gutka and its effect on public health. The committee was appointed under the chairmanship of the director general of health services (DGHS).

The committee had entrusted a Chandigarh-based institute to undertake clinical studies in multiple species of animals to get evidence of carcinogenicity in experimental animals. The committee also asked the Gujarat Cancer Research Institute, Ahmedabad to undertake studies in collaboration with institutes in Bihar and UP to examine the cancer-causing effects of tobacco on humans. Also roped in was the Indian Council of Medical Research (ICMR), which contributed to the findings of this committee by proving that gutka is associated with oral cancer.

All the studies concluded that there was strong correlation between intake of tobacco (in any form) and cancer, Mr Lakhina said.

Adding to the pressure on gutka manufacturers was a public interest litigation filed in May 1997 by a consumer activist in the Aurangabad court, seeking a ban on gutka. The court ruled in favour of a total ban on gutka.

Mr Lakhina said that the new government will have to give legal effect to the health ministry's resolution, also in response to the rulings of the Rajasthan and Aurangabad courts.

If the government failed to take the necessary action, the courts would do so, Mr Lakhina said.

Observers said the ban could result in an increase in cigarette sales as consumption would shift to other tobacco substitutes. In response to a question on the impact of the ban on government revenues, Mr Lakhina responded: "Thousands of lives will be saved."

INDIAN EXPRESS (BOMBAY)
12 OCT 1997

Centre chews on State's plea for *gutka* ban

MANJIRI KALGHATGI
MUMBAI, OCT 11

THE Government of Maharashtra has recommended to the Central government that *gutka* should be banned in the State. Maharashtra Minister for Health, Dr Daulatrao Aher, told *The Indian Express* that he had written to the Centre in July and also spoken to Union Health Minister Renuka Choudhary in this regard. However, there has been no reaction from the Centre yet, Aher informed.

Gutka is a propriety food which means it has not been standardised under the Prevention of Food Adulteration Rule (1955). According to this act, *pan masala* should be free from added coaltar coloring matter and other ingredients injurious to health. This means that tobacco and artificial flavours and colours in *gutka* are not allowed.

India is the largest producer of tobacco in the world with over 80 million kg tobacco cleared for consumption in the country.

The *gutka* industry has a turnover of Rs 1500 crores and generates a revenue of 300 crores. 400 manufacturers of branded *gutka* (holding 65 per cent of the market share) employ 10,000 employees in the country. In Maharashtra, there are 20 manufacturers of *gutka*.

Banning *gutka* will be comparatively easier for the State Government as the revenue generated from it is very low and most of the income is undeclared. The number of labourers rendered jobless by the *gutka* ban is also negligible and can be accommodated elsewhere. For instance, the annual revenue collected from Rahul Fine products was Rs 2 lakhs, Rs 20 lakhs from Johnny Walker tobacco and Rs 7 lakh from Sanket Food products. The number of workers in these companies is only 74, 65 and 46 respectively.

If *gutka* is banned in the state, permits to set up *pan* shops will be given only after ensuring that it is not sold there.

According to Dr Aher, such outlets will have a list of products they are permitted to sell and shop licenses will not be renewed if *gutka* is being sold.

However, maintaining that *gutka* is harmless, Bharat Thakkar, Founder Coordinator of All India Pan Masala and Tobacco Manufacturers Association AIPMTMA said: "The Centre cannot ban *gutka* until a direct link with cancer is proved." Despite this claim, Thakkar admitted that spurious ingredients used in *gutka* could be harmful.

J M Joshi, Founder Chairman of AIPMTMA suggested that the government specify which ingredients are to be banned. "*Gutka* can be manufactured leaving out those materials" he said.

Suggesting a middle path, Joshi said a General Manufacturing Practice (GMP) should be introduced to ensure quality production of *gutka*. "At present, inspectors appointed by the government are paid off by factory owners while workers continue to have long dirty nails and handle *chuna* with bare hands," he remarked.

THE TIMES OF INDIA
(BOMBAY)
- 5 DEC 1997

D 75

Kerala set to ban pan masala, gutka

By P.K.Surendran
The Times of India News Service

KOCHI: Kerala is set to ban pan masala and gutka. The Kochi Municipal Corporation has banned the sale of these items while a number of municipalities have followed suit.

What makes the effort different is the fact that the entire merchant community seems supportive to the cause even at the obvious loss of considerable profit.

The alacrity in action against pan masala followed some studies by both consumer fora and independent organisations on how pan masala, gutka, and their varities, are catching on among teenagers. The masalas have special attractions as compared to cigarette or pan. They come in handy satchets and priced low. They can be consumed without ostensible effect and the chances of detection are less.

A recent survey by Regional Cancer Centre, Thiruvananthapuram, found four per cent of girls and 10 per cent of boys in four colleges were addicted to "Pan Parag" and other varieties of masala. Many more admitted to have "tasted them" at least once. The study said these varities were far more habit forming and harmful than cigarette and beedi.

While the Kochi Corporation has, in its council meeting last week, passed a resolution unanimously to ban sale of pan masala, the North Paravoor municipality in Ernakulam district was the trail blazer. The municipality banned the tobacco-based habit-forming stuffs a couple of months ago setting to motion a chain of similar action by municipalities and panchayats.

On Monday the Kalamasseri municipality, again in Ernakulam, has banned the sale of pan masala in its area. At least three panchayats have so far followed suit. It may be pertinent to note that Koolimad village of Kozhikode had banned all tobacco- based items two years ago.

T.K. Ravindran, secretary, Kochi Corporation told TOINS that health inspectors and food inspectors had begun checking shops especially kiosks, to ensure the banned items were not stocked. The existing stock is allowed to be sold. The secretary said violators would find their licence suspended.

The Kerala Vyapari Vyavasai Ekopana Samity, the apex body of the Kerala merchants, which had till recently been fighting Hindustan Lever Limited, has turned its ire against the pan masala recently. The Samiti leaders of Ernakulam had indeed approached the corporation with the promise of cooperation if the corporation would prohibit the sale of all masalas. The Samiti has 224 units in Ernakulam and all of them have been asked to shun the purchase and sale of pan masalas.

"It sure involves considerable loss of profit," agreed secretary of the Samiti. "But we have a social responsibility too," he said. According to the Samiti pan masala and its many varieties had been the top earner of profit to small merchants. The sale of such masalas were to the tune of Rs 30 lakhs a month in Ernakulam.

The Samiti's Thiruvananthapuram unit has also sent a directive to its units to discontinue buying pan masala varieties. Efforts are on to induce Kozhikode Corporation too to follow the example of Kochi.

D 75

INDIAN EXPRESS
(BOMBAY)

- 5 DEC 1997

Ban *gutkha*, says Central panel

5/12/97 M134 D75/IE

SVATI CHAKRAVARTY BHATKAR
DECEMBER 4

THE high-powered Central Committee on Food Standards (CCFS) has demanded a nationwide ban on *gutkha* and pan masala. Declaring the tobacco products as carcinogenic capable of causing oral cancer, the government body, chaired by the Director General Health Services, conveyed its views to the government through a resolution passed on November 27.

Anil Lakhina, Commissioner, Food and Drugs Administration (FDA) and a member of the CCFS said, "The Committee is the apex body of experts authorised to take such a decision. After reviewing all the evidence on pan masala and *gutkha*, we came to the firm conclusion that the product is harmful. It causes cancer. Therefore, we have recommended that it should be banned." Armed with this verdict, the government can now amend the Prevention of Food Adulteration Act (1954) and empower the state governments to ban both products.

The CCFS resolution is significant, especially since the government cannot ignore the suggestions. However, anti-tobacco activists are sceptical and expressed doubts about an effective ban.

Dr P C Gupta, a cancer researcher and scientist at the Tata Institute of Fundamental Research (TIFR) said, "There's many a slip between the cup and the lip. First, the ministry has to accept the demand, then the law has to be amended. Even if an order is passed, the pan masala makers will definitely move the courts. They are bound to take the matter up to the Supreme Court and that will take years."

Faulty implementation is another pitfall, point out anti-tobacco activists. They cite the example of banned toothpastes laced with tobacco. The legal challenges to the ban dragged on for years as the manufacturers took appeals up to the Supreme Court. Months ago, the SC passed an order upholding the ban. But the banned toothpastes are freely available.

Scepticism about a real ban is also fuelled by the fact that pan masala is a money-spinner for the central and state governments. In the year 1990, the World Health Organisation (WHO) had estimated the Indian pan masala market to be worth Rs 20 billion. Today, the revenue department expects to net close to Rs 500 crore additional excise from the pan masala industry in the current financial year.

THE STATESMAN
(DELHI)
- 2 DEC 1997

Pan masala banned in Kochi

STATESMAN NEWS SERVICE

KOCHI, Dec. 1. — The Corporation of Cochin has banned the sale of pan masala in all areas within its jurisdiction. The resolution, which was moved and unanimously adopted at a council meeting on 25 November is effective from today.

The decision was adopted following a series of complaints from parents of school children and voluntary social organisatioins. They claimed that many students were streadily getting addicted to "chewable" tobacco products like pan masala and "thambakku" (tobacco).

"These products contain unhealthy substances, which are not only carconogemic, but addictive and even intoxicating. Since complaints have been pouring from many social organisations that a growing number of youth are falling prey to these products, we decided to take a firm stand," Mr K KSomassundara Panicker, Mayor of Kochi, said to The Statesman today.

Samples of pan masala products were tested in laboratories to prove that they did contain harmful elements, he said.

Special squads have been formed under the Food and Health inspectors to conduct random checks in kiosks known to sell these products. Those retailers found selling pan masala products and "thambakku" will have their trade licenses cancelled and their goods seized, Mr Panicker said.

While the ban has so far been effected within the corporation jurisdiction, efforts are on to spread it in the outskirts of Kochi have taken similar steps.

While the Corporation of Cochin is the first of the three corporations in Kerala to adopt such a resolution, the other two, Trivandrum and Calicut, were also considering similar steps to give it a State-wide character, Mr Panicker said.

One of the first such moves was noted in January this year in the Pallipuram gram panchayat on the outskirts of Kochi, where tobacco products, like pan masala, were banned following a sustained campaign by voluntary organisationsreported by The Statesman on 4 February.

The campaign which kicked off on 18 January was led by a voluntary organisatioin called Kaliarangu, which began an awareness programme in the area by putting up posters and signs cautioning people against these products. The "social" ban was made effective from 30 January.

The ban has shaken pan massala dealers in the state, who have challenged in the court and even petitioned to the Chief Minister, Mr T K Narayan. In areas under Cochin Corporation, however, they have have removed posters of pan parag till a settlement is heard on their appeal.

The ban may severely affect their profits, believed to be of about Rs 200 a day.

Gutkha promotion continues unabated

By Rakshanda Italia

MUMBAI: Even as gutkha manufacturers have agreed to refrain from using event sponsorship as a means of product promotion, advertisements for gutkha continue with unabated vigour. Faced with a glut of aggressive gutkha ads, anti-tobacco lobbyists are sceptical of the industry's promise to tone down hard-sell of the health-injurious gutkha.

Activists have been shocked by a high-profile "contest" recently launched in the print media by a gutkha company. The only concession to the industry's agreement to reduce marketing hype is a line in the ad which states that the contest is open "only to gutkha eaters."

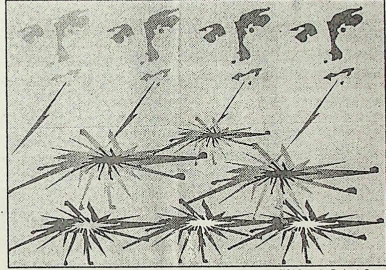
This has enraged a section of consumers and activists as well as advertising circles. They say that the line "is clearly an attempt by the manufacturer to steer clear of any messy legalities and to shirk moral obligations towards society."

Kesari Tobacco Pvt. Ltd., which markets a gutkha called Ruki, has issued advertisements in leading papers announcing a contest with tempting prizes — the first and second prizes are gold (20 and 10 gms respectively). To enter, one has to attach three empty pouches of the gutkha brand and send in a short statement describing one's "experience" after consuming the product.

Advertising industry insiders say that besides the one-line statement, which is "clearly eye-wash," there is no way entrants are going to be screened into non-gutkha and gutkha eaters.

Says advertising agency Sistas Saatchi and Saatchi chairman S.V. Sista: "First and foremost, the advertisement is not brand advertisement but a lifestyle one. It has all the attributes of the gutkha enlisted in it and one sells products by selling the benefits and the virtues, which is attempted in this ad. Moreover, if you do not want to increase sales, you would not spend thousands of rupees advertising. This is not a public service advertisement." (The advertisement shows a young couple in the background with a line that says "....*Dil ki pasand zabban par ruki.*")

Iris Advertising, which created the ad, claims the line was inserted to deter non-gutkha eaters. Iris Advertising chief Parvez Waris maintains that gutkha advertising does not lure non-gutkha eaters, but induces existing gutkha eaters to switch brands.



TOI Graphic: Prakash Sanap

This argument does not hold much water for die-hard gutkha opposers. Says Cancer Patients Aids Association representative Viji Venkatesh: "These contests are a modern way of advertising traditional forms of tobacco eating." According to her, these advertisements are targeted at first-timers and younger adolescents. "Cancer is also only for gutkha eaters," she adds vehemently.

Ms Venkatesh states that studies have shown that young children view cricketers and filmstars as role models, and whether one likes it or not, they do tend to be lured into buying products endorsed by their heros. In fact, a study conducted by a group in Goa after the Wills Cup revealed startling findings. While many adolescents thought that most of the cricketers smoked the brand, there were others who would be actually induced to buy the brand and try it out.

"This Ganapati one hopes will be different," says Brihanmumbai Municipal Corporation public health committee chairman Ram Barot, who feels that the lure of fancy prizes such as gold could induce impressionable people to try the product. He adds that gutkha manufacturers have been asked to desist from sponsoring events. There is also a plan to ban the sale of gutkha within two hundred metres of schools.

However, Mr Barot says that as there is no legislation in Maharashtra banning the sale and advertising of gutkha, it is still a moral issue which people need to adhere to.

Activists say that this is a matter that the Union government needs to immediately implement. But with the state government earning Rs 300 crores from tobacco and gutkha sales, one wonders if legislation banning this hazardous product will ever be introduced.

29 AUG 1997

DTS

29/8/97 D75/TOI M110

TIMES OF INDIA BOMBAY

TOI 19/3/2000

Pan masala, gutka can leave your mouth stiff

Sriranjan Chaudhuri

BANGALORE: When Varadaraj (name changed) visited oral and maxillo-facial surgeon Dr K. Umesh he could barely open his mouth. Just a straw could pass through to the mouth. He suffered from oral sub-mucous fibrosis (OSMF) developed from consuming smokeless tobacco.

Says Dr Umesh, "This condition is pretty common and affects about one per cent of population. It is seen among young males, usually below 35 (60-70 per cent of cases) who use smokeless tobacco for long. According to a recent data, 30 to 60 per cent of OSMF is seen among gutka and pan masala chewers."

Sub-mucous fibrosis is a permanent hardening of the inner lining of the mucosa of the mouth. The substances used in pan masala and gutka cause irritation to the mouth then to the skin inside mouth. Gradually, capacity to open mouth reduces and the person may not be able to open his mouth at all.

Says Dr Umesh, "Smokeless tobacco is as dangerous as smoking cigarettes, beedies or cigars, whether taken along with areca or betel nut or used as gutka, pan masala or zarda. In fact, even tobacco placed between the cheek and mouth could lead to OSMF."

Initial signs of OSMF are, burning sensation when consuming spicy food and a progressive inability to open mouth because of scarring of cheek skin. The skin of mouth is easily irritated when eating spicy food.

According to Dr Umesh, "Fibrosis and scarring of mucosa leads to reduced ability to open mouth and sinking of cheeks. The inner surface of cheek is commonly affected, However, it can also affect all areas of the mouth, like under the surface of the tongue, gums, hard and soft palate, floor of mouth and sometimes even pharynx."

According to studies carried out on OSMF, it has been proven that paan contains mutagens which can be cancerous. "OSMF itself though is not carcinogenic, but it makes the skin of the mouth prone to cancer. Research shows that 5-8 per cent of OSMF cases may progress into oral cancer," stresses Dr Umesh.

A few common signs indicating malignant changes are: Ulcers in mouth; red lesions that undergo changes; burning sensation in mouth; mass of tissue forms a cauliflower shaped growth.

(For more information Dr K Umesh can be contacted on 6681088 or 98440-12671).

implications among other

70/9/2/00

Maharashtra restriction on sale of gutka

The Times of India News Service

MUMBAI: In a significant decision, the Democratic Front government on Tuesday announced a ban on sale, consumption and advertisement of gutkha within 100 metres of educational institutions and government offices.

"The addiction to gutkha had reached alarming proportions among youngsters. A recent survey shows that 40 per cent of school students and 70 per cent of the collegians are addicted to gutkha.

The government has, therefore, decided to prohibit its sale in the neighbouhood of educational institutions and also near government offices," Chief Minister Vilasrao Deshmukh said at a press conference on Tuesday.

The ban on gutkha will also cover government and semi-government offices, government-run corporations and state undertakings, he said after a meeting of the cabinet. The ban will come into force immediately.

Those found violating the ban will be liable for criminal prosecution under Sections 7 and 10 of the Food Adulteration Act. The punishment for offenders will range between six months to 2 years of imprisonment or a fine of Rs 1,000.

Kick the butt - Drop the Weed

07 2200 smokers died in India today. So did 10,000 of tobacco related diseases ! By 2020 tobacco will cause more deaths than HIV, TB, maternal mortality, motor vehicle accidents, suicide and homicide combined. Advance 3 steps.Tell people of our daily tobacco death toll.

11 Tobacco use becomes a powerfully compulsive behaviour.A BAT official commented: " Because of the nicotine level in the blood a person simply cannot choose to use tobacco or not as we would choose to walk on one pavement or the other. He can no longer make an adult choice." (1980). Miss a turn. Ask consumers how they feel about being reduced, by tobacco companies, to zombies facing severe health risks.

15 Smoking early builds a strong nicotine dependence within a year. Lung damage is also much greater.Surveys show half the youth in Chennai smoke at private parties, girls included. Repeat 6 tobacco related diseases, or move back 2 steps.

20 In Jaipur, 53% of the girls in a group of 200 youth, aged 21 - 22, smoked. The $ 6 m annual investment of tobacco com- anies telling girls that smoking makes them relaxed, attractive, slim, successful and accepted has paid off ! Miss a turn. As a girl, reflect on their efforts to dupe you.

22 Tobacco companies subtly promote smoking among youth at discos, private parties and pool clubs by paying a youth Rs.250 an evening to hand out cigarette packs of their premier brands. Youth are targetted because they are the largest block in our population pyramid - the largest potential market ! To advance 3 steps challenge your peer group with 4 questions.

26 With Western markets shrinking, tobacco MNCs are targetting Third World youth. 7.5m youth between 15-24 in Karnataka smoke and 60,000 more begin every year ! Alan Landers, the Winston Man, quips, "If 4 million customers die every year, won't you try to get new ones? " For another turn, compose resistance songs on "To oblige or not / To die or not."

30 You think you now smoke a milder brand of cigarettes which still guarantees nicotine satisfaction ? Miss a turn.'Mild, light, low yield' are misleading terms to make smokers feel they are using a healthier safer product ! You have been fooled !

34 For another turn, repeat these acute health risks of tobacco use : increased heart rate and carbon monoxide levels in the blood, shortness of breath and worsening of ashtma, impotence, infertility, gangrene which results in more amputations than accidents.

38 To advance 6 steps, repeat these long term risks: a narrowing of the blood vessels, a drop in oxygen levels in the blood, loss of appetite, cholesterol plug formation in the arteries, creation of free radicals, increased kidney damage resulting from diabetes, an increased white blood cell count and a decrease in the NK cells which fight tumours in the body.

40 Advance a step. Reflect with women on these risks of tobacco use during pregnancy : birth disorders, spontaneous abortions, premature babies, retarded mental and physical development of the child in the womb, low birth weight,and sudden infant death syndrome. Smoking around the infant causes

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respiratory problems, and middle ear infections.

43 This is no trendy mouthwash ! 4 college students in Delhi had their tongues surgicallly removed. In two years chewing pan masala and gutka had led to mouth cancer. Advance 4 steps. Publicize gutka ingredients: a mixture of tobacco, areca nut, lime, lead, arsenic, and magnesium carbonate. Some leading brands even add cadminium and lead ! Note, gutka sales are much higher than cigarettes and bidis put together !

48 In India 53% of all adult males smoke making half the children in the country passive smokers. Smokers inhale only 15% of the smoke - the rest is in the air. This side stream smoke has 40 times more carcinogens than mainstream smoke.

51 Surveys show that 80% decide to quit, but only 35% actually do and less than 5% succeed. Advance 4 steps to spread the good news of Nicotine Replacement Theraphy to those willing but not able ! Use skin patches, chewing gum, lozenges and inhalers but for never more than 8 weeks !

54 What is NRT ? An habitual smoker gets used to a certain level of nicotine in his blood which falls when he stops smoking, causing withdrawal symptoms within hours of the last cigarette. So he smokes again. NRT maintains a low blood nicotine level to eliminate these withdrawal symptoms.

58 You think Ashok is difficult, irritable, impatient. Go back 3 steps for not recognizing his withdrawal symptoms. He could also be depresssed, anxious, unable to concentrate. Tell him strenuous exercise will bring relief even without NRT.

61 Psychologists say a smoker goes through 5 stages while trying to stop smoking. He 1) knows he has to stop but makes excuses; 2) seriously thinks of stopping, 3)decides to stop, 4) actually stops, 5) tries to avoid a relapse. Kicking the butt for 48 hours ensures success. To advance 6 steps explain why.

63 Miss 2 turns to provide those in stage 1) motivation; in2) information; in 3) a cessation programme with a definite quit date, no tapering off ; in 4) help to remove things around him associated with tobacco; 5) support to avoid places, situations, and persons which could bring on the temptation to smoke.

65 Go back 2 steps. For 48 hours after the last cigarette, advise the quitter to spend time in places where smoking is prohibited: places of worship, libraries, hospitals. It helps.

68 Advance 2 steps to the Quit & Win Competition where Appiah is sharing how and why he decided to quit tobacco and the strategies he used to quit successfully. Personal testimonies have a strong appeal and are a good motivating force.

72 Advance 2 steps.Tell smokers about this Quit Smoking Theraphy. They smoke during specific hours during the day. Over 3 - 4 weeks, the intervals between these smoking slots are lengthened until the smokers are down to 2-3 cigarettes a day. They are then ready to kick the butt.

75 Dr. M.S.Khan, known as the 'nashewalla doctor', in Hauz Rani, Delhi, has de-addicted 8000 chain smokers with his own medicines restoring the electro-magnetic balance of the body and creating a revulsion to tobacco. Patients stay away from gadgets emitting electro-magnetic pulses(mobile phones,etc) during treatment.Have 2 turns. Send smokers to visit him.

78 Repeat these facts for 2 turns. 20 minutes after his last cigarette, Anup's blood pressure and pulse rate as well as the temperature of his hands and feet became normal. 8 hours later, the carbon monoxide level in his blood dropped to normal and the oxygen level increased to normal. 48 hours later, he was less irritable. His sense of taste and smell improved as hisnerve endings had adjusted to the absence of nicotine.

83 Anup breathed more easily 3 days late. His bronchial tubes were relaxed and his lung capacity increased. Walking was easier. Repeat these further benefits to advance 6 steps.

86 Go back 4 steps.Stop nagging Amit for his 'bad' habits. Smoking is not totally an individual decision. Take time to help him see how his decisions are influenced; how the market subverts health messages; how global trade policies subvert national decison making. Both the tobacco user and the Government are addicted ! Health educators must empower people to refuse to be enslaved and to help liberate the Government from tobacco bondage, too.

90 Tobacco earns big money for India : Rs. 8,000 crore in exports and Rs. 7,000 crore in taxes. But nearly Rs. 22,000 crore is spent on treating tobacco related diseases. Is the blood money worth it? Your father, a tobacco user, has lung cancer. Ask 3 why questions of a relevant Government official.

96 Despite 2 harvests a year, Kenya imports food. Farmers grow enough tobacco to chew, smoke, and sell, but not enough food to eat ! Indian farmers receive a support price of 450% for tobacco but only 150% for rice.Are we heading in the same direction ? Advance 2 steps to organize a debate on : Tobacco versus Food.

99 Monitoring sales at the village outlets and talking to the villagers, a group of Sri Lankan youth assessed the total annual expenditure on tobacco and alcohol in the village at Rs. 80,000 - enough to provide educational and medical facilities, electricity and roads to access the village ! They showed the villagers how tobacco was a major threat to sustainable development. Miss 2 turns to see what you can do.

102 The British took opium to China. The Portuguese brought gutka to India in the l7th cnetury from Mozambique and sold it in Goa to buy textiles for Portugal. Advance 3 steps to join Dr. Sharad Vaidya's struggle against gutka. It goes beyond health to the economic, political, and finance dimension of the problem.

105 After tobacco sponsored cricket matches, 15-20% of the students interviewed said gutka improves the memory, and cigarettes make you a good cricketeer. Strange conclusions ! Alan Landers strongly condemns sponsorhip by tobacco companies. Ask 5 players to comment on his condemnation of blood money.

107 The Advertising Standards Council of India introduced a new code. No ad is to suggest that tobacco is safe, healthy, natural or necessay and that it leads to extraordinary success in various areas of human effort, including sexual success. Miss a turn to compose spoofs on the claims of tobacco ads.

111 Review images of the hero on the big/ small screen and the stage: talking authoritatively with a cigarette dangling from the mouth ; blowing smoke rings up into the air; puffing and chewing on the corner of a cigar ; tapping, filing the pipe withstudied movements. And the heroine ? Puffing away,

flicking the ash off the cigarette with class ! Organize skits provoking reflection on how these media images shape day to day behaviour and thought.

114 Since l998,court cases have exposed internal documents of tobacco companies proving they knew the health risks of tobacco for more 20 years.They suppressed, denied or denigrated unfavourable health research. 39 articles in scientific journals between l980 - l995 claimed passive smoking was not harmful. 29 of these were written by those connected with the industry. Advance 4 steps to make known this information.

118 Advance 2 steps. Join the campaign for these to be declared criminal offences : targetting youth with tobacco products; spiking tobacco with ammonia; raising nicotine levels.

122 In June l999, the Railway Ministry banned the sale of cigarettes / gutka on trains and railway platforms where 30% of the total sales of these tobacco products took place. Empowering people is the only way to help implement these bans. Public awareness is the key to public health.

126 Singapore, Australia, New Zealand and parts of USA now use a shock theraphy to stop smoking: strong slogans with gory pictures of the damage done to the body. A picture of bleeding brains goes with the slogan : Get this into your Head. Smoking can lead to a Stroke. Miss a turn to use available information for similar strong slogans for your neighbourhood.

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ORAL HEALTH PROBLEMS OF TOBACCO CHEWERS

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R. Varalakshmi[1] *R. Jayasree*[2] *T. Mamatha Rani*[3]

"Our teeth in our mouth
Are the guardians of our health"

Oral health problems affect the quality of life. According to WHO (1992), for maintaning healthy life style it is essential to maintain the most desirable levels of oral health (WHO Report; 1992).

An even and bright set of teeth can make a world of diffenrence, so far as our looks are concerned. Diseases of the teeth and the adjacent oral structures are among the most common maladies affecting human beings perhaps because they are so common and seldom life threatening, they usually do not receive the attention they deserve.

Habits like irregular brushing, improper brushing, avoiding rinsing of mouth after meals or eating sweets or after tobacco chewing, leads to bad oral health and the mouth invites several micro-organisms responsible for carcinogenic activity leading to dental problems like dental caries, bad breath, cracks, dental decaying etc.

Heavy use of tobacco is a well established factor in the development of oral cancer. (Graham et al; 1977, Madh Berg 1981; Wyder et al., 1977). More recently viruses like cytomegalovirus, epstein barvirus, papillomavirus have been associated with intraoral carcinoma and that may play a significant etiological role. The various ways in which tobacco is used, held in mouth, chewed are associated with the location and type of malignancy.

While in most Asian countries oral malignancies constitute some 5 per cent of all cancers diagnosed, among the Indians

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Jn 30/6/03

the relative frequency of oral cancer is closer to 45 per cent (Pindborg et al., 1977). Even in India the variation in frequency is great in different parts of the country and in different population groups.

Over 80 per cent of India's mammoth 100 crores population suffer from dental caries. It is time to shift our focus on to this problem and organise efforts to prevent oral health problems. The need of the hour is a well planned educational interaction on a massive scale. The planned intervention should involve both mass media and interpersonal channels of communication.

In this context the present paper tries to find out the oral health problems of tobacco chewing adult rural working women in the age group of 20 to 40 years in Noolukunta village of Kuppam mandal in Chittoor District of Andhra Pradesh. This paper is based on an empirical study.

The main objective of the study was to find out the incidence of oral health problems of tobacco chewers. The study also assessed the knowledge and practices regarding oral hygiene and demonstrated few intervention strategies to improve the oral health status among the women.

Methodology

A sample of 100 adult women in the age group of 20-40 years were selected. The sample women were screened from the general population on the basis of tobacco chewing habits. The dental examination was carried out in natural light using dental probe and mirror and the dentition status was recorded.

An interview schedule was prepared to collect the information such as socio-economic status, dentition status, knowledge and practices of dental care, chewing practices and oral health problems. After analysing oral health practices and tobacco chewing habits, an intervention (education) programme was launched to explain the negative effects of tobacco, good oral health practices like the right way of brushing, proper rinsing of the mouth after chewing tobaccco, brushing after eating food atleast twice a day to promote

oral health and make them aware of curative methods to prevent further damage to teeth.

Results and Discussion

Socio-Economic Status of the Respondents

Age: For the present study, the sample population was selected purposely from adult women in the age group of 20-40 years, because they are the potential age group getting addicted to chewing habits and it is essential to change their behaviour and habits without further damage to their health. Among the total sample, 53 of them were in the age group of 20-30, and the rest (47) belonged to 30-40 years age group.

Education: Regarding the educational status of the respondents, more than half (55%) were illiterates followed by 33 per cent with primary level education and only 10 per cent of them had secondary education.

Occupation: As Indicated earlier, the respondents of the present study were rural women working in unorganised sectors. The majority of the respondents were working in the agricultural sector (38%), followed by daily wagers (36%) and another 26% of them were engaged in petty business, or as sweepers and domestic maids.

Income: All the respondents belonged to low socio-economic group. Among them, 30% had family income of Rs. 5000 per annum, another 30% had income ranging from Rs. 5000 to 10,000 and another 40% of the respondents had family income ranging from Rs. 10,000 - 15,000 However none of them had family income above Rs. 15,000.

Habits of Tobacco Chewing

Motivation for Tobacco Chewing: Environment and personal influence are responsible to a great extent to cultivate the habit of tobacco chewing. The major factors observed were; influenced by neighbours (43%) and influence of family members (32%) another 25% of them started this habit in order to avoid eating snacks and to get stimulation while doing hard work.

Consumption of Tobacco

Consumption of tobacco at a time range from 20 gms to about 100 gms. The highest percentage of the respondents (46%) used to consume 50-100 gms of tobacco for a single chewing, another 20% of the respondents consumed about 20-50 gms of tobacco in one serving, nearly a quarter per cent of them (23%) consumed above 100 gms of tobacco. 11% of them consume below 20 gms of tobacco for one serving. On an average they consumed 5 to 6 times a day. This high consumption of tobacco clearly indicates the high prevalence of oral health problems among the rural women. ***The high frequency of chewing habit is directly related to the occupational status of the respondent because the rural labourers habituated for chewing while working in the fields were getting stimulation to work.***

Materials used for Cleaning the Teeth:-

A variety of materials used for cleaning the teeth among the respondents of the present study, 95 per cent use locally available and traditional materials like charcoal, sand, neem stick. Only 5 per cent of the respondents used toothpaste for cleaning their teeth. Among the traditional materials, charcoal stands first, nearly half of the respondents (49%) indicated that they use charcoal for cleaning the teeth, other materials like sand (30%) and neem stick (16%) were also in use. This data indicated that the use of charcoal and sand were the major determinants for high prevalence of oral health problems among the population. However, the use of neem sticks is scientifically good for oral health but its use is low compared to charcoal and sand, though neem sticks are easily available in this area. Hence necessary awareness should be created to the use of neem sticks in the rural area in order to promote oral health.

Regarding the habit of rinsing the mouth after chewing and eating food, it is sad to know that nealry (80%) of the respondents do not have the habit of rinsing the mouth after chewing tobacco / eating food. This bad habit also determines the high prevalence of oral health problems. However, it is interesting to note that atleast 10% of the respondents have the habit of brushing twice a day. It has also been noted

that 3/4th of the respondents have the habit of chewing during sleep. The poor hygienic practices are also responsible for the high prevalence of oral health problems.

Types of oral health problems: Through scientific studies, the positive relationship of tobacco chewing and oral cancer has been proved. In India more than half of the cancers in men and 20% of cancers in women are tobacco related. Poor oral hygiene is an added factor for different kinds of oral health problems such as bad breath, dental caries, deterioration of teeth, recession of gums, ulcer, etc. Cent per cent of the respondents of the present study were identified with one or the other dental problems as mentioned earlier. More than half of the respondents (52%) were identified for the problem of dental carries, 80% of them have recession of gums, however 30% of them had ulcer, only a neglible percentage (5%) were identified for the problem of oral cancer. However, the habit of tobacco chewing for a long period of time leads to the formation of ulcers in the oral cavity and it may leads to the pre cancer and cancer stages if they continue the habit of chewing without taking proper medical care. It was also noted that half of the respondents were identified with multiple problems like bad breath, deterioration of teeth and recession of gums. Thus the data revealed that chewing of tobacco leads to a series of oral problems.

Knowledge of Oral Health Problem

Nearly half of the respondents were unaware of the oral problems. Regarding the reasons for oral health problems, only 32% reported the chewing of tobacco as the reason for oral problem, another 13% of them reported improper or irregular brushing as the reason for oral problems. This clearly indicates the poor knowledge of oral health problems among the respondents.

Intervention Programme:

On the basis of the knowledge and practices of the women about oral hygiene; an intervention programme was carried out to bring about desirable behavioural changes. This programme was Organised through Audio Visual Aids focusing on the impact of tobacco on teeth and oral health problems. To teach the basic concepts of teeth, a model teeth set was

used and effect of tobacco on teeth was explained through visual aids and the respondents were asked to examine their teeth through a mirror. After examining the teeth through mirror they identified the problems of their teeth because of tobacco chewing. This intervention helped the women to know about the concept of healthy teeth, and decaying of teeth due to tobacco chewing, besides oral health problems. By the end of the session, women were convinced that oral problems are caused mainly due to tobacco chewing.

Another awareness programme focused on food habits and oral hygiene. From the data it was found that women do not know about mouth rinsing and carcinogenic foods. These women were given proper orientation about mouth rinsing after consumption of tobacco / sweets / sticky foods etc. They were also motivated to use tooth brush and the technique of brushing was also demonstrated. They were also encouraged to use neem sticks and discouraged the use of sand, charcoal and other harmful materials. Impact of the sessions was positive.

Conclusion

From this study, it may be confirmed that tobacco chewing has a positive influence on oral health problems. Proper and effective intervention programmes may change the habits of chewing and help the women to adopt better lifestyle practices.

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Table: No:1 Motivation for Tobacco Chewing

Motivation	Number	%
Influence of neighbours	43	43
Influence of Family members	32	32
To stimulate work	25	25
Total	100	100

Table No: 2 Knowledge of Oral Health Problems

Reasons	Number	%
Eating Tobacco	32	32
Irregular Brushing	13	13
Not aware	55	55

Table No: 3 Quality of Tobacco Consumption

Quality (gms)	Number	%
Below 20	11	11
20-50	20	20
50-100	46	46
above 100	23	23

Table No. 4 Materials Used For Cleaning Teeth

Materials	Number	%
Tooth paste	4	4
Neem stick	16	16
Coal	50	50
Sand	30	30
Total	100	100

Table No: 5 Type of Oral Health Problems

Problem	Number	
Dental Caries	52	
Recession of Gums	80	
Ulcer	30	
Cancer	5	

Multiple problems were reported by the respondents.

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GLOBAL YOUTH TOBACCO SURVEY

KARNATAKA, INDIA

The use and the consequent adverse health effects of tobacco is a major public health concern that demands urgent action. Tobacco is a silent killer that is fast becoming a greater cause of death and disability than any other single disease. It is a known cause for more than 25 different diseases affecting human beings. Tobacco and smoke should concern not just smokers but also non-smokers as well. The harmful effect of tobacco is turning out to be a global threat. In every region, while new markets are being opened by the tobacco industry activities, old markets have not yet been closed.

Tobacco contains about 4000 chemicals. Many more toxic chemicals are formed when it is burning, including at least 250 chemicals known to be toxic or capable of causing cancer. It is the major cause in diseases like lung cancer, oral cancer, bronchitis and emphysema. Tobacco-related cancers account for about half of all cancers among men and one-fourth among women. Oral cancer accounts for one-third of the total cancer cases, with 90% of the patients being tobacco chewers. India has one of the highest rates of oral cancer in the world, and the number of cases is still increasing. It is now known that over 60% of heart disease patients who are less than 40 years age have been tobacco users. Tobacco consumption has been explicitly linked to high incidence of heart diseases. Among women, consumption of tobacco leads to spontaneous abortion and cervical cancer. Apart from these, tobacco usage is responsible for many more disease conditions.

Tobacco is used in many ways: Smoking is one of the commonest forms; People also chew tobacco commonly along with betel nut, lime and leaf or apply tobacco (Snuff). According to some studies in India, nearly 30 to 40% of men were found to be using some form of tobacco. Amongst them nearly 50% were smoking tobacco (75% using beedies and 25%

using cigarettes) and remaining used smokeless tobacco. Amongst Males in India, smoking rates tend to be higher in rural areas than urban areas. Studies done in the year 2001 showed that in urban areas more number of females had started using tobacco as compared to those in rural areas. The overall smoking prevalance has increased in the recent years: the percentage of smokers amongst males had increased by 13% over a 8 year period. Amongst adolescents this increase is very significant. Changing life styles, increased money availability, decreasing parental control, growing influence of television, films and such other factors have contributed to this dangerous trend. Unfortunately, smoking is considered a status symbol among urban educated youths. Most appear to be unaware of the hazards of smoking, whether it is beedis or cigarettes.

Environmental Tobacco Smoke (ETS) or Second hand smoke is the complex mixture of gases formed out of the smoke escaping from a burning tobacco product (Lighted Cigaratte / beedi). The smoke exhaled by the smoker is another component. Exposure to ETS is referred to as "passive smoking" or "involuntary tobacco smoke". For nonsmokers inhaling tobacco smoke is equally harmful (I) It contains the same carcinogens / toxic substances that are inhaled by the smoker, probably even more and (II) it causes lung cancer and other diseases, aggravates allergies and asthma as in the case of a smoker.

In India, as in many other countries, information on tobacco use and behaviours of tobacco users is lacking. This is a major limitation to formulate any tobacco prevention and control programmes. The Global Youth Tobacco Survey (GYTS) under the Tobacco Free Initiative is a major effort by the WHO to document the problem and determinants of tobacco use. The GYTS survey is being undertaken in many countries of the world. In India, the Ministry of Health, Government of India has launched the "Tobacco Free Initiative". The Department of Psychiatry, NIMHANS is one of the centers involved in treating tobacco users to cure and prevent tobacco dependence. The Department of Epidemiology, NIMHANS is undertaking the GYTS in Karnataka. It is being undertaken in randomly chosen educational institutions across Karnataka to determine the usage and influence of tobacco amongst the students. This would help to understand the problem and plan interventions.

JOIN US IN THIS CAMPAIGN TO MAKE THIS WORLD FREE OF TOBACCO.

WHAT CAN YOU DO

As the head of the school or college you can:

- ☞ **CREATE** a healthy, and **smoke free environment**. Make your institution Tobacco free and proudly say ***"Ours is a tobacco free school / college"***.
- ☞ **BAN** the sale / marketing of **tobacco products** near your institution.
- ☞ At every opportunity **IMPRESS** upon the members of the community/ leaders about the **harmful** / **addictive effects of tobacco** use. Strive for establishing more and more 'Tobacco free schools / environment'.
- ☞ **CONDUCT** debates, quizzes, drawing and painting **competition** and such other extra-curricular activities with the theme being anti-tobacco. Start a wall magazine, which provides information about the harmful effects of usage of tobacco, methods of stopping use of tobacco and advantages of quitting the tobacco habit.

As a Class / School Teacher you can:

- ☞ **INFORM** children about the harmful effects of using tobacco not just in the long run (Lung cancer, Other Lung diseases) but also the problems they have to face immediately (cough, exacerbation of Asthma, Yellowish discolouration of teeth, etc).
- ☞ **BE A ROLE MODEL & HELP STUDENTS** to develop the desirable attitudes to life and living (Smoking a cigarette is not being strong and imitating heroes / heroines is not always beneficial).
- ☞ **LISTEN EMPATHETICALLY** to students personal and academic problems. Conduct sessions on Life skills development.
- ☞ **ORGANISE** programmes for giving anti-tobacco messages (Quiz, Painting, drawing, poster, wall papers, etc.,)
- ☞ **EQUIP** students to face life/crisis situations **WITHOUT TOBACCO**

If you are a parent

- ☞ If you smoke or use tobacco in any form: **STOP SMOKING / STOP USING TOBACCO**
- ☞ **EXPLAIN** to your child the harmful / addictive effects of tobacco use.
- ☞ **ENCOURAGE** your child to be part of the anti-tobacco campaigns.
- ☞ **HELP** your child to assert and demand a tobacco-free environment.
- ☞ **EQUIP** your child to face life/crisis situations **WITHOUT TOBACCO**

If you are a student

- ☞ **STOP SMOKING** and **HELP YOUR FRIENDS** to quit smoking.
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PH-17

Institute of Tropical Medicine
Master's in Disease Control
2001 - 2002

Public Health

Part 1. Basic Concepts in Public Health

Notes gathered by Vincent De Brouwere
Department of Public Health

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Chapter 1. Health, public health and public health approach

1. Health

The W.H.O. definition

The World Health Organisation has defined health as "*a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity*" [1]. This definition presents certain important aspects. Health is no longer defined as the opposite of disease. It is not defined in terms of "normality". The "normal" state could have been that to which one is accustomed, the one that appears "normal". This is very different from a good state of health. For example a mild degree of protein-energy malnutrition in a child is not always felt to be a bad state of health by the mother. The W.H.O. definition has therefore a positive approach to health. In addition it integrates physical, mental and social aspects, i.e. it considers health in its holistic terms. This implies a notion of balance between these three components.

Nevertheless the WHO definition is not one that is useful in practice[2] as it assumes a state of health that is ideal, universal, good for all, that it is difficult to define in an absolute manner. But, it is a dynamic notion that must be upheld because the state of health is appreciated by a given society as a function of multiple factors that influence its value system.

Alternative definitions?

It is difficult, indeed, to define health in a positive way (see Box 1). We know, now, following the work of René Dubos[3] (1959), McKeown[4] and Record (1976), that health is primarily influenced by socio-economic factors. These authors showed that the steepest decline in mortality in England and Wales occurred in the nineteenth century, before medicine was established on scientific foundations, and few gains were made in the third quarter of the twentieth century despite huge investments in medicine[5]. For example, the treatment of tuberculosis by streptomycin (the first effective therapy, which was introduced in 1947) contributed only 3.2 percent of the total reduction of deaths from that disease in the period 1848 to 1971 in England and Wales (McKeown, 1976).

But if it is clear that health is not primarily, or even largely, the product of health services, it is also clear that health care influences health. Daily examples of people treated, and sometimes cured, bring the evidence that health care alleviate suffering.

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[1] *World Health Organization Constitution.* Geneva: WHO, 1946.
[2] For a more operational definition see the Alma-Ata Declaration, article V
[3] Dubos R. 1959. *Mirage of Health.* New York: Harper.
[4] McKeown T. 1976. *The role of Medicine – Dream, Mirage or Nemesis.* Nuffield Provincial Hospitals Trust, London
[5] Turshen, M. A new vocabulary. In: *The politics of public health.* London:Zed Books Ltd, 1997, p. 9-32.

Box 1. Health and mortality (from Turshen M.[6])

There is no positive definition of health in the conventional literature. When one looks at the available definitions, including the WHO (UN World Health Organisation) motto "*Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity*", one finds health described in terms of absence of disease or disability or in terms that are general, descriptive, subjective, individual, and unmeasurable. If one cannot define health, one cannot measure the success or failure of efforts to improve health.

If there are no acceptable or globally recorded measurements of health, there are several of disease, some of which have been in use for more than a century – incidence (the number of cases over a period of time), prevalence (the number of cases at any point in time), age-specific morbidity (the numbers of cases in an age-group such as infancy), and age-specific mortality (the numbers of deaths in an age-group). England and Wales have registered the cause of death since 1838. The central and critical contemporary question for public health workers is whether a relationship exists between documented falls in disease-specific mortality (that is, the conquest of specific diseases, of which the most spectacular example is the global eradication of smallpox) and improvement of health. The question is crucial because, despite medical and technical advances, the evidence of persistent and widespread ill health world-wide is persuasive.

Powles (1973), McKeown (1976), McKinlay and McKinlay (1977), and others explain the fall in mortality before 1950 in terms of the improved diet and hygiene that accompanied rising standards of living in England and the United States. They arrive at their conclusion by examining disease-specific mortality in order to assess the factors that contributed to the fall in death rates. Their purpose is to identify the relative role of medicine (immunisation and therapy), which they find to be very minor. But this method is misleading because it gives the overall impression that the aggregate fall is the sum of these parts (drops in the leading causes of death), when in fact the parts are interchangeable and do not, in this sense, account for lowered total death rates.

It is only that specific diseases are not always accurately diagnosed. Tuberculosis, for example, is a poorly defined constellation of symptoms with multiple causes. McKeown (1976, 31) says, "there must be doubts about the diagnosis of tuberculosis at a time when it was not possible to X-ray the chest or identify the tubercle bacillus". And in the conditions obtaining in many parts of the Third World, or given the summary diagnosis offered to minorities in many advanced countries, such doubts must persist.

Nor is it only that the particular composition of the death rate is specific to a society in a given historical period. What people die of is associated with the kind of work they undertake, with social stratification, and with the organisation of everyday life. For example, E.P. Thompson (1968, 352) writes of early nineteenth century England that "The industrial town-dweller often could not escape the stench of industrial refuse and of open sewers, and his children played among the garbage and privy middens". As could be expected, infectious diseases contributed heavily to child mortality in these circumstances.

The type of disease is a separate issue from the burden of mortality and morbidity. If English and American mortality rates fell in the nineteenth century because standards of living improved, then, very simply, high mortality is due to low or falling standards of living. The radical conclusion to be drawn from the work of McKeown and his followers is that mortality is not disease-specific. What the distinction between types and numbers of deaths comes down to is the underlying cause of health or illness.

2. Public health

According to Winslow[7] (as soon as 1920), "*Public health is the science and art of preventing disease, prolonging life and promoting mental and physical health and efficiency through organised community efforts for the sanitation of the environment, the control of communicable infections, the*

[6] Turshen, M. A new vocabulary. In: *The politics of public health.* London: Zed Books Ltd, 1997, p. 9-32

[7] Winslow C.E.. 1923. *The evolution and significance of the modern public health campaign.* New York, Yale University Press

education of the individual in personal hygiene, the organisation of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery to ensure to every individual a standard of living adequate for the maintenance of health, so organising these benefits as to enable every citizen to realise his birthright of health and longevity". Later, in 1966, a EURO symposium[8] suggested that the definition should be expanded to include the organisation of medical care services.

In a wide sense, modern public health can be defined as the synthesis of all the specific activities that aim at re-establishing, maintaining or promoting health in a community. The four main public health strategies which are expected to influence health in a community consist in i) the prevention of diseases and health promotion, ii) the improvement of medical care, iii) the promotion of sound attitudes and iv) the sanitation (control of environmental hazards).

3. The health problem and disease

The concept of a "health problem" is different from that of "disease". Disease is a biological or psychological process, the consequence of which is a bad state of health for the individual that will prevent him or her from enjoying a state of well being. Disease is the cause of the health problem and is seen as the disruption in the equilibrium of an individual.

Certain authors define therefore the health problem as « *a prevailing unsatisfactory state of health of a community and the difficulties involved in improving it* ». It can also be defined as "*the consequence of a process which disturbs the basic state of health and causes individual and/or collective suffering*".

To attack the disease is not necessarily to resolve the health problem. For example, solving the problems of the elderly or of diabetics is more a matter of teaching people how to live with their illness or infirmity than of curing all their diseases.

The concept of a health problem must take into account *individual suffering* and the *social consequences for the community* (i.e. the *social cost* both in terms of loss of activity and in terms of deleterious effects on the family), whether these sufferings are *actual* or *potential*. An example of a potential suffering is that of yellow fever in a country where the disease has been absent for many years but which cannot be said to have been definitively eradicated. If immunisation levels are not maintained, the risk of resurgence of the disease exists. Vaccination is therefore maintained to resolve a potential problem. It is this *notion of risk* that enables the importance of this type of potential health problem to be appreciated. It is possible to summarise the differences between disease and health problem like in Table 1:

Table 1. The differences between disease and health problem

	Disease	Health problem
Dimension	biological / psychological	psycho-socio-cultural/ socio-economic
Suffering	cause of suffering	actual or potential suffering
Classification	by mechanism (physiopathological)	by solutions proposed to cope with the problem

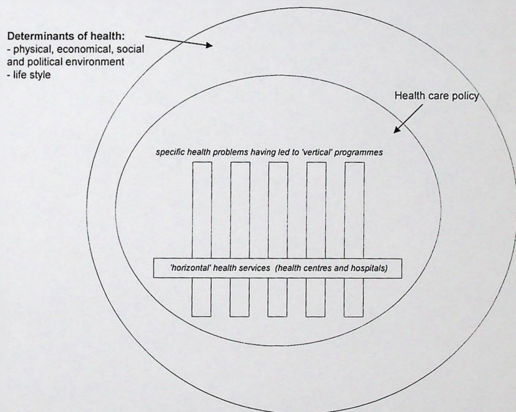
[8] *The Education of the Public Health Physician in Relation to his Work* in the Community. 1966. Report of a symposium, Lisbon, EURO, 337, p.3.

4. The public health approach

The Public Health approach may be defined as the synthesis of all the specific activities that aim to re-establish, to maintain or to promote the health of a community. The public health approach may be carried out on the basis of (Figure 1):

- *health problems (vertical approach)*: starts with a health problem and organises services that deploy methods in order to solve the problem ;
- *methods or services (horizontal approach)*: starts with a service, this service is organised in such a way as to respond to the various health problems encountered.

Figure 1. Vertical and horizontal approaches in a health system



The outset of the ITM DPH on health services organisation – according to the public health approach – is well being, which implies a vision of health and health problems which goes beyond the biomedical vision. Well being is related to a series of general principles which underlie our understanding of HSO: principles of equity and solidarity, effectiveness and efficiency of health activities, participation (or involvement) of individuals and communities, interrelations of health and overall socio-economic development, autonomy and self-reliance (see further). This course deals mainly with health care. However, it should be acknowledged that care is only one of the determinants of health.

The public health approach differs from the traditional medical approach of the clinician by its *responsibility to the community*. In the traditional approach, responsibility is limited to the patient (Table 2).

Table 2 . Comparison between the Traditional approach and the Public health approach

	Traditional clinical approach	Public Health approach
The population concerned	patients	patients and healthy individuals
The responsibility of the provider	only to those who spontaneously consult	even to those who do not consult
The responsibility of the people	comply with the treatment	participating decision making
Case management	at the time they consult	until the time of re-assimilation into the community and the problem has been controlled
Resource management	cost does not matter	takes into account resources that are available and can be controlled

Responsibility towards the community involves elements that do not exist in the traditional approach: health promotion, primary prevention, early diagnosis, continuity of care, tertiary prevention, etc. We will return to these issues later.

Chapter 2. Suffering, care demands, supply, and needs

1. Suffering and the demand for care

Each community perceives health in a different way. What some people consider a good state of health could very well be seen by others as impossible to live with and vice versa (for example: the homes for the aged in Europe, or the conditions of hygiene in Africa). These different perceptions of health correspond to different needs and different responses: this makes up the *health culture* of a population.[9]

The perceived lack of health, real or potential, leads to a *suffering* (or a perceived risk of suffering). One could say that suffering is *every deficiency perceived by a population or an individual as a lack of well being* (it does not therefore only mean physical suffering). For those experiencing the lack, in relation to their own criteria, it's an objective notion. This does not prevent suffering being the result of socio-economic factors and the prevailing health culture.

Suffering in an individual or a population expresses itself by a demand. The demand may be defined as *the behaviour by which an individual or a community seeks relief for its suffering.*

2. The needs

Faced with this suffering and the population's demand, there are what are called the *needs* of the population. The word "need" often leads to confusion because it is used in two different ways.

Conceptually, the "need" is a condition characterised by the total or partial lack of a necessary thing, requiring help or an external contribution. The term "needs" is therefore used to speak of the suffering of a population. Suffering and needs are therefore intermingled.

In public health the word "need" is used in its operational sense. According to T.Hall, needs are "*the estimation, in the opinion of the professionals and according to the state of medical science; of manpower and of the quantity of services necessary to ensure an optimum level of health care*"[10]. To this definition should be added: taking into account the available resources. This operational definition is different from the conceptual definition. It is generally accepted, in public health, that when speaking of "needs" one speaks of needs as they have been defined by the health service. The term "need" implies therefore « **as defined by the health technician** ».

3. Needs and demand: "felt needs"

The response to the population's demand, to its "needs" as defined by the health technician, constitutes the basis for the planning of health care activities. The relationship between demands and needs is presented in a diagrammatic form in Figure 2. It shows

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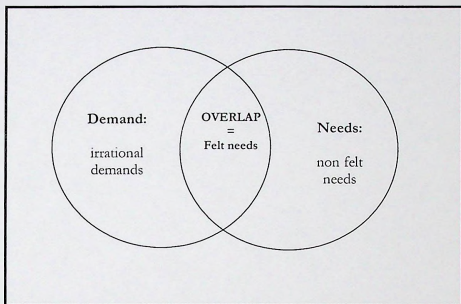
[9] The health culture of a population is of course a heterogeneous notion; this is not a fixed notion: it is in constant evolution.

[10] Hall T. and Meja. 1978. *Health manpower planning, principles, methods, issues.* WHO, Geneva.

that demands and need only partially overlap. The health technician will consider that section of demand which, according to him, does not correspond to a need, as an « irrational demand »; the section of need which does not correspond to a demand as « unfelt needs »; the section where needs and demand correspond as « felt needs » or « rational demand ».

Figure 2. The relationship between needs and demand



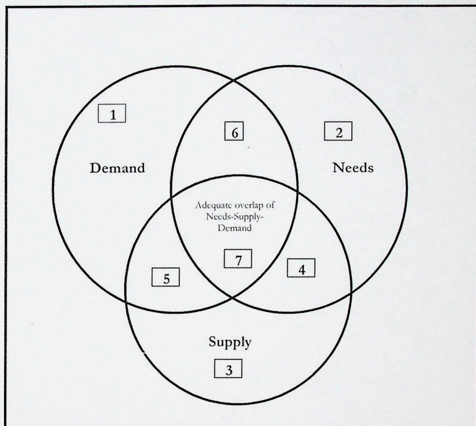
The relationship between demand and needs is not static; it is dynamic and changes over time. It is on the basis of felt needs that health services can be organised. At the interface between the population and the health services the health culture of the population must be taken into account in terms of its capacity to resolve some problems, and in terms of demand, even if irrational.

This requires, on the part of the health services, a capacity for empathy. Empathy is, within the dialogue with the population, the ability to understand suffering, to perceive the loss of well being of a person or of a group of persons and in this way to be able to find adequate solutions. It is not a total identification with suffering. Sympathy does not replace empathy. It tempers the technocratic attitude and allows an appropriate balance to be found between demand and needs as defined by the health professionals.

4. The provision of care

The provision of care (the so-called 'supply') is partially conditioned by demand (people's subjective perception), partially by needs (professional's theoretically objective perception), also by the historical and present environment (social, economic, administrative, political, etc.), and in particular by the interests of social and professional groups. The provision of services does not necessarily bring about a rise in the level of health. This technical factor is not the only one that must be taken into account. There are other factors - economic, political, social -cultural, operational - which determine both the level of health and the action of the health services. Figure 3 represents the relationship between demand, needs and health care supply.

Figure 3. The relationship between demand, needs and health care provision



The different figures may be defined as :

space 1 : unsatisfied « irrational demand »

space 2 : needs identified by the health technicians but without provision of services

space 3 : inappropriate provision of services

space 4 : unused supply, which corresponds to a need but not to a demand

space 5 : satisfied demand but which does not correspond to a need

space 6 : potential demand corresponding to a need but without supply by the services

space 7 : equilibrium between needs - supply - demand

It is to be noted that the supply of care generally covers neither all the needs nor all the demand. Moreover, the health sector alone would not be able to achieve health promotion. Other development sectors (agriculture, education...) also intervene.

5. The utilisation of health services

The combination of health care supply and demand determines the use of health services by the population. The operational relationship between the services and the population depends on several factors.

The first factor is *suffering*, but all suffering does not necessarily result in a demand for and use of a service.

Next comes the behaviour of individuals, i.e. the translation of suffering into a desire to receive care. This motivation is in itself a function of *confidence* in the health service (the service offered is perceived as being able to relieve the suffering) and of its *accessibility*, i.e. all the factors that overcome geographical, temporal, psychological or cultural barriers. Generally, when speaking of *acceptability* one is speaking of psychological or cultural accessibility. One could say that a service is accessible and acceptable when the positions of the two parties concerned correspond. This is illustrated by Table 3

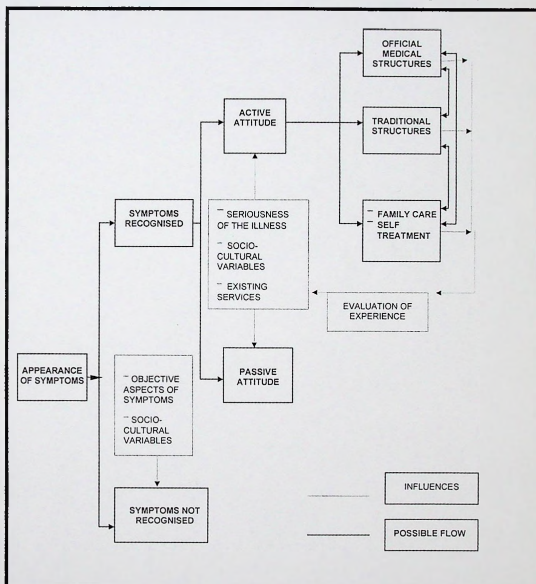
Table 3. The position of the population and the health services in relation to the supply of services

POPULATION	HEALTH SERVICE
Perceives the problem 'x' as suffering	Perceives the problem 'x' as a need
Perceives the service as able to respond to this problem	Services exist for responding to this problem
Can reach the health service easily	Services are organised close to the population
Can easily make themselves understood	The providers establishes an empathetic relationship
Can afford the care	Health care is provided at a cost corresponding to the population's income

The real accessibility of the supply of health care will be indicated by the utilisation of the health services by the population. But we should not forget that the health seeking behaviour of the patient is influenced by are numerous socio-cultural components many of which are dependent on the supply of health care. Nuyens has suggested a model illustrating this behaviour (Figure 4)

When symptoms appear, if they are recognised, the patient could, depending on a variety of influences (degree of severity of the disease, socio-cultural variables, existing services), adopt an active attitude (take on the sick role). If he adopts an active attitude, he will call on one or more of the existing structures for a response to his problem (health service, traditional healer, self-medication). The evaluation that he will make of his experience will influence his future attitude and response.

Figure 4. Health Seeking Behaviour in the case of illness (according to Nuyens)



6. Coverage and utilisation rates

Two important terms quantify health services utilisation - the "coverage rate" and the "utilisation rate". These two terms denote two different ideas and must not be interchanged.

A coverage rate indicates the extent to which a "service" or "episode of clinical care" objective has been attained. It is the degree of use of an available service by those who need it. It is taken for granted that this objective corresponds to a need. When there are a certain number of problems to be treated or people to be served (denominator), all or only parts will be reached (numerator). The relation between numerator and denominator measures the degree to which the objective has been realised. This figure is expressed as a percentage. The coverage is therefore a proportion where the

denominator expresses an objective. This objective could be ideal or operational (in which case an objective that should really be reached is fixed). It is important always to be extremely careful to define the numerator and the denominator. For example, an ante-natal visit coverage of x% can signify:

- that x% of pregnant women were seen at least once at the ante-natal clinic ;
- or that x% of pregnant women followed the complete antenatal programme.

It is important therefore to define in each case the denominator as well as the numerator that is appropriate with respect to that denominator.

One can understand that coverage rates may be more easily used for various preventive needs. These may often be easily defined. However, this will be much more difficult for curative care. Correctly speaking a « global curative cover » does not exist. In fact it is not possible to say how many people need curative care given the heterogeneity of pathology[11].

Instead of speaking in terms of coverage one would then speak in terms of *utilisation rate* to measure within a defined population (denominator) the number of times a curative service was used (numerator). Contrary to coverage, which is expressed as a percentage, the utilisation rate is expressed in units per individual per year. In this case, the denominator does not express either an objective or a need. As with coverage rates it is important to clearly define what one is talking about. In this way an utilisation rate may be expressed in terms of:

- the number of contacts per inhabitant per year ;
- the number of new cases of a disease per inhabitant per year ;
- the number of people that have used the health service at least once during the year.

Each alternative has its advantages and its disadvantages. The important thing is to be vigilant that what is included in the numerator and denominator really expresses what one wishes to measure.

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[11] One may sometimes speak of coverage for certain curative needs when a specific need has been defined and translated into an objective to be attained.

Chapter 3. Health activities

1. The typology of health activities

Preventive and curative activities must be considered as being *barriers* to the natural evolution of disease within the individual and the community. For each health problem, technologies exist that enable the application of one or the other of these activities. It is most important to consider the complete evolution of the disease process and find the most judicious level of action (Figure 5). It is possible to use either the spontaneous presentation of the patient (passive detection) or direct intervention (active detection).

Within this range of activities it will be possible to observe that:

- there is no sharp distinction between the different types of prevention and between prevention and cure.
- the division of preventive and curative activities is artificial: it is even possible to say that curative activities play an essential part in secondary and tertiary prevention (Figure 6). Some intermediary methods (for example, diagnostic activities) do not directly lead to a health benefit. These are strictly speaking not health activities by themselves. Health education, whose objective is to "change behaviour" , is not a health activity in itself, but an intermediate method which could be useful within each health activity.

Figure 5. The natural history of disease and health care

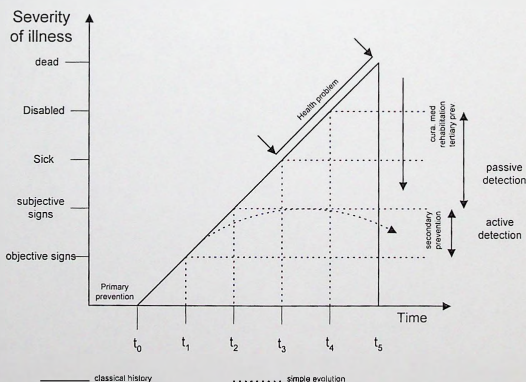
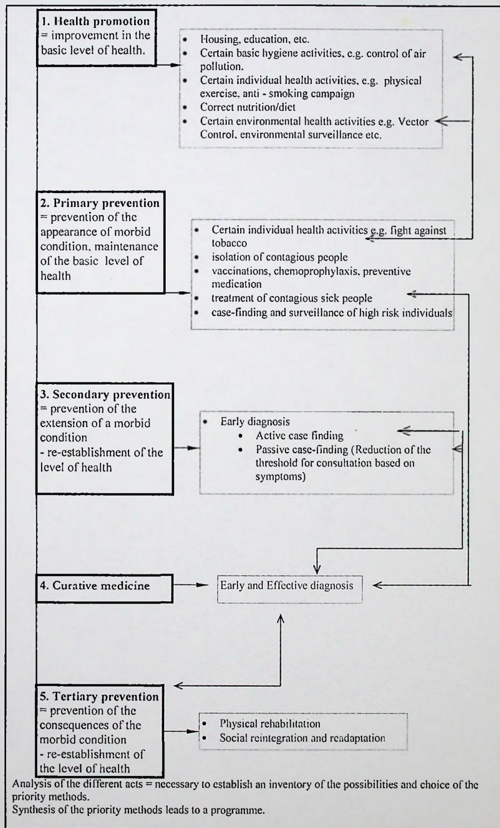


Figure 6. Public Health Methods



2. The specificity of preventive medicine

Conceptually there is no defined separation between preventive and curative activities, and the artificial barriers (administrative) erected between the two can only reduce the effectiveness of the services. Nevertheless prevention does have some specific characteristics that are useful to recognise:

2.1. The concept of risk

Preventive activity responds to a potential problem (hence, the notion of risk, of probability), whereas curative activity responds to an actual problem.

This concept of "risk" results in two major consequences, economic and psychological.

1. The economic consequences

The number of people that benefit from a preventive activity does not correspond to the number of people that are subjected to it. It is equal to the number of people who would have fallen ill, if they were not subjected to the preventive activity. In this way, when a vaccination campaign is evaluated, it is the number of people *protected* that is important not the number of people vaccinated. For example, let us suppose that in a population of 1000 children, 100 children are at risk of contracting the disease. If 1000 of these children are vaccinated with a vaccine that is 80% effective, 80 children would have been protected .... thus 920 unnecessary vaccines have been given. 900 to children not at risk and 20 ineffective vaccines to children at risk. All that remains to be done is to compare the cost of vaccinating 1000 children and treating 20 cases with the cost of treating 100 cases (the 100 children that will present with the disease if they had not been vaccinated). To this one must add the social cost of vaccination.

This example enables us to understand:

- that a curative act corresponds to the person who will benefit from the treatment (according to its effectiveness), therefore: 1 cost unit = 1 benefit unit
- that a preventive act corresponds to several people at risk. The only real beneficiaries are those who would have fallen ill if the activity had not taken place. If the risk (probability) of falling ill is $1/x$, then: x cost units = 1 benefit unit

The unit cost of a preventive activity must therefore be x times lower than the cost of a curative activity for there to be an economic advantage to prevention.

2. The psychological consequences:

The result of the preventive activity is:

- negative: often concretely imperceptible if the problem is avoided. This reduces the acceptability by the population and lowers health personnel stimulus.
- random: people are not convinced that they will personally benefit from the preventive activity (which is correct). This reduces acceptability.
- delayed: a present effort is made for a future gain. This reduces the interest of people who always give priority to their present problems. It is the notion of the importance/value given by people to one problem in relation to another.

2.2. The concept of initiative

Preventive activities are undertaken on the initiative of the health service, Curative activity however takes place as a result of an initiative on the part of the patient. This has both ethical and administrative consequences.

1. *The ethical consequences* : a curative activity is a response, using the means available, to a request. In prevention, the initiative of the health service is its moral undertaking: it cannot suggest to the population an activity without having carefully weighed up the advantages and disadvantages. The scientific base on which the decision has been taken must be sufficiently strong to be able to affirm that the advantages outweigh the disadvantages.

2. *The operational consequences*: in the field of curative care, some aspects of a strategy are self-defined by the patients' initiative (objective, target population, health service personnel contacted, etc.....) and others are defined by the relatively standard character of the situation (complete clinical examination).

With preventive activities the health service must define a *complete strategy* (why? to do what? to whom? where? when? by whom?) without which nothing will happen. An objective must be defined without which there is a risk that the activity will not be appropriate. The complete clinical examination, for example, does not correspond to any objective defined within the context, and so is completely unnecessary.

These activities also have a *consequence on health service organisation*: a preventive activity can be organised on a periodic basis (possibly mobile). A curative activity on the contrary, must be integrated within a service which is permanently accessible in order to respond to the patient's initiative which motivates him to make contact with the health service at the time of the appearance of the problem

3. Epidemiological surveys, Screening and Case finding

3.1. Definition of concepts

Epidemiological surveys involve the measurement of demographic, social, behavioural, and biological characteristics of representative samples of carefully selected populations. These measurements may be unrelated to specific diseases entities, and, because the objective of the survey is new knowledge, no health benefit to the participants is implied. Thus, although the survey teams usually include medically qualified investigators, and citizens found to have important and clear-cut health problems are usually referred to their physicians, the health information gained through epidemiological surveys is as privileged as any other –those who fear its effects upon their employability or insurability (e.g. those with haemoglobin S) have the right to demand confidentiality[12].

Screening, on the other hand, is the testing, not of carefully selected population samples, but of apparently healthy volunteers from the general population for the purpose of separating them into groups with high and low probabilities for a given disorder. Screening was defined by the Commission on Chronic Illness (1951) as "*the presumptive identification of unrecognised disease or defect by the application of tests, examinations or other procedures which can be applied rapidly*". As in the epidemiological surveys, the encounter is initiated by those who do the tests. However, the objective of screening is unique: the early detection of those diseases whose treatment is either easier or more effective when

[12] Text from Sackett D.L. and Holland W.W. 1975. Controversy in the detection of disease. *Lancet* II, pp. 357-9.

undertaken at an earlier point in time. There is thus an implicit promise that those who volunteer to be screened will benefit (i.e., that they will be followed up to exact diagnosis and long-term care and will receive treatment of proven efficacy).

A screening test is not intended to be diagnostic, thus. Screening can be conducted on the whole population or on a major subgroup (e.g. adults), when it is called *mass screening*, or it can be carried out on selected subgroups of the population (selected as being at relatively high risk on the basis of epidemiological research) when it is called *selective screening* (e.g., selected by age, sex, genetic history, occupation). With both these forms of screening, the programme may offer one or a limited number of tests (e.g. cervical cytology, mass miniature chest radiography) or it may extend in some programmes of *multiphasic screening* to include a medical history and physical examination and a range of measurements and investigations (e.g. chemical and haematological tests on blood and urine specimens, lung-function assessment, audiometry, and measurement of visual acuity), all of which can be performed rapidly with the appropriate staffing organisation and equipment[13].

The aim of screening, in other words, is to detect disease before symptoms present and before the patient presents with the disease. The initiative lies essentially with the medical professional, not the patient. *Case-finding* (see below) is 'opportunistic' screening- the application of the test procedure (be it enquiry, examination, or investigation) during a consultation by a patient for another reason[14].

The basic principles of screening and the criteria which should be satisfied by a screening programme were drawn up by Wilson in 1965 and summarised by Wilson and Jungner in 1968 (Table 4).

Table 4. The principles of screening

The condition sought should be an important health problem
There should be an accepted treatment for patients with recognised disease
Facilities for diagnosis and treatment should be available
There should be a recognisable latent or early symptomatic stage
There should be a suitable test or examination
The test should be acceptable to the population
The natural history of the disease, from latent phase to declared disease, should be adequately understood
There should be an agreed policy on whom to treat as patients
The cost of case-finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole
Case-finding should be a continuing process and not a 'once for all' activity

Source : Wilson J.M. and Jungner G. 1968. *Principles and practice of screening for disease.* WHO, Geneva

Screening has the potential to do harm as well as good. Before a screening programme is introduced, therefore, both benefits and disadvantages need to be assessed and efficacy and feasibility evaluated. Cochrane and Holland (1971) suggested seven criteria for assessment of any screening test (Table 5).

[13] Text coming from Whitby L.G. 1974. Screening for disease. Definitions and criteria. *Lancet III*, pp.819-22.

[14] Text coming from Fowler G. 1997. Screening. In: *Oxford Textbook of Public Health*, edited by R. Detels, W. W. Holland, J. McEwen, and G. S. Omenn, New York:Oxford University Press, ch.29, pp. 1583-99.

Table 5. Criteria for assessing a screening test

Simplicity - a test should be simple to perform, easy to interpret, and where possible, capable of use by paramedical and other personnel

Acceptability - since participation in screening is voluntary, a test must be acceptable to those undergoing it

Accuracy – a test must give a true measurement of the condition or symptom under investigation

Cost – the expense of the test must be considered in relation to the benefits of early detection of disease

Precision and repeatability – the test should give consistent results in repeated trials

Sensitivity – the test should be capable of giving a positive finding when the person being screened has the disease being sought

Specificity – the test should be capable of giving a negative finding when the person being screened does not have the disease being sought

Source : Cochrane A.L. and Holland W.W. 1971. Validation of screening procedures. *British Medical Bulletin*, 27, 3-8.

In contrast with screening, ***case-finding*** is the testing of patients who have sought health care for disorders which may be unrelated to their chief complaints (e.g., the measurement of blood-pressure in an MDC participant who has come to the surgery to have his ears syringed). The encounter is initiated by the patient and the purpose here is comprehensive assessment of health. While the results of the manoeuvre may require long-term arrangements for clinical services, the execution of case-finding does not carry an implied guarantee that the patients will benefit, only that they will receive the highest standard of care available at that time and place. So, while case-finding[15] may be considered an option, especially for the very busy clinician or when no efficacious therapy exists, diagnosis is not. ***Diagnosis*** is the application of a variety of questions, examinations, and other tests to patients who have actively sought health services in order to identify the exact cause for their chief complaints[16]. Early diagnosis occurs when the disease, identified in patients (who initiated the encounter) by a clinician, is at an early stage, at a moment when it is easier to cure the patient.

Table 6 summarises the concepts presented above.

[15] Some authors distinguish 'active' from 'passive' case-finding. They say case-finding is active when signs – unrelated to the chief complaint of patients – are sought, that is in our vocabulary a screening. And they say passive when it actually is a diagnosis.

[16] Text from Sackett D.L. and Holland W.W. 1975. Controversy in the detection of disease. *Lancet* II, pp. 357-9

Table 6. Summary of concepts: early diagnosis, early detection (case-finding and screening)

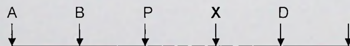
	Early diagnosis	Early detection	
		Case-finding	*Screening*
Who does take the initiative?	The patient	The patient	The clinician (or the health service)
Who is the target of the action?	The patient who consults	All the people (or a subgroup of high risk people) who spontaneously consult for any health problem	General population (mass screening) or a subgroup with a defined (high) risk in the general population (selective screening)
Sought stage of disease	A disease at an early stage but already with symptoms	Risk factors or 'pre-symptomatic' stages of defined diseases	
Place of symptoms or complaints presented by the patient in the process	Central (they suggest the possibility to early diagnose a disease)	None (clinician seeks something else, taking the opportunity of a contact with the patient)	None (*a priori* people are healthy)
Ethical basis	The patients will benefit appropriate health care but without guarantee to get profitable result: they will get the best available standard at that time and place.	Guarantee is given (at least implicitly) that patients will benefit from the (active) early detection: they will receive follow up to exact diagnosis and treatment of proven efficacy.	
Other names		Opportunistic screening Individual detection Passive detection	Prescriptive screening Preventive screening Active screening

Source: Grodos D. 1991. *Prévention, dépistage, diagnostic précoce. Mise au point théorique et terminologique.* Health & Community Working Paper. N°21. ITG Press, Antwerp.

3.2. Critical point in the evolution of a disease[17]

In 1960, Hutchison[18] presented a model of the natural history of a disease clarifying the issue of early case-finding programmes (Figure 7). Hutchison specified that his model should only be applied to a disease which is already running its course. Therefore, it should not be applied to 'pre-pathological' stages of a disease, i.e. to risk factors and to precursor stages.

Figure 7. Natural history of a disease according to Hutchison



Point A (biologic onset) is the beginning of the pathogenesis and point I the final outcome (recovery, chronic disability, or death). Clinical signs appear in point P and the disease is usually diagnosed in point D.

[17] Adapted from Grodos D. 1991. *Prévention, dépistage, diagnostic précoce. Mise au point théorique et terminologique.* Health & Community Working Paper. N°21. ITG Press, Antwerp.

[18] Hutchison GB. 1966. Evaluation of preventive services. In: Lilienfeld AM and Gifford AJ ed. *Chronic Diseases and Public Health.* Baltimore. The John Hopkins Press, pp. 147-55.

The definition of point P has to be clarified. Indeed, it is in point P that the disease undergoes a pathological *recognisable* modification. This can be the beginning of symptoms, the modification of an organ identifiable by physical examination or the change in some laboratory data. The event occurring in point P is usually neglected or misunderstood, be it because of the patient or because of the doctor, and the diagnosis is not made till point D.

Point B is the first moment we can apply the most sensible detection means for this disease. It is the first moment an early detection test may be applied, so before any clinical sign of the disease (i.e. before point P).

The interest of the Hutchison model lies in the introduction of the critical point X in the course of the disease. In point X, a critical event occurs: a treatment given before this point is less difficult or more effective than given after point X.

More specifically:

- if it is a vulnerable disease, treatment applied after point X can't achieve any longer the reversibility of the current pathological process;
- if it is a disease involving, at one given time in its evolution, a permanent invalidity or disability, treatment applied after point X won't be able to prevent this disability or malformation;
- if it is an incurable disease, but for which it is possible to slow down the evolution, treatment applied after point X won't offer any advantage compared to a treatment given in point D (the usual moment when the diagnosis is made);

It is possible, for a particular disease, to have several critical points X (X, X' or X"), located between A and X. Treatment established before X or X' is still more effective or easier. These points X' or X" can correspond <u>or not</u> to identifiable modifications in the pathological process.

Hutchison drew lessons from his model: the four basic conditions that should be met before proposing an early detection programme:

1. there should exist, for the disease in question, a known effective treatment
2. there should exist a detection means at an earlier moment (B) than the usual moment when it is diagnosed in the studied community (D)
3. there should exist, in the natural history of the disease, at least one critical point X beyond which the treatment becomes less effective or more difficult to establish
4. such a critical point should occur after the moment when detection becomes possible (B) and before the usual moment of diagnosis (D).

Moreover, he noted two important things:

a) The longer the interval between B and D, the greater the chance to early detect cases through the implementation of a screening programme. The shorter the interval between B (possibility to detect) and D (the usual time at diagnosis), the more frequent the early detection activities are necessary if we want to keep the programme effective.

b) The chance to get a real prevention effect is proportional to the length of the interval BX. This probability is lower than the probability to find early cases (depending on BD). Indeed, the number of cases found earlier than usual (by 'passive' case finding) will generally exceed the number of those for which the

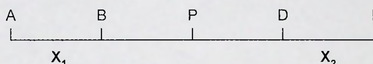
prognosis will actually be improved because some cases can be found earlier than usual but already too late (between X and D) to have a useful consequence.

But point D can occur earlier. It should be noted, indeed, that the natural history events described here are dependant on the environmental setting, including the generally available medical care, as well as on the biological characteristics of the disease. The time of usual diagnosis will vary with education of the population, alertness of physicians, and scientific development in medicine.

3.3. Development of the Hutchison model

There exist situations in which the critical point X is not located between point B (possible detection) and point D (usual time at diagnosis) (Figure 8).

Figure 8. Critical point X outside the space B - D



If the critical point is situated in X_1, that is between the onset (A) and the first time when a detection test is positive for the disease (B), any early detection is useless: the moment a possible detection test can identify the disease is beyond the critical point.

On the other hand, if the critical point is situated in X_2, beyond the usual time at diagnosis, that is between D and I, then any early detection effort is a waste of energy, money and credibility: 'passive' case-finding is sufficient.

But how to know where point X is situated? Randomised controlled trials can answer. If mortality in the experimental group (submitted to the detection programme followed by treatment) is less than mortality in the controlled group (treated after the usual time at diagnosis), we can consider that there is a critical point X between B and D. Instead of mortality, we can compare morbidity, but this is more difficult to get the evidence.

It is possible to define more specifically the nature of events occurring in the disease process. Hutchison described two kinds of points: some belong to the nature of the disease (points A, P, X and I), others come from an external intervention, be it the physician or the health system (points B and D). It is possible to consider a third series of points related to the perception of the disease by the patient (illness), splitting points P and D as follows.

Generally speaking, point P corresponds to the emergence of an objective sign; it can be simultaneously accompanied by subjective signs, but the latter usually occur later in the course of the disease. Let's call S the time when subjective symptoms emerge.

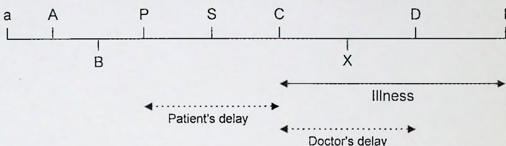
Between the emergence of signs (P), or symptoms (S), and the usual time at diagnosis (D), two further steps can take place. The patient may feel sick and will decide after a period of time to seek health care. Let's call C the time when the patient decides to consult.

The interval SC (or PC if the objective sign is perceived by the patient) corresponds to the diagnosis delay attributable to the patient (patient's delay) and the interval CD the delay attributable to the doctor or the health system (iatrogenic delay or doctor's delay).

Finally, it is possible to extend the Hutchison model to possible precursor stages that can be, in some situations, early detected. Let's call 'a' precursor stage of the disease. This

can lead to a new model (Figure 9) in which the location of point B will depend on the current technical advances and point X on the potential development of every particular disease.

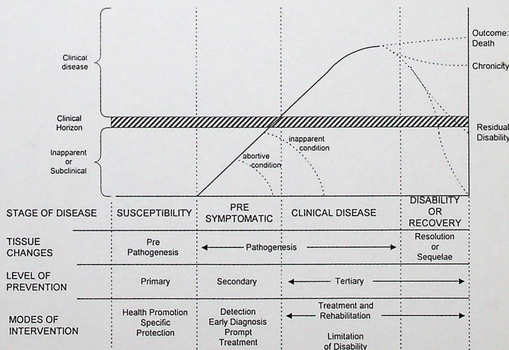
Figure 9. Natural history of a disease, adapted from Hutchison



Legend	
a: precursor stage of disease (possible)	S: emergence of subjective symptoms (can take place in P)
A: beginning of the pathological process	C: decision to consult
B: early detection test possible	X: critical point beyond which treatment is more difficult or less effective
P: recognisable pathologic change (objective signs)	D: usual time at diagnosis
	I: final issue (recovery, diability or death)

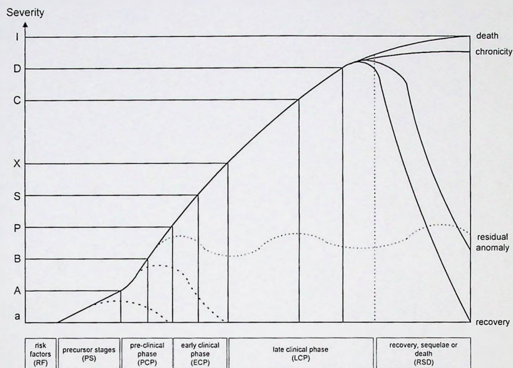
Taking into account the natural history of disease and the levels of prevention according to Mausner and Bahn (Figure 10) and the Hutchison model (Figure 9), it is now possible to suggest an 'integrated' model (Figure 11).

Figure 10. Natural history of a disease and levels of prevention



Source: Mausner JS and Bahn AK. 1974. *Epidemiology. An introductory text.* WB Saunders, Philadelphia, London, Toronto. pp. 237-63.

Figure 11. Natural history of a disease according to Hutchison, Mausner & Bahn



Source: Grodos D. 1991. *Prévention, dépistage, diagnostic précoce. Mise au point théorique et terminologique.* Health & Community Working Paper. N°21. ITG Press, Antwerp.

Chapter 4. An introduction to miscellaneous basic concepts used in Public Health

1. Effectiveness, efficacy and efficiency[19]

Much effort has been devoted by WHO committees, working groups, etc. to defining these three terms and distinguish between them.

Of the three terms, *efficacy* is the most limited in sense. It was defined as follows: "*Efficacy is the benefit or utility to the individual of the services, treatment regimen, drug, preventive or control measure advocated or applied*" (WHO Expert Committee on Health Statistics, 1971). Efficacy requires that a clinical procedure achieve benefits to individuals in defined populations (often narrowly defined) when it is applied under ideal or optimal circumstances; this is the familiar terrain of RCTs[20]. Efficacy is constant for a given intervention carried out in theoretically ideal and controlled circumstances.

Effectiveness is the degree to which a plan, a programme, or a project has achieved its purpose within the limits set for reaching its objective. Effectiveness is thus related to the results achieved (or planned to be achieved). Effectiveness requires that – if it is a clinical procedure – a clinical procedure do more good than harm for the typical patient in ordinary or average settings and circumstances.

Efficiency is the effects or end-results achieved in relation to the effort expended in terms of money, resources and time. In other words, it is the ratio between the result that might be achieved through the expenditure of a specified amount of resources and the result that might be achieved through a minimum of expenditure. Efficiency is thus related to the cost, in terms of resources, of achieving the results.

2. Economic concepts

As far as the choice of activities is concerned we have already touched on certain economic aspects (see Chapter 3, economic consequences of the concept of risk). In order to go further, we will now cover other fundamental aspects of health economics: the concepts of cost-effectiveness, opportunity cost, marginal costs and cost benefit.

Cost Effectiveness

To reason in terms of cost effectiveness means comparing the relative effectiveness of different methods at a given cost, or, in other words, identifying the method which, for a given amount, will be the most effective. One would say, a treatment that cures more patients than another for the same price, is more " efficient", i.e. it is more cost-effective.

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[19] Hogarth J. 1978. *Glossary of health care terminology*. Regional Office for Europe. WHO, Copenhaen.
[20] K. Lohr, K. Eleazer, and J. Mauskopf. 1998. Health policy issues and applications for evidence-based medicine and clinical practice guidelines. *Health Policy* 46:1-19.

There is thus a tension between effectiveness (responsibility for one individual patient, related to evidence-based medicine if it is a clinical procedure) and efficiency (responsibility for a population, related to evidence-based purchasing).

Example:

Treatment A has an effectiveness of adding 5 years of (quality) life for a cost of 1,500 euros. While treatment B has an effectiveness of adding 10 years of (quality) life for a cost of 7,000 euros. Product of A costs 300 euros per added year of life while product of B costs 700 euros per added year of life. We can also see the equation as: the advantage of B over A is 5 extra added years (unfortunately, at a cost of an extra 5,500 euros) or at a marginal cost of 1,100 extra euros per extra added life (see below).

Marginal cost

When, for example, two treatments are compared, one could be satisfied with the comparison of the average cost per treatment. Treatment A cures 100 out of 1000 patients at an average cost of 1$; treatment B cures 110 patients at an average cost of 2$ a patient. The real question in this case is not, to know if we are ready to spend 2$ instead of one per patient to have more chance of a cure, nor if we are ready to spend 19 or 10 $ per cure; the real question is to know if we are ready to pay 1000 $ more in order to have 10 more patients cured: « the additional effect » of 10 more cures will involve a "additional cost " of 1,000 more dollars, or a marginal cost of 100 $/case. This example reveals that the interpretation of the cost and effectiveness data of various interventions can be difficult.

Opportunity cost

Spending money on one treatment means, unless we have unlimited resources, there is another treatment for which that money is no longer available. When a programme is chosen on its direct cost, to this cost must be added that which is lost by giving up another programme which will no longer be possible. This could be the situation, for example, of a university teaching hospital financed through international aid. The financial resources necessary for it to function must be taken from somewhere, from other hospitals' budgets. Or if, for example, one should abandon the treatment of 1,000 tuberculosis patients in order to carry out plastic surgery, to the cost of this operation must be added the social cost of the non treatment of the tuberculosis patients. This is the opportunity cost: the cost of the opportunity lost for treating the tuberculosis patients because there are no more resources available.

Cost benefit

The fourth key concept to be taken into account within the economic aspects of planning is that of " cost-benefit". It is more complex and its practical use is limited to the planning of long term investments (mass campaigns, vaccination or nutrition programmes, for example). The principal is that an action will only be undertaken if the benefits out-weigh the costs. In order to do this the costs and the benefits must be expressed in the same way. One must, therefore, and this is the difference with cost-effectiveness analysis, express the effects (immediate and future) as monetary values, including results of a social nature (which is the weakness of this method, as many of these advantages cannot be expressed as a monetary value). Let's study the example of a family planning programme. One can calculate the cost of each avoided birth (how much a child will cost in terms of food, housing, education, etc. until he is 14 years old) where the cost-advantage will obviously be favourable. But if the age limit for the calculation

were increased to adulthood, the productive age, would this relationship remain favourable? In this case the employment situation, industrial or agricultural growth, etc.. must be taken into account. The complexity of the method and the underlying choices which it involves is obvious.

Economic analysis does not offer guarantees for automatically choosing "the best" solution, but it contributes to compose the "evidence-base" for "rational" decision making.

3. Values

Equity[21]

Equity is a term frequently used, though usually extremely loosely. It is often confused with equality. Equity however though related, is different, in particular through its incorporation of the idea of social justice. A variety of possible definitions of equity exist, including the following:

- Equal access
- Equal access to health care
- Equal utilisation of health care
- Equal access to health care according to need
- Equal utilisation of health care according to need

The first of these at first sight accords most closely to the [Alma Ata] WHO goal; however, it has to be recognised that it is unattainable. While possibly a desideratum, it is of little practical use to the planner seeking criteria against which to develop plans. The second and third definitions are also unworkable, and possibly undesirable. One would not, for example, regard a situation as equitable where everyone used health care the same number of times (equal utilisation), irrespective of their degree of ill health. Similarly, equal access to health care, in a world of limited resources, may imply *unequal* access relative to need. Given the importance of social justice in the concept of equity, it is fair to suggest that the last two definitions come closest to the philosophy of primary health care.

Which is closer depends in part on how broadly 'access' is defined. If it is defined narrowly to imply *physical* access alone (albeit this is impossible to achieve – it is impossible to envisage a health system where *everyone* with equal needs lives at exactly the same distance from health facilities!), then the presence of any other factor inhibiting the take-up of health care is likely to make 'access' alone an unacceptable definition. If the health system, for example, charges a fee, then utilisable access is dependent on ability to pay as well as on proximity to the service.

The alternative to that concerned with access concerns utilisation. Utilisation of services is recognised to be related to a variety of factors, including distance from the service. Analysis of such factors suggest that three overall underlying factors that incorporate various of these more specific factors are the class, race, and gender of an individual. Social epidemiological studies have been conducted to examine the importance of these factors. In the UK, for example, one study demonstrated marked difference in the utilisation of health services between different classes (the poorest the

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[21] Text coming from Green A. 1992. *An introduction to health planning in developing countries*. Oxford University Press, Oxford, pp 55-9.

least). Studies in Zimbabwe also showed differences in both health status and utilisation according to race.

If access is more broadly defined to incorporate such factors, the both the definitions of equity, whether couched in terms of utilisation or of access, are likely to have similar implications. The difference between them is reduced to individual decisions to utilise health care. The importance of this depends on the degree to which one believes such decisions are affected by one's environment.

A useful distinction has been made between 'vertical' and 'horizontal' equity (West, 1981). Horizontal equity implies *equal* treatment for *equal* need. For example, all pregnant women without complications would receive similar care. Vertical equity implies the *unequal* treatment of *unequal* need. It suggests that differing levels of health provision be made available for pregnant women expecting no complications from those with likely complications. It also suggests different levels of care for pregnancy as compared to other health needs, such as coronary patients. In planning services it is relatively easy to understand the concept of horizontal equity, although it may be difficult to achieve. However, the concept of vertical equity is far harder to apply, requiring a working definition of need, and value judgements about how to react and how to prioritise services for relative needs. To continue the example above, similar provision of services for all pregnant women with no complications is easy to understand and to monitor. However, decisions as to the relative emphasis and hence resources to be placed on services for pregnant women compared with coronary care require a judgement as to the relative needs of and priority to be given to each group of patients.

In planning for PHC, the first key essential must be a clear, well-defined and workable understanding of equity, and resultant criteria for monitoring movement towards it. If, for example, the utilisation-based definition is employed, horizontal equity would suggest that utilisation rates by different groups (by class, location, occupation, gender, or race) should be similar for similar health needs.

In summary, equity can be understood either as equity to each according to his merits, contribution or equity to each according to his needs. In the Primary Health Care needs-based approach, there is an implicit recognition that equity (as distinct from equality) requires that within the spectrum of health needs, individuals with equivalent needs should receive (or have equal access to) equal care, and that by implication, individuals with less needs should receive less care[22]. This has been described as horizontal equity – "the equal treatment of equals" – together with vertical equity – "the unequal treatment of unequals".

This social value lies on a perception (theory) of justice. The question is in fact to characterise the equity: equity in liberty? Opportunity? Endowment? Income? Power? Rights? Fair chances? Access?

Solidarity

According to the dictionary, solidarity is a "unity based on shared interests and standards" or a "relation between persons who are aware of a common interest which results in the moral obligation not to do harm to each other and to come to their aid". This means that it would result in some willingness to accept responsibility for the fate of (from the most focus to the most extended) other members of the family, the extended family, the society, the nation, the cultural identity, race, continent, human species. In

[22] Collins C. and Green A. 1994. Decentralization and primary health care: some negative implications in developing countries. *Int.J.Health Serv.* 24 (3):459-475.

solidarity, there is some acceptance to do for others what they are not likely to be able to do for you. There are links between equity, solidarity, health and development.

Participation

It can be understood as sharing in contribution (providing resources) or as sharing in decision making (using resources). It can be individual (direct) or collective (representative).

The necessary condition is information. That implies:

- willingness to share information and make it available
- willingness to place decision making between "providers" and "clients".

There is of course a link with autonomy, determinants of health, 'holistic care' or 'whole person medicine' and development (capabilities).

If restoring or preserving health (well being) aims at "optimising people's capability to undertake valuable and valued doings and beings", this implies the capacity to make conscious choices, without undue dependence on others.

A balance has to be found between:

- security (possibly – extreme – in a state of total dependence)
- and "autonomy" (possibly – extreme – in a state of total command)

Autonomy

Dictionary: "self-determined freedom and especially moral independence".

It is both an essential element of well being (reduced by illness) and an (ethical) principle of freedom/liberty (at stake in the doctor-patient relationship).

Balance between cure, care and autonomy. Cure has to be in balance with care; both cure and care can lead to more dependency; both need to be balanced with consideration for autonomy.

Autonomy can also be seen both as a right and a fact. As a 'fact', it needs to be taken into account in pursuing effectiveness (compliance, appropriation).

PH-17

Public Health Education Network Event

31st December 2012

Introduction

SOCHARA School of Public Health Equity and Action (SOPHEA) is glad to have been part of public health related networking events and initiatives in Bangalore/Karnataka/India. Many of the organisations which are part of this emerging public health education and research network have been initiating field projects, academic training programs, health communications, research projects, and many other initiatives that are helping to strengthen the public health system in the state using various approaches and engaging with the public health system in various ways.

SOPHEA believes that Bangalore is emerging as the public health education, research, and policy activism hub of the country and we invite you all of you, who have been part of these initiatives to join us in a day's reflective celebration of this emerging network. We hope to provide a platform for organizations to share about their work during the year, there future plans and share documents/reports and education materials that have emerged from their activities.

As a background to this event a set of the documents are circulated which helps contextualize the current public health education and related initiatives in India/Karnataka.

Venue: CHC -SOCHARA, Madiwala, Bangalore.

No. 85/2, 1st main, Maruthi Nagara, Madiwala, Bangalore -560068

Tel: +91-80-25531518 +91-80-25525372

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CAPACITY BUILDING FOR PUBLIC HEALTH IN THE ASIA PACIFIC REGION

-Dr. Thelma Narayan

A Policy Document prepared for UNESCAP office in Bangkok in 2004. The UNESCAP had initiated measures to strengthen public health, including public health education in the 62 countries that come under the Asia Pacific region.

Introduction

1. The historic sixtieth session of UNESCAP held in Shanghai, through its resolution 60/2 on 28th April 2004 gave a "Regional Call for Action to enhance capacity building in public health". It recalled the Millennium Development Goals, especially those that were health related, and the UN General Assembly resolution 58/3 of 2003 to enhance capacity building in global public health. In a significant step it has mandated the formation of a Health and Development subcommittee which is scheduled to have its first meeting in December 2004.

2. The Asia Pacific region, with 62% of the global population, has several strengths. The region has shown consistent economic progress and dynamism over the past few decades, which in turn has contributed to improved living conditions and health of people. It also has a wealth of rich cultural, spiritual, health and healing traditions. However poverty, hunger, disease and disability continue to afflict significant proportions of the population, with growing intra and inter-country inequities in income levels. Current global macro-economic policies and trends have also affected the region, resulting in loss of livelihoods, increased rural distress and migration, environmental pollution and destruction, and an increase in conflicts. These deeper socio-economic and environmental determinants have a major impact on the health of people and enhance the transmission and incidence of disease.

3. The cost of diagnostics, drugs, and of health care in general, are increasing, while public expenditure on health and health care is declining. Health gains achieved over five decades are beginning to reverse in some population groups and countries. Inequities in health status and access to health care are growing.

4. In more recent times HIV/AIDS, SARS and avian flu provide a wake up call and a challenge to the health systems of countries in the Region. Older, long standing problems such as tuberculosis, malaria, diarrhea, anemia and under-nutrition take a heavier toll in suffering and death but do not attract media or political attention. There is therefore an urgent need, and an opportunity to revitalize public health and its practice, and strengthen health systems, building on the infrastructure, experience and expertise, developed over the decades.

5. Capacity building for public health and strengthening of health systems in response to the emerging problems and social context will need to be done through a process of dialogue, consultation and international cooperation. This will be undertaken within the region, with public health professionals in the region and with community participation. Collaboration with WHO, UNICEF, FAO,UNDP, ILO and other international and bilateral agencies will be explored with a strong focus on building local capacity and self reliance, rather than being dependant on external experts and consultants. Special focus will be given to the needs of least developed economies, landlocked and island developing economics and economies in transition. Sharing of human, technical, knowledge-based and financial resources within the Region will be encouraged through institutional mechanisms. Given the mandate and traditions of ESCAP multi-ministerial support and involvement will be sought for capacity building in public health. Reviews using participatory, qualitative and quantitative methods will be undertaken with strengthened monitoring and evaluation systems, in order to assess the health, social and economic impact of the strategy an to learn from innovative approaches and processes that may be used. ESCAP and its member countries will work in close partnership with the World Health Organization, including its regional and country offices. The public health expertise of the WHO is a

valued asset. It will be drawn upon extensively for strengthening public health capacity in the Asia Pacific Region. ESCAP in turn will contribute through its mandate of working on the economic, social and environmental determinants of health. It can assist capacity building of public health systems in the region by expanding horizons beyond a disease focused approach, to include policy action directed at the broader determinants.

Evolving Definitions of Public Health and Primary HealthCare

6. Public heath is an evolving, dynamic concept. The practice of public health, together with improved economic and living conditions, have resulted in major health gains for populations in several countries around the world since the early nineteenth century. This took place through social policies introduced even before the development of vaccines and antibiotics. They included measures to improve sanitation, hygiene, water supply, housing, nutrition, social security etc.

7. The Primary Health Care (PHC) approach as a strategy to attain the international social goal of Health for All by 2000 was articulated at the landmark Alma Ata Conference organized by WHO and UNICEF in 1978. It drew on community level experience sand challenges from countries in different continents including the Asia Pacific. It received a mandate from 134 member countries. PHC expanded the scope and strategies for public health through increasing social control and democratic political processes over health and related services. It attempted to give communities greater voice in health systems through decentralization and institutional mechanisms for participation in health decision making. Moving beyond bio-medicine PHC stressed inter-sectoral collaboration to address the deeper determinants of health. It was rooted in principles of equity and social justice in health and health care. In order to reach the social goal of health for all, PHC emphasized self-reliance at individual, community and national level, and recommended the use of appropriate technology to serve peoples needs. It promoted social means to reach these goals. Primary health care not unsurprisingly met with resistance early on.

8. The International Association of Epidemiologists also defines public health with a broad perspective "Public health is one of the efforts organized by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social action. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same; to reduce the amount of disease, premature death and disease produced discomfort and disability in the population" (JM Last, 1995).

9. More recently the Oxford Textbook of Public Health (2002) describes public health as "the process of mobilizing and engaging local, state, national and international resources to assure the conditions in which people can be healthy." It recognizes that public health is only one of the major influences on the health of communities and that basic economic and social conditions impact directly on people's health and wellbeing.

10. The initiative for public health capacity building can experiment with social arrangements for greater involvement of people, particularly the poor and vulnerable, in the development of their own health services. Thus the public can be brought back into public health. Public health has focused on improving the health of communities and individual persons through comprehensive preventive, promotive, curative and rehabilitative interventions addressing risk factors that could be social or behavioral. The present challenge is to include the deeper layer of social, economic and environmental or developmental determinants of health. The way has already been shown by some communities and countries. The need and challenges have been articulated in the Peoples Charter for Health of the Peoples Health Movement. The World Health Organization is making initiatives to set up a commission for social and environmental determinants of health. The contribution of UNESCAP and its member countries in this regard would be pioneering and would help the achievement of the millennium Development Goals. The current initiative offers an opportunity to further build the concept, principles, and practice of public health in relation to the current times and challenges in the regional context.

Strategies for capacity building in Public Health

11. Human resource development- Developing a pool of well-trained, competent, highly motivated professionals and workers in public health is a priority for all countries in the region. There is an urgent requirement for a range of public health skills and competencies – including specialist epidemiologists, policy analysts, health administrators, program managers, trainers, health economists demographers, statisticians, researchers, social and behavioral scientists, public health nurses, health promoters/educators, laboratory technicians, social workers, multipurpose workers, health assistants, community health workers, health animators and others. While specialization in sub-sections of public health will be inevitable, the key focus should be on training more multi purpose, integrated, socially relevant, public health generalists at different levels.

12. Planning and forecasting the numbers of trained staff in public health required at different levels of the health system is a task to be undertaken by each country. Based on a needs assessment, numbers retiring per year, and overall attrition rates, the numbers to be trained every year can be calculated, keeping in hand a reserve stock of personnel who can manage leave vacancies, respond to emergencies, undertake consultancies etc. Most important is the policy recognition that in order to achieve effectiveness, relevance and quality, some positions at specific levels in the health system will necessarily need professionals with competency and training in public health. The tendency to appoint clinicians to public health positions, and to be susceptible to political compulsions, needs to be avoided if public health objectives are to be met.

13. Public health staffs are often given a lower social status as compared to clinicians, though their jobs may be more complex and thankless. This results in lower morale and self-esteem and needs to be rectified through an enabling environment with adequate recognition, remuneration, and encouragement. Considering the complexity of their tasks and the multidisciplinary multi-tasking nature of their activities, they should be given opportunities for professional growth. Along with these reforms a realistic focus on outcomes, impact, quality, integrity, and responsiveness to feedback from the community, is required.

14. Team work in public health is crucial for it success. Adequate training is needed in team functioning with clarity about roles and responsibilities and lines of communication. Supportive supervision, trust building and problem solving exercises are essential. Public health professionals can be drawn from both medical and social sciences streams and should not become doctor dominated.

15. Continuing education of staff is essential, given the rapid growth in knowledge and the contextual changes that are occurring. Distance education courses, workshops, seminars, newsletters and access to electronic means of updation need to be well developed. Accreditation systems at district or state levels for public health staff will help to ensure basic standards with mandatory requirements for attending a certain number of courses and achieving competencies required for different levels.

16. Ability to work with communities and local government functionaries, with community organizations, and community leaders both informal and formal, is an important skill for public health professionals. This is best developed through experiential learning and in-service training.

17. There is an urgent need to build capacity in developing an evidence based approach for public health interventions. Investment is required in training and retaining research professionals competent in qualitative and quantitative methods. Their findings would be used by a multidisciplinary policy team for developing, reviewing and evolving public health interventions. Skill development is required for recording and reporting systems to be strengthened, with adequately disaggregated data collection to measure differences in social groupings. Analysis and utilization of data for decision making should be done as close to the point of data collection as possible. This in itself will enable capacity development closer to the community.

18. Capacity needs to be developed across sectors to deepen the understanding of the inter-sectoral dimension of health and health action. We need to strengthen the ability to dialogue and involve counterparts in other

departments of development, be it food, water, sanitation, environment, women and children's welfare, education, agriculture, labour, and other departments.

Training Methodologies for Public Health Practitioners for the Asia –Pacific Region

19. An alternative pedagogical method that is participatory, reflective, transforming and located in a socio-cultural paradigm, should be used in teaching public health workers and professionals.

20. It is important for countries in the region to consider the underlying philosophy, educational methods and processes of learning, adopted in the higher education of public health professionals. Two foundational premises that continue to have a major influence have been the biomedical scientific roots of public health and its proximity with state power. These developed historically within the then dominant social context often linked with the industrial revolution, capitalism and colonialism. At the interface with people in the Asia Pacific region, who have their won culture and knowledge base, there is often an alienation of philosophy, concept and praxis. Public health practice is often perceived to be an expert driven, top-down, centralized, prescriptive approach, implemented in a heavy handed manner by the government bureaucracy. This does not win the hearts and minds of people and is often met with scopticism if not with resistance, non-action and non-adherence. Development of pedagogical methods, and the learning environment and process, will ne[illegible] careful thought in order for students of public health to identify and retain the core principles and elements of the discipline, to be sensitive to the cultural and social context of communities with whom they work and to best utilize the right knowledge base and traditional health and healing practices in the region. Since the 1970s much experience has been gained, particularly through community health and development projects in the voluntary sector, in the use of participatory, experiential, reflective and transformatory learning processes. While these methods initially evolved through working with communities, they have also been used in the education of professionals who find it a more liberating, meaningful and motivating process of learning and personal growth. Besides theoretical content and competencies, it includes experiential learning in community based programmes, self awareness and reflection, teamwork, social skills, understanding culture and community dynamics, spiritual and ethical dimensions of health and public ethics, among others. This qualitative change in the method of teaching-learning, enhances social effectiveness and community support increases personal motivation, prevents burnout and helps the creation of a social network among public health workers.

21. These aspects have not been adequately stressed or integrated in public health training programmes in the West. While international collaborative efforts to strengthen public health capacity in the ESCAP region will involve linkages with training centres in the west based on a different history and paradigm, a creative contextual local adaptation of theory and practice of public health is a necessary.

Training Approaches

22. Medical officers of Primary Health Centres and other levels of government health centres play an important role as leaders of health teams. They need to be adequately trained in public health and health management. In practice in several countries a large proportion do not have a post-graduate qualification in the subject and are more clinically oriented. They will need an in-service public health training for at least 6 months which would include the basic theoretical concepts and a period of experiential training under guidance. A mentorship programme could be considered. Exercises in leadership training, communication, team-work, gender sensitization, social analysis, understanding community dynamics and community organization, and public health ethics are important to supplement the traditional public health components.

23. Participatory training methods that are learner – centered, using principles of adult learning, and problem solving and experiential innovative approaches are very helpful. Use of role plays, simulation games, case-studies, films and field visits help the learning process. Debriefing, with analytical reflections of different experiences and method help in the personal growth and motivation of participants besides enabling a deeper understanding of the issue.

24. Team training of primary health care teams for up to 5 -7 days is also a useful method to enhance the quality of public health work. Training is undertaken together as a team to understand each other and internalize the goals and objectives of their collective endeavors. Their different roles and responsibilities are clarified. Systems for communication, recording and reporting, measuring indicators of progress, getting community feedback and of participatory reviews can be discussed. This process helps in bonding together and creating better working relationships. Efficacy of public health work depends to a large extent on the cohesiveness of the teams, their conflict resolution mechanisms, and the feeling of community among themselves, which need to be constantly developed and nurtured.

25. In several countries there has been good inter-action between health systems, and integration of indigenous systems of health and healing into the national health system. Indigenous systems and practices that are beneficial to health cold find an explicit place In national health policies and systems, rather than being a parallel system that is under resourced and sometimes subaltern. This spirit of mutual cooperation between systems needs to be reflected in the training of health workers and health professionals.

Training Content

26. Both traditional public health, as well as the new public health, recognize the close links between the underlying determinants of health and the health status of populations. Teaching curricula for public health however are still dominated by biomedical components, based on a reductionist paradigm. Consequently public health interventions tend to be narrowly focused, vertical programmes; lacking a societal process element. For instance the delivery or social marketing of public goods such as diagnostics, drugs vaccines, condoms etc are given much greater importance than social relationships and processes through which change can occur and where people have a voice. The contextual complexities of social, economic and environmental determinants of health are discussed and researched in very few schools of public health across the world. The Asia Pacific region could be a potential leader in introducing systematic teaching and research into these issues with a public health perspective in order to protect public interest and human rights and to reduce social inequality, with resultant benefits to the health, and wellbeing of people.

27. Content areas to be covered in the training would include
    - Guiding principles and values of public health, which include social justice and equity in health and health care; health and access to health care as a fundamental human right; health as central to sustainable development; community participation and self-reliance; good governance, oversight and accountability.
    - Public health ethics and law
    - Food security and nutrition
    - Poverty and health inter linkages
    - Gender perspectives on health
    - Macro-economic and trade policies and health.
    - TRIPS, GATS and implications for access to medicines and to health care
    - Conflict, violence, disasters and health
    - Environmental health issues with corporate and government accountability
    - Peoples social movements, peoples health movement
    - Environmental health movement
    - Population movement; migration, urbanization.

28. Preparation of learner friendly teaching material and modules; developing a critical mass of teaching staff in the region; and establishing centres that research and intervene in these areas, will need to be undertaken in a systematic manner. Enhancing and disseminating databases on these complex subjects will also need to be undertaken.

Developing Centres of Excellence for Teaching and Research

29. There is a need for a number of centres of excellence for teaching and research in public health and community health in the Asia Pacific region. While countries with large populations may have more than one centre, smaller countries could share a centre or send their professionals to recognized centres. Mechanisms for generation of financial and technical resources could be developed. Regular exchange and electronic networking between academic and research centres in the region, and close collaboration with WHO regional and country offices would be beneficial. Mapping of existing centres and resource groups in the region could be initiated by the secretariat. Scholarships could be established for least developed economies. Electronic methods of communication could be institutionalized so that whenever required rapid mobilization of expertise and quick sharing of information is facilitated. These centres will be the nerve centers for knowledge generation and application, and will need to be very dynamic and alive. Countries are advised that the leadership, management systems, library and information centres and financial security of these centres are critical areas for development. Their purpose would be to be socially relevant to the public heath related issues and concerns in their countries and neighboring areas. Interaction and alliance building with the local health services, NGOs and social movements would enable them as a group to impact on the determinants of health.

Strengthening Health Systems Financially

30. Health systems form the basic skeletal framework for public health action. Over the past century public sector health systems in the region have undertaken preventive health work, health promotion, communicable disease and outbreak control, and other measures on a countrywide basis with resultant public health gains. However over the past decade a weakening of the public health system has taken place in some countries where decision makers have uncritically supported and promoted the privatization of the health services. In other countries investment in public health systems has been consistently low and unproductive. In these cases there is a need for strengthening of public health systems to meet public health goals, and to privatize further. The Commission on Microeconomics and Health has pointed out the critical importance of adequate investments in health in the public sector and the economic and social benefits of these investments. Countries have been strongly encouraged to increase their public health expenditure up to the minimum norms.

31. There is an urgent need for countries in the region to build national and local capacity in health financing and in establishing and running National Health Accounts Systems. Capacity building in financial management with accountability and transparency for health institutions at sub-district and district levels and for primary health care is also required.

Capacity Building for Priority Public Health Problems

Environmental health, water, sanitation and waste disposal

32. Despite significant improvements, there is a long standing lack of access to water and sanitation facilities for a significant section of the population particularly the poor in some countries of the region. This is compounded by new challenges. Groundwater is being used faster than it is being recharged. If water conservation strategies are ineffectively implemented, drinking water shortages are predicted to occur. Contaminated water is a vehicle for disease transmission. Poor quality and inadequate quantities of water are estimated to account for about 10% of the total disease burden in developing countries. Privatization of water is reducing access for the poorer sections of society. Industrial and chemical pollution of rivers, groundwater and water bodies and agricultural runoffs contaminated by fertilizers and pesticides are rapidly growing areas of concern.

33. Countries are encouraged to ensure universal access to safe, potable water supply by 2010. Inter-sectoral action between water supply and sanitation boards pollution control boards, departments of health, local

government bodies communities and consumer groups is essential to ensure adequate provision and utilization of water, without wastage, and to undertake health promotion and public awareness campaigns so as to reduce prevalence of water and sanitation related diseases.

34. There is a need for adequate technical capacity in the region to work effectively and efficiently on this issue. Time bound goals and indicators could be set to reduce mortality and morbidity due to the following conditions:
    a) water washed disease – scabies, trachoma
    b) water based diseases – schistosomiosis and dracunculiasis (guinea worm disease)
    c) water related diseases – malaria, filariasis, dengue fever.
    d) Waterborne disease – diarrhea, dysentery, cholera, typhoid, hepatitis A, amoebiasis, giardiasis, helminthic infestation / intestinal worms, camphlobacter etc.

    Prevalence and incidence rates will be collected and analyzed through the disease surveillance system / health information system, for which capacity is also being developed.

35. Capacities need to be strengthened for accelerated interventions to ensure access to household and environmental sanitation facilities (toilets, drainage systems, sanitary waste disposal). This will help minimize disease spread by the faecal-oral route of transmission, which continues to be widespread. Control of these diseases requires a combination of interventions including improved water quantity and quality, sanitation systems but also food hygiene and good personal hygiene. This requires health promotion, advocacy, social mobilization in addition to infrastructure development and regulation. A multi-sectoral approach involving public health engineers, sewage boards, and departments of urban and rural development, water supply and elected representative and community members is critical.

36. Capacities to handle waste management in a professional, toxic free manner are also urgently required to be developed. This area has become very complex over the past few decades and encompassed household waste; solid waste at village, town and city level, non-biodegradable waste; hospital and health care waste; hazardous industrial and chemical wastes; nuclear waste; agricultural wastes etc. Some waste disposal methods, such as incineration are themselves toxic. Short and long term consequences on public health and the environment are significant.

37. In addressing issues of water, sanitation and waste disposal, the role of the state is important. Public health specialists need to work in collaboration with public health engineers and a host of stakeholders, including the environmental justice movement and legal advisors. Adequate sensitization and awareness regarding the issues need to be ensured in the training and continuing education of all public health workers. A few would opt for more specialized training in this area. This stream would need to have an institutional base wherein their higher education, job opportunities and career planning would be considered.

38. The public health system would required the skills and capacity to pick up instances of impact on human health following environmental pollution from industry, including the chemical industry, agriculture (pesticides, fertilizers etc) and the dumping of toxic waste. This is a major emerging social and health problem in the region, which has become the global manufacturing base at low economic cost. Health and safety of workers and communities need to be safeguarded. Other major environmental, issues affecting human life, health and wellbeing including climate change, global warming, ozone layer depletion etc, need urgent research and action. Health impact assessments of new technologies, industries and development projects need to be undertaken. Environmental epidemiologists and occupational health specialists are still scarce in the region and need to be trained in larger numbers. They would need to work closely with government policy makers, health providers, NGOs, the environmental movement and communities.

Nutrition

39. The public health systems of many countries in the region are inadequately equipped to address the challenges of nutritional deficiencies and under nutrition, or the emerging challenge of non-communicable

disease which have a food, diet and lifestyle component to their causation. The magnitude of nutrition related health disorders in the Asia Pacific region is large. The impact on mortality, morbidity, vulnerability to other infections and disease, disability and economic productivity is enormous. However the significance and potential for positive health and development impacts through policy measures has often not been adequately understood or acted upon by policy makers and public health practitioners. Advocacy, sensitization, capacity building and effective action on nutrition deserve the highest priority.

40. Practical training on nutrition needs to be mandatory for all levels of health workers and professionals. The teaching content will need to be relevant to the nutrition problems and issues obtaining in a country or area, keeping in mind the dynamic changes that keep occurring. District-wise nutrition mapping would provide an information base. Centers for nutrition research need support and the findings and recommendations from their work need to be acted upon and also introduced into training programmes, public education and policy interventions.

41. Broader issues of agricultural policy, food diversity, food security, international trade and pricing of agricultural products are issues of national and regional priority. Public health policy workers and practitioners need to have a general awareness about these issues. They need to understand their specific roles and responsibilities in regard to nutrition security, and in improving the nutrition status of people of different age groups, at individual and community levels and through integrated health and nutrition interventions.

Disability

42. The Asian and Pacific is home to an estimated 400 million persons with disability, the biggest number in the world. A large majority are poor, and lack social opportunities and access to good rehabilitative care, that can enable and assure a meaningful productive life. Many disabilities are also preventable.

43. The first Asian and Pacific Decade of Disabled Persons (1993 to 2002), and the recently launched second decade (2003 – 2012), have facilitated many positive regional and country level initiatives. These include a comprehensive and integral approach to the protection of promotion of the rights and dignity of persons with disabilities; improving disability measures for policy use, promoting active participation of women with disabilities; poverty alleviation among people with disabilities; among others.

44. The public health community in the Region needs to be capacitated and encouraged to join, support and expand these initiatives. Multi-ministerial and inter- country cooperation, already initiated, will be further strengthened. Active participation of persons with disability in planning oversight and reviews will be ensured. There will be a special focus on children with disability.

Promoting Mental Health

45. Mental illness takes a heavy toll through the long-term suffering of affected persons and their families. Patients continue to experience stigma and discrimination, and the treatment and care of the mentally ill persons is still an orphan area in most health systems. Mental and emotional ill health, tobacco and alcohol related problems and violence have been widely recognized during the past decade, as major public health issues. The time now is to act. This is a complex issue of human behaviour and social relations in an increasingly stressful environment. Health personnel working in primary care settings in both the public and private sector need to be trained adequately to recognize and diagnose mental health problems. Treatment options that are currently available should be widely accessible. In order to make this a reality there is a need to enhance the number of psychiatrists, clinical psychologists, counselors and social workers, and also to take appropriate measures to reduce their migration. Drug patenting issues will need to be considered to ensure availability of newer drugs at affordable prices. More importantly initiatives to promote positive mental health and to build caring, supportive communities need to be expanded through training of trainers and other methods. These include parenting skills, life skills education, meditation and yoga. Parents, school teachers,

religious bodies, and community leaders all have an important role. Legal, regulatory and related capacities will need to be strengthened to dealt with control of tobacco, alcohol and substance abuse.

Infectious Disease Control

46. Old and new infectious diseases take a heavy toll in terms of disease burden and mortality in the region. The risk of transmission within and between countries has become higher with social instability, conflict displacement, migration and increased mobility. Capacity building for control of infectious diseases is one of the highest priorities in the region. This needs to be implemented with a sense of urgency in a time bound manner. Infectious disease control requires widespread public education and awareness, sharing the known scientific features of the diseases, stressing preventive and control measures at individual and community level, and minimizing misinformation which results in fear and panic. Government departments of health education and health promotion need to be alert, up-do-date, pro-active and creative, using a mix of communication methods and interacting with mass media groups. Health systems need strengthening with adequate budgets, trained health personnel, good laboratory facilities, supply systems for drugs and consumables, communication systems and disease surveillance systems/health information systems. Inter-country collaboration needs improvement. However, most importantly there is a need to focus on the developmental determinants of these diseases through intersectoral, multiministerial interventions, as many of these diseases thrive in conditions of poverty. There is a need to ensure that dominant paradigms eg the bio-medical approach, and dominant institutions do not monopolise policy making. Independent implementation audits and public hearings can be utilized to elicit peoples perspectives on how effective and accessible infectious disease control efforts are. Capacity building is required for all these components.

47. Tuberculosis, malaria, filariasis, dengue hemorrhagic fever and vector borne diseases need special attention, and close collaboration with WHO control programmes. However, rather than managing a multitude of vertical, single disease focused programmes, countries in the region could adopt an integrated primary health care approach wherein early detection, complete treatment, recording and reporting systems function through comprehensions primary health care centres dispersed in the community. Health promotion and community participation are integral components of the approach. Most countries have over the past 3 – 4 decades established a primary health care infrastructure. This needs to be strengthened, guarding against policy advice from international financial agencies and others who suggest a targeted approach with enhanced privatization. The international community and public health experts have universally recognized the important role of the state in infectious disease control through public health systems, popular education and people's participation. In the current neo-liberal context this role needs to be re-inforced.

48. Newer problems of HIV/AIDS, SARS AND Avian flu have been addressed by the UNESCAP over the past few years in its resolutions. The recent 3x5 initiative of the WHO, which aims to increase access to treatment is welcome as a timely response to the severity and magnitude of the disease and to the treatment access campaign. Dialogue between UNESCAP and WHO will help to enhance coverage and capacity building in Asia as early as possible. Newer treatment protocols, simplified procedures, etc will be adopted, monitored and constantly updated as new knowledge becomes available, after reviewing its social applicability. Most importantly countries could use the existing provisions in the WTO clauses to ensure adequate supply of good quality, generic drugs at affordable prices. Lessons could be learnt from Thailand, Cambodia, India and other countries. Health education efforts regarding these diseases should not generate fear but spread positive messages. Methods of positive living for persons already infected could been encouraged. Use of adjunct therapies such as herbal remedies, massage and other forms of healing that recognized not to cause harm will be encouraged. Life skills education and women's health empowerment that has already been initiated in most countries will be expanded through widespread capacity building.

49. The region is faced with a double burden of diseases with non-communicable diseases (NCD) and traffic accidents taking a heavy toll. The Pacific island countries, Japan, China, Australia and New Zealand have already initiated health promotion campaigns through the government, voluntary sector, private sector and professional associations to bring about lifestyle changes such as adequate exercise, healthy diets, stress

management, compulsory use of helmets and seat belts, rules about drinking and driving etc. With an ageing population these measures are necessary to reduce the burden of cardiovascular diseases, hypertension, stroke, diabetes and other NCDs. Abuild up of capacity in the public and private sector for management of these disorders is necessary. Ratification of the Framework Convention for Tobacco Control (FCTC) and implementation of bans on advertising and sponsorship of tobacco products, smoking in public places and stringent curbs on smuggling, would help control the epidemic of tobacco related diseases, including cancers in the Region. Other measures for prevention, control and care of cancer also need to be instituted.

50. The health internet work project of the WHO has piloted the use of the internet and information and communication technology (ICT) for providing easy access to research information on important public health problems to health providers and citizens. ICT offers great potential and needs to be widely used. Internet based public health training programmes are being designed. The use of hand held computers by health workers in the field for recording and reporting will greatly reduce their burden of work.

Community capacity building for public health

51. Traditional public health has been critiques for being rigid, with a techno-managerial, bureaucratic approach which leaves little scope for the creative, empowering and enabling involvement of communities [illegible] collectively address the deeper determinants of disease. There is an opportunity now for a change in paradigm based on greater community participation and control, with mechanisms for social accountability and measurement of progress in achieving goals. We could move forward towards achieving the global vision of better health for all, based on the universally accepted premise that the Right to Health and Health care is a basic human right.

52. Capacity building for public health is therefore understood in its broadest sense. This will involve representation from all sections of communities including women, children, persons with disabilities, disadvantaged section of society, the elderly, and persons with HIV/AIDS and other illnesses, so that their perspectives, concerns, and valuable suggestions based on lived experience, will help to evolve the strategies.

53. Where elected representatives function at the level of local bodies and have responsibilities for health, there is a need for innovative training to enable them to improve the governance of the public health system. This exercise may take a few years, but has proved to be effective in several places such as Kerala state in South India.

54. Formation of self-help groups of women is widespread in the region. The value of adding a health and social dimension to their economic activities has been shown to be effective in Bangladesh, Nepal and several countries. This approach could be more widely used. Care needs to be taken that methods used a[illegible] empowering and liberating without adding additional responsibilities and burdens to women who are already overworked and fatigued.

55. Self-help groups of persons living with particular illnesses who also become advocates for preventive and promotive action play an important role. Involvement of persons living with HIV/AIDS at all levels of health decision making has significantly altered the public health discourse. Shifting the balance between experts, health providers and patients from one of dependency to one of greater autonomy and equality has been an important step forward.

56. Involvement of school teachers and parent sis critical to health promotion. It is important for young people to be touched or moved at a personal level, for personal motivation for positive health to be ignited. Training of trainers for parenting education, life skills education, counseling and health promotion on the basis of the Ottawa charter and subsequent charters would bear great fruit.

57. Politicians and bureaucrats are often placed in positions where they make major decisions that impact on health and health care. They may not have the requisite information and knowledge easily available to weigh

the matter objectively. Various lobbies and interest groups present them with sophisticated material favoring their position. Public health groups need to prepare well-researched, objective policy briefs that protect and promote public interest.

58. Experience across the region has shown the great value addition of involving communities with health institutions through a variety of institutional mechanisms that include:
    a) Setting up health communities at health centre and sub-centre level.
    b) Establishing boards of visitors, help-desks and help-lines run by volunteers in hospitals and elsewhere.
    c) Mandating local bodies or elected representatives with specific constitutional responsibilities for the governance of health institutions and programmes
    d) Making adequate provisions for the citizen's right to information to include the heath sector as well.
    e) Establishing mechanisms for participatory management of health institutions, making space for community voice to be heard and responded to.

All these efforts help to increase community ownership and management of health institutions.

59. Information and communication technology (ICT) could be used proactively by governments to overcome the digital and knowledge divide in health. The necessary infrastructure will need to be established and skill training undertaken. A community participatory model to the Health Inter-network project being piloted by WHO has shown that the sharing of health information with communities, health workers and staff from health related departments using a mix of communication methods including ICT served an unmet information need.

60. Communities have also participated actively and effectively in participatory action research that study some of the developmental determinate of health such as environmental an health consequences resulting from industrial pollution, use of pesticides, mining etc. Community involvement in the research as river-keepers measuring water quality, as community patrols measuring air quality or as bucket brigades has enabled them to gather evidence and become agents for change in a positive manner.

61. Public campaigns on health related issues have become increasingly common in the region as well as globally. The women's movement has been effective in increasing gender sensitization of health policies, in promoting reproductive rights, and in raising gender concerns in health research and in medical education. One of the current campaigns is to increase women's access to primary health care and to reduce violence against women. The people's health movement has been campaigning for a revitalization of the spirit and principles of primary healthcare. The Peoples Charter for HIV/AIDS has resulted in formation of the Asian Peoples Alliance for Combating HIV/AIDS (APACHA). The Peoples Charter for Health of the PHM has also become a rallying point for a campaign to reduce wars, conflicts and violence. The pulse of people can be felt and responded to by listening to the issues raised by people's campaigns and movements. This is an important third force that is countering the threats to peoples health caused by corporate globalization, liberalization and the commercialization of health care.

62. Use of the principle of subsidiarity in decentralization of health care services, with appropriate training, management and preparation of people, helps to bring services closer to people. However it is necessary to take adequate measures to ensure a focus on primary health care and public health.

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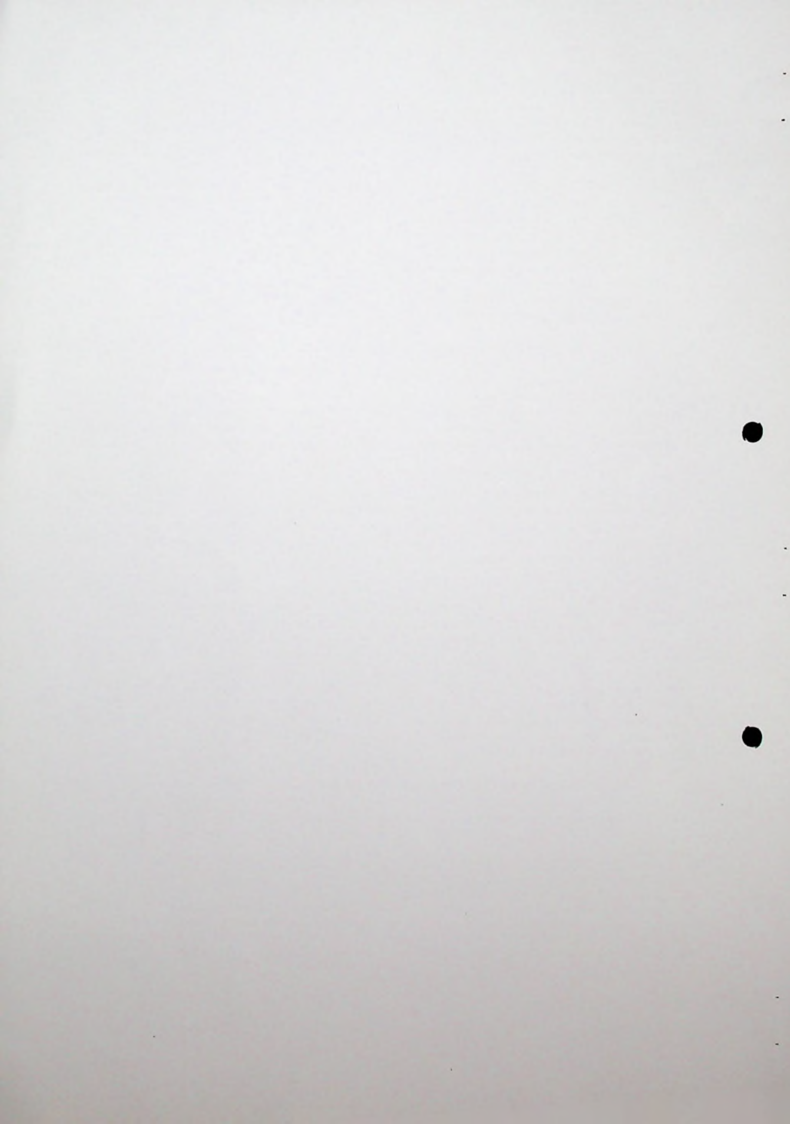


Public Health definition for India (a dialogue)

Various definitions of public health, community health and primary health care were looked for, reviewed and considered in the Indian context. These definitions, along with their sources, are available in the appendix of this document. Relevant themes were identified from these definitions and from professional experience in relation to the Indian setting to come up with the proposed definition, which built further on the initial template provided by Dr Farooque Ahmed and the suggestions of Dr Sanjay Chaturvedi (see appendices). The suggested definition and compilation of phrases is as follows:

"Public Health is the science and art of promoting health, preventing disease, and prolonging life

- *-to ensure for everyone a standard of living adequate for the maintenance of a healthy and productive life,*
- *-by developing a social movement, as an integral part of community development, through inter-sectoral coordination and organized community effort emphasising equity, participation, ownership, rights and responsibilities*
- *while maintaining healthy environment; empowering people to maintain a healthy life style & behaviour; controlling communicable and non communicable diseases;*
- *-addressing social, cultural, economic, political, ecological and environmental realities having a bearing on health;*
- *formulating health policies, interventions and programmes; and by evolving and organizing human resource and health care systems to facilitate health promotion, disease prevention, early diagnosis, treatment and rehabilitation, through informed choices of our society, communities and individuals,*
- *which is available universally, distributed equitably, ethical, socially relevant and accessible to all irrespective of their ability to pay."*

This definition has been submitted for peer review, comments and further additions/modifications.

Dialogue on Public Health Definition

Definition of Public Health: C.E.A. Winslow's Definition of Public Health as quoted in Hanlon & Picket 1984: *"Public Health is the science and the art of (1) preventing disease. (2) Prolonging life and organized community efforts for (a) the sanitation of the environment (b) the control of communicable infections, (c) the education of individuals in personal hygiene (d) organization of medical and nursing services for early diagnosis and preventive treatment of disease and (e) the development of social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birth right of health and longevity"*

Farooque's modified definition: *"Public Health is the science and art of Promoting Health, Preventing disease, prolonging life, to ensure everyone a standard of living adequate for the maintenance of health and be economically active life, and to enable every citizen to realize his birth right of health and longevity, by developing a social machinery, as an integral part of Community Development, through intersectoral coordination and organized community effort & participation to maintain a healthy environment, to educate people to maintain a healthy life style & behavior , to control communicable, non communicable diseases and other social & behavioral maladies, by organizing a medical and nursing services to deliver a comprehensive*

health care package consisting of health promotion, prevention, early diagnosis, treatment and rehabilitation of diseases which is to be universally available, equitably distributed and accessible to all at an affordable cost".

Sanjay's modified definition: *"Public Health is the science and art of promoting health, preventing disease, and prolonging life to ensure for everyone a standard of living adequate for the maintenance of a healthy and productive life, by developing a social movement, as an integral part of community development, through intersectoral coordination and organized community effort, participation, equity and ownership – while maintaining healthy environment; empowering people to maintain a healthy life style & behavior; controlling communicable and non communicable diseases; addressing social and cultural realities having a bearing on health; informing health policies, interventions and programmes; and by evolving and organizing human resource and health care systems to deliver health promotion, disease prevention, early diagnosis, treatment and rehabilitation, which is available universally, distributed equitably and accessible to all at an affordable cost."*

SOCHARA's modified definition: *"Public Health is the science and art of promoting health, preventing disease and prolonging life*

- *-to ensure for everyone a standard of living adequate for the maintenance of a healthy and productive life,*
- *-by developing a social movement, as an integral part of community development, through inter-sectoral coordination and organized community effort emphasising equity, participation, ownership, rights and responsibilities*
- *while maintaining healthy environment; empowering people to maintain a healthy life style & behaviour; controlling communicable and non communicable diseases;*
- *-addressing social, cultural, economic, political, ecological and environmental realities having a bearing on health;*
- *formulating health policies, interventions and programmes; and by evolving and organizing human resource and health care systems to facilitate health promotion, disease prevention, early diagnosis, treatment and rehabilitation, through informed choices of our society, communities and individuals,*
- *which is available universally, distributed equitably, ethical, socially relevant and accessible to all irrespective of their ability to pay."*

[please note that the items underlined in the above modified definitions by Dr Sanjay and SOCHARA are the suggested changes/additions to Dr Farooque's original suggested definition]

Dr Farooque's explanation for modifications:

The modified definition of Winslow on Public Health by Indian Academy of Public Health is an overarching one encompassing the whole gamut of Health activity enshrined in the HFA and its strategy document. The definition has three distinctive sections. The first section depicts the Goal of public health as

"Promoting Health, Preventing disease, prolonging life, to ensure everyone a standard of living adequate for the maintenance of health and be economically active life, and to enable every citizen to realize his birth right of health and longevity". The second sections includes the broad strategy of "developing a social machinery, as an integral part of Community Development, through intersectoral coordination and organized community effort & participation" The penultimate and the third section of the definition outlines the specific health intervention activities "maintain a healthy environment, to educate people to maintain a healthy life style & behavior, to

control communicable, non communicable diseases and other social & behavioral maladies". And the last and the fourth section depicts the service delivery system and the package and the manner of its delivery "organizing a medical and nursing services to deliver a comprehensive health care package consisting of health promotion, prevention, early diagnosis, treatment and rehabilitation of diseases which is to be universally available, equitably distributed and accessible to all at an affordable cost"

To translate the definition of public health C.E.A. Winslow's or the modified one of IPHA one should refer to the chapter on Organization of Public Health services of Hanlon's Book on Public Health administration. It states of two distinct approaches for providing public health services in a community. They are "personal health care Services" focusing on individual health services and "Public health care/ Community care services" focussing on the community. One should have a clear understanding of the basic difference between the "personal Health Care"& "Public Health/ community care services. The focus of personal health care service is to deliver the health care package as described in the definition of Public Health which speaks of a "comprehensive health care package consisting of health promotion, prevention, early diagnosis, treatment and rehabilitation of diseases." And to achieve the characteristics of services as defined in Public Health "to be universally available, equitably distributed and accessible to all at an affordable cost" the health service in India is organized on the concept of "***Regionalized Graded Institution supported community based Health care System***" Briefly it describes the Indian Health care system. The most peripheral service unit is the community (village), and a community based health worker ASHA/AWW provides a support base and acts as a link worker to provide essential health care services by the most peripheral trained health worker from her community based institution of "Sub-centre". The services and referral support is provided by a chain of health Institution in an hierarchical pattern (Graded)and serving an ear marked catchment area (Regionalized). To start with it is the Primary Health Centre manned by Medical Officers, supported by a Community Health Centre acting as a First referral unit for treatment purpose which is manned by specialists (or trained generalist) of Obstetrics & Gynecology, Pediatrics or Medicine, Surgery and , Anesthesia. The next health Institution is s Sub-divisional/ Taluka Hospital with specialist in major disciplines(not available all throughout) but which is universally supported by a District Hospital having all the facilities of specialist care. The care given by a Female health worker to an Antenatal mother in her area which includes delivery of Antenatal, intra-natal and post natal packages both institutions based as well as at home if during this process she develops permanent disability she is also supposed to provide some rehabilitative package (may not be included in the program). One can extend the same thinking to other public health programs like RNTCP, Malaria, AID'S control etc. This type of workers should essentially be equipped primarily with clinical skills to deal with the individual medical problem. And to interact effectively with the patients, beneficiaries and the family members and the other members of the health team he/ she should be equipped with a communication and behavioral skill. Besides these two specific skills she/he should be familiar with the basic office management skills for reporting and recording and be familiar with the public health programs and ready to cooperate.

On the other hand the Public/ community Health care service provider's focus is on the public/community. Its main as per the definition of Public Health is to "maintain a healthy environment, to educate people to maintain a healthy life style & behavior , to control communicable, non communicable diseases and other social & behavioral maladies, by organizing a medical and nursing services and to deliver a comprehensive health care package consisting of health promotion, prevention, early diagnosis, treatment and rehabilitation of diseases which is to be universally available, equitably distributed and accessible to all at an affordable cost" . The job responsibility of a public health worker is to monitor the health status & environment, disease surveillance, of the community he serves and assist /arrive at a community diagnosis, devising and implementing a health intervention program, organizing a health services to deliver the comprehensive health care package and to ensure its effective utilization by the community at large. The core competencies required for such job will be

Basic human biology which should include social & psychological aspect, Environmental & Ecological science, Behavioural sciences, Biostatistics, Demography, Epidemiology, Management sciences, History & evolution of Health & Public Health services. The skills to be developed in a public health worker are epidemiological skill, Basic Public Health skills, Communication skills Health system management skills. The health system management skills should include skills to manage organizational, personal, material and financial issues. Addressing the health needs of the community as well as for effective functioning of a health service system, requires a seamless relationship between different type of service institutions like hospitals and the community based service programs requiring communities participation and the support and coordination of other departments related to human development. As such the public health worker should also have the ability to interact with the public as well as other service providers.

At present all the existing health work force is providing both the personal and public health care. Can one believe that the main players of the personal care service providers are also providing a complex package of public health service all throughout the country and implementing health programs galore including NRHM? With the non existence (in most of the states) of Male Health worker the Female Health worker is the key worker most inadequately supported by a dwindling species of Lady Health Visitors (in many a states and if at all they are mostly untrained promoted on attaining a service seniority) and the so called Public Health nurses. The poor medical officer is blamed. But please examine the support he is getting in providing a community based public health services. While for providing institution based Clinical care he has the option to have the support of Nurse, Pharmacist, laboratory technician, OT technician, Blood bank technician, CT technician and hordes of others but in public health none except a Computer and a Block extension educator under the Family welfare program. They too are not formally trained. No one has to do another multi-centric study under the aegis of ICMR or the Planning commission to find out the inadequacies of a dedicated public Health work force. This is evident as it exists today in our health services. This is because of our ignorance of the exact nature and scope of public health and an "ostrich" like attitude for not listening to others' views on the issue. Understanding the basic difference between the two and appreciating the necessity of these complimentary approaches to improve the health services will be epoch making step in ameliorating the ruts afflicting the health care delivery system and lead to fulfill the MDG goal as well as make the definition of Public Health as achievable.

Dr Sanjay's explanantion for modification:

reservations and explanation: **(based on Winslow's definition):**

Winslow inherited a lot. **Will it be rational (or scientific) and fair to 'totemize' a whole heritage with one name? Emancipation from a Eurocentric discourse** may have other ideas and options too. Lingual structure and framework do not belong to an individual. An if that has been a tradition, it needs to be stopped. **Winslow's work should be referred to, instead.**

....and be economically active life, ...:
Why place a premium on 'economical' alone – and trap ourselves?

...every citizen.....:
Citizen is a loaded word. Public health should aim to reach out to **non-citizen** as well. To **non-people** (not people like us) as well.

... to educate people...:
Betrays a patronizing sentiment. Empowering may be a better word.

SOCHARA's explanation for modifications:

We would also agree that we should not only refer to Winslow's definition, but to others as well. While putting another document together from various sources (see document "public health definition database"), we also felt the need to review two other terms that are now commonly being used in public health circles, sometimes synonymously and sometimes with clarity of understanding of the subtle difference. These are the "new public health" and "community health". While reviewing these we discovered that both Farooque and Sanjay have already introduced these newer ideas and concepts, but there are three additions we would like to suggest to locate the definition in today's context.

The first is to add the concept of both "rights and responsibilities" taking from the newer community health and new public health definitions.

The second is to add "economic/political/ecological" when we mention "social and cultural realities". You will recall, that this was accepted in the WHO SEARO meeting of Epidemiologists in the region in February 2009 when they accepted in the declaration of the meeting and added the following:

"The scope and reach of epidemiology, which is an integral part of public health must be expanded to include the study of social, cultural, economic, environmental, ecological and political determinants of health, and constitute the key stone for use of evidence for development of public health policy."

The third is to add "ethical and socially relevant" when we describe the system and not just make it "universal, distributed equitably and affordable".

The fourth is to add words like "formulating/facilitating" rather than "delivering" to ensure that we are less "top-down" and more process oriented, or bottoms-up in our policy making.

The fifth is to question whether "accessible to all at an affordable cost", is an acceptance of today's economic policy since the Bhore committee had used "irrespective of their ability to pay". If IPHA is committed to "Health for All" and not "Health for those who can pay" we have to change this phrase as well.

While we are happy to move beyond Winslow's definition – we would like to emphasise that the original definition also had an additional phrase which was – "informed choices of society/organisation, public and private, communities and individuals". I feel this phrase emphasising both "informed choice" which is evidence driven rather than idea, opinion or emotion driven, is very important in today's public health policy evolution. The same phrase also shows the diversities of sectors – government, private and civil/community which emphasises partnerships. We need to consider this aspect as well.

Public Health Definitions

Public Health (International Association of Epidemiology dictionary – JM Last, 1983)
Public Health is one of the efforts organized by society to protect, promote, and restore the peoples' health. It is the combination of sciences, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services, and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death, and disease-produced discomfort and disability in the population. (Public health is thus a social institution, a discipline, and a practice).
Available from: http://www.merriam-webster.com/dictionary/public+health?show=0&t=1317192822

Public health: the art and science dealing with the protection and improvement of community health by organized community effort and including preventive medicine and sanitary and social science
Available from: http://medical-dictionary.thefreedictionary.com/public+health

Public Health (pŭb´ lĭk)
The science and practice of protecting and improving the health of a community, as by preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards.

Source: The American Heritage® Medical Dictionary Copyright © 2007, 2004 by Houghton Mifflin Company. Published by Houghton Mifflin Company. All rights reserved.

Public Health
a field of medicine that deals with the physical and mental health of the community, particularly in such areas as water supply, waste disposal, air pollution, and food safety. In the United States there are more than 3000 state, county, or city public health agencies. The U.S. Public Health Service was organized in 1798 to provide hospital care for American merchant seamen. Subsequent legislation has expanded the role of the federal agency to include such services as the Food and Drug Administration; the National Library of Medicine; health care for Native Americans and Alaska Natives; protection against impure and unsafe foods, drugs, cosmetics, and medical devices; control of alcohol and drug abuse; and protection against unsafe radiation-producing projects.
Source: Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

Public Health
the field of health science that is concerned with safeguarding and improving the physical, mental, and social well-being of the community as a whole. The UNITED STATES PUBLIC HEALTH SERVICE (USPHS) is a federal health agency that is part of the United States Department of Health and Human Services. State and county public health agencies function under the supervision of and with financial support from the Department of Health and Human Services.

Public Health Nursing the branch of nursing concerned with providing nursing care and health guidance to individuals, families, and other population groups in settings such as the home, school, workplace, and other community settings such as medical and health centers. The nurse in this field, a COMMUNITY HEALTH NURSE, must have a baccalaureate degree and training in public health nursing theory and practice; employment is typically with a local agency such as a nonprofit proprietary organization or with an agency under the United States Department of Health and Human Services. The work involves implementing such programs as school and preschool health programs, immunization and treatment of communicable diseases, maternal and child health clinics, and home visits for the purpose of providing health education and nursing care. There is also frequent participation in educational programs for nurses, allied professional workers, and civic organizations, and involvement in studying, planning, formulating public policy, and putting into action local and national health programs.

Source: Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition. © 2003 by Saunders, an imprint of Elsevier, Inc. All rights reserved.

Public Health: In a field of medicine that deals with the physical and mental health of the community, particularly in such areas as water supply, waste disposal, air pollution, and food safety.
Source: Mosby's Dental Dictionary, 2nd edition. © 2008 Elsevier, Inc. All rights reserved.

Public Health: The field of human medicine that is concerned with safeguarding and improving the physical, mental and social well-being of the community as a whole. There are marginal roles for veterinarians in this service, especially in the area of zoonoses.
Source: Saunders Comprehensive Veterinary Dictionary, 3 ed. © 2007 Elsevier, Inc. All rights reserved
http://www.medterms.com/script/main/art.asp?articlekey=5120

Public health: The approach to medicine that is concerned with the health of the community as a whole. Public health is community health. It has been said that: "Health care is vital to all of us some of the time, but public health is vital to all of us all of the time."

The mission of public health is to "fulfill society's interest in assuring conditions in which people can be healthy." The three core public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
- The formulation of public policies designed to solve identified local and national health problems and priorities;
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care.
  http://en.wikipedia.org/wiki/Public_health

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals"
Available From: http://www.whatispublichealth.org/

NEW PUBLIC HEALTH
A new public health approach would therefore not only move from its present "behavioural epidemiology" and "surveillance" mode to a more environmental and social approach, but would aim to tackle the risk patterns of our societies with new basic assumptions.
Source; http://heapro.oxfordjournals.org/content/4/4/265.extract [Ilona Kickbusch. Approaches to an ecological base for public health. Health promotion. Vol 4, no.4, 265]

By the early 1990s, there was general agreement within the public health community that health promotion, based on the Ottawa Charter principles, constituted the "new public health."13,14 Yet analysis of the health promotion framework reveals the legacies of previous eras, thus prompting the question, "What's new about the 'new public health'?" In addressing this question, I demonstrate that original health promotion innovations, and the legacies of previous eras, are "new" in the sense that the latter have been revised in the light of advances in knowledge, increasing concerns about human rights, and emerging threats to health.
What is new about the new public health is not the originality of strategies to ensure healthy conditions, but the manner in which health promotion discourse has adapted core doctrines of previous eras to address the public health threats of our era. New public health eras usually arise when the dominant public health framework becomes obsolete as a result of changing health patterns and advances in health knowledge. Currently, public health theorists and commentators appear to be losing confidence in the capacity of the health promotion paradigm to effectively address major contemporary public health threats, such as health inequalities and terrorism. Source: Niyi Awofeso, What's new about new public health? Am J Public Health. 2004 May; 94(5): 705–709. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448321/

The New Public Health is derived from the experience of history. Organized activity to prevent disease and promote health had to be relearned from the ancient and post-industrial revolution worlds. As the 20th century draws to a close, we need to learn from a wider framework how to use all health modalities, including clinical and prevention-oriented services to effectively and economically preserve, protect and promote the health of the individual and of society. The New Public Health, as public health did in the past, faces ethical issues that relate to health expenditures, priorities and social philosophy. Throughout the course of this book, we discuss these issues, and try to indicate a balanced approach toward the New Public Health.
http://www.google.co.in/url?sa=t&source=web&cd=7&ved=0CHoQFjAG&url=http%3A%2F%2Fwww.elsevierdirect.com%2Fcompanions%2F9780123708908%2Fcasestudies%2FNPH%2520Teaching%2520guide.doc&ei=1vabTpyJM4L5rQe_jOGmBA&usg=AFQjCNGe5gDqWWUyh-KKzGq6CXNUS6YcDQ&sig2=_ZRgFTzmz3biGlHYJFFrHw

"The New Public Health is not so much a concept as it is a philosophy which endeavors to broaden the older understanding of public health so that, for example, it includes the health of the individual in addition to the health of populations, and seeks to address such contemporary health issues as are concerned with equitable access to health services, the environment, political governance and social and economic development. It seeks to put health in the development framework to ensure that health is protected in public policy. Above all, the New Public Health is concerned with action. It is concerned with finding a blueprint to address many of the burning issues of our time, but also with identifying implementable strategies in the endeavor to solve these problems." [Ncaayiyana D, Goldstein G, Yach D. New Public Health and the WHO's Ninth General Program of Work: A discussion Paper. Geneva: World Health Organization, 1995.]

Defining new public health (NPH):
The NPH is a comprehensive approach to protecting and promoting the health status of the individual and the society, based on a balance of sanitary, environmental, health promotion, personal and community oriented preventive services, coordinated with a wide range of curative, rehabilitative and long term care services.
The NPH requires an organized context of national, regional and local governmental and non-governmental programs with the object of creating healthful social, nutritional and physical environmental conditions. The content, quality, organization and management of component services and programs are all vital to its successful implementation.

The NPH is based on responsibility and accountability for defined populations in which financial systems promote achievement of these targets through effective and efficient management, and cost-effective use of financial, human and other resources. It requires continuous monitoring of epidemiological, economic and social aspects of health status as an integral part of the process of management, evaluation and planning for improved health.
The NPH provides a framework for industrialized and developing countries, as well as countries in political-economic transition such as those of the former Soviet system. They are at different stages of economic, epidemiologic and socio-political development, each attempting to assure adequate health for its population with limited resources

Additional Reading:

1. Ahmed FU. Defining public health. Indian Journal Public Health 2011;55:241-5 Available from: http://www.ijph.in/text.asp?2011/55/4/241/92397 accessed on 28th December 2012.

Public Health competencies for health professionals in India-

(Developed for Indian public Health Association (IPHA) Supported by World Health Organisation (WHO) - Country Office for India)

Several documents on public health competencies were reviewed from Indian and foreign institutions and universities. Contact was maintained with other members working on this project, and their feedback was considered. A potential list of core and cross-cutting competencies was prepared and dispatched for peer-review and comments:

Core competencies:

1. Health planning
2. Epidemiological skills
3. Family and community diagnosis
4. Health management (including financial management)
5. Managing and implementing health programmes (including program planning)
6. Monitoring and evaluation (including health surveillance)
7. Health promotion (including prevention and protection)
8. Training
9. Research (including biostatistics and demography)
10. Working with community (including community dimensions of practice)
11. Partnership and advocacy
12. Public health laws and ethics
13. Public health biology competency
14. Environmental health competency

Cross cutting:

1. Critical analysis and systems thinking (including problem solving)
2. Socio-cultural competency (including all social and behavioural sciences like economics and political sciences)
3. Leadership
4. Communication (including informatics)
5. Life-long learning
6. Equity
7. Human resource development
8. Policy and advocacy
9. Governance and decentralisation
10. Conflict resolution

Convergence and hierarchy of levels of public health competencies

An ad-hoc assessment was also made on the degree and type of competencies needed at each level of education. This comparison was made to clarify that competencies may be shared between various types and levels of education, but competencies may be of differing levels.

Comparative competencies and degree/level of competencies for the Indian scenario:

Competency	MBBS (PSM/CM)	MD-PSM (Consultant)	MPH (Practitioner)	MHA /MSc
CORE				
Health planning	+	+++	++	
Epidemiological skills	+	+++	+++	
Family and community diagnosis	++	+++	-	

Health management (including financial management)	+	+++	++	
Managing and implementing health programmes (including program planning)	+	+++	+++	
Monitoring and evaluation (including health surveillance)	+	+++	+++	
Health promotion (including prevention and protection)	++	+++	+++	
Training	+	+++	+++	
Research (including biostatistics and demography)	+	+++	++	
Working with community (including community dimensions of practice)	++	+++	+++	
Partnership and advocacy	+	+++	+++	
Public health laws and ethics	+	+++	+++	
Public health biology competency	++	+++	+	
Environmental health competency	+	+++	++	
CROSS-CUTTING				
Critical analysis and systems thinking (including problem solving)	+	+++	+++	
Socio-cultural competency (including all social and behavioural sciences like economics and political sciences)	+	+++	++	
Leadership	+	+++	+++	
Communication (including informatics)	++	+++	+++	
Life-long learning	+	+++	++	
Equity	+	+++	+++	
Human resource development	+	+++	++	
Policy and advocacy	+	+++	++	
Governance and decentralisation	+	+++	+++	
Conflict resolution	+	+++	+++	

Key:

+: basic understanding (public health oriented general practitioner)

++: basic understanding and skill/capacity for practice (public health practitioners)

+++: advanced understanding for both practice and system-development (public health consultants)

(this applies only to MBBS, MPH and MD. Special masters programmes for example MSc Epidemiology, MSc Health Promotion, MSc Health Services Management, MSc Health Policy and Planning etc may be specialist enough to produce consultants for system-development in those areas)

Beijing Statement from the Second Global Symposium on Health Systems Research

3 November, 2012 Beijing, China

From 31 October to 3 November, 2012, 1,775 participants from over 110 countries gathered in Beijing, China for the Second Global Symposium on health systems research. Around the theme of inclusion and innovation towards Universal Health Coverage (UHC), the Second Symposium reviewed state-of-the art research and discussed strategies for strengthening the field of health systems research. Over four days comprising nearly 200 program events including keynotes, plenaries, concurrent sessions, satellites, posters, films and informal discussions and debates, the following action points related to the inclusion and innovation themes have emerged:

- In our endeavor to achieve UHC, we must ensure the centrality of social and gender equity. UHC is not only a health system's task but a societal goal that requires inclusion of diverse actors, different types of knowledge and innovation across local, district, national, regional and global contexts.
- Effective inclusion recognises the paramount priority of the collective development of indicators that can be used to monitor countries' progress towards the goal of UHC, as well as being used by civil society to hold governments accountable. Such measures must be relevant to local and national contexts, first and foremost, and amenable to global comparisons.
- Most urgently, local capacities for critical health systems' analysis is required for individual countries to understand what aspects of their health systems (in terms of service delivery, financing and governance) require change so as to make real progress to UHC with equity.
- The social, methodological and technical innovations shared in this Symposium provide a well-spring of knowledge and an enormous opportunity, provided they can be appropriately integrated to bring about systemic change to accelerate progress towards UHC.

Key ideas for action that have emerged related to the objectives of the program include:

- The cutting edge of health systems research should be advanced by supporting analysis of politics and policy; community action interventions; fiscal innovations; equity oriented health metrics; and Longitudinal methods to capture dynamism and long-term impact of interventions.
- Symposium participants want more research on: social inequalities in health, including urbanisation and ageing; social exclusion; governance; and the balance of sectors, including informal, private, and public.
- The development of social science methodologies, health metrics and monitoring and evaluation systems in a balanced manner should be encouraged in order to appreciate the complexity of health systems, policies and implementation processes and capture their historical origins, current status and future long-term impacts.
- Other innovations that warrant support include strengthened data surveillance systems; better documentation of financial flows at all levels; nesting research and incorporation of knowledge uptake in research design for improved monitoring and accountability, including by communities, in implementation of UHC.
- Knowledge translation should be facilitated by developing communities of practice and trust between researchers, practitioners and policymakers; drawing from multiple sources of knowledge and

evidence, including real-world experiences; strengthening open-access databases; and enhancing South-South exchange of innovations to achieve UHC.

- Long term and public financing for public research institutions for health systems research is desired. Interest groups and partnerships should be supported for various forms of training in health systems research, that include communication, values, power relations and context analysis as capacities at all levels.

We note with pride some accomplishments of key milestones committed to in Montreux, 2010

1. The launch of the WHO Strategy on Health Policy and Systems Research represents a significant step forward for the field. It calls for increasing the relevance and utility of Health Systems Research by making it more demand driven. It suggests options for action by member states to embed research into decision-making to ensure that HPSR is grounded in political realities and at the same time, the grounding of policy processes in evidence and science.

2. The creation of a first international society for health systems research. With more than 1400 members and 11 newly elected board members, Health Systems Global held its first Board and Annual General Meeting and began on its path to catalyse and convene its membership to strengthen the field health systems research in the pursuit of more just and equitable health systems.

3. Furthermore to meet the expectation, clearly expressed in Montreux, that HSR inform policies more systematically, participants contributed to the first meetings of the global consultation on health in the post-2015 development agenda as part of the United Nations Secretary General's High-Level Panel process. Understanding how to build on the MDGs, address emerging issues, measuring new goals, and linking these to accountability mechanisms relevant to each country requires continued contributions by the health systems research community.

In support of the Symposium themes and recommendations, funders expressed broad support for the establishment of a new mechanism, a Research Consortium for UHC (RC UHC), to improve the coordination of resources to accelerate the knowledge and know-how for universal health coverage. With a committed core of funders and a clear agenda for research, the development and operationalization of RC UHC will be finalized and launched in 2013.

In 2014, we will gather for a Third Global Symposium on Health Systems Research to continue to evaluate progress, share insights and recalibrate the agenda of science to accelerate universal health coverage. Following a call for proposals, applications from South Africa and Canada, are being reviewed by the Board of HS Global with a decision expected by the end of 2012.

Approved by the Executive Committee of the Second Global Symposium on Health Systems Research

Contribution to The Beijing Statement of the Second Global Symposium on health systems research

Best idea provided for action form the sessions in one of the six areas that are most relevant to the session.

A. Knowledge Translation

1. Poorest countries are taking steps for improving access but the steps differ significantly across countries- from introduction to national health insurance to more active role of private sector. (5)

2. Grass root level capacity to deliver basic health care so there is support for health reform(15)
3. i. A new proposal on parallel importation rule- important to explore who should be more protected- innovations or poor people.
   ii. Proposal on material to train communities on advertisement assessment. (18)
4. Written information needs to be combined with real world experience. (21)
5. Tax based financing is the way. Institutions like NHSO Thailand with good capacity are crucial. Private Insurance contracting is increasing the administrative cost has produced mixed results in terms of UHC or ethics.(26)
6. Market failures and state failures would therefore require new forms of PPP as practical and pragmatic relations. (27)
7. Support the ongoing enhancements to and use of one stop shops for synthesized research evidence,, such as Cochrane library for questions about public health programme and services, and health systems evidence for questions about health systems arrangements and information strategies. (30)
8. Opportunities exist to strengthen the contributions of HSR
   i. Supporting HSR as a scientific endeavor.
   ii. Build National capacity for HSR
   iii. Embedding HSR as a core function of Health Systems. (33)
9. KT is not about translating research to policy. It is also about translating problems into good research questions. (61)
10. To establish communities of practice to link researchers, funders and policy makers on areas of core interest. (66)
11. i. Relationships are key (long term trust)
    ii. Decision maker involvement throughout is needed. (69)
12. Expanding population coverage is not enough- financial package also needs to be expanded. (88)
13. More investment in strengthening capacities of decision makers to demand and use evidence. (109)
14. More research needed to measure potentially inappropriate medication or PIMS and better policies required for meeting the cost of MCD in LIMC's. UHC as a concept when translated into policy and programmes tends exclude groups like elderly and health problems like NCD. (117)
15. Researchers and policy makers need to appreciate each other's role and work together. (118)
16. South south exchange of health systems innovation to achieve UHC works. (122)

B. State of the Art research on the health systems research

1. Need to further develop theory and models to better understand how health systems approaches can be fine tuned to ensure maximum impact on the diagonal. (3)
2. Out of pocket expenses have affected poverty levels in countries, policy options needed to reduce the negative effects of catastrophic out of pocket expenditure. (5)
3. That the intersection of fiscal analysis and political connections is poorly understood. (8)
4. It is important to examine the role and efficiency of community programm's on health outcomes. (12)
5. i. Efficiency of grass roots institutions
   ii. Motivate medical Professional. (15)
6. Indicators used on the World health organization packages- they are widely used, it is important to invest continuously on their improvement. (18)
7. Longitudinal Methods are valuable in capturing the dynamics and complexity of health policy and systems development. (68)
8. Give enough time for high quality evaluation of innovations. (105)

9. Responsiveness and effectiveness studies are badly needed to address the problems. (115)
10. Health System tends to commit medication related errors in case of treating elderly. Measuring potentially inappropriate medications or PIMS is important. PIMS index is state of the Art research to make health system provide appropriate treatment to elderly. (117)
11. Developing a framework to monitor and evaluate the health systems effects of performance based financing. (120)

C. Health systems research methodologies

1. Evidence on Impact of Health insurance is limited but promising. We need better M&E system to improve the evidence quickly. (7)
2. WHO Building Blocks is only a starting point, but should not be used as research framework when looking at health systems strengthening of interventions. (9)
3. Aligning health metrics is beneficial, doable and can/should be a scientific and inclusive process. (11)
4. i. Policy research focusing on capacity building, (human resource for Health)
   ii. Research on urbanization and ageing. (15)
5. Very important to Offer training on methods and on research communications. Presenters missed to address important methods features. (18)
6. Need to develop better mixed methods on the causes of performance shortfalls linked to health finance and delivery. (20)
7. Further Encourage the development of qualitative or mixed methods approaches that better describe and evaluate policy programmes formulation and implementation process. (22)
8. More have to be studied regarding balance of public- private- people (non profit) sectors. (27)
9. Scale up methodologies can have an enormous impact on health systems. Different frameworks can help identify where the particular contributions have the most potential impact. (62)
10. Be critical and Challenge the assumptions behind research methods. (74)
11. Use of training in research applications and skills. (90)
12. Methodology of measuring medical expenditure for NCD's at OPD level; and measurement of improvement due to OPD medical expenditures. (117)
13. Importance of increased focus on social value judgments again as priority affairs framework for multicriteria analysis tool. (119)
14. Robust and Comparable measures of UHC are paramount to informing and monitoring progress towards UHC it must be measurable at country level as well as globally. Practitioners are encouraged to contribute to papers to this website www.wewanttohearfromyou.org. (109)

D. Innovations in Health Systems Research

1. Monitoring effective coverage holding systems accountable (6)
2. Grass root level institutions providing essential health package- basic health services for all! Social governance. (15)
3. No Sound innovations on research but nice to see more and more people involved into research and implementing controlled experiences. (18)
4. We need more examples of how systems thinking can be applied in research and practice in LMIC's. ((56)
5. To develop a community of practice that links researchers, practitioners and policy makers conducting social research analysis. (70)

6. Using Innovative approaches to strengthen data survey systems in presence can improve health system. (86)
7. Improving service delivery performance by assessing performance- A must!. (115)
8. Using PIMS Index to ensure appropriate medication thereby brining down morbidity and motivating due to high risk medication. (117)

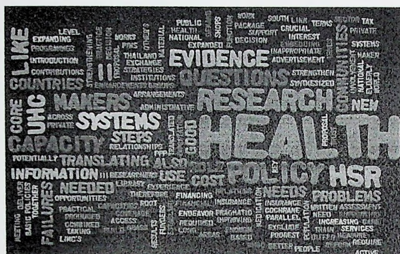
E. Neglected priorities or population groups in health systems research

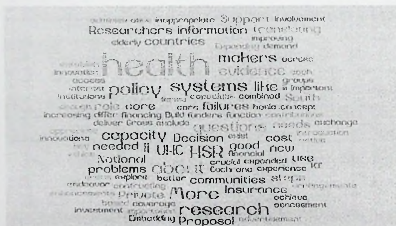
1. Critical to emphasize health promotion and prevention in UHC. (1)
2. Targeting is challenging but not doing so is even worse. (4)
3. Single MDG for health –UHC, rather than specific ones as health needs are so diverse. (10)
4. Accelerate UHC+ Essential drugs+ Grass Roots/ Model for UHC with PHC reforms (CHINA). (14)
5. Increased reimbursement rates for vulnerable populations. (15)
6. Important inequalities in service rise are wide spread and deserve explicit attention. (17)
7. This panel addressed groups generally neglected- women, poor people. It is why it is important to empower these representations on research methods. (18)
8. Not enough with going to universal health coverage without taking equity into account and prioritizing it in the pathway of UHC. (32)
9. Case studies and Cross analysis of using tanahashi for district level reduction of health inequities. (59)
10. New journal on infectious disease of poverty that covers health systems and other research areas- a multi disciplinary approach. (91)
11. More efforts and attention have been exerted to the disadvantaged groups however wastes are also an outstanding issue, worsening inefficiencies. (112)
12. Demand Side strategy Assessments. (115)
13. Training in applied state of the art longitudinal methods for generating valid evidence as impacts of changes in health systems. (116)
14. Elderly as a group is neglected in the health systems of low and middle income similarly NCD's are out of health systems of these countries. (117)

F. Financing and capacity building for health systems research

1. Universal Insurance systems through increased budget! (15)
2. Health finance Diaries are an innovative tool for more accurately capturing small frequent outpatient expenditures. (16)
3. Financing Should Include capacity building on research. (18)
4. That HSPR capacity building while being of national policy relevant through joint partnerships between South and South, north and north, University and Ministry of health for PhD and other forms of training. (55)
5. ii. Workshops (at national Level + marginal) of scenario building, applied learning for district level managers on using tanahashi for identifying barriers to UHC. (59)
6. Communication, values, power relations, qualitative methods and context analysis to be included as themes/ capacities in capacity building initiatives for health research and all levels. (100)
7. Meeting the financial burden of Burden of NCD is a challenge which needs multiple options to financing the management of NCD's. (117)
8. This session focused on financing challenges - seeing 7 countries in their path towards universal health coverage. (131)

Contribution to The Beijing Statement word clouds (all text)





Towards a Community Oriented Public Health System Development in Karnataka

by

Mission Group on Public Health

December, 2012

Karnataka Jnana Aayoga
(Karnataka Knowledge Commission)
Government of Karnataka

www.jnanaayoga.in

FOREWORD

The Mission Group on Public Health of the Karnataka Jnana Ayoga (Karnataka Knowledge Commission) was entrusted the task of making a situation analysis of public health challenges and systems in Karnataka and suggest appropriate recommendations for action. The Mission Group undertook the task by evolving a Public Health Charter. The Charter envisioned Public Health Policy which encompass many aspects which impact on the well being of people of Karnataka. The Charter also recognizes that 'Public Health' is not just a set of medical interventions at community level but has a larger connotation of action that addresses the mental, environmental, nutritional, social and cultural determinants of health. The Charter also focused on capacity building, governance, inter-sectoral action, pluralism and integration, communitization and alertness to emerging health challenges.

For arriving at such a strong and viable Public Health Policy within the framework of the Charter, the Mission Group held several consultative meetings with experts across all disciplines and sectors in health through a stakeholder's consultation that included. Primary health care workers, urban and rural health NGOs, civil society organizations working on rational drug policy, violence against women, child and maternal malnutrition and public health experts and consultants who have participated in in-depth deliberations and gave their suggestions. These deliberations resulted in some key initiatives and a consensus outlined in this report. These key initiatives included free and universal access to medicines; development of urban primary health policy; promoting medical pluralism in public health; strengthening public health human resource development and addressing the emerging challenge of chronic diseases through a community oriented approach.

The major concern of the Group was the increasing challenge of multi-sectoral action and convergence of the State's efforts to provide food, water, sanitation and initiatives for development of women and children so that public health gets a real boost in the State. The development of a strong and responsive public health system is thus an urgent policy imperative if Karnataka has to move towards the emerging goal of Universal Health Coverage within the vision of Health for All. We hope the Charter and suggested action thrusts will facilitate the journey of the State towards these goals.

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A STATE PUBLIC HEALTH CHARTER

The Karnataka State Task Force on Health and Family Welfare considered the following definition by the Association of Epidemiologists as the frame work for public health system development.

"Public Health is one of the efforts organised by society to protect, promote and restore people's health. It is the combination of services, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social actions. The programs, services and institutions involved emphasize the prevention of disease and the health needs of the population on the whole. Public Health activities change with changing technology and social values, but the goals remain the same; to reduce the amount of disease, premature death and discomfort of diseases in the population"

The Task Force also emphasized the following principles when considering Public Health System development in the State. These included:

1. **State's primary responsibility for Health and Health Care**
2. **Recognizing the political economy of public health system development and the challenge of access and universality**
3. **The challenge of Inter-sectoral action including safe water supply, sanitation and nutrition**
4. **The Primary Health Care approach to infectious disease and non-communicable disease control**
5. **The focus on Equity and Social Justice in health and health care**
6. **The convergence of AYUSH, LHTs and the Public Health System**

The Mission Group on Public Health endorsed the above definition and principles and held many deliberations to evolve the following Public Health Charter:

The Public Health Charter for Karnataka

Building on the historic Public Health consciousness in the State which has been neglected and distorted in recent years, the State has to evolve policies and programs based on recommendations of the taskforce to cover the following challenges and system development issues outlined in this Public Health Charter.

Through the Public Health Charter, the Karnataka State will continue to develop a comprehensive, integrated Public Health System that will be committed to the following values: **Equity, Quality** and **Integrity** emphasized by the earlier Taskforce and **Communitization, Pluralism, Gender Sensitivity** and **Accountability** added by the current Mission Group.

The existing system will be further strengthened by initiatives in the following six dimensions:

1. **Public Health – Capacity building**
   - The State will evolve and establish a **Public Health Cadre** to strengthen the capacity of the health system particularly focusing on the district and beyond.
   - The state will develop a **HRD unit in Health Department** which will rationalize the functions, salaries, promotions and transfers and also focus on capacity development and continuing education of all cadres.
   - The State will promote a **School of Public Health** to strengthen public health capacity and skills at all levels from district level health administrators to ANM's and ASHA's. This will enhance the development of evidence based policies, strengthen institutional capacities and human resources, promote health promotion, public health regulations and research towards the goal for Health for All.

2. **Public Health – Governance**
   - The State will evolve mechanisms of **Accountability and Transparency** in all its public health programs and campaigns.
   - The State will **enhance governance** and supervision of peripheral Public Health care systems with a special focus on **decentralization and partnership with Panchayat Raj Institutions**.
   - The State will promote **community participation** in all its programs and also enhance the role of **community in monitoring** and providing feedback through the **Communitization** process now evolved by the National Rural Health Mission.

- To enhance outreach and access, within the public health system the State in **partnership with NGOs and private sector will promote values of equity, social justice** and strengthen the government's role towards 'Health for All' without compromising the constitutional mandate and taking care to prevent market distortions of such partnerships.

3. **Public Health – Inter-sectoral action**
   - **Nutrition**: The State will tackle the increasing malnutrition challenges using inter-sectoral and multi-disciplinary approaches that address the problem from grass root level upwards by strengthening the public distribution systems and food security, food and agricultural policy, anganwadi and school feeding programs, individual and community nutrition education and health promotion campaigns.

   - **Safe water supply**: The State will promoting safe water supply and mechanisms to apply standards for water quality at all levels using appropriate technology to enhance access and purification of water, while preventing commercialization and commodification of water.

   - **Sanitation Campaigns:**
     - ➢ The State will support the recently announced **Total Sanitation Abhiyan** and enhance promotion of sanitation with the focus on schools, meeting halls, bus stands and public places even as individual house and communities are encouraged to adapt sanitation systems.
     - ➢ While promoting sanitation, the State will also take steps to:
       - **Abolish manual scavenging** in State
       - Strengthen measures to enhance the **Health of Pourakarmikas**

4. **Public Health-Response to some current health system challenges**
   - The State will enhance the **access to Free Medicines** for Primary Health Care throughout the State by adopting an essential medicines list, rationalizing logistics of medicine warehousing and distribution mechanisms, promoting rational medicine prescribing and policy initiatives and tacking some of the obstacles to universalizing access to medicines.

- The State will evolve an **urban primary health charter** that will focus on multi-sectoral services integrated through a primary health care approach focusing on women and children's health, violence against women. The Charter should include access to basic health services, mental health and other emerging urban health challenges.

- The State will adopt the newly announced national program for non-communicable diseases and enhance the **primary health care approach to chronic diseases** with focus on management and re-orientation of personnel, providing support and upgrading services, improving HMIS, building new partnerships and strengthening operational research.

- The State will enhance **healthy life style promotion** as part of the youth oriented policies of the State while simultaneously linking it to **health promotion and education against substance abuse.**

5. **Public Health – Promoting pluralism and Integration**
   - The State will evolve **Accreditation and Certification System for local Health Practitioners and Knowledgeable Women** involving Universities such as IGNOU to support Traditional /Community Knowledge Systems.

   - The State will promote **Public Health Orientation and Training for all AYUSH Health Personnel** starting with government sector and later offering it to private registered medical practitioners as well as including community supported LH practitioners on voluntary basis.

   - The State will **strengthen Swasthya Vritta Programme** presently being experimented in five districts and enlarge this program to cover the whole State gradually. It will also draw upon the health promoting traditions of other system as well.

   - The State will **strengthen Yoga awareness and skills through Health Promotion** in School and college curriculum.

- The State will **strengthen community health and knowledge practices related to food and dietary practices** using traditional knowledge and practices for promoting healthy nutritional status.

- The State will **strengthen documentation of clinical outcomes in AYUSH** sector including LHTs at all levels by introducing a standardized system.

6. **Public health – Strengthening HMIS and Knowledge translation**
   - The State will further strengthen the **Health Information system** by providing universal access to available information to all categories of users by removing the present imbalance between providers and users.

   - The State will adopt and enhance **e-governance within public health system** at all levels.

   - The State in collaboration of the Health Department and the evolving State GIS platform will enhance the development of **an effective health GIS.**

In conclusion, through the adoption of this six point, Public Health Charter, committed to the above values, the State will enhance the capacity of the Public Health System to handle the emerging heath problems and challenges; enhance the commitment to human resource development; enhance accountability, decentralised government, communitization and strengthen the ability of the existing system to deal with the new emerging challenges.

THE WAY FORWARD – Recommendations of MGPH-KJA

All over the country Public Health had been neglected, and underfunded post independence after an initial two decades of Policy support. Karnataka State was no exception. Since 2000 AD a revival of Public Health capacity building and system development has emerged in the country as a significant policy initiative. The first Annual Report to the People on Health by the Ministry of Health and Family Welfare, GOI presented to the Parliament on September 2010 for public discussion and debate clearly outlines the urgent need and challenge for a new public health policy by stating the following:

> ***"A new Public Health Policy needs to be drafted which will reconfigure the health system to make it more efficient and equitable,,,,,,,. Such a policy must be evolved through wide ranging consultations in which the voice of multiple segments of society are heard, unlike in the past where policies have been influenced mainly by recommendations of expert groups or international organisations. The new initiatives in health must be uniform and influenced by vigorous public debate. The consensus of national goals, emerging from such a process is likely to gain greater acceptance and ownership by professional bodies, civil society organisations, the private sector and community representatives,,,,,,,,. It is for this generation to make the choice to which road to travel".***

The National Rural Health Mission, the National and State Health Systems Resource Centres, the new chain of Public Health Institutes and courses and the recent dialogue initiated by the planning commission on Universal Health Coverage are signs of this Public Health Policy and disciplinary revival.

The tasks of public health system development in all States including Karnataka needs a multidisciplinary and multisectoral policy responce that focuses on an emerging paradigm shift constituted by the following:

- **Moving beyond a narrow biomedical and techno-managerial view to a more intersectoral, and Community Health oriented view of public health**

- **To base Public Health development on Community empowerment and system development particularly at district level and below**
- **To be practitioner oriented with close interaction and engagement with the public health system rather than an elitist, consultant orientation**

Karnataka has the multi-disciplinary and multi sectoral-institutional and human resources to make a difference. The formation of a Mission Group on Public Health by the State Knowledge Commission building on the earlier State Task Force on Health and Family Welfare is a sign of this commitment. A strong public health system is the way forward. This system as it gets evolved and operationalized must address the following system challenges outlined by a recent WHO document:

Development of evidence based public health policies

- Development of institutional capabilities for closing the gap between knowledge and practice
- Development of appropriate human resource at all levels
- Health promotion, healthy lifestyles with involvement of civil society
- Strengthening of public health regulation and health financing
- Community health based public health research
- Ability to solve complex societal problem through multidisciplinary research"

Source: WHO-SEARO

As a beginning to this public health strengthening process the Mission Group on Public Health makes the following key and additional action recommendations, details of which are outlined earlier on this report

KEY RECOMMENDATIONS:

1. UNIVERSAL ACCESS TO FREE MEDICINES:

The Karnataka State should provide universal access to free medicines in Karnataka by initiating the following six policy supported steps:

i. The Karanataka Government needs to scale up public funding on drugs from the current 6-7 % to atleast 15% of overall Government expenditure on health care.

ii. Reconfigure medicine procurement and supply chain system through a centralized procurement and decentralized distribution model

iii. All procurement of medicines should be based on essential medicine list updated every two to three years and a set of standard treatment guidelines in all public health facilities.

iv. Improve the functioning of the State Medicine Regulatory System by substantial investment in infrastructure and adequate skilled workforce.

v. Strengthen State level Capacity Building efforts including management, accounting and logistic capacities

vi. Build strong monitoring and evaluation system which monitores the procurement process to ensure that only generic medicines are procured and there is strict adherence to ethical promotion of medicines balanced by independent and continuous prescription audit in the public health facilities.

2. URBAN PRIMARY HEALTH POLICY MISSION:

The state should form an urban primary health policy mission group to evolve a public health charter which will focus on multisectoral services through a primary health care approach reaching the urban poor and marginalised specifically

i. The Urban Primary Health Policy and services will include: Access to basic services; Women's heath including violence against women; Child health; Mental Health and substance abuse; Services for marginalised including people with disabilities, aged, street children and migrants; and Intersectoral convergence

3 . AYUSH AND PUBLIC HEALTH - INTEGRATIVE MISSION

The state should evolve a integrative AYUSH and public health mission, jointly hosted by AYUSH and Health Department, that will develop a plural public health system with strong ayush convergence and involvement

This integrative commission will focus on six broad themes:

i) Creation of institutional mechanisms in the department of AYUSH to work on planning, implementation, statistics and research

ii) Training and utilization of AYUSH man power in primary health care and public health care.

iii) Inclusion of Public Health Curriculum in AYUSH institutions and AYUSH Curriculum in non AYUSH institutions at the Health University level

iv) Strengthening of primary health care by recognition of traditional healers and home remedies through state and university accreditation mechanisms including IGNOU

v) Involvement of AYUSH in Health care especially child, adolescent, reproductive and geriatric care as well as in NCD's and nutrition.

vi) Strengthening research capacity in AYUSH institutions and increasing integrated and collaborative research between AYUSH, Allopaths and modern scientists.

4. PUBLIC HEALTH CAPACITY STRENGTHENING

The State will strengthen public health capacity by evolving a state public health cadre policy, a HRD unit in the health department and a multidisciplinary state school of public health as three steps towards increasing skill, capacity and competence at all levels.

The public health oriented HRD capacity building process will include the following six steps

i. Development of a multidisciplinary state school of Public Health that will provide a range of short courses and training programmes focussing on competency based skill development and research.

ii. Development of a state public health cadre that will ultimately be multisectoral and include health professionals from medicine, nursing, dentistry, AYUSH, Pharmacy, and Social Sciences who have requisite public health qualifications.

iii. Development of an HRD unit in the health department that will strengthen and supervise all aspects of human resource development in the large team of health professionals from medical officers to ANM's deployed in the health services all over the state.

iv. Development of a training strategy to strengthen public health skills and capacities at all levels of the public health and primary health care system

v. To strengthen convergence between department s of Health and Family Welfare, Women and Child Development, Medical Education, Public Works Department, Education and Rural Development and others.

vi. Strengthening Public Health consciousness in other disciplines including social work, law, management, engineering, agriculture, environment, journalism and others.

5. PROMOTING INTEGRATED , COMMUNITY BASED MANAGEMENT OF CHRONIC ILLNESS.

Building on the existing provisions of the latest national program- National Program for Prevention and Control of Cancer, Diabetes, CVD and Stroke and through the setting up of a multidisciplinary state Technical Resource Group(TRG), the state will promote a major public health initiative focussing on the emerging non communicable disease / chronic illness epidemic.

The TRG will initiate action on the following :

i. Reorientation of health personnels from physicians to ASHA's on chronic care principles including supportive care, psychological, social and economical aspects and counselling.

ii. Providing support and upgradation through health promotion focusing on empowerment, prevention, culturally sensitive interventions and appropriate home based care.

iii. Strengthening Health Management Information Systems integrating AYUSH and process indicator aspects

iv. Partnership with local health care providers at community level and with ngo and private sector.

v. Operational research to identify the gaps in policy and implementation

vi. Evolving accreditation criteria for all levels and involving insurance schemes, and community as well as promoting inter-departmental collaboration.

Public health information Source

Websites

Achutha Menon Centre for Health Science Studies- AMCHSS

AMCHSS is a centre of excellence for public health training by the Ministry of Health and Family Welfare government of India. The centre focuses on research in the areas of non-communicable diseases, gender and health, health policy and management. AMCHSS conducts a Master of Public Health (MPH) program, Diploma in Public Health and Phd Programme.

http://www.sctimst.ac.in Accessed on 6th December 2012.

All India Drug Action Network- AIDAN

AIDAN is an independent network of several non government organizations working to increase access and improve the rational use of essential medicines. It works to promote Essential medicine Concept, for better controls on drug promotion and the provision of balanced, independent information for prescribers and consumers.

http://aidanindia.wordpress.com/ Accessed on 6th December 2012.

Communityhealth.in

Communityhealth.in is a collaborative project which aims to create a comprehensive, online resource on community health and the Health For All movement in India.

http://www.communityhealth.in Accessed on 3rd December 2012.

Catholic Health Association of India

Catholic Health Association of India is charitable, voluntary, non-profit Catholic Christian organization working with a commitment for Health For All. It promotes community health as a process of enabling the people to be collectively responsible to attain and maintain their health and demand health as a right while ensuring availability of health care of reasonable quality at reasonable cost.

http://chai-india.org Accessed on 4th December 2012.

Christian Medical Association of India-CMAI

CMAI is the non-profit registered organization and a health arm of national council of churches in India. They undertake programmes in training, research, community service, policy advocacy, information dissemination and others.

http://www.cmai.org Accessed on 6th December 2012.

Health Systems Research India- initiative-HSRII

HSRII is a network of public health professionals and works towards collating and assimilating health knowledge to strengthen health system development. HSRII engages experts in the field of public health, epidemiology and social science, law etc, who would help towards managing or initiating challenging tasks that would benefit population at large. They intend to put together a team of young and experienced

people drawn from diverse background with hands on working knowledge in health.

http://groups.google.co.in/group/hsri-india
http://hsriindia.blogspot.in/ Accessed on 3rd December 2012.

Indian Association of preventive and Social Medicine- IAPSM

IAPSM provides a forum for the regular exchange of views & information on education, research, and programs of Community Medicine and is dedicated to the promotion of public health. It works towards improving teaching standards of Preventive and Social Medicine at all levels. They also publish a peer reviewed quarterly journal.

http://www.iapsm.org Accessed on 6th December 2012.

Indian Clinical epidemiology Network – IndiaClen.

Indiaclen is a network of Academic Health Care researchers across 135 Medical colleges/Institutions in India including IPEN. It is dedicated to improving the health by promoting clinical practice based on the b[illegible] evidence of effectiveness and the efficient use of resources.

http://indiaclen.org Accessed on 4th December 2012.

Indian Institute of Health Management and Research -IIHMR

IIHMR is dedicated to the improvement in standards of health through better management of health care and related programs. It works extensively on capacity building of health professionals to effectively manage health services at the national, global level and to disseminate latest knowledge and management technology in India and other developing countries.

http://www.iihmr.org Accessed on 6th December 2012.

Institute of Public Health -IPH

The Institute of Public Health, Bangalore is a public health research and training institute based in Bangalore, India. IPH is a value based, community-oriented public health institute, involved in the entire gamut of public health activities- training, research, consultancy and advocacy. The institute is also involved in IP[illegible] formed a consortium of five organisations, [Institute of Public Health, Bangalore (IPH); Centre for Global Health Research, Bangalore (CGHR); Centre for Leadership and Management in Public Services (C-LAMPS); Institute of Health Management and Research (IHMR), Bangalore; Karuna Trust (KT); and Karnataka Health Promotion trust (KHPT)] called Swasthya Karnataka (SK) which aims to improve the management capacity at a district and sub district level.

http://www.iphindia.org Accessed on 3rd December 2012.

Indian Public Health Association-IPHA

IPHA works towards promotion and advancement of public health and allied sciences in India. They hold annual convention and periodic meetings or conferences. They publish a Scientific Journal, specially adapted to the needs of the administrators, programme managers and research workers in the field of public health in India.

http://www.iphaonline.org Accessed on 6th December 2012.

Jan Swasthya Abhiyan- JSA

The Jan Swasthya Abhiyan is the Indian circle of the People's Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health. JSA is a coalition of networks and organisations as well of individuals who have endorsed the Indian People's Health Charter.
http://www.phm-india.org

Medico Friend Circle-mfc

Medico Friend Circle is a nation-wide platform of secular, pluralist, and pro–people, pro-poor health practitioners, scientists and social activists interested in the health problems of the people of India.

http://www.mfcindia.org Accessed on 6th December 2012.

Public Health in India

A group of 1000 + members on face book. It is a platform for discussions in Public Health, technical guidance, advocacy and information.

https://www.facebook.com/groups/publichealthindia/ Accessed on 3rd December 2012.

Voluntary Health Association of India-VHAI

VHAI is a non-profit, registered society and one of the largest health and development networks promoting health issue of human right and development. It advocates people-centered policies and support innovative health and development programmes at the grassroots with the active participation of the people.

http://www.vhai.org Accessed on 3rd December 2012.

Public Health Resource Network-PHRN

PHRN works through NGO networks and state health societies, to accelerate and consolidate the potential gains from the NRHM. They run module based programme for capacity building which is more informal, open ended participatory learning. This programme complements the official processes of capacity building and is not a substitute for the formal training and certification of public health management.

http://www.phrnindia.org Accessed on 6th December 2012.

National Institute of Epidemiology-NIE

National Institute of Epidemiology conducts training programmes annually in bio-statistics, controlled clinical trials and basic epidemiology for medical doctors, PG medical students and para-medical workers. The Institute has expertise in the areas of bio-statistics and epidemiology. The institute has strated a school of public health which offers a range of courses.

http://www.nie.gov.in Accessed on 6th December 2012.

National Institute of Mental Health and Neuro Sciences- NIMHANS

NIMHANS is a multidisciplinary Institute for patient care and academic pursuit in the frontier area of Mental Health and Neuro Sciences. The Institute functions under the direction of Ministry of Health and Family Welfare, Govt. of India and Ministry of Health and Family Welfare, Government of Karnataka. NIMHANS has started Centre for Public Health, which will commence masters on public health shortly.

http://www.nimhans.kar.nic.in Accessed on 3rd December 2012.

National Institute of health and Family Welfare-NIHFW

NIHFW is an autonomous organization, under the Ministry of Health and Family Welfare, Government of India, and acts as an 'apex technical institute' to addresses a wide range of issues on health and family welfare from a variety of perspectives through various departments. The Institute offers arnge of courses like Phd, certificate courses and teaching programme.

http://www.nihfw.org Accessed on 6th December 20

National Health Systems Resource Centre - NHSRC

National Health Systems Resource Centre (NHSRC), is India's Technical Support unit under the Ministry of Health & Family Welfare working across the country through the National Rural Health Mission (NRHM).NHSRC facilitate the attainment of universal access to equitable, affordable and quality healthcare through technical support and capacity building for strengthening public health systems.

http://nhsrcindia.org Accessed on 3rd December 2012.

Public Health Foundation of India- PHFI

The Public Health Foundation of India (PHFI) is a public private initiative that has collaboratively evolved through consultations with multiple constituencies. It is an independent foundation which adopts a broad, integrative approach to public health, tailored to Indian conditions. It has Established 5 Institutes of Public health which run Academic Programmes.

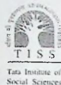
http://phfi.org Accessed on 4th December 2012.

Society for Community Health Awareness Research and Action- SOCHARA

SOCHARA is a Community health resource group who are committed to the 'Health for All' goal. SOCHARA works with a large network of non-government and government institutions, health and developmental campaign groups and people's movements to make them part of this 'Health for All' movement. SOCHARA team provided space, support, peer encouragement, vocational guidance and facilitation of self-study to young professionals in community health. This was formalized into Community Health Fellowship Programme, and now as SOCHARA School of Public Health, Equity and Action (SOPHEA). Presently SOPHEA runs the fellowship Programme in MP and Karnataka.

www.sochara.org Accessed on 3rd December 2012.

Tata Institute of Social Sciences –TISS



The Tata Institute of Social Sciences is a post-graduate school of social work which engages continuous study of Indian social issues and problems and impart education in social work to meet the emerging need. It has Various Schools like, Education, Management and Labour Studies, Rural Development, Social Work, Health Systems Studies, Habitat Studies, Law, Rights and Constitutional Governance, Vocational Education, Development Studies, Media and Cultural Studies.

http://www.tiss.edu Accessed on 4th December 2012.

Journals

- Indian Journal of Public Health-IJPH- http://www.ijph.in/
  Indian Journal of Public Health is a peer-reviewed international journal published Quarterly by the Indian Public Health Association. It is indexed by major international indexing systems and allows for free access (Open Access) to its contents. The journal's full text is available online at www.ijph.in.
- Indian Journal of Community medicine-IJCM- http://www.ijcm.org.in
  Indian Journal of Community medicine is a peer-reviewed quarterly publication of the Indian Association of Preventive and Social Medicine (IAPSM). It is indexed across various indexing systems and full text is available on line.
- Indian Journal of Medical Research-IJMR-http://www.icmr.nic.in/Publications/IJMR.html
  The Indian Journal of Medical Research is one of the oldest medical Journals which strated as quarterly publication in 1913 presently it is published monthly, in two volumes and 12 issues per year. The journal is published from Indian Council of medical research.
- Indian Journal of Medical Ethics-IJME- http://www.ijme.in
  The Indian Journal of Medical Ethics (formerly Issues in Medical Ethics) is a platform for discussion on health care ethics with special reference to the problems of developing countries like India.
- National Medical Journal of India-NMJI- http://www.nmji.in/
  The National Medical Journal of India is a premier bi-monthly health sciences journal published from India. The archives are available online from 1998.
- The Economic and Political weekly (EPW)- www.epw.in
  EPW, is the only social science journal published by the Sameeksha Trust. The weekly publication contains analysis of contemporary affairs side by side with academic papers in the social sciences. Access to current four issues are available from www.epw.in.

Others

- **Health Action**
  Started as a in-house bulletin named Catholic Hospital -Medical Service evolved into Health Action published under a separate society registered as Health Accessories for all (HAFA) in 1987. Health Action disseminates information on various health topics to enable people to gain adequate knowledge of health so that they can take care of their health as well as that of others. It promotes health, health activism and community development and promotes alternative systems of medicine and low-cost therapies.

- **Health for the millions**

  Bimonthly magazine since 1975. It provides insights into innovative and fascinating grassroots interventions as well as important policy changes, which affect the lives of millions.

- **Health Round Up**

  Health roundup is the compilation on all health – related news, views, policies and latest statistics from various publications to the notice of the reader. It is a bi monthly update on books journals and other sources that come to Community Health Library and Information Centre of the SOCHARA. Please write up to chlic@sochara.org to receive the periodical.

- **Health Digest**

  Health digest is a compilation on all health – related news Community Health Library and Information Centre of the SOCHARA. Please write up to chlic@sochara.org to receive the compilation.

- **Medico Friend Circle Bulletin**

  The MFC bulletin (first published in 1975) is the main medium of communication through which experiences, ideas and information about MFC and its activities are shared. It carries articles which usually represent varying points of view of our membership within the broad mfc perspective. Archives of the bulletin are available from http://www.mfcindia.org/main/bulletins.html.

- **NRHM News Letter**

  NRHM Newsletter is a bi-monthly publication brought out by the Department of Health and Family Welfare, MOHFW on the National Rural Health Mission. The issues are available from http://www.mohfw.nic.in/NRHM.htm, Address: 409-D, Nirman Bhavan, Department of Health and Family Welfare, Ministry of Health and Family Welfare, New Delhi - 110 011

- **Selected readings on health systems-** Selected readings on health systems is an initiative of Indian Hub on Health Systems at the Institute of Public Health, Bangalore. It is supported by Switching International Health Policies & Systems (SWIHPS) network at the Institute of Tropical Medicine, Antwerp.

  Archives are available from http://www.iphindia.org/resources/ihhs/. Write to km@iphindia.org

- **E Groups –discussion mails**
  - **Communityhealth.in-discuss:** Discussion group for communityhealth.in project members and editors. Write to lalit82@gmail.com to become a member of the group.
  - **Disease Surveillance** - Disease Surveillance e-Group is conceptualized to exchange innovative ideas, strategies and sharing of field/personal expereinces not only in surveillance but any aspect of Public health practice. Write to prabirkc@yahoo.com to become a member of the group
  - **JAAK**- This is a discussion group formed to enable group discussions among the members of the Janaarogya Andolana, a campaign for the health rights of the common people. Write to chc@sochara.org to become a member of the group.
  - **KPHP**- This group is for professionals interested and committed for Public health infrastructure and services in Karnataka state. Write to epigiridhar@gmail.com to become a member of the group.

- MFC – Discussion groups of mfc members Membership to the group requires introduction from existing member. – Write to sunil@theant.org to become a member of the group.

- **Compilation of Health Committee and Commission Reports**

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revealed that over 80 per cent of participants believed plain packaging would reduce the attractiveness, appeal and promotional value of the tobacco pack, over 60 per cent believed plain packaging would help in reducing experimentation and initiation of tobacco among youth and over 80 per cent believed, it would motivate tobacco users to quit[24]. Multi-disciplinary researchers and tobacco control advocates are strongly proposing introduction of plain packaging of tobacco products in India to enhance effectiveness of graphic warnings in India. A Private Members' Bill has been introduced on this issue in the Indian Parliament, which remains to be discussed[25].

A TAPS ban should be comprehensive as partial bans or voluntary arrangements do not work. A comprehensive ban on all TAPS could achieve a reduction in tobacco use by seven per cent[5].

Counter-advertising through mass media accompanied with school- or community-based programmes, warning about the dangers of tobacco use has been an effective strategy in preventing tobacco use as well as encouraging the users to quit[7]. Mass media campaigns form a major strategy for tobacco control under India's NTCP[22]. Counter-advertising through Government efforts needs to be stepped up to counter misleading messages conveyed by the tobacco industry through TAPS campaigns.

Conclusion

The WHO, while proposing targets for reducing the NCD burden, has proposed a 30 per cent reduction in tobacco use globally by 2025. The global narrative on tobacco control is increasingly exploring the concept of tobacco endgame, which envisions reducing tobacco prevalence and availability to minimal levels. Experts aiming at the endgame give a target for tobacco-free world, where prevalence for tobacco use in each country would reduce to less than five per cent by 2040[26]. This would require tobacco control measures be strictly enforced as per FCTC guidelines and innovative measures beyond FCTC be introduced in countries having political commitment to end the tobacco epidemic in their country.

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Editorial

Prohibiting tobacco advertising, promotions & sponsorships: Tobacco control best buy

In the 1990s tobacco smoking and exposure to second hand smoke (SHS) ranked among the top three risk factors contributing to the global burden of disease along with childhood underweight and household air pollution. Today, after two decades, tobacco smoking and exposure to SHS still rank among the top three risk factors despite the other risk factors being replaced by high blood pressure and alcohol use, which are essentially risk factors contributing to non-communicable diseases (NCDs)[1]. Tobacco control has been identified as a high priority, cost-effective intervention along with reduction of dietary salt intake and treatment of people at high risk for cardiovascular disease, which can aid in achieving the global target of 25 per cent reduction in NCD related mortality by 2025[2].

Tobacco industry has been instrumental in spreading the tobacco epidemic globally through aggressive marketing campaigns. It is the only industry that kills its 5.4 million loyal customers every year[3]. In 2005, the WHO Framework Convention on Tobacco Control (WHO FCTC), the first treaty negotiated under the auspices of the WHO, came into force[4]. Article 13 of FCTC suggests a comprehensive advertising ban, within five years of entry into force of FCTC for each party. Currently, only 19 countries of the world (representing 6% of the global population) are covered by comprehensive ban on tobacco advertising, promotion and sponsorship (TAPS), with 101 countries imposing partial bans and 74 countries having no ban at all[5]. This is a matter of public health concern. Comprehensive TAPS ban would lead to reduction in initiation and continuation of tobacco use; as such a policy measure would have large population level impact, thereby reducing demand for tobacco. Therefore, it is regarded as a tobacco control 'Best Buy'[6]. The theme for the World No Tobacco Day this year is 'Ban Tobacco Advertising, Promotion and Sponsorship', the objective being to encourage the Parties to impose a comprehensive TAPS ban and to strengthen efforts to reduce tobacco industry interference in introducing and enforcing such comprehensive bans.

Despite existing TAPS prohibition laws, tobacco industry circumvents the laws to promote their products by employing innovative and at times, covert marketing strategies. Indirect or surrogate tobacco advertising such as dark advertising, brand stretching, corporate social responsibility (CSR) activities, promotion through films and new media such as internet, discounts or free-gift offers, distribution of free samples, sale of tobacco products in the form of children's sweets/ toys, *etc.* gained momentum with increasing pressure on tobacco industry[7,8]. Guidelines for implementing Article 13 of FCTC, describe comprehensive TAPS ban to apply to all form of commercial communication, recommendation or action and all forms of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly[9].

Exposure to tobacco advertising among Indians

To protect the general populace from harmful effects of tobacco use, the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA), 2003 was enacted in India. Section 5 of COTPA prohibits all forms of TAPS in line with Article 13 of the WHO FCTC. Despite the existence of TAPS ban in India, exposure to tobacco advertising and promotion is still prevalent. Among

This editorial is published on the occasion of World No Tobacco Day - May 31, 2013.

Indian school-going youth aged 13-15 yr, exposure to pro-cigarette advertisements on billboards in the past 30 days increased from 71.6 in 2006 to 74.4 per cent in 2009[10,11]. Twenty eight per cent of Indian adults are exposed to cigarette advertising, and 47 and 55 per cent, respectively are exposed to *bidi* and smokeless tobacco (SLT) advertisements as per GATS (Global Adult Tobacco Survey) 2010[12]. COTPA allows 'On-Pack advertising' and 'Point of Sale (PoS) advertising' with some restrictions.

Need for comprehensive TAPS ban

Substantial evidence now exists of a causal relationship of tobacco advertising and promotion with increased tobacco use, especially in the youth[7,13]. Cross-sectional[14,15] and longitudinal studies[16] conducted with school-going adolescents in India also support these findings. A review of international studies suggests that PoS marketing and displays are associated with increased smoking susceptibility, experimentation, and uptake among children, and with increased craving among adults[17]. Celebrity endorsement of tobacco products in films is also causally associated with tobacco use among the youth with a dose-response relationship[7]. A study conducted with about 4000 school-going adolescents in Delhi concluded that students highly exposed to tobacco use in Bollywood films are at more than twice the risk of being ever tobacco users compared with the least exposed[18]. Comprehensive TAPS ban would ensure that youth and adults are not misled by these advertisements and promotions. Tobacco companies have designed product promotion campaigns around sports and music events providing links on Facebook and Twitter, clearly targeting youngsters through this powerful communication channel. Advertising through these new media channels needs to be addressed under comprehensive TAPS ban.

Engagement in CSR activities by tobacco industry is a more recent strategy wherein, the tobacco companies try to portray their image as being socially responsible and ethical[19]. The industry on one hand funds activities such as youth anti-smoking programmes, reforestation campaigns and environmental camps for school children, and on the other hand continues the promotion and sale of tobacco products[8,19]. Article 5.3 of the FCTC guidelines recommend, denormalising and regulating activities described as 'socially responsible' by the tobacco industry, including but not limited to activities described as CSR[20].

In India, PoS advertising by tobacco companies is rampant and most common violations in this regard include oversized advertisement boards, which are frequently backlit, placement of two boards together to give the impression of one large board, placement of multiple advertisements on one board and placement of advertisement boards on shops not selling tobacco[21]. India needs to step up enforcement of its TAPS ban legislation, as indirect methods of advertising and promotions are rampant. There is also imminent need to amend COTPA to remove "On pack advertising" and "PoS" advertising.

Recent progress in India on restricting TAPS

The Hon'ble Supreme Court of India on January 3, 2013 vacated the stay on rules related to the PoS advertising of tobacco products, which was imposed by the Bombay High Court in 2006, demonstrating commitment of the Indian judicial system towards better health of its citizens through effective tobacco control. Following the hearing in January 2013, Ministry of Health and Family Welfare (MoHFW), Government of India (GOI), issued a letter to the Chief Secretaries and Director Generals of Police of all Indian States/UTs to ensure that all steps are taken to curb the violations of PoS advertising rules. Under India's National Tobacco Control Programme (NTCP), monitoring committees specifically for Section 5 of COTPA at State and district levels, as well as a national level steering committee, have been mandated, to take cognizance of direct/indirect advertising of tobacco products[22]. The MoHFW has continued to show its commitment to tobacco control by introducing comprehensive tobacco control legislation and for some measures, India has been identified as a global leader. The Government of India has recently introduced trendsetting rules related to depiction of tobacco imagery in Indian films, a popular entertainment media[23].

What needs to be done?

The only advertising venue now allowed in India for the tobacco industry is 'on-pack' advertising. Tobacco packs are important means of advertising for the industry and they employ attractive imagery such as logos, brand names, colours, *etc.* on the pack for the same. Plain, standardized tobacco packaging as currently being implemented by the Australian Government, mandates prevention of promotion through on-pack advertising and enhances effectiveness of graphic health warnings on the pack. Results of a feasibility study for plain packaging of tobacco products conducted in Delhi

revealed that over 80 per cent of participants believed plain packaging would reduce the attractiveness, appeal and promotional value of the tobacco pack, over 60 per cent believed plain packaging would help in reducing experimentation and initiation of tobacco among youth and over 80 per cent believed, it would motivate tobacco users to quit[24]. Multi-disciplinary researchers and tobacco control advocates are strongly proposing introduction of plain packaging of tobacco products in India to enhance effectiveness of graphic warnings in India. A Private Members' Bill has been introduced on this issue in the Indian Parliament, which remains to be discussed[25].

A TAPS ban should be comprehensive as partial bans or voluntary arrangements do not work. A comprehensive ban on all TAPS could achieve a reduction in tobacco use by seven per cent[5].

Counter-advertising through mass media accompanied with school- or community-based programmes, warning about the dangers of tobacco use has been an effective strategy in preventing tobacco use as well as encouraging the users to quit[7]. Mass media campaigns form a major strategy for tobacco control under India's NTCP[22]. Counter-advertising through Government efforts needs to be stepped up to counter misleading messages conveyed by the tobacco industry through TAPS campaigns.

Conclusion

The WHO, while proposing targets for reducing the NCD burden, has proposed a 30 per cent reduction in tobacco use globally by 2025. The global narrative on tobacco control is increasingly exploring the concept of tobacco endgame, which envisions reducing tobacco prevalence and availability to minimal levels. Experts aiming at the endgame give a target for tobacco-free world, where prevalence for tobacco use in each country would reduce to less than five per cent by 2040[26]. This would require tobacco control measures be strictly enforced as per FCTC guidelines and innovative measures beyond FCTC be introduced in countries having political commitment to end the tobacco epidemic in their country.

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FRAMEWORK CONVENTION
ALLIANCE
BUILDING SUPPORT FOR TOBACCO CONTROL

WORLD NO TOBACCO DAY 2013

Why ban tobacco advertising, promotion and sponsorship (TAPS)?

Experts say tobacco advertising and promotion increase consumption. In 2009 a comprehensive review of tobacco-related research was released by The National Cancer Institute (US). The monograph was compiled by 23 authors, 63 expert reviewers and took five years to produce. The two main scientific conclusions were:

1. There is a causal relationship between tobacco advertising and promotion and increased tobacco use.
2. Comprehensive bans reduce tobacco consumption but partial bans only lead to greater expenditure in 'non banned' areas, resulting in no net reduction of tobacco use.

The report also found that generally tobacco advertising and promotion exhibits three main themes:

» Providing satisfaction (taste, freshness)
» Reducing fears about the dangers of tobacco use (mildness)
» Creating associations between tobacco and desirable characteristics (social success, sexual attraction, thinness etc).

It is clear that in countries with weak regulation, marketing reaches a very high proportion of people. For example according to the 2011 National Adult Tobacco Survey of Cambodia, 80 percent of respondents had seen tobacco advertising in the past months.

Advertising, promotion and sponsorship normalise tobacco, making it seem like any other consumer product. This increases its social acceptability and hampers efforts to educate people about the hazards of tobacco use.

The tobacco industry maintains that the role of advertising and promotion is solely to encourage smokers to switch brands. However, another impact is to increase the desirability of smoking by associating it with characteristics such as independence, glamour and machismo[1].

In countries where partial bans prohibit direct advertising and promotion of tobacco products in traditional media, tobacco companies frequently employ indirect marketing tactics to circumvent the restrictions. Tactics include:

» sport and music event sponsorship
» pack designs and displays
» branded merchandise
» product placement
» so-called corporate social responsibility activities
» new media technology campaigns.

What is TAPS?

"Tobacco advertising, promotion and sponsorship applies to all forms of commercial communication, recommendation or action and all forms of contribution to any event, activity or individual with the aim, effect, or likely effect of promoting a tobacco product or tobacco use either directly or indirectly." (Guidelines for implementation of Article 13 of the FCTC)

In some countries the tobacco industry still uses print and broadcast media, billboards, electronic mail and direct mail and the internet to market its products.

Point of sale promotion is particularly powerful, and is allowed in practically every country in the world.

1 Bates C, Rowell A. Tobacco explained: the truth about the tobacco industry. ..in its own words. London: Action on Smoking and Health, 2004. www.who.int/tobacco/media/en/TobaccoExplained.pdf

- Ban on all forms of direct and indirect advertising*
- Ban on national television, radio and print media as well as on some but not all other forms of direct and indirect advertising
- Ban on national television, radio and print media only
- Complete absence of ban, or ban that does not cover national televison, radio and print media
- Data not reported
- Data not available

*Direct advertising bans include: national television and radio; local magazines and newspapers; billboards and outdoor advertising; point of sale. Indirect advertising bans: free distribution of tobacco products in the mail or through other means; promotional discounts; non-tobacco goods and services identified with tobacco brand names (brand extension); brand names of non-tobacco products used for tobacco products; appearance of tobacco products in television and/or films; sponsored events. *Map source: WHO Report on the Global Tobacco Epidemic, 2011. Appendix X.*

Advertising, promotion and sponsorship bans work

Comprehensive bans on direct and indirect advertising, promotion and sponsorship protect people – particularly youth – from industry marketing tactics and can substantially reduce tobacco consumption.

Comprehensive bans significantly reduce the industry's ability to market to young people who have not started using tobacco and to adult tobacco users who want to quit.

Comprehensive bans can be achieved by following the international best practice standards outlined in the Guidelines for implementation of Article 13 of the WHO Framework Convention on Tobacco Control (WHO FCTC).

A comprehensive ban on all advertising and promotion reduces tobacco consumption by about 7 percent, independent of other interventions. Some countries have seen consumption drop by as much as 16 percent following an ad ban.

The WHO Framework Convention on Tobacco Control (FCTC) states:

Article 13

... a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products.

Each Party shall ... undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship.

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Indian J Med Res 137, May 2013, pp 867-870

Editorial

Prohibiting tobacco advertising, promotions & sponsorships: Tobacco control best buy

In the 1990s tobacco smoking and exposure to second hand smoke (SHS) ranked among the top three risk factors contributing to the global burden of disease along with childhood underweight and household air pollution. Today, after two decades, tobacco smoking and exposure to SHS still rank among the top three risk factors despite the other risk factors being replaced by high blood pressure and alcohol use, which are essentially risk factors contributing to non-communicable diseases (NCDs)[1]. Tobacco control has been identified as a high priority, cost-effective intervention along with reduction of dietary salt intake and treatment of people at high risk for cardiovascular disease, which can aid in achieving the global target of 25 per cent reduction in NCD related mortality by 2025[2].

Tobacco industry has been instrumental in spreading the tobacco epidemic globally through aggressive marketing campaigns. It is the only industry that kills its 5.4 million loyal customers every year[3]. In 2005, the WHO Framework Convention on Tobacco Control (WHO FCTC), the first treaty negotiated under the auspices of the WHO, came into force[4]. Article 13 of FCTC suggests a comprehensive advertising ban, within five years of entry into force of FCTC for each party. Currently, only 19 countries of the world (representing 6% of the global population) are covered by comprehensive ban on tobacco advertising, promotion and sponsorship (TAPS), with 101 countries imposing partial bans and 74 countries having no ban at all[5]. This is a matter of public health concern. Comprehensive TAPS ban would lead to reduction in initiation and continuation of tobacco use; as such a policy measure would have large population level impact, thereby reducing demand for tobacco. Therefore, it is regarded as a tobacco control 'Best Buy'[6]. The theme for the World No Tobacco Day this year is 'Ban Tobacco Advertising, Promotion and Sponsorship', the objective being to encourage the Parties to impose a comprehensive TAPS ban and to strengthen efforts to reduce tobacco industry interference in introducing and enforcing such comprehensive bans.

Despite existing TAPS prohibition laws, tobacco industry circumvents the laws to promote their products by employing innovative and at times, covert marketing strategies. Indirect or surrogate tobacco advertising such as dark advertising, brand stretching, corporate social responsibility (CSR) activities, promotion through films and new media such as internet, discounts or free-gift offers, distribution of free samples, sale of tobacco products in the form of children's sweets/toys, *etc.* gained momentum with increasing pressure on tobacco industry[7,8]. Guidelines for implementing Article 13 of FCTC, describe comprehensive TAPS ban to apply to all form of commercial communication, recommendation or action and all forms of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly[9].

Exposure to tobacco advertising among Indians

To protect the general populace from harmful effects of tobacco use, the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA), 2003 was enacted in India. Section 5 of COTPA prohibits all forms of TAPS in line with Article 13 of the WHO FCTC. Despite the existence of TAPS ban in India, exposure to tobacco advertising and promotion is still prevalent. Among

This editorial is published on the occasion of World No Tobacco Day - May 31, 2013.

Indian school-going youth aged 13-15 yr, exposure to pro-cigarette advertisements on billboards in the past 30 days increased from 71.6 in 2006 to 74.4 per cent in 2009[10,11]. Twenty eight per cent of Indian adults are exposed to cigarette advertising, and 47 and 55 per cent, respectively are exposed to *bidi* and smokeless tobacco (SLT) advertisements as per GATS (Global Adult Tobacco Survey) 2010[12]. COTPA allows 'On-Pack advertising' and 'Point of Sale (PoS) advertising' with some restrictions.

Need for comprehensive TAPS ban

Substantial evidence now exists of a causal relationship of tobacco advertising and promotion with increased tobacco use, especially in the youth[7,13]. Cross-sectional[14,15] and longitudinal studies[16] conducted with school-going adolescents in India also support these findings. A review of international studies suggests that PoS marketing and displays are associated with increased smoking susceptibility, experimentation, and uptake among children, and with increased craving among adults[17]. Celebrity endorsement of tobacco products in films is also causally associated with tobacco use among the youth with a dose-response relationship[7]. A study conducted with about 4000 school-going adolescents in Delhi concluded that students highly exposed to tobacco use in Bollywood films are at more than twice the risk of being ever tobacco users compared with the least exposed[18]. Comprehensive TAPS ban would ensure that youth and adults are not misled by these advertisements and promotions. Tobacco companies have designed product promotion campaigns around sports and music events providing links on Facebook and Twitter, clearly targeting youngsters through this powerful communication channel. Advertising through these new media channels needs to be addressed under comprehensive TAPS ban.

Engagement in CSR activities by tobacco industry is a more recent strategy wherein, the tobacco companies try to portray their image as being socially responsible and ethical[19]. The industry on one hand funds activities such as youth anti-smoking programmes, reforestation campaigns and environmental camps for school children, and on the other hand continues the promotion and sale of tobacco products[8,19]. Article 5.3 of the FCTC guidelines recommend, denormalising and regulating activities described as 'socially responsible' by the tobacco industry, including but not limited to activities described as CSR[20].

In India, PoS advertising by tobacco companies is rampant and most common violations in this regard include oversized advertisement boards, which are frequently backlit, placement of two boards together to give the impression of one large board, placement of multiple advertisements on one board and placement of advertisement boards on shops not selling tobacco[21]. India needs to step up enforcement of its TAPS ban legislation, as indirect methods of advertising and promotions are rampant. There is also imminent need to amend COTPA to remove "On pack advertising" and "PoS" advertising.

Recent progress in India on restricting TAPS

The Hon'ble Supreme Court of India on January 3, 2013 vacated the stay on rules related to the PoS advertising of tobacco products, which was imposed by the Bombay High Court in 2006, demonstrating commitment of the Indian judicial system towards better health of its citizens through effective tobacco control. Following the hearing in January 2013, Ministry of Health and Family Welfare (MoHFW), Government of India (GOI), issued a letter to the Chief Secretaries and Director Generals of Police of all Indian States/UTs to ensure that all steps are taken to curb the violations of PoS advertising rules. Under India's National Tobacco Control Programme (NTCP), monitoring committees specifically for Section 5 of COTPA at State and district levels, as well as a national level steering committee, have been mandated, to take cognizance of direct/indirect advertising of tobacco products[22]. The MoHFW has continued to show its commitment to tobacco control by introducing comprehensive tobacco control legislation and for some measures, India has been identified as a global leader. The Government of India has recently introduced trendsetting rules related to depiction of tobacco imagery in Indian films, a popular entertainment media[23].

What needs to be done?

The only advertising venue now allowed in India for the tobacco industry is 'on-pack' advertising. Tobacco packs are important means of advertising for the industry and they employ attractive imagery such as logos, brand names, colours, *etc.* on the pack for the same. Plain, standardized tobacco packaging as currently being implemented by the Australian Government, mandates prevention of promotion through on-pack advertising and enhances effectiveness of graphic health warnings on the pack. Results of a feasibility study for plain packaging of tobacco products conducted in Delhi

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A TAPS ban should be comprehensive as partial bans or voluntary arrangements do not work. A comprehensive ban on all TAPS could achieve a reduction in tobacco use by seven per cent[5].

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Conclusion

The WHO, while proposing targets for reducing the NCD burden, has proposed a 30 per cent reduction in tobacco use globally by 2025. The global narrative on tobacco control is increasingly exploring the concept of tobacco endgame, which envisions reducing tobacco prevalence and availability to minimal levels. Experts aiming at the endgame give a target for tobacco-free world, where prevalence for tobacco use in each country would reduce to less than five per cent by 2040[26]. This would require tobacco control measures be strictly enforced as per FCTC guidelines and innovative measures beyond FCTC be introduced in countries having political commitment to end the tobacco epidemic in their country.

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Invitation

A State Level Consultation

Ban On
"Tobacco Advertising, Promotion And Sponsorship"

on Friday 5th July, 2013

Timing : 9.00 AM onwards

To,

Rajiv Gandhi University of Health Sciences,
Jayanagar, 4th 'T' Block,
Bangalore, - 560 041.
Karnataka

SOCHARA
359, 1st Main, 1st Block
Koramangala,
Bangalore-560 041
Karnataka

SOCHARA

&

Rajiv Gandhi University of Health Sciences, Karnataka

Jointly Organizes a State Level Consultation on

Ban on "Tobacco Advertising, Promotion and Sponsorship"

in Association with State Anti-Tobacco Cell, Karnataka.

At

Dhanvanthri Hall, Rajiv Gandhi University of Health Sciences,
Jayanagar, 4th 'T' Block, Bangalore-560 041.

on

Friday 5th July, 2013

Timing : 9.00 AM onwards

Inauguration

Shri U.T. Khader

Hon'ble Minister for Health and Family Welfare,
Government of Karnataka.

Presided by

Dr. K.S. Sriprakash

Hon'ble Vice-Chancellor, Rajiv Gandhi University of Health Sciences, Bangalore.

Chief Guest

Dr. Sharanaprakash Rudrappa Patil

Hon'ble Minister for Medical Education & Pro-Chancellor,
Rajiv Gandhi University of Health Sciences, Karnataka

Guests of Honour

Shri M. Madan Gopal, I.A.S.

Principal Secretary to Government.
Health and Family Welfare Department, Karnataka

Shri V.B. Patil, I.A.S.

Commissioner
Health and Family Welfare Department, Karnataka

Dr. K.H. Govinda Raju, I.A.S.

Secretary to Government,
Department of Medical Education, Karnataka

Dr. B.N. Dhanya Kumar

Director
Health and Family Welfare Services, Karnataka

Resource Person

Dr. Thelma Narayan,

Director - SOCHARA. Bangalore

Panel Discussion on:

Ban on
"TOBACCO ADVERTISEMENT PROMOTION AND SPONSORSHIP"
With the experts from Health, Education, Law, Police, Agriculture and Media,
Moderated by: **Ms. Nupur Basu, Former NDTV Journalist**

Program Details (9.00 AM onwards)

Registration 9.00 AM to 9.30 AM

- Welcome Address
- Inaugural Address
- Presidential Address
- Tea Break
- Lunch

Dr. Prem Kumar
Registrer, RGUHS

- Inauguration
- Address by the Dignitaries
- Vote of Thanks
- Panel Discussion
- Action plan-way forward

Dr. Thelma Narayan
Director - SOCHARA

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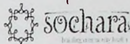

Society for Community Health Awareness Research and Action

State level consultation on ban on 'Tobacco Advertising Promotion and Sponsorship' (TAPS)

Minute to minute Program

Date: 5th July, 2013

Venue: Dhanvanthri Hall, Rajiv Gandhi University of Health Sciences

Press Release

The global tobacco epidemic kills nearly six million people each year, of which more than 600 000 are non-smokers dying from breathing second-hand smoke. Unless we act, the epidemic will kill more than eight million people every year by 2030. More than 80% of these preventable deaths will be among people living in low- and middle-income countries.

The ultimate goal of any tobacco control initiative is to contribute to protect present and future generations not only from these devastating health consequences, but also against the social, environmental and economic scourges of tobacco use and exposure to tobacco smoke.

SOCHARA has been actively involved in tobacco free initiatives since 1998. It played an active role in tobacco control measures taken at local, national and international levels. Over the years SOCHARA has been addressing the demand and supply side issues through various programs and campaigns. SOCHARA is one of the founding members of the network 'Consortium for tobacco free Karnataka' (CFTFK) founded in the year 2001.

The theme of the World No Tobacco Day (WNTD) - 2013 is ***'Ban tobacco advertising, promotion and sponsorship'*** this issue is covered under section-5 of COTPA Act-2003 as **'Tobacco *Advertisement, Promotion and Sponsorship'* (TAPS).** Recently SOCHARA participated at a national consultation on TAPS for 13 states including Karnataka organized by HRIDAY, MoHFW and WHO country office in Delhi. One of the recommendations of the national consultation was to organize state level consultations with various government departmental officers who are responsible for implementing COTPA to sensitize and strengthen their role, with active participation of civil society organizations.

Karnataka State Anti Tobacco Cell, Rajiv Gandhi University of Health Sciences (RGUHS) and SOCHARA are jointly organizing a state level consultation on **ban on Tobacco Advertisement, Promotion and Sponsorship' (TAPS).** **on Friday 5th July 2013 Dhanvanthri Hall, RGUGHS, 4th T Block, Jayanagar, Bangalore-560 041 from 9 AM to 4 PM.**

A comprehensive ban of all tobacco advertising, promotion and sponsorship is required under the WHO Framework Convention for Tobacco Control (WHO FCTC) for all Parties to this treaty within five years of the entry into force of the Convention for that Party. ***Evidence shows that comprehensive advertising bans lead to reductions in the numbers of people starting and continuing smoking. Statistics show that banning tobacco advertising and sponsorship is one of the most cost-effective ways to reduce tobacco demand and thus a tobacco control "best buy".***

Mr. S J Chander, Trg& Research Associate, SOCHARA
Mob-9448034152

Dr. K. S. Nagesh, Director Public Health, RGUHS

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FRAMEWORK CONVENTION ALLIANCE

BUILDING SUPPORT FOR TOBACCO CONTROL

WORLD NO TOBACCO DAY 2013

Why ban tobacco advertising, promotion and sponsorship (TAPS)?

Experts say tobacco advertising and promotion increase consumption. In 2009 a comprehensive review of tobacco-related research was released by The National Cancer Institute (US). The monograph was compiled by 23 authors, 63 expert reviewers and took five years to produce. The two main scientific conclusions were:

1. There is a causal relationship between tobacco advertising and promotion and increased tobacco use.
2. Comprehensive bans reduce tobacco consumption but partial bans only lead to greater expenditure in 'non banned' areas, resulting in no net reduction of tobacco use.

The report also found that generally tobacco advertising and promotion exhibits three main themes:

- Providing satisfaction (taste, freshness)
- Reducing fears about the dangers of tobacco use (mildness)
- Creating associations between tobacco and desirable characteristics (social success, sexual attraction, thinness etc).

It is clear that in countries with weak regulation, marketing reaches a very high proportion of people. For example according to the 2011 National Adult Tobacco Survey of Cambodia, 80 percent of respondents had seen tobacco advertising in the past months.

Advertising, promotion and sponsorship normalise tobacco, making it seem like any other consumer product. This increases its social acceptability and hampers efforts to educate people about the hazards of tobacco use.

The tobacco industry maintains that the role of advertising and promotion is solely to encourage smokers to switch brands. However, another impact is to increase the desirability of smoking by associating it with characteristics such as independence, glamour and machismo[1].

In countries where partial bans prohibit direct advertising and promotion of tobacco products in traditional media, tobacco companies frequently employ indirect marketing tactics to circumvent the restrictions. Tactics include:

- sport and music event sponsorship
- pack designs and displays
- branded merchandise
- product placement
- so-called corporate social responsibility activities
- new media technology campaigns.

What is TAPS?

"Tobacco advertising, promotion and sponsorship applies to all forms of commercial communication, recommendation or action and all forms of contribution to any event, activity or individual with the aim, effect, or likely effect of promoting a tobacco product or tobacco use either directly or indirectly." (Guidelines for implementation of Article 13 of the FCTC)

In some countries the tobacco industry still uses print and broadcast media, billboards, electronic mail and direct mail and the internet to market its products.

Point of sale promotion is particularly powerful, and is allowed in practically every country in the world.

1 Bates C, Rowell A. Tobacco explained: the truth about the tobacco industry ..in its own words. London. Action on Smoking and Health, 2004. www.who.int/tobacco/media/en/TobaccoExplained.pdf

- Ban on all forms of direct and indirect advertising*
- Ban on national television, radio and print media as well as on some but not all other forms of direct and indirect advertising
- Ban on national television, radio and print media only
- Complete absence of ban, or ban that does not cover national television, radio and print media
- Data not reported
- Data not available

*Direct advertising bans include: national television and radio; local magazines and newspapers; billboards and outdoor advertising; point of sale. Indirect advertising bans: free distribution of tobacco products in the mail or through other means; promotional discounts; non-tobacco goods and services identified with tobacco brand names (brand extension); brand names of non-tobacco products used for tobacco products; appearance of tobacco products in television and/or films, sponsored events. *Map source: WHO Report on the Global Tobacco Epidemic, 2011. Appendix X.*

Advertising, promotion and sponsorship bans work

Comprehensive bans on direct and indirect advertising, promotion and sponsorship protect people – particularly youth – from industry marketing tactics and can substantially reduce tobacco consumption.

Comprehensive bans significantly reduce the industry's ability to market to young people who have not started using tobacco and to adult tobacco users who want to quit.

Comprehensive bans can be achieved by following the international best practice standards outlined in the Guidelines for implementation of Article 13 of the WHO Framework Convention on Tobacco Control (WHO FCTC).

A comprehensive ban on all advertising and promotion reduces tobacco consumption by about 7 percent, independent of other interventions. Some countries have seen consumption drop by as much as 16 percent following an ad ban.

> The WHO Framework Convention on Tobacco Control (FCTC) states:
>
> *Article 13*
>
> *... a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products.*
>
> *Each Party shall ... undertake a comprehensive ban of all tobacco advertising, promotion and sponsorship.*

ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಗಳು

ಮಾಹಿತಿ ಕೈಪಿಡಿ

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ತಂಬಾಕು (ಹೊಗೆಸೊಪ್ಪು) ಭಾರತದಲ್ಲಿ ಉಪಯೋಗಿವಾಗುತ್ತಿರುವ ತಂಬಾಕಿನ ನಿಜಸ್ಥಿತಿ

ಭಾರತದಲ್ಲಿ ತಂಬಾಕಿನ ಪದಾರ್ಥಗಳನ್ನು ಎಷ್ಟು ಜನ ಉಪಯೋಗಿಸುತ್ತಾರೆ ?

* ಇಂದು ಭಾರತಲ್ಲಿ 260 ದಶಲಕ್ಷ ಮಂದಿ ತಂಬಾಕಿನ ಉಪಯೋಗ ಮಾಡುವವರಿದ್ದಾರೆ.
* 15 ವರ್ಷಕ್ಕೆ ಮೇಲ್ಪಟ್ಟ 142 ದಶಲಕ್ಷ ಮಂದಿ ಗಂಡಸರು ಮತ್ತು ಹೆಂಗಸರು ತಂಬಾಕನ್ನು ವಿವಿಧ ರೀತಿಯಲ್ಲಿ ಉಪಯೋಗಿಸುತ್ತಾರೆ.
* ಉಳಿದವರು 15 ವರ್ಷದ ಕೆಳಪಟ್ಟ ಮಕ್ಕಳು
* ಶೇಕಡ 14 ರಷ್ಟು ಜನ ಸಿಗರೇಟನ್ನು ಸೇವಿಸುತ್ತಾರೆ
* ಶೇಕಡ 38 ರಷ್ಟು ಜನ ಬೀಡಿಗಳನ್ನು ಸೇವಿಸುತ್ತಾರೆ
* ಶೇಕಡ 48 ರಷ್ಟು ಜನ ತಂಬಾಕನ್ನು ಅಗಿಯುತ್ತಾರೆ
* ಮಾರುಕಟ್ಟೆಯಲ್ಲಿ 400ಕ್ಕೂ ಹೆಚ್ಚು ಅಗಿಯುವ ತಂಬಾಕಿನ ಪದಾರ್ಥಗಳು ದೊರೆಯುತ್ತವೆ
* ಸಿಗರೇಟುಗಳು ಮತ್ತು ಬೀಡಿಗಳು ವಿವಿಧ ಗುರುತು ಮತ್ತು ಅಳತೆಗಳಲ್ಲಿ ದೊರೆಯುತ್ತವೆ

ತಂಬಾಕಿನ ಕಾರ್ಖಾನೆಗಳ ಪಾತ್ರವೇನು ?

ತಂಬಾಕಿನ ಕಾರ್ಖಾನೆಗಳು ವಾರ್ಷಿಕ 10 ರಿಂದ 18 ವರ್ಷಗಳೊಗಿರುವ ಮಕ್ಕಳನ್ನು ಕೆಲಸಕ್ಕೆ ತೆಗೆದುಕೊಳ್ಳುತ್ತವೆ

ತಂಬಾಕಿನಲ್ಲಿ ಯಾವ ಯಾವ ರಾಸಾಯನಿಕಗಳು ಮತ್ತು ವಿಷದ ಪದಾರ್ಥಗಳು ಇವೆ?

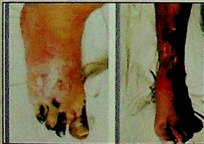
ತಂಬಾಕಿನಲ್ಲಿ 4700 ವಿವಿಧ ರಾಸಾಯನಿಕಗಳಿವೆ ಆದರಲ್ಲಿ 60 ರಷ್ಟು ರಾಸಾಯನಿಕಗಳು ಕ್ಯಾನ್ಸರ್ ರೋಗವನ್ನು ಉಂಟುಮಾಡುವ ಶಕ್ತಿಯನ್ನು ಹೊಂದಿರುತ್ತವೆ.

ತಂಬಾಕಿನಲ್ಲಿ ಇರುವ ಕೆಲವು ರಾಸಾಯನಿಕ ವಸ್ತುಗಳು

ರಾಸಾಯನಿಕದ ಹೆಸರು	ಅದರ ಉಪಯೋಗ
ಶಂಕಪಾಶಾಣ	ಇಲಿ ಪಾಶಾಣ
ಮೂತ್ರಲವಣ	ಶೌಚಾಲಯ ಶುದ್ಧೀಕರಣಕ್ಕೆ ಉಪಯೋಗಿಸಲ್ಪಡುತ್ತದೆ
ಅಸಿಟೋನ್	ಉಗುರಿಗೆ ಹಚ್ಚಿದ ಬಣ್ಣವನ್ನು ತೆಗೆಯುವುದು.
ಕಾರ್ಬನ್ ಮಾನಾಕ್ಸೈಡ್	ವಾಹನಗಳಿಂದ ಹೊರಬರುವ ಹೊಗೆಯಲ್ಲಿ ತುಂಬಿರುವ ಅನಿಲ
ಫಾರ್ಮುಲಾಕ್ಸೈಡ್	ಮೃತದೇಹಗಳನ್ನು ಸಂರಕ್ಷಿಸಿ ಇಡುವ ಉಪಯೋಗಿಸುವ ರಾಸಾಯನಿಕ ದ್ರವ

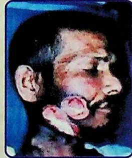
ತಂಬಾಕಿನ ಉಪಯೋಗದಿಂದ ಆರೋಗ್ಯದ ಮೇಲೆ ಆಗುವ ದುಷ್ಪರಿಣಾಮಗಳು ?

ತಂಬಾಕು ಪದಾರ್ಥಗಳ ಉತ್ಪಾದಕರ ಉದ್ದೇಶ ತಂಬಾಕಿನ ಚಟವುಂಟುಮಾಡುವುದು ಈ ಚಟವು ಪ್ರಾಣಹಾನಿಕಾರಕ ಕಳೆದ ನಾಲಕು ದಶವರ್ಷಗಳಲ್ಲಿ 70,000 ವೈಜ್ಞಾನಿಕ ಪ್ರಬಂದಗಳು ಇದನ್ನು ಧೃಡಪಡಿಸಿವೆ, ಭಾರತದಲ್ಲಿ ವರ್ಷಕ್ಕೆ 9,00,000 ಜನರನ್ನೂ, ಪ್ರಪಂಚದಾದ್ಯಂತ 50,00,000 ಜನರನ್ನು ತಂಬಾಕುಕೊಲ್ಲುತ್ತದೆ.



ತಂಬಾಕಿನ ಉಪಯೋಗವು 25 ಕ್ಕೂ ಹೆಚ್ಚು ಖಾಯಿಲೆಗಳೊಂದಿಗೆ ಜೋಡಣೆಯಾಗಿದೆ ಅವುಗಳಲ್ಲಿ ಕೆಲವು ಯಾವುವೆಂದರೆ

* ತಂಬಾಕನ್ನು ಅಗಿಯುವುದರಿಂದ ಮತ್ತು ದವಡೆಯಲ್ಲಿಟ್ಟು ಕೊಳ್ಳುವುದರಿಂದ ಬಾಯಿ ಕ್ಯಾನ್ಸರ್, ಒಸಡುಗಳ ಖಾಯಿಲೆಗಳು ಮತ್ತು ಕೆನ್ನೆಯ ಮಾಂಸಖಂಡಗಳ ಸೆಳೆತ ಆಗುವುದರಿಂದ ಆಹಾರವನ್ನು ನುಂಗಲು ಮತ್ತು ಸ್ಪಷ್ಟವಾಗಿ ಮಾತನಾಡಲು ತೊಂದರೆಯಾಗುವುದು (ಪ್ರಯಾಸವಾಗುವುದು)
* ಹೃದಯದ ಖಾಯಿಲೆ ,ಪಾರ್ಶುವಾಯು, ಕ್ಯಾನ್ಸರ್, ಶ್ವಾಸಕೋಶದ ಖಾಯಿಲೆಗಳು ಮೊದಲಾದವು ಧೂಮಪಾನಮಾಡದ ಅಮಾಯಕ ಜನರಲ್ಲಿಯೂ ಸಹ ಈ ಖಾಯಿಲೆಗಳು ಕಂಡುಬರುತ್ತವೆ ಕಾರಣ ಈ ಜನರು ಧೂಮಪಾನಿಗಳಿಂದ ಹೊರಬರುವ ಹೊಗೆಯನ್ನು ಉಸಿರಾಡುವುದರಿಂದ



ಧೂಮಪಾನ ಮಾಡದೆಯೇ ತೊಂದರೆಗೊಳಗಾಗುವವರ ವಿಷಯಗಳು

* ಧೂಮಪಾನಮಾಡುವವರು ಶೇ 15 ರಷ್ಟು ಹೊಗೆಯನ್ನು ಮಾತ್ರ ಸೇವಿಸುತ್ತಾರೆ. ಅವರ ಸುತ್ತಲೂ ಇರುವವರು ಉಳಿದ ಶೇ 85 ರಷ್ಟು ಹೊಗೆಯನ್ನು ಮತ್ತು ತಂಬಾಕಿನ ವಿಷಗಳನ್ನು ಸೇವಿಸುವವ -ರಾಗಿದ್ದಾರೆ.
* ಈ ವಿದದ ಹೊಗೆಸೇವನೆ ಎಲ್ಲರ ಆರೋಗ್ಯಕ್ಕೂ ಹಾನಿಕಾರಕ ವಿಶೇಷವಾಗಿಚಿಕ್ಕಮಕ್ಕಳಿಗೆ. ಇಂತಹ ಚಿಕ್ಕಮಕ್ಕಳಲ್ಲಿ ಉಸಿರಾಟದ ತೊಂದರೆ,ಕಿವಿ ಕೇಳಿಸದ ತೊಂದರೆ,ಜನ್ಮದಿಂದ ಬರುವ ಅಂಗವಿಕಲತೆಗಳು ಕಂಡುಬರುತ್ತವೆ.

ತಂಬಾಕಿನ ವ್ಯವಸಾಯದಿಂದ ಮತ್ತು ಉಪಯೋಗದಿಂದ ಆರ್ಥಿಕ [ಹಣಕಾಸಿನ] ಪರಿಸ್ಥಿತಿಯ ಮೇಲೆ ಉಂಟಾಗುವ ಪರಿಣಾಮಗಳು

* ಫ್ರಾನ್ಸ್ ದೇಶದಲ್ಲಿ ಮಾಡಿದ ಸಂಶೋದನೆಯ ಪ್ರಕಾರ ಧೂಮಪಾನಿಗಳು ಧೂಮಪಾನಮಾಡದವರಿಂದ ಕಡಿಮೆ ಉತ್ಪನ್ನ ಮಾಡುವರು
* ಒಂದು ದಿನಕ್ಕೆ ಕನಿಷ್ಟ 20 ಸಿಗರೇಟುಗಳನ್ನು ಸೇದುವವರು ವರ್ಷಕ್ಕೆ ಸರಾಸರಿ 10,950 ರೂಗಳನ್ನು ಈ ಚಟಕ್ಕಾಗಿ ವ್ಯಯಿಸುವವರು.
* ಈತನು ತಂಬಾಕು ಸೇವನೆಗಾಗಿ 30 ವರ್ಷಗಳಲ್ಲಿ ವೆಚ್ಚಮಾಡುವ ಹಣ 3,28,500 ರೂಗಳು ಕನಿಷ್ಟ ಎರಡು ಮಕ್ಕಳ ಉನ್ನತ ವಿದ್ಯಾಭ್ಯಾಸಕ್ಕೆ ಸಾಕಾಗುತ್ತದೆ.
* ಭಾರತದಲ್ಲಿ ತಂಬಾಕಿಗೆ ಸಂಬಂದಪಟ್ಟ ಖಾಯಿಲೆಗಳ ಚಿಕಿತ್ಸೆಗೆ ಪ್ರತಿ ವರ್ಷ 277.611 ಬಿಲಿಯನ್ ರೂಗಳ ವೆಚ್ಚವಾಗುತ್ತದೆ
* ಪ್ರಂಚದದಾದ್ಯಂತ ತಂಬಾಕಿಗೆ ಸಂಬಂದಿಸಿದ ಖಾಯಿಲೆಗಳು ಚಿಕಿತ್ಸೆಗಾಗಿ ವಾರ್ಷಿಕ 6.5 ದಶಲಕ್ಷ ಡಾಲರ್‌ಗಳ ವೆಚ್ಚತಗಲುತ್ತದೆ(ಡಬ್ಲೂ.ಹೆಚ್. ಒ)
* ತಂಬಾಕಿನಿಂದ ದೊರೆಯುವ ವರವಾನದಲ್ಲಿ ಸಿಂಹಪಾಲು ಲಾಭ ತಂಬಾಕಿನ ಕಂಪನಿಗಳಿಗೆ ಸಲ್ಲುತ್ತದೆ.

ತಂಬಾಕು ಬೆಳೆಯುವುದರಿಂದ ಉಂಟಾಗುವ ತೊಡಕುಗಳು

* ಕಾಡುಗಳ ನಾಶಕ್ಕೆ ತಂಬಾಕಿನ ಬೆಳೆ ಬಹುತೇಕ ಕಾರಣವಾಗಿದೆ

* 300 ಸಿಗರೇಟುಗಳ ಧೂಮಪಾನಕ್ಕೆ ಬೇಕಾಗುವಷ್ಟು ತಂಬಾಕನ್ನು ಬೆಳೆಯಲು ಎಲ್ಲಿಯೋ ಒಂದುಕಡೆ ಯಾರೋ ಒಬ್ಬರು ಒಂದು ಸಂಪೂರ್ಣಬೆಳೆದಿರುವ ಮರವನ್ನು ಕಡಿದು ಹಾಕಿರುತ್ತಾರೆಂದು ಅಂದಾಜುಮಾಡಲಾಗಿದೆ
* ಒಂದು ಕಿಲೋ ತಂಬಾಕನ್ನು ಶುದ್ಧೀಕರಿಸಲು 8 ಕಿಲೋ ಸೌದೆಯನ್ನು ಸುಡಬೇಕು. ಒಂದು ಹೆಕ್ಟೇರ್ ಭೂಮಿಯಲ್ಲಿ ಬೆಳೆದ ತಂಬಾಕನ್ನು ಶುದ್ಧೀಕರಿಸಲು ಇನ್ನೂ ಒಂದು ಹೆಕ್ಟೇರಿನಲ್ಲಿ ಬೆಳೆದಿರುವ ಮರಗಳನ್ನು ಕತ್ತರಿಸಿ ಸುಡಬೇಕು.
* ಸಿಗರೇಟುಗಳನ್ನು ಸುತ್ತಲು 7000 ಬಿಲಿಯನ್ (ಲಕ್ಷ ಕೋಟಿ) ಟನ್ ಕಾಗದವು ಉಪಯೋಗಿ-ಸಲ್ಪಡುತ್ತದೆ
* ಅಂತರ್ಜಲದ ಹೆಚ್ಚಿನಂಶವು ಈ ತಂಬಾಕಿನ ಬೆಳೆಗೆ ಉಪಯೋಗಿಸಲ್ಪಡುತ್ತದೆ.
* ಹೆಚ್ಚು ಹೆಚ್ಚಾಗಿ ಉಪಯೋಗಿಸಲ್ಪಡುವ ಕ್ರಿಮಿನಾಶಕಗಳು ಮತ್ತು ಮಣ್ಣು ಸರಿಯುವುದರಿಂದ ಕಾಡುಗಳು ನಾಶವಾಗುತ್ತವೆ

* ತಂಬಾಕಿನ ಕಾರ್ಖಾನೆಗಳು ಮಕ್ಕಳನ್ನು ಮತ್ತು ಯೌವನಸ್ಥ ತರುಣ,ತರುಣಿಯರನ್ನು ತೀಕ್ಷಣವಾಗಿ ಗುರಿಯಾಗಿಟ್ಟುಕೊಳ್ಳುತ್ತವೆ
* ಅದು ನೇರವಾದ ಮತ್ತು ನೇರವಲ್ಲದ ಪ್ರಚಾರಗಳನ್ನು ತಂಬಾಕಿನ ಪದಾರ್ಥಗಳ ಅಭಿವೃದ್ಧಿಗಾಗಿ ಉಪಯೋಗಿ-ಸಿಕೊಳ್ಳುತ್ತದೆ

ಪ್ರಖ್ಯಾತ ವ್ಯಕ್ತಿಗಳನ್ನೂ, ಸಿನಿಮಾತಾರೆಗಳನ್ನು ಪ್ರಾಯಸ್ಥರು ಮತ್ತು ಮಕ್ಕಳನ್ನು ಆಕರ್ಷಿಸಲು ಉಪಯೋಗಿಸಿಕೊಳ್ಳುತ್ತದೆ.

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ತಂಬಾಕು

ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಗಳು

ಮಾ ಹಿ ತಿ ಕೈ ಪಿ ಡಿ

: ಸಹಯೋಗ :

ಐಇಸಿ ವಿಭಾಗ ಹಾಗೂ ರಾಜ್ಯ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಘಟಕ
ಕರ್ನಾಟಕ ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳು
ಆನಂದ್ ರಾವ್ ವೃತ್ತ, ಬೆಂಗಳೂರು-9

ಒಳನೋಟ...

ಪುಟ ಸಂಖ್ಯೆ

ಭಾರತದಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾನೂನು

ಅಧ್ಯಾಯ 1 : ಸಾರ್ವಜನಿಕ ಪ್ರದೇಶಗಳಲ್ಲಿ ಧೂಮಪಾನ ನಿಷೇಧ 7

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1.2 ಸಾರ್ವಜನಿಕ ಪ್ರದೇಶಗಳಲ್ಲಿ ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಜನರ ಆರೋಗ್ಯದ ಮೇಲೆ ಆಗುವ ದುಷ್ಪರಿಣಾಮಗಳು 11

1.3 ಕಾನೂನು ಜಾರಿಗೆ ತರುವ ಅಧಿಕಾರಿಗಳ ಪಾತ್ರ

ಅಧ್ಯಾಯ2 : ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹಿರಾತು ನಿಷೇಧ

2.1 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹಿರಾತು, ಪ್ರೋತ್ಸಾಹ ಹಾಗೂ ಪ್ರಾಯೋಜಕತ್ವ ನಿರ್ಬಂಧಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಕಾನೂನು 12

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3.2 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳಿಂದ ಮಕ್ಕಳು ಹಾಗೂ ಯುವ ಜನತೆಯನ್ನು ರಕ್ಷಿಸಲು ಕಾರಣಗಳು 17

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4.1 ಆರೋಗ್ಯ ಹಾನಿ ಕುರಿತಂತೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮೇಲೆ ನಮೂದಿಸುವ ಎಚ್ಚರಿಕೆಗೆ ಸಂಬಂಧಿಸಿದ ಕಾನೂನು

4.2 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮೇಲೆ ಸಚಿತ್ರ ಎಚ್ಚರಿಕೆ ನೀಡಲು ಸಕಾರಣ 22

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ಪರಿಚಯ

ತಂಬಾಕು ಸೇವನೆಯನ್ನು ನಿಯಂತ್ರಿಸಲು ಸಮಗ್ರ ಕಾನೂನು ಇದ್ದರೂ ಕೂಡ ನಮ್ಮ ದೇಶದಲ್ಲಿ ತಂಬಾಕು ಸೇವನೆ ಸಾರ್ವಜನಿಕ ಜೀವನಕ್ಕೆ ಒಂದು ಗಂಭೀರ ಸವಾಲಾಗಿ ಪರಿಣಮಿಸಿದ್ದು, ಅಪಾರ ಪ್ರಮಾಣದಲ್ಲಿ ರೋಗ-ರುಜಿನು ಹಾಗೂ ಸಾವು ನೋವುಗಳಿಗೆ ಕಾರಣವಾಗಿದೆ.

ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯ ಅನುಷ್ಠಾನ ಮತ್ತು ಜಾರಿಗೆ ನೆರವಾಗುವುದು ಹಾಗೂ ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಶ್ರಮಿಸುತ್ತಿರುವವರಿಗೆ ಸೂಕ್ತ ಕಾನೂನು ಮಾಹಿತಿ ಒದಗಿಸುವುದು ಈ ಕೈಪಿಡಿಯ ಉದ್ದೇಶ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಗಳನ್ನು ಪರಿಣಾಮಕಾರಿಯಾಗಿ ಅಳವಡಿಸಬೇಕಾದರೆ ಆ ಕಾಯ್ದೆಗಳ ಬಗ್ಗೆ ಸರಿಯಾದ ಮಾಹಿತಿ ಮತ್ತು ಅವುಗಳನ್ನು ಅನುಷ್ಠಾನಕ್ಕೆ ತರುವುದರಿಂದ ಸಮಾಜಕ್ಕೆ ಆಗುವ ಉಪಯೋಗಗಳ ಕುರಿತು ಕಾನೂನು ಅಧಿಕಾರಿಗಳಷ್ಟೇ ಅಲ್ಲ, ಸಾರ್ವಜನಿಕರಿಗೆ, ವಾಣಿಜ್ಯ ಸಂಸ್ಥೆಗಳಿಗೆ ಹಾಗೂ ತಂಬಾಕು ಮಾರಾಟಗಾರರಿಗೆ ಮತ್ತೆ ಮತ್ತೆ ಮನವರಿಕೆ ಮಾಡುವ ಅವಶ್ಯಕತೆ ಇದೆ. ಮುಖ್ಯವಾಗಿ ಕಾನೂನು ಜಾರಿಗೆ ತರುವ ಅಧಿಕಾರಿಗಳನ್ನುಗಮನದಲ್ಲಿರಿಸಿಕೊಂಡು ಈ ಕೈಪಿಡಿ ತಯಾರಿಸಲಾಗಿದ್ದು, ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಿಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ಆಸಕ್ತಿ ಹಾಗೂ ಜವಾಬ್ದಾರಿ ಹೊಂದಿರುವ ಎಲ್ಲರಿಗೂ ಇದರಲ್ಲಿನ ಮಾಹಿತಿ ಉಪಯುಕ್ತವಾಗಿದೆ.

ತಂಬಾಕನ್ನು ಪೋರ್ಚುಗೀಸರು ಭಾರತದಲ್ಲಿ 16ನೇ ಶತಮಾನದಲ್ಲಿ ಪರಿಚಯಿಸಿದರು. ಇದೊಂದು ಹಾನಿಕಾರಕ ಪದಾರ್ಥ ಎಂದು ಕೆಲವು ಜನರು, ಮುಖ್ಯವಾಗಿ ವೈದ್ಯರು ಸಂದೇಹಿಸಿದರಾದರೂ ತಂಬಾಕು ಶೀಘ್ರವೇ ಭಾರತದಲ್ಲಿ ಜನಪ್ರಿಯವಾಯಿತು. ವರ್ಷಗಳು ಕಳೆದಂತೆ ಇದರ ಬಳಕೆ ಹಾಗೂ ಬೆಳೆ ಜಾಸ್ತಿಯಾಗುತ್ತ ಬಂದು ಹದಿನೇಳನೇ ಶತಮಾನದಲ್ಲಿ ಜಹಂಗೀರ್ ಮಹಾರಾಜ ಧೂಮಪಾನನಿಷೇಧ ಜಾರಿಗೆ ತಂದನಾದರೂ ಈ ಕಾಯ್ದೆ ಬಹುಕಾಲ ಉಳಿಯಲಿಲ್ಲ. ಆ ನಂತರ ಹತ್ತೊಂಬತ್ತನೇ ಶತಮಾನದ ಮೊದಲರ್ಧ ಭಾಗದವರೆಗೂ ಯಾವುದೇ ಮಹತ್ವದ ಕಾಯ್ದೆ ಜಾರಿಗೆ ಬರಲಿಲ್ಲ. ನಂತರ 1960ರ ದಶಕದಲ್ಲಿ ಬ್ರಿಟನ್ನಿನ ರಾಯಲ್ ಕಾಲೇಜ್ ಹಾಗೂ ಅಮೇರಿಕದ ಸರ್ಜನ್ ಜನರಲ್ ಸಲಹಾ ಸಮಿತಿ ನಡೆಸಿದ ಅಧ್ಯಯನಗಳು ತಂಬಾಕು ಹಾಗೂ ಕ್ಯಾನ್ಸರ್ ನಡುವಣ ಕಾರಣ-ಪರಿಣಾಮಗಳ ಮೇಲೆ ಬೆಳಕು ಚೆಲ್ಲಿದವು. ತಂಬಾಕು ಬಳಕೆ ಒಂದು ಜಾಗತಿಕ ಸಮಸ್ಯೆಯಾಗಿ ಪರಿಣಮಿಸಿತು. ಸಾಕ್ಷಧಾರಿತ ಅಧ್ಯಾಯನಗಳ ಆಧಾರದ ಮೇಲೆ ಹಲವಾರು ದೇಶಗಳು ತಂಬಾಕು ವಿರೋಧಿ ಕಾನೂನುಗಳನ್ನು ಕ್ರಮೇಣವಾಗಿ ಜಾರಿಗೆ ತರಲು ಆರಂಭಿಸಿದವು. ಇತ್ತೀಚಿನ ದಶಕಗಳಲ್ಲಿ ಈ ಕಾನೂನುಗಳು ಕಟ್ಟು ನಿಟ್ಟಾಗುತ್ತಿದ್ದು, ತಂಬಾಕು ವಿರುದ್ಧದ ಸಮರದಲ್ಲಿ ಬಹುತೇಕ ದೇಶಗಳು ಹೆಚ್ಚಿನ ಬದ್ಧತೆಯನ್ನು ತೋರಿಸುತ್ತಿದೆ. ವಿಶ್ವಆರೋಗ್ಯ ಸಂಸ್ಥೆಯ (WHO) ತಂಬಾಕು ನಿಯಂತ್ರಣ ಸಮ್ಮೇಳನದ (FCTC-Framework convention of Tobacco Control) ಪ್ರಥಮ ಅಂತರರಾಷ್ಟ್ರೀಯ ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಒಡಂಬಡಿಕೆಗೆ 164 ದೇಶಗಳು ಸಮ್ಮತಿಸಿದ್ದು ಇದಕ್ಕೆ ಸಾಕ್ಷಿ.

ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಜಗತ್ತಿನಲ್ಲಿ ವರ್ಷಕ್ಕೆ ಐದು ಮಿಲಿಯನ್‌ಗೂ ಹೆಚ್ಚುಜನ ಸಾವನ್ನಪ್ಪುತ್ತಾರೆ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯನ್ನುಸೂಕ್ತವಾಗಿ ಅನುಷ್ಠಾನಕ್ಕೆ ತರಬೇಕಾಗುವ ತುರ್ತು ಅವಶ್ಯಕತೆಯನ್ನು ಈ ಅಂಕಿ ಅಂಶಗಳು ಸಾರಿ ಹೇಳುತ್ತವೆ. ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಸಾರ್ವಜನಿಕರ ಆರೋಗ್ಯದ ಮೇಲೆ ಉಂಟಾಗುವ ಹಾನಿ ಸರ್ಕಾರದ ಮೇಲೊಂದು ದೊಡ್ಡ ಆರ್ಥಿಕ ಭಾರವೇ ಸರಿ. ಭಾರತೀಯ ವೈದ್ಯಕೀಯ ಸಂಶೋಧನಾ ಮಂಡಳಿಯ (ICMR – Indian Council of Media Research) ಪ್ರಕಾರ, ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಉಂಟಾಗುವ ಶ್ವಾಸಕೋಶ ಕಾಯಿಲೆ (COPD – Chronic Obsructive Pulmonary Disease) ಹೃದಯ ಕಾಯಿಲೆ (CAD – Coronary Artery Disease) ಹಾಗೂ ಕ್ಯಾನ್ಸರ್ ಚಿಕಿತ್ಸೆಗೆ 2002-2003 ರಲ್ಲಿ ರೂ. 308.33 ಬಿಲಿಯನ್ ವೆಚ್ಚ ತಗುಲಿದ್ದು, ಇದು ತಂಬಾಕು ಉದ್ದಿಮೆಯಿಂದ ನಿರ್ಮಾಣವಾಗುವ ಉದ್ಯೋಗಾವಕಾಶಗಳಿಂದ ಉಂಟಾಗುವ ಲಾಭಕ್ಕಿಂತ ಅತ್ಯಂತ ಹೆಚ್ಚಾಗಿದೆ.

ಅಲ್ಲದೇ, ಸಾರ್ವಜನಿಕರ ಆರೋಗ್ಯವನ್ನು ಸುಧಾರಿಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ಸರ್ಕಾರದ ಮೇಲೆ ಇರುವ ಸಂವಿಧಾನಿಕ ಜವಾಬ್ದಾರಿ ಹಾಗೂ ಉತ್ತಮ ಜೀವನದ ಹಕ್ಕನ್ನು ರಕ್ಷಿಸುವ ಕಾರಣದಿಂದಾಗಿಯೂ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆ ಅತ್ಯಾವಶ್ಯಕವಾಗಿದೆ. ಈ ಕಾರಣದಿಂದಲೇ ಆರೋಗ್ಯ ಹಾಗೂ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸಚಿವಾಲಯವು 2001 ರಲ್ಲಿ ಸಿಗರೇಟ್ ಹಾಗೂ ಇತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ (ಜಾಹಿರಾತು ನಿಷೇಧ ಹಾಗೂ ವ್ಯಾಪಾರ-ವಾಣಿಜ್ಯ, ಉತ್ಪಾದನೆ ಪೂರೈಕೆ ಹಾಗೂ ಹಂಚಿಕೆ) ಮಸೂದೆಯನ್ನು ಪರಿಚಯಿಸಿತು.

ಇದೇ ಸಮಯದಲ್ಲಿ ಭಾರತ ತಂಬಾಕು ವಿರುದ್ಧದ ಸಮರ ಹಾಗೂ WHO FCTC ಅಭಿವೃದ್ಧಿಯಲ್ಲಿ ಪ್ರಮುಖ ನಾಯಕತ್ವವಹಿಸಿತು. ಸಿಗರೇಟ್ ಕಾಯ್ದೆ,1975 ಜಾರಿಗೆ ಬಂತು.

ತಂಬಾಕು ನಿಯಂತ್ರಣ ಬೆಂಬಲ ಸಂಘ (AFTC- Advocacy for Tobacco Control) ವು ತಂಬಾಕು ವಿರೋಧಿಸುವ ಎಲ್ಲ ಜನರಿಗೆ, ಸಂಘಗಳಿಗೆ ಒಂದು ಉತ್ತಮ ವೇದಿಕೆಯಾಗಿ ಪರಿಣಮಿಸಿತು. AFTC ಯ ಮೂಲಕ ನಡೆದ ವ್ಯಾಪಕ ಚಳುವಳಿ, ಪ್ರಚಾರದಿಂದಾಗಿ ಒಂದು ಸುಧಾರಿತ, ಸಮಗ್ರ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯನ್ನು ಸಂಸತ್ತಿನಲ್ಲಿ ಫೆಬ್ರವರಿ, 2003 ರಲ್ಲಿ ಮಂಡಿಸಲು ಸಾಧ್ಯವಾಯಿತು. ಈ ಮಸೂದೆಯು ರಾಷ್ಟ್ರಪತಿಗಳ ಅಂಗೀಕಾರದ ನಂತರ ಮೇ 18,2003 ರಂದು ಶಾಸನವಾಗಿ, ಪರಿವರ್ತನೆಗೊಂಡು ಮೇ 1, 2004 ರಂದು ಜಾರಿಗೆ ಬಂತು.

ಸಿಗರೇಟ್ ಹಾಗೂ ಇತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ (ಜಾಹಿತರಾತು ನಿಷೇಧ ಹಾಗೂ ವ್ಯಾಪಾರ, ವಾಣಿಜ್ಯ, ಉತ್ಪದನೆ ಪೂರೈಕೆ ಹಾಗೂ ಹಂಚಿಕೆ ನಿಯಂತ್ರಣ) ಕಾಯ್ದೆಯು The Cigarettes and other Tobacco Products Act-2003 (COTPA) ತಂಬಾಕು ಸೇವಿಸುವ ಜನರನ್ನು ಹಾಗೂ ತಂಬಾಕು ಸೇವಿಸದಿದ್ದರೂ ಇತರರು ಸೇವಿಸುವುದರಿಂದ ತೊಂದರೆ ಅನುಭವಿಸುವ ಜನರನ್ನು ತಂಬಾಕಿನ ದುಷ್ಪರಿಣಾಮಗಳಿಂದ ರಕ್ಷಿಸುವ ಗುರಿ ಹೊಂದಿದೆ. ತಂಬಾಕಿನಲ್ಲಿ ಕ್ಯಾನ್ಸರ್‌ಕಾರಕ ಹಾಗೂ ಇತರ ಹಾನಿಕಾರಕ ಅಂಶಗಳಿರುತ್ತವೆ. ತಂಬಾಕು ಜಾಹೀರಾತುಗಳನ್ನು ನಿಷೇಧಿಸುವುದು ಹಾಗೂ ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರ ಕೈಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು ನಿಲುಕದಂತೆ ನೋಡಿಕೊಳ್ಳುವುದು ಈ ಕಾಯ್ದೆಯ ಉದ್ದೇಶಗಳಲ್ಲಿ ಒಂದು. ಆದರೆ ಇಂಥದೊಂದು ಕಾಯ್ದೆ ಇದೆ ಎಂದ ಮಾತ್ರಕ್ಕೆ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳನ್ನು ತಂಬಾಕು ಮುಕ್ತವಾಗಿಸುವುದಾಗಲೀ, ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರು ತಂಬಾಕು ಚಟಕ್ಕೆ ಬಲಿಯಾಗುವುದನ್ನು ತಪ್ಪಿಸುವುದಾಗಲೀ ಸಾಧ್ಯವಾಗುವುದಿಲ್ಲ. ಈ ಕಾಯ್ದೆಯನ್ನು ಜಾರಿಗೆ ತರಲು ಸಂಪೂರ್ಣವಾಗಿ, ಶ್ರದ್ಧಾಪೂರ್ವಕವಾಗಿ ಪ್ರಯತ್ನಗಳನ್ನು ಮಾಡದೇ ಇದ್ದರೆ ಇದರ ನಿಜವಾದ ಪ್ರಯೋಜನವಾಗುವುದಿಲ್ಲ. ರಾಜ್ಯ ಹಾಗೂ ರಾಷ್ಟ್ರಮಟ್ಟದಲ್ಲಿ ಈ ಕಾಯ್ದೆಯನ್ನು ಸರಿಯಾಗಿ ಜಾರಿಗೆ ತರುವ ಅವಶ್ಯಕತೆಯಿದೆ.

ಒಂದು ಕಾಯ್ದೆಯನ್ನು ಅನುಷ್ಠಾನ ಹಾಗೂ ಜಾರಿಗೊಳಿಸಲು ಆ ಕಾಯ್ದೆಯ ಸಕಾರಣತೆ, ಅದರ ಉದ್ದೇಶ , ಅದು ಒಳಗೊಂಡಿರುವ ಅಂಶಗಳು ಹಾಗೂ ವಿಧಾನಗಳನ್ನು ಸರಿಯಾಗಿ ಅರ್ಥ ಮಾಡಿಕೊಳ್ಳುವುದು ಅತ್ಯವಶ್ಯ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆ, ಅದರ ಮಹತ್ವ, ಹಾಗೂ ಅದನ್ನು ಸೂಕ್ತವಾಗಿ ಜಾರಿಗೆ ತರಲು ರಾಜ್ಯಸ್ಥಳೀಯ ಆಡಳಿತವು ಪಾಲಿಸಬೇಕಾದ ವಿಧಿ ವಿಧಾನಗಳನ್ನು ವಿವರಿಸುವುದು ಈ ಕೈಪಿಡಿಯ ಉದ್ದೇಶ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯನ್ನು ಜಾರಿಗೊಳಿಲಸುವ ಎಲ್ಲ ಅಧಿಕಾರಿಗಳಿಗೆ, ಸಿಬ್ಬಂದಿಗಳಿಗೆ ಈ ಕೈಪಿಡಿ ಅತ್ಯಂತ ಪ್ರಯೋಜನಕಾರಿಯಾಗಿದೆ.

ಭಾರತದಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆ

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ತಂಬಾಕು ನಿಷೇಧ ; ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹಿರಾತು, ಉತ್ತೇಜನ ಹಾಗೂ ಪ್ರಯೋಜಕತ್ವ ; ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ತಂಬಾಕು ಮಾರುವುದರ ಮೇಲೆ ನಿರ್ಬಂಧ ಹಾಗೂ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ

ಮೇಲೆ ಆರೋಗ್ಯಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಶಾಸನ ವಿಧಿಸಿದ ಎಚ್ಚರಿಕೆಯನ್ನು ಪ್ರಕಟಿಸುವುದು–ಈ ಎಲ್ಲ ಅಂಶಗಳನ್ನೊಳಗೊಂಡಿದೆ

(COTPA) ಅಡಿಯಲ್ಲಿ ನಮೂದಿಸಲಾಗಿರುವ ಉದ್ದೇಶಗಳನ್ನು ಸಾಧಿಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ಕೇಂದ್ರ ಸರ್ಕಾರ ಆಯಾ ಸಮಯದಲ್ಲಿ ನಿಯಮಗಳನ್ನು ಜಾರಿಗೊಳಿಸುತ್ತದೆ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯನ್ನು ಜಾರಿಗೊಳಿಸುವ ಸಿಬ್ಬಂದಿ ಹಾಗೂ ಅಧಿಕಾರಿಗಳ ಪ್ರಯೋಜನಕ್ಕೋಸ್ಕರ ಇರುವಂತಹ ನಿಯಮಗಳನ್ನು ಇದರಲ್ಲಿ ಚರ್ಚಿಸಲಾಗಿದೆ.

ತಂಬಾಕು ನಿಯಂತ್ರಣಕ್ಕೆ ಬೆಂಬಲ ನೀಡುವ ರಾಷ್ಟ್ರೀಯ ಹಾಗೂ ಅಂತರರಾಷ್ಟ್ರೀಯ ಕಾನೂನು ವ್ಯವಸ್ಥೆ ಹಾಗೂ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯನ್ನು ಸಮಗ್ರವಾಗಿ ಅರಿಯಲು ಇದು ಸಹಾಯಕವಾಗುತ್ತದೆ. ಅಧಿಕಾರಿಗಳು ತಮ್ಮ ಜವಾಬ್ದಾರಿಗಳನ್ನು ಅರಿತುಕೊಂಡು ಕರ್ತವ್ಯ ನಿರ್ವಹಿಸುವಲ್ಲಿಯೂ ನೆರವಾಗುತ್ತದೆ. ತಂಬಾಕು ನಿಯಂತ್ರಣಕ್ಕೆ ಸಂಬಂಧಿಸಿದಂತೆ ಅಪರಾಧ ಸಂಹಿತೆ, 1973 ಹಾಗೂ ಭಾರತೀಯ ದಂಡ ಸಂಹಿತೆ, 1860ರಲ್ಲಿ ವಿಧಿಸಲಾದ ಪ್ರಕ್ರಿಯೆಗಳನ್ನೂ ಇದರಲ್ಲಿ ಚರ್ಚಿಸಲಾಗಿದೆ.

ಭಾರತದಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯ ಅನುಷ್ಠಾನ ಹಾಗೂ ಜಾರಿಯನ್ನು ಉತ್ತಮಗೊಳಿಸಲು ಅಗತ್ಯವಿರುವ ಅಂಶಗಳನ್ನು ಇಲ್ಲಿ ವಿಶ್ಲೇಷಿಸಲಾಗಿದೆ. ಪೋಲೀಸ್ ಅಧಿಕಾರಿಗಳು, ಔಷಧಿ ನಿರೀಕ್ಷಕರು, ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಗಳ ಮುಖ್ಯಸ್ಥರು ಹಾಗೂ ಹೋಟೆಲ್, ರೆಸ್ಟೋರೆಂಟ್, ವಿಮಾನ ನಿಲ್ದಾಣದಂತಹ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳ ಮಾಲೀಕರಿಗೆ, ವ್ಯವಸ್ಥಾಪಕರಿಗೆ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯನ್ನು ಸೂಕ್ತವಾಗಿ ಜಾರಿಗೆ ತರುವಲ್ಲಿ ಈ ಮಾಹಿತಿ ನೆರವಾಗುತ್ತದೆ.

ಅಧಿಕೃತ ಅಧಿಕಾರಿಗಳು ಹಾಗೂ ಅಪರಾಧ ಹಾಗೂ ಶಿಕ್ಷೆಯನ್ನು ದಾಖಲಿಸುವ ವಿಧಾನಗಳನ್ನು ಅನುಬಂಧದಲ್ಲಿ ಪಟ್ಟಿ ಮಾಡಲಾಗಿದೆ.

ಭಾರತದಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾನೂನು

ಭಾರತೀಯ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಯ ಪ್ರಮುಖ ಅಂಶಗಳು ಹೀಗಿವೆ

1. ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ನಿಷೇಧ
2. ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು, ಉತ್ತೇಜನ ಹಾಗೂ ಪ್ರಾಯೋಜಕತ್ವದ ಮೇಲೆ ಹೇರಲಾದ ನಿರ್ಬಂಧ
3. ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರುವುದರ ಮೇಲೆ ವಿಧಿಸಿದ ನಿರ್ಬಂಧ
4. ಎಲ್ಲ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮೇಲೆ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯನ್ನು ಪ್ರಕಟಿಸುವುದು.

ಈ ನಾಲ್ಕು ಅಂಶಗಳನ್ನು ಪ್ರತ್ಯೇಕ ಅಧ್ಯಾಯಗಳಲ್ಲಿ ಚರ್ಚಿಸಲಾಗಿದೆ. ಸಬ್-ಇನ್ಸಪೆಕ್ಟರ್ ಹಾಗೂ ಅದಕ್ಕೆ ಮೇಲ್ಪಟ್ಟ ಹುದ್ದೆ ಹೊಂದಿರುವ ಪೋಲೀಸ್ ಅಧಿಕಾರಿಗಳು ಅಥವಾ ಇದಕ್ಕೆ ಸಮನಾದ ಹುದ್ದೆ ಹೊಂದಿರುವ ಆಹಾರ ಹಾಗೂ ಔಷಧಿ ನಿಯಂತ್ರಣ ಅಧಿಕಾರಿಗಳು ಅಥವಾ ಇದಕ್ಕೆ ಸಮಾನಾದ ಹುದ್ದೆ ಹೊಂದಿರುವ ಇತರ ಅಧಿಕಾರಿಗಳು ಅಥವಾ COTPA ಅಡಿಯಲ್ಲಿ ಕ್ರಮ ಕೈಗೊಳ್ಳಲು ರಾಜ್ಯ ಸರ್ಕಾರ ಅಥವಾ ಭಾರತ ಸರ್ಕಾರದಿಂದ ನಿಯೋಜಿತಗೊಂಡಿರುವ ವ್ಯಕ್ತಿಗಳನ್ನು ತಂಬಾಕು ಕಾಯ್ದೆ ಜಾರಿಗೆ ತರುವ ಅಧಿಕಾರಿಗಳೆಂದು ಉಲ್ಲೇಖಿಸಲಾಗಿದೆ.

ಅಧ್ಯಾಯ-1

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ನಿಷೇಧ

1.1 ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ನಿಷೇಧಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಕಾನೂನು ಯಾವುದೇ ವ್ಯಕ್ತಿ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡಕೂಡದು.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳದ ವ್ಯಾಖ್ಯೆ [S.3(1)]

COTPA ಅಡಿಯಲ್ಲಿ ವ್ಯಾಖ್ಯಾನಿಸಿದ ಪ್ರಕಾರ, ಸಾರ್ವಜನಿಕರು ಭೇಟಿ ನೀಡುವ ಸ್ಥಳಗಳನ್ನು 'ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳು' ಎನ್ನಲಾಗುತ್ತದೆ. ಖಾಲಿ ಪ್ರದೇಶಗಳು ಇದರಲ್ಲಿ ಸೇರಿಲ್ಲ, ಆದರೆ ತೆರೆದ ಸಭಾಂಗಣಗಳು, ಕ್ರೀಡಾಂಗಣಗಳು, ರೈಲ್ವೆ ನಿಲ್ದಾಣಗಳು, ಬಸ್‌ನಿಲ್ದಾಣಗಳು ಹಾಗೂ ಇಂತಹ ಇತರ ಪ್ರದೇಶಗಳು ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳ ವ್ಯಾಪ್ತಿಗೆ ಸೇರಿವೆ.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಸಿಗರೇಟ್ ಸೇದುವುದನ್ನು COTPA ಕಾಲಂ 4 ನಿಷೇಧಿಸುತ್ತದೆ. 30 ಹಾಗೂ ಅದಕ್ಕಿಂತ ಹೆಚ್ಚು ಕೋಣೆಗಳನ್ನು ಹೊಂದಿರುವ ಹೋಟೆಲ್ ಅಥವಾ 30 ಅಥವಾ ಅದಕ್ಕಿಂತ ಹೆಚ್ಚು ಸೀಟ್‌ಗಳನ್ನು ಹೊಂದಿರುವ ರೆಸ್ಟೋರೆಂಟ್‌ಗಳಲ್ಲಿ ಹಾಗೂ ವಿಮಾನ ನಿಲ್ದಾಣಗಳಲ್ಲಿ ಧೂಮಪಾನಕ್ಕೆ ಪ್ರತ್ಯೇಕವಾದ ಸ್ಥಳವನ್ನು ಮೀಸಲಿಡಲು ಅನುಮತಿ ಇದೆ.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳದಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡಿದರೆ ವಿಧಿಸಲಾಗುವ ದಂಡ (S.21)

ಸಾರ್ವಜನಿಕ ಸ್ಥಳದಲ್ಲಿ ಸಿಗರೇಟ್ ಸೇದುವ ಯಾವುದೇ ವ್ಯಕ್ತಿಗೆ ರೂ. 200 ರವರೆಗೆ ದಂಡ ವಿಧಿಸಲಾಗುತ್ತದೆ.

ಧೂಮಪಾನ ಮುಕ್ತ ಸಾರ್ವಜನಿಕ ಪ್ರದೇಶಗಳನ್ನು ನಿರ್ಮಿಸುವುದು (S.25 ಹಾಗೂ 28)

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವ ವ್ಯಕ್ತಿಗಳ ವಿರುದ್ಧ ಕ್ರಮ ಕೈಗೊಳ್ಳಲು ರಾಜ್ಯ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರವು ಅಧಿಕಾರಿಗಳನ್ನು ನಿಯೋಜಿಸಬಹುದು. ಈ ಅಪರಾಧಕ್ಕೆ ದಂಡವನ್ನು ಅಧಿಕಾರಿಗಳು ಸ್ಥಳದಲ್ಲಿಯೇ ವಿಧಿಸಬಹುದು. ಅಥವ 1973ರ ಅಪರಾಧ ಸಂಹಿತೆಯ ಪ್ರಕಾರ ಇತರ ಕ್ರಮ ಕೈಗೊಳ್ಳಬಹುದು. COTPA ಅಡಿಯಲ್ಲಿ ಕಾರ್ಯನಿರ್ವಹಿಸುವ ನಿಯೋಜಿತ ಅಧಿಕಾರಿಗಳನ್ನು ಸಾರ್ವಜನಿಕ ಸೇವೆಯಲ್ಲಿರುವ ಅಧಿಕಾರಿಗಳು ಎಂದು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವುದು ನಿಷೇಧಿಸುವ ನಿಯಮಗಳು:

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನವನ್ನು ನಿರ್ಬಂಧಿಸಲು ಫೆಬ್ರವರಿ 2004 ರಲ್ಲಿ ನಿಯಮಗಳನ್ನು ಪ್ರಥಮ ಬಾರಿಗೆ ಪರಿಚಯಿಸಲಾಯಿತು. ಈ ನಿಯಮಗಳಲ್ಲಿ ಕೆಲವು ಲೋಪದೋಷಗಳಿದ್ದವು. ಉದಾಹರಣೆಗೆ, ಈ ನಿಯಮಗಳನ್ನು ಜಾರಿಗೆ ತರುವ ಜವಾಬ್ದಾರಿಯುತ ಅಧಿಕಾರಿಗಳು ಯಾರು ಎಂಬುದರ ಬಗ್ಗೆ ಸ್ಪಷ್ಟತೆ ಇರಲಿಲ್ಲ ಹಾಗೂ ಧೂಮಪಾನ ಅನುಮತಿ ಇರುವ ಹಾಗೂ ಇಲ್ಲದೇ ಇರುವ ಸ್ಥಳಗಳನ್ನು ಸೂಕ್ತವಾಗಿ ವಿಂಗಡಿಸಿರಲಿಲ್ಲ. ಈ ಲೋಪದೋಷಗಳನ್ನು ಸರಿಪಡಿಸಲು ಮೇ 30, 2008 ರಂದು ಹೊಸ ನಿಯಮಗಳನ್ನು ಜಾರಿಗೆ ತರಲಾಯಿತು.

(ಸಾರ್ವಜನಿಕ ಸ್ಥಳದಲ್ಲಿ ಪ್ರದರ್ಶಿಸಲಾದ ನಾಮಫಲಕ)

ಮೇ 30, 2008 ರಂದು ಉಲ್ಲೇಖಿಸಲಾದ ನಿಯಮಗಳು ಅಕ್ಟೋಬರ್ 2 ರಂದು ಜಾರಿಗೆ ಬಂದವು. ಈ ನಿಯಮಗಳ ಪ್ರಕಾರ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳನ್ನು ನಿರ್ವಹಿಸುತ್ತಿರುವ ಆಡಳಿತ ಮಂಡಳಿ ಈ ಕೆಳಗಿನ ವಿಷಯಗಳನ್ನು ಗಮನದಲ್ಲಿರಿಸಿಕೊಳ್ಳಬೇಕು.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಪ್ರದರ್ಶಿಸಬೇಕಾದ ಮಾದರಿ ನಾಮಫಲಕಗಳು

- ಯಾವುದೇ ವ್ಯಕ್ತಿ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಸಿಗರೇಟು

ಸೇದಕೂಡದು. (ರೆಸ್ಟೋರೆಂಟ್ ಹಾಗೂ ಹೋಟೆಲ್ ಸೇರಿದಂತೆ)

- ಧೂಮಪಾನ ನಿಷೇಧಿತ ಪ್ರದೇಶ–ಇಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವುದು ಅಪರಾಧ ಎಂದು ಬರೆದ 60X30 ಸೆ.ಮೀ. ಬೋರ್ಡನ್ನು ಈ ಕೆಳಗಿನ ಪ್ರದೇಶಗಳಲ್ಲಿ ಎಲ್ಲರೂ ಗಮನಿಸುವ ಹಾಗೆ ಪ್ರದರ್ಶಿಸಬೇಕು.

  ಅ: ಪ್ರತಿಯೊಂದು ಪ್ರವೇಶ ದ್ವಾರ

  ಆ: ಪ್ರತಿ ಮಹಡಿ

  ಇ: ಪ್ರತಿ ಮೆಟ್ಟಿಲು ಸ್ಥಳ

  ಈ: ಪ್ರತಿಯೊಂದು ಲಿಫ್ಟ್ ಬಳಿ

  ಉ:ಒಳಗಡೆ ಸುಲಭವಾಗಿ ಎದ್ದು ಕಾಣುವಪ್ರದೇಶಗಳಲ್ಲಿ

- ಒಂದು ವೇಳೆ ಯಾರಾದರೂ ನಿಯಮಗಳನ್ನು ಉಲ್ಲಂಘಿಸಿದರೆ, ಯಾರಿಗೆ ದೂರು ಕೊಡಬೇಕು ಎಂಬುದನ್ನು ಸ್ಪಷ್ಟವಾಗಿ ಉಲ್ಲೇಖಿಸಬೇಕು.

- ಆಶ್ ಟ್ರೇ, ಲೈಟರ್, ಬೆಂಕಿಪೊಟ್ಟಣ ಹೀಗೆ ಸಿಗರೇಟು ಸೇದಲು ಪೂರಕವಾದ ಯಾವುದೇ ಸೌಲಭ್ಯಗಳನ್ನು ಒದಗಿಸುವಂತಿಲ್ಲ.

(ಸಾರ್ವಜನಿಕ ಉದ್ಯಮಗಳಲ್ಲಿ ಪ್ರದರ್ಶಿಸಲಾದ ನಾಮಫಲಕ)

- ಮೂವತ್ತು ಅಥವಾ ಅದಕ್ಕಿಂತ ಹೆಚ್ಚು ಕೋಣೆಗಳಿರುವ ಹೋಟೆಲ್‌ಗಳಲ್ಲಿ, ಮೂವತ್ತು ಅಥವಾ ಅದಕ್ಕಿಂತ ಹೆಚ್ಚು ಸಿಗರೇಟುಗಳನ್ನು ಹೊಂದಿರುವ ರೆಸ್ಟೋರೆಂಟ್‌ಗಳಲ್ಲಿ ಹಾಗೂ ಏರ್‌ಪೋರ್ಟ್‌ಗಳಲ್ಲಿ ಧೂಮಪಾನಕ್ಕಾಗಿ ವಿಶೇಷ ಸ್ಥಳಗಳನ್ನು ಮೀಸಲಿಡಲು ಅವಕಾಶವಿದೆ. ಇಂತಹ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನಕ್ಕೆ ಅವಕಾಶವಿರುವ ಸ್ಥಳ ಎಂದು ಸ್ಪಷ್ಟವಾಗಿ ಇಂಗ್ಲೀಷ್ ಹಾಗೂ ಆಯಾ ಪ್ರದೇಶದ ಸ್ಥಳಿಯ ಭಾಷೆಯಲ್ಲಿ ಬರೆಯಬೇಕು.

- ಹೀಗೆ ಧೂಮಪಾನಕ್ಕೆ ಅವಕಾಶವಿರುವ ಸ್ಥಳಗಳು ಧೂಮಪಾನಕ್ಕೆ ಮಾತ್ರ ಸೀಮಿತವಾಗಿರಬೇಕು. ಅಲ್ಲಿ ಇತರ ಯಾವುದೇ ಸೇವೆ ಒದಗಿಸುವ ಹಾಗಿಲ್ಲ.

ಧೂಮಪಾನಕ್ಕೆ ಅವಕಾಶ ಇಲ್ಲದೇ ಇರುವ ಜಾಗಗಳಲ್ಲಿ ಯಾರಾದರೂ ಕಾನೂನು ಉಲ್ಲಂಘಿಸಿದ್ದು, ಅಂತಹವರ ಕುರಿತು ಬಂದ ದೂರುಗಳನ್ನು ಮಾಲೀಕ, ವ್ಯವಸ್ಥಾಪಕ ಅಥವಾ ಮೇಲ್ವಿಚಾರಕ ಮುಂತಾದ ಹುದ್ದೆಯಲ್ಲಿರುವವರು ನಿರ್ಲಕ್ಷಿಸಿದರೆ ಅವರು ದಂಡತೆರಬೇಕಾಗುತ್ತದೆ.

ಧೂಮಪಾನಕ್ಕೆ ಅವಕಾಶವಿರುವ ಪ್ರದೇಶ

ನಿಯಮ 2 (e) ರಲ್ಲಿ ಉಲ್ಲೇಖಿಸಿದಂತೆ ಧೂಮಪಾನ ಪ್ರದೇಶವು ಇತರ ಸ್ಥಳಗಳಿಂದ ಪ್ರತ್ಯೇಕವಾಗಿ ಇರಬೇಕು ಹಾಗೂ ನಾಲ್ಕೂ ಕಡೆಯಲ್ಲಿ ಎತ್ತರವಾದ ಗೋಡೆಗಳಿದ್ದು, ಸಂಪೂರ್ಣವಾಗಿ ಗಾಳಿ, ಬೆಳಕು ಆಡುವಂತಿರಬೇಕು. ಈ ಕೋಣೆಗೆ ಸ್ವಯಂಚಾಲಿತ ಬಾಗಿಲು ಇರಬೇಕು ಹಾಗೂ ಅದು ಸಾಮಾನ್ಯವಾಗಿ ಮುಚ್ಚಿರಬೇಕು. ಅಲ್ಲಿ ಸಿಗರೇಟಿನಿಂದ ಹೊರಹೊಮ್ಮುವ ಹೊಗೆ, ಆ ಕಟ್ಟಡದ ಇತರ ಕೋಣೆಗಳಿಗೆ ಪಸರಿಸದೇ, ನೇರವಾಗಿ ಆಚೆ ಹೋಗಲು ಎಕ್ಸಾಸ್ಟ್ ಫ್ಯಾನ್ ಅಥವಾ ಹವೆಯನ್ನು ಶುದ್ಧಗೊಳಿಸುವ ವ್ಯವಸ್ಥೆಯನ್ನು ಅಳವಡಿಸಬೇಕು.

ಧೂಮಪಾನ ಮಾಡಲು ಪ್ರತ್ಯೇಕ ಕೋಣೆ

- ಮೂವತ್ತು ಅಥವಾ ಅದಕ್ಕಿಂತ ಹೆಚ್ಚು ಕೋಣೆಗಳನ್ನು ಹೊಂದಿರುವ ಹೊಟೆಲ್‌ಗಳಲ್ಲಿ ಸಿಗರೇಟು ಸೇದಲು ಪ್ರತ್ಯೇಕ ಕೋಣೆಯನ್ನು ಮೀಸಲಿಡಬಹುದು. ಆದರೆ, ಹಾಗೆ ಮಾಡಲು ಈ ಕೆಳಗಿನ ನಿಯಮಗಳನ್ನು ಪಾಲಿಸಬೇಕಾಗುತ್ತದೆ.

* ಇಂತಹ ಕೋಣೆಯು ಆ ಮಹಡಿಯಲ್ಲಿರಬೇಕು ಪ್ರತ್ಯೇಕ ವಿಭಾಗದಲ್ಲಿರಬೇಕು. ಒಂದು ವೇಳೆ ಹೆಚ್ಚು ಮಹಡಿಗಳಿದ್ದರೆ, ಇಂತಹ ಕೋಣೆ ಯಾವುದಾದರೊಂದು ಮಹಡಿಯಲ್ಲಿರಬೇಕು.
* ಧೂಮಪಾನ ಕೋಣೆ ಎಂದು ಅಲ್ಲಿ ಸ್ಪಷ್ಟವಾಗಿ ಎದ್ದು ಕಾಣುವ ಹಾಗೆ ಇಂಗ್ಲೀಷಿನಲ್ಲಿ ಹಾಗೂ ಆಯಾ ಪ್ರದೇಶಕ್ಕೆ ಅನ್ವಯಿಸುವ ಭಾರತೀಯ ಭಾಷೆಯಲ್ಲಿ ಬರೆಯಬೇಕು.
* ಇಂತಹ ಕೋಣೆಗಳಿಂದ ಹೊಗೆ ನೇರವಾಗಿ ಹೊರಹೋಗುವಂತೆ ವ್ಯವಸ್ಥೆಯಿರಬೇಕು.

(ಧೂಮಪಾನಕ್ಕೆ ಮೀಸಲಿಟ್ಟ ಪ್ರತ್ಯೇಕ ಸ್ಥಳ)

ಅಧಿಕೃತ ಅಧಿಕಾರಿಗಳು

ಈ ಕಾಯ್ದೆಯ ನಾಲ್ಕನೇ ಅನುಚ್ಛೇದದ ನಿಯಮಗಳನ್ನು ಜಾರಿಗೊಳಿಸಲು, ಹನ್ನೆರಡು ವಿಭಾಗಗಳಿಗೆ ಸೇರಿದ ಅಧಿಕಾರಿಗಳನ್ನು ನಿಯೋಜಿಸಲಾಗುತ್ತದೆ. ಇತರ ಅಧಿಕಾರಿಗಳಲ್ಲದೇ ಒಂದು ಸಂಸ್ಥೆಯ ಮುಖ್ಯಸ್ಥ, ಮಾನವ ಸಂಪನ್ಮೂಲ ಅಧಿಕಾರಿ ಅಥವಾ ಆಡಳಿತಾಧಿಕಾರಿ ಕೂಡ ತಪ್ಪಿತಸ್ಥರ ಮೇಲೆ ದಂಡ ವಿದಿಸಲು ಹಾಗೂ ದಂಡ ಸಂಗ್ರಹಿಸಲು ಅಧಿಕಾರ ಹೊಂದಿರುತ್ತಾರೆ.

ಕೋರ್ಟ್ ಆದೇಶ

ಈ ನಿಯಮಗಳು ಪರಿಣಾಮಕಾರಿಯಾಗಿದ್ದು, ಇದರ ಅನುಷ್ಠಾನವನ್ನು ತಡೆಯಲು ತಂಬಾಕು ಉತ್ಪನ್ನತಯಾರಿಕಾ ಉದಿಮೆಯು ದೆಹಲಿ ಉಚ್ಚನ್ಯಾಯಾಲಯದ ಕಟ್ಟೆ ಏರಿತು. ನಾಲ್ಕು ಪ್ರಕರಣಗಳ ಆಧಾರವಿಟ್ಟುಕೊಂಡು, ಈ ಕಾಯ್ದೆಯ ಅನುಷ್ಠಾನವನ್ನು ಪ್ರಶ್ನಿಸಿ ಅದಕ್ಕೆ ತಡೆ ತರಲು ಪ್ರಯತ್ನಿಸಿತು. ಕೇಂದ್ರ ಸರ್ಕಾರದ ಮನವಿಯ ಮೇರೆಗೆ ಸುಪ್ರೀಂ ಕೋರ್ಟ್ ಮೊರೆ ಹೋಗಲು ಸರ್ಕಾರಕ್ಕೆ ಅನುಮತಿ ನೀಡಿತು . ಈ ಪ್ರಕರಣವನ್ನು ಕೈಗೆತ್ತಿಕೊಂಡ ಸುಪ್ರೀಂ ಕೋರ್ಟ್, ಈ ನಿಯಮಗಳಿಗೆ ತಡೆಯಾಜ್ಞೆ ನೀಡಲು ನಿರಾಕರಿಸಿತು, ಅಷ್ಟೇ ಅಲ್ಲ, ಇದಕ್ಕೆ ತಡೆಯಾಜ್ಞೆಯನ್ನು ದೇಶದ ಬೇರೆ ಯಾವ ನ್ಯಾಯಾಲಯಗಳೂ ತರುವ ಹಾಗಿಲ್ಲ ಎಂದು ಘೋಷಿಸಿತು.

COTPA ಹೊರತಾಗಿ ಇತರ ಕಾನೂನುಗಳು :

ರೈಲ್ವೆಬೋಗಿಗಳಲ್ಲಿ ಧೂಮಪಾನವನ್ನು ಭಾರತೀಯ ರೈಲ್ವೆ 1989 ರಿಂದ ನಿಷೇಧಿಸಿತು. ಭಾರತೀಯ ರೈಲ್ವೆ ಕಾಯ್ದೆ, 1989 ಅನುಚ್ಛೇದ 167 ರ ಪ್ರಕಾರ, ಸಹಪ್ರಯಾಣಿಕರು ಆಕ್ಷೇಪಿಸಿದರೆ, ಯಾವುದೇ ವ್ಯಕ್ತಿ ರೈಲಿನಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವ ಹಾಗಿಲ್ಲ. ಇದಲ್ಲದೇ ಯಾವುದೇ ರೈಲಿನಲ್ಲಿ ಅಥವಾ ರೈಲಿನ ಒಂದು ಭಾಗದಲ್ಲಿ ಧೂಮಪಾನವನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ನಿಷೇಧಿಸುವ ಹಕ್ಕು ಭಾರತೀಯ ರೈಲ್ವೆಗೆ ಇದೆ. ಈ ನಿಯಮವನ್ನು ಉಲ್ಲಂಘಿಸಿದ ವ್ಯಕ್ತಿ ಶಿಕ್ಷಾರ್ಹನಾಗಿದ್ದು, ಆ ವ್ಯಕ್ತಿಗೆ ನೂರು ರೂಪಾಯಿಯವರೆಗೆ ದಂಡ ವಿಧಿಸಲಾಗುತ್ತದೆ.

ಗ್ರಾಹಕ ಹಿತರಕ್ಷಣಾ ಕಾಯ್ದೆ, 1986 ಗ್ರಾಹಕರ ಹಕ್ಕುಗಳನ್ನು ರಕ್ಷಿಸುವ ಗುರಿ ಹೊಂದಿದೆ. ಈ ಕಾಯ್ದೆಯ ಅನ್ವಯ ಯಾವುದೇ ಹೋಟೆಲ್ ಹಾಗೂ ರೆಸ್ಟೋರೆಂಟ್‌ಗಳಲ್ಲಿ ದೋಷಪೂರಿತ ಉತ್ಪನ್ನ ಹಾಗೂ ಅಸಮರ್ಪಕ ಸೇವೆಯನ್ನು ಗ್ರಾಹಕರು ವಿರೋಧಿಸಿ, ಕಾನೂನಿನ ಅಡಿಯಲ್ಲಿ ಪ್ರಶ್ನಿಸಬಹುದು. ಒಂದು ವೇಳೆ ಯಾವುದೇ ರೆಸ್ಟೋರೆಂಟ್ ಮಾಲೀಕ ತನ್ನ ರೆಸ್ಟೋರೆಂಟಿನಲ್ಲಿ ಸಾರ್ವಜನಿಕ ಧೂಮಪಾನಕ್ಕೆ ಅನುಮತಿ ನೀಡಿದರೆ, ಆ ರೆಸ್ಟೋರೆಂಟಿನಲ್ಲಿ ಪೂರೈಸಲಾಗುವ ಆಹಾರ ಪರೋಕ್ಷ ಧೂಮಪಾನದಿಂದಾಗಿ ಕಲುಷಿತವಾಗುತ್ತದೆ. ಈ ರೀತಿ ಸಿಗರೇಟ್ ಹೊಗೆಯಿಂದ ಆಹಾರದಲ್ಲಿ ಹಾನಿಕಾರಕ ರಾಸಾಯನಿಕಗಳು ಸೇರಿಕೊಂಡಿದ್ದರೆ ದೋಷಪೂರಿತ ಉತ್ಪನ್ನ (ಕಲುಷಿತ ಆಹಾರ) ಹಾಗೂ ಅಸಮರ್ಪಕಸೇವೆ (ಕಲುಷಿತ ಆಹಾರ ಪೂರೈಕೆ) ಯನ್ನು ಪ್ರಶ್ನಿಸಿ ಗ್ರಾಹಕರು ಸಂಬಂಧಪಟ್ಟ ಅಧಿಕಾರಿಗಳಿಗೆ ದೂರು ನೀಡಬಹುದು.

ರೆಸ್ಟೋರೆಂಟ್ ಹಾಗೂ ಹೋಟೆಲ್‌ಗಳು ಸೇವಾಕ್ಷೇತ್ರದ ಅಡಿಯಲ್ಲಿ ಬರುತ್ತವೆ. ತಮ್ಮ ಗ್ರಾಹಕರಿಗೆ ಅತ್ಯುತ್ತಮ ಸೇವೆ ನೀಡುವುದು ಅವುಗಳ ಕರ್ತವ್ಯ.. ಧೂಮ ಹಾಗೂ ಇತರ ಹಾನಿಕಾರಕ ರಾಸಾಯನಿಕಗಳಿಂದ ಆವರಿಸಿದ ಜಾಗದಲ್ಲಿ ಆಹಾರ

ಸೇವಿಸಲು ಯಾವುದೇ ಗ್ರಾಹಕ ಇಷ್ಟಪಡುವುದಿಲ್ಲ. ಇತರ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಿಗೂ ಇದು ಅನ್ವಯಿಸುತ್ತದೆ.

ನೌಕರರ ಪರಿಹಾರ ಕಾಯ್ದೆ 1923 ಉದ್ಯೋಗಿಗಳ/ಕೆಲಸಗಾರರ ಹಕ್ಕುಗಳನ್ನು ರಕ್ಷಿಸುವ ಗುರಿ ಹೊಂದಿದೆ. ಈ ಕಾಯ್ದೆಯ 3ನೇ ಅನುಚ್ಛೇದ ಅನ್ವಯ ಯಾವುದೇ ನೌಕರ ತನ್ನ ಉದ್ಯೋಗ ಸ್ಥಳದಲ್ಲಿರುವ ಕೆಲಸದ ಸ್ವರೂಪ, ವಾತಾವರಣ, ಪರಿಸ್ಥಿತಿಯಿಂದಾಗಿ ಯಾವುದೇ ಕಾಯಿಲೆಗೆ ಗುರಿಯಾದರೆ, ಆ ನೌಕರನಿಗೆ ಮಾಲೀಕ ಪರಿಹಾರ ಕೊಡಬೇಕಾಗುತ್ತದೆ. ರೆಸ್ಟೋರೆಂಟ್‌ಗಳಲ್ಲಿ ಅಥವಾ ಇನ್ನಿತರ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಪರೋಕ್ಷ ಧೂಮಪಾನಕ್ಕೆ ಗುರಿಯಾಗಿ ನೌಕರರು ವಿಷಪೂರಿತ ಗಾಳಿಯನ್ನು ಸೇವಿಸುವಂತಹ ಸಂದರ್ಭಗಳಲ್ಲಿ ಈ ಕಾಯ್ದೆಯನ್ನು ಬಳಸಬಹುದು. ಪರೋಕ್ಷ ಧೂಮಪಾನ ಪರಿಣಾಮವಾಗಿ ನೌಕರರು ಕ್ಯಾನ್ಸರ್, ಹೃದಯರೋಗ ಹಾಗೂ ಶ್ವಾಸಕೋಶ ಸಂಬಂಧಿತ ಕಾಯಿಲೆಗಳಿಂದ ಬಳಲುವ ಸಾಧ್ಯತೆ ಇದೆ. ಇಂತಹ ಸಂದರ್ಭಗಳಲ್ಲಿ ಸಂಸ್ಥೆಯ ಮಾಲೀಕರು ಉದ್ಯೋಗಿಗಳಿಗೆ ಸೂಕ್ತ ಪರಿಹಾರ ಕೊಡಬೇಕಾಗುತ್ತದೆ.

1.2 ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವುದರಿಂದ ಸಾರ್ವಜನಿಕರ ಆರೋಗ್ಯದ ಮೇಲೆ ಆಗುವ ಪರಿಣಾಮಗಳು

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನಕ್ಕೆ ಅನುಮತಿ ನೀಡಕೂಡದು. ಏಕೆಂದರೆ:

1. ಸಿಗರೇಟು ಹೊಗೆಯಲ್ಲಿ ಸುಮಾರು 4000 ರಾಸಾಯನಿಕಗಳಿದ್ದು, ಆ ಪೈಕಿ ಬಹುತೇಕ ವಿಷಪೂರಿತವಾಗಿರುತ್ತವೆ. ಈ ಹೊಗೆಯ ಸಂಪರ್ಕದಲ್ಲಿ ಬರುವುದರಿಂದ ಶ್ವಾಸಕೋಶ ಕ್ಯಾನ್ಸರ್, ಶ್ವಾಸ ಸಂಬಂಧಿ ಕಾಯಿಲೆಗಳು, ಹೃದಯರೋಗ ಇತ್ಯಾದಿ ಗಂಭೀರ ಕಾಯಿಲೆಗಳು ತಗಲುವ ಅಪಾಯವಿದೆ. ಇದಲ್ಲದೇ, ಸ್ತನ ಕ್ಯಾನ್ಸರ್‌ನ ಅಪಾಯವೂ ಇದೆ ಎಂದು ಇತ್ತೀಚಿನ ಕೆಲವು ಅಧ್ಯಯನಗಳು ಸಿದ್ಧಪಡಿಸಿವೆ. ಈ ಮೊದಲೇ ಅಸ್ತಮಾ, ಬ್ರೊಂಕೈಟಿಸ್ ಸೇರಿದಂತೆ ಶ್ವಾಸ ಸಂಬಂಧಿ ಕಾಯಿಲೆಗಳು ಹಾಗೂ ಹೃದ್ರೋಗವಿರುವ ವ್ಯಕ್ತಿಗಳಲ್ಲಿ ಪರೋಕ್ಷ ಧೂಮಪಾನದಿಂದಾಗಿ ಕಾಯಿಲೆ ಇನ್ನೂ ಉಲ್ಬಣಗೊಳ್ಳುವ ಸಾಧ್ಯತೆಗಳಿವೆ. ಕೆಲವು ಸಂದರ್ಭಗಳಲ್ಲಿ ಇದು ಜೀವಕ್ಕೆ ಅಪಾಯಕಾರಿಯಾಗಿ ಪರಿಣಮಿಸಬಹುದು.

2. ಮನೆಯಲ್ಲಿ ಅಥವಾ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ನೇರವಾಗಿ ಅಥವಾ ಪರೋಕ್ಷವಾಗಿ ಧೂಮಪಾನಕ್ಕೆ ಗುರಿಯಾಗುವ ಶಿಶುಗಳ ಹಕ್ಕುಚ್ಯುತಿಯಾಗುತ್ತದೆ. ಇತರರು ಮಾಡುವ ತಪ್ಪಿನಿಂದಾಗಿ ಈ ಶಿಶುಗಳು ಘೋರವಾಗಿ ಬಳಲಬೇಕಾಗುತ್ತದೆ (ರಾಷ್ಟ್ರೀಯ ಮಾನವ ಹಕ್ಕು ಆಯೋಗ, 2001). ಮಕ್ಕಳಲ್ಲಿ ಕಂಡುಬರುವ ಅಸ್ತಮಾ, ಬ್ರೋಂಕೈಟಿಸ್ ಹಾಗೂ ಉಸಿರಾಟದ ತೊಂದರೆಗಳಲ್ಲಿ 40–60 ಪ್ರತಿಶತ ಪ್ರಕರಣಗಳು ಪರೋಕ್ಷ ಧೂಮಪಾನದಿಂದ ಉಂಟಾಗುತ್ತವೆ ಎಂದು ತಿಳಿದುಬಂದಿದೆ. ಇದು ಕಿವಿಯ ಸೋಂಕನ್ನೂ ಉಂಟುಮಾಡಬಹುದು. ಜೀವಕ್ಕೆ ಅಪಾಯವಾಗುವಂತಹ ತುರ್ತು ಸಂದರ್ಭಗಳು ಬರಬಹುದು. ಪರೋಕ್ಷ ಧೂಮಪಾನದಿಂದ ರಕ್ಷಣೆ ಪಡೆಯುವುದು ಮಕ್ಕಳ ಹಕ್ಕು ಹಾಗೂ ಮಕ್ಕಳನ್ನು ಅದರ ಅಪಾಯಗಳಿಂದ ರಕ್ಷಿಸುವುದು ನಮ್ಮೆಲ್ಲರ ಕರ್ತವ್ಯ.

3. ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನಕ್ಕೆ ಅನುಮತಿ ಕೊಟ್ಟರೆ ಅದರಿಂದ ಸಮಾಜದ ಮೇಲೆ ಕೆಟ್ಟ ಪರಿಣಾಮಗಳಾಗುತ್ತವೆ. ಇತರರು ಸೇದುವುದನ್ನು, ಅದಕ್ಕೆ ಅನುಮತಿ ಇರುವುದನ್ನು ಗಮನಿಸುವ ಜನ, ವಿಶೇಷವಾಗಿ ಯುವಜನತೆ ಅದರ ಪ್ರಭಾವಕ್ಕೊಳಗಾಗುತ್ತಾರೆ, ಧೂಮಪಾನ ಒಂದು ಸಹಜ ಪ್ರಕ್ರಿಯೆ, ಅದಕ್ಕೆ ಸಮಾಜದ ಒಪ್ಪಿಗೆ ಇದೆ ಎಂದು ಭಾವಿಸುತ್ತಾರೆ. ಇತರರು ಸಿಗರೇಟು ಸೇದುವುದನ್ನು ನೋಡಿದರೆ ತಮಗೂ ಸೇದಬೇಕೆನಿಸುತ್ತದೆ ಎಂಬುದು ಧೂಮಪಾನಿಗಳ ಅಭಿಪ್ರಾಯ.

4. ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ನಿಷೇಧಿಸುವುದರಿಂದ ಜನರ ಆರೋಗ್ಯದ ಮೇಲೆ ಆಗುವ ದುಷ್ಪರಿಣಾಮಗಳನ್ನು ತಪ್ಪಿಸಬಹುದು. ಇಂತಹ ನಿರ್ಬಂಧ ಹೇರುವುದರಿಂದ ಧೂಮಪಾನಿಗಳಿಗೂ ಕೂಡ ಒಳಿತಾಗುತ್ತದೆ, ಅವರಿಗೆ ಧೂಮಪಾನದ ದುಷ್ಪರಿಣಾಮಗಳನ್ನು ಮನವರಿಕೆ ಮಾಡಿಕೊಡಲು ಅನುಕೂಲವಾಗುತ್ತದೆ. ಅದರ ಪರಿಣಾಮ ಧೂಮಪಾನ ತ್ಯಜಿಸಬೇಕೆಂಬ ಭಾವನೆ ಅವರಲ್ಲಿಯೂ ಬೆಳೆಯಬಹುದು.

5. ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ನಿಷೇಧಕ್ಕೆ ಧೂಮಪಾನಿಗಳು ಸೇರಿದಂತೆ ಬಹುಪಾಲು ಜನ ಬೆಂಬಲ ಸೂಚಿಸಿದ್ದಾರೆ. ತಂಬಾಕು ಬಳಕೆ ಕುರಿತ ಸಮೀಕ್ಷೆ 2001 ಹಾಗೂ ಗ್ಲೋಬಲ್ ಯೂಥ್ ಟೊಬ್ಯಾಕೊ ಸರ್ವೆ (GYTS), ಭಾರತ, 2001-2004 ಮುಂತಾದವು ಇದನ್ನು ಸಿದ್ಧಪಡಿಸುತ್ತವೆ,

6. ಪರೋಕ್ಷ ಧೂಮಪಾನದ ವಿಪರೀತ ಪರಿಣಾಮಗಳನ್ನು ಪ್ರಮುಖವಾಗಿ ಎದುರಿಸುವವರು ನೌಕರರು. ಆಹಾರ ಸೇವಾ ಕ್ಷೇತ್ರದಲ್ಲಿ ಕೆಲಸ ಮಾಡುವವರು, ಉದಾಹರಣೆಗೆ ಬಾರ್ ಹಾಗೂ ರೆಸ್ಟಾರೆಂಟ್‌ಗಳಲ್ಲಿ ಆಹಾರ, ಪಾನೀಯ ಸರಬರಾಜು ಮಾಡುವ ವೇಟರ್‌ಗಳು ಹಾಗೂ ಇತರ ಸಿಬ್ಬಂದಿಯಲ್ಲಿ ಶ್ವಾಸಕೋಶ ಕ್ಯಾನ್ಸರ್ ಕಾಣಿಸಿಕೊಳ್ಳುವ ಸಾಧ್ಯತೆ ಇತರರಿಗೆ ಹೋಲಿಸಿದರೆ 50 ಪ್ರತಿಶಿತ ಹೆಚ್ಚು ಎಂಬುದನ್ನು ಅಧ್ಯಯನಗಳು ಸಿದ್ಧಪಡಿಸಿವೆ.

1.3 ಕಾನೂನು ಜಾರಿಗೆ ತರುವ ಅಧಿಕಾರಿಗಳ ಪಾತ್ರ

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆ ಸರಿಯಾಗಿ ಜಾರಿಯಲ್ಲಿದೆಯೇ ಎಂಬುದನ್ನು ಪರಿಶೀಲಿಸಲು ಅಧಿಕೃತ ಅಧಿಕಾರಿಗಳು, ಪ್ರಮುಖವಾಗಿ ಪೋಲೀಸ್ ಹಾಗೂ ಆಹಾರ ಮತ್ತು ಔಷಧಿ ನಿಯಂತ್ರಣ ಇಲಾಖೆಯ ಅಧಿಕಾರಿಗಳು ರೆಸ್ಟೋರೆಂಟ್‌ಗಳಲ್ಲಿ, ಹೋಟೆಲ್‌ಗಳಲ್ಲಿ ಹಾಗೂ ಸರ್ಕಾರಿ ಹಾಗೂ ಇತರ ಸಾರ್ವಜನಿಕ ಕಟ್ಟಡಗಳಲ್ಲಿ, ಬಸ್ ಹಾಗೂ ರೈಲು ಸೇರಿದಂತೆ ಸಾರ್ವಜನಿಕ ಸಂಚಾರ ವಾಹನಗಳಲ್ಲಿ ನಿಯಮಿತ ತಪಾಸಣೆ ನಡೆಸಬೇಕು ಹಾಗೂ ಸರ್ಕಾರಿ ಹಾಗೂ ಇತರ ಸಾರ್ವಜನಿಕ ಕಟ್ಟಡಗಳಲ್ಲಿ, ಬಸ್ ಹಾಗೂ ರೈಲು ಸೇರಿದಂತೆ ಸಾರ್ವಜನಿಕ ಸಂಚಾರ ವಾಹನಗಳಲ್ಲಿ ನಿಯಮಿತ ತಪಾಸಣೆ ನಡೆಸಬೇಕು ಹಾಗೂ ಅನಿರೀಕ್ಷಿತ ಭೇಟಿ ನೀಡಬೇಕು. ಇದಲ್ಲದೇ ಅಧಿಕಾರಿಗಳು ತಮ್ಮ ವ್ಯಾಪ್ತಿಗೆ ಬರುವ ಸಾರ್ವಜನಿಕ ಪ್ರದೇಶಗಳಲ್ಲಿ ಜನರು ಧೂಮಪಾನ ಮಾಡುತ್ತಿದ್ದಾರೆಯೇ ಎಂಬುದರ ಕಡೆ ನಿಗಾವಹಿಸಬೇಕು. ನಿಯಮ ಉಲ್ಲಂಘನೆ ಮಾಡುವವರನ್ನು ಹಿಡಿದು ಸಮರ್ಪಕ ರೀತಿಯಲ್ಲಿ ದಂಡ ವಿಧಿಸಬೇಕು. ಹಾಗೂ ಇದೇ ಸಂದರ್ಭದಲ್ಲಿ, ತಂಬಾಕು ಸೇವನೆಯ ದುಷ್ಪರಿಣಾಮಗಳನ್ನು ಅವರಿಗೆ ತಿಳಿಸಿ ಹೇಳಬೇಕು.

ಅನುಚ್ಛೇದ 4 ರಲ್ಲಿರುವ ನಿಯಮಗಳನ್ನು ಅನುಷ್ಠಾನಗೊಳಿಸಲು ಕೇಂದ್ರ ಸರ್ಕಾರವು ವಿವಿಧ ಇಲಾಖೆಗಳ 21 ವಿಭಾಗಗಳಿಂದ ಅಧಿಕಾರಿಗಳನ್ನು ಅರ್ಹರೆಂದು ಅದಿಸೂಚಿಸಿದೆ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕ್ರಮಗಳನ್ನು ಹೆಚ್ಚು ಪರಿಣಾಮಕಾರಿಯಾಗಿಸಲು ಇನ್ನೂ ಹೆಚ್ಚಿನ ಸಂಖ್ಯೆ ಅಧಿಕಾರಿಗಳನ್ನು ರಾಜ್ಯ ಸರ್ಕಾರಗಳು ನಿಯೋಜಿಸಬೇಕಾದ ಅವಶ್ಯಕತೆ ಇದೆ. ಕೆಲವು ರಾಜ್ಯಗಳು ಆರೋಗ್ಯ, ಆಹಾರ ಹಾಗೂ ಔಷಧಿ ನಿಯಂತ್ರಣ, ಗ್ರಾಮೀಣ ಅಭಿವೃದ್ಧಿ, ಪರಿಸರ, ನ್ಯಾಯಾಂಗ, ಶಿಕ್ಷಣ, ನಗರ ಪಾಲಿಕೆ, ತೆರಿಗೆ ಹಾಗೂ ಅಬಕಾರಿ ಇಲಾಖೆಗಳಿಂದ ಅಧಿಕಾರಿಗಳನ್ನು ಈ ಕಾರ್ಯಕ್ಕೆಂದು ಗುರುತಿಸಿ ಅಧಿಸೂಚಿಸಿವೆ. COTPA ಅನುಷ್ಠಾನವನ್ನು ಪರಿಣಾಮಕಾರಿಯಾಗಿಸುವಲ್ಲಿ ಇದೊಂದು ಮಹತ್ತರ ಕ್ರಮ. ಈ ಅಧಿಕಾರಿಗಳು ತಮ್ಮ ವ್ಯಾಪ್ತಿಗೆ ಬರುವ ವಿಭಾಗಗಳಲ್ಲಿನ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಯಾವುದೇ ವ್ಯಕ್ತಿ ಧೂಮಪಾನ ಮಾಡದ ಹಾಗೆ ನೋಡಿಕೊಳ್ಳಬೇಕಾದುದು ಅವಶ್ಯ.

ಕಾಯ್ದೆಯು ಪರಿಣಾಮಕಾರಿಯಾಗಿ ಜಾರಿಯಾಗಬೇಕೆಂದರೆ ಅಧಿಕೃತ ಅಧಿಕಾರಿಗಳು ಸೂಕ್ತವಾಗಿ ನಿಗಾವಹಿಸಿ, ನಿಯಮಿತ ತಪಾಸಣೆ ಮಾಡುತ್ತಿರಬೇಕು. ಅಪರಾಧಕ್ಕೆ ಅನ್ವಯಿಸುವ ಕಾನೂನಿನ ಜ್ಞಾನ ಈ ಅಧಿಕಾರಿಗಳಿಗೆ ಇದೆ ಎಂಬುದನ್ನು ಸರ್ಕಾರ ಮನದಟ್ಟು ಮಾಡಿಕೊಳ್ಳಬೇಕು. ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡಿದರೆ, ರೂ. 200 ರವರೆಗೂ ದಂಡ ವಿಧಿಸಬಹುದು. ಆಯಾ ವ್ಯಕ್ತಿಯ ಹಣ ತೆರುವ ಸಾಮರ್ಥ್ಯ ಹಾಗೂ ಅದು ಆ ವ್ಯಕ್ತಿ ಮೊದಲ ಬಾರಿ ಮಾಡಿದ ಅಪರಾಧವೋ ಅಥವಾ ಮತ್ತೆ ಮತ್ತೆ ಎಸಗುತ್ತಿರುವ ಅಪರಾಧವೋ ಎಂಬುದರ ಮೇಲೆ ದಂಡದ ಮೊತ್ತವನ್ನು ನಿಗದಿಗೊಳಿಸಬೇಕಾಗುತ್ತದೆ. ಅಪರಾಧ ದಾಖಲೆ ಹಾಗೂ ದಂಡದ ಮೊತ್ತ ತುಂಬಿಸಿಕೊಳ್ಳಲು ಅಧಿಕಾರಿಗಳ ಬಳಿ ಸೂಕ್ತವಾದ ರಶೀದಿ ಪುಸ್ತಕಗಳಿರಬೇಕು.

ಅಧ್ಯಾಯ-2

ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು ನಿಷೇಧ

2.1 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು, ಬೆಂಬಲ ಮತ್ತು ಪ್ರಾಯೋಜಕತ್ವ ಕುರಿತ ಕಾನೂನು

ಯಾವುದೇ ವ್ಯಕ್ತಿ ಯಾವುದೇ ತಂಬಾಕು ಉತ್ಪನ್ನವನ್ನು ಜಾಹೀರುಪಡಿಸುವುದು ಅಥವಾ ಪ್ರಾಯೋಜಿಸುವುದು ಸಲ್ಲ.

ಜಾಹೀರಾತಿನ ವ್ಯಾಖ್ಯೆ (S.3 a)

COTPA ನಿರೂಪಣೆಯಂತೆ 'ಜಾಹಿರಾತು' ಎಂದರೆ ನೋಟೀಸು, ಕರಪತ್ರ, ಸೂಚನೆ, ಸುತ್ತೋಲೆ, ಹಣೆಪಟ್ಟಿ ಪತ್ರ ಕವಚ ಒಳಗೊಂಡಂತೆ ಕಣ್ಣಿಗೆ ಕಾಣುವ ಯಾವುದೇ ದಾಖಲೆಯ ಮೂಲಕ ಪ್ರಕಟಣೆ ಮತ್ತು ಮೌಖಿಕ ಅಥವಾ ಇನ್ನಿತರ ರೂಪಗಳಲ್ಲಿ ಘೋಷಣೆ ಅಥವಾ ಬೆಳಕು, ಶಬ್ದ, ಹೊಗೆ ಅಥವಾ ಅನಿಲ ರೂಪದ ಅಭಿವ್ಯಕ್ತಿ.

ತಂಬಾಕು ಜಾಹೀರಾತು, ಬೆಂಬಲ ಮತ್ತು ಪ್ರಾಯೋಜಕತ್ವ ನಿಗ್ರಹ (S.5)

ಕಾಯ್ದೆಯು ಸಿಗರೇಟು ಮತ್ತಿತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ನೇರ ಮತ್ತು ಪರೋಕ್ಷ ಜಾಹಿರಾತುಗಳು, ಮತ್ತು ಅವುಗಳನ್ನು ಬೆಂಬಲಿಸುವ ಮತ್ತು ಪ್ರಾಯೋಜಿಸುವುದನ್ನು ಒಳಗೊಂಡ ಯಾವುದೇ ಕ್ರಮವನ್ನು ನಿಷೇಧಿಸುತ್ತದೆ.

ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತನ್ನು ನಿಷೇಧಿಸುವ ಉದ್ದೇಶಕ್ಕಾಗಿ, ಕಾಯ್ದೆಯು ಸಬ್-ಇನ್ಸಪೆಕ್ಟರ್ ಅಥವಾ ಮೇಲ್ಪಟ್ಟದ ದರ್ಜೆಯ ಪೋಲೀಸ್ ಅಧಿಕಾರಿ, ರಾಜ್ಯ ಆಹಾರ ಅಥವಾ ಔಷದ ಇಲಾಖೆಯ ಅಧಿಕಾರಿ, ಅಥವಾ ಕೇಂದ್ರ ಅಥವಾ ರಾಜ್ಯ ಸರ್ಕಾರ ಮಾನ್ಯತೆಗೆ ಸಮನಾದ ದರ್ಜೆಯ ಯಾವುದೇ ಅಧಿಕಾರಿಗೆ ಪ್ರಸ್ತುತ ಕಾಯ್ದೆಯನ್ನು ಉಲ್ಲಂಘಿಸಿದ ಅನುಮಾನಕ್ಕೀಡಾದ ಯಾವುದೇ ಕಟ್ಟಡ ಅಥವಾ ಆವರಣವನ್ನು ಪ್ರವೇಶಿಸುವ ಮತ್ತು ಅಲ್ಲಿ ಹುಡುಕಾಟ ನಡೆಸುವ ಅಧಿಕಾರ ನೀಡುತ್ತದೆ.

ಅನುಸೂಚಿತ ಅಧಿಕಾರಿಯು ಕಾಯ್ದೆಯನ್ನು ಉಲ್ಲಂಘಿಸುವಂತಹ ಜಾಹೀರಾತು ಮತ್ತು ಸಿಗರೇಟು ಪೊಟ್ಟಣ ಹಾಗೂ ಇನ್ನಿತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪೊಟ್ಟಣಗಳನ್ನು ವಶಪಡಿಸಿಕೊಳ್ಳಬಹುದು.

ಕಾಯ್ದೆ ಉಲ್ಲಂಘಿಸುವಂಥ ಯಾವುದೇ ತಂಬಾಕು ಉತ್ಪನ್ನ ಹಾಗೂ ಜಾಹೀರಾತು ವಸ್ತುವು ವಶಪಡಿಸಿಕೊಳ್ಳಲು ಅರ್ಹವಾಗಿದೆ.

ತಪ್ಪು ರುಜುವಾತಾದರೆ, ವಶಪಡಿಸಿಕೊಂಡ ಅಥವಾ ಸ್ವಾಧೀನಪಡಿಸಿಕೊಂಡ ಜಾಹೀರಾತು ಅಥವಾ ಜಾಹೀರಾತು ವಸ್ತುಗಳನ್ನು ಸರ್ಕಾರದ ಸುಪರ್ದಿಗೆ ಒಪ್ಪಿಸಿ ನಿಯಮ ಪ್ರಕಾರ ಹಾಜರು ಪಡಿಸಬಹುದು.

ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು ಪ್ರಕಟಣೆಗೆ ಶಿಕ್ಷೆ (S.22)

ಅನುಚ್ಛೇದ 5ರ ಉಲ್ಲಂಘನೆಗಾಗಿ ವ್ಯಕ್ತಿಯು ಎರಡು ವರ್ಷದ ಸಜೆ ಅಥವಾ ರೂ. 1000 ದಂಡ ಅಥವಾ ಎರಡಕ್ಕೂ ಗುರಿಯಾಗುತ್ತಾನೆ. ವ್ಯಕ್ತಿಯು ಎರಡನೇ ಬಾರಿ ತಪ್ಪಿತಸ್ಥನಾಗಿದ್ದರೆ, ದಂಡವು ರೂ, 5000 ಮತ್ತು ಸಜೆಯ ಅವಧಿ 5 ವರ್ಷ.

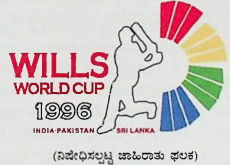
ಜಾಹೀರಾತು ನಿಷೇಧಕ್ಕೆ ನಿಯಮಗಳು

ನೇರ ಮತ್ತು ಪರೋಕ್ಷ ಜಾಹೀರಾತು ಪ್ರಕಟಣೆಯನ್ನು ನಿಷೇಧಿಸುವ ಕುರಿತ ಅಧಿಸೂಚನೆಯನ್ನು ಸರ್ಕಾರ ಕಾಲಕಾಲಕ್ಕೆ ಹೊರಡಿಸತಕ್ಕದ್ದು. ಈ ಕೆಳಕಂಡ ಗಾತ್ರಗಳಲ್ಲಿ ಫಲಕಗಳನ್ನು ತಂಬಾಕು ಉತ್ಪನ್ನ ಮಾರಾಟ ಮಾಡುವ ಅಂಗಡಿ ಅಥವಾ ಸಂಗ್ರಹಿಸುವ ಗೋದಾಮಿನ ಮುಂಭಾಗದಲ್ಲಿ ಪ್ರಕಟಿಸತಕ್ಕದ್ದು.

- ಫಲಕದ ಗಾತ್ರ : 60 ಸೆಂ.ಮೀ X 45 ಸೆಂ.ಮೀ
- 20 ಸೆಂ.ಮೀ X 15 ಸೆಂ.ಮೀ ಗಾತ್ರದ ಮೇಲ್ಬುದಿಯನ್ನು ಹೊಂದಿರುವ ಫಲಕದಲ್ಲಿ ಕೆಳಕಂಡ ಎಚ್ಚರಿಕೆಯನ್ನು ಪ್ರಕಟಿಸಬೇಕು:
    - ತಂಬಾಕಿನಿಂದ ಕ್ಯಾನ್ಸರ್ ಬರುತ್ತದೆ
    - ತಂಬಾಕು ಸಾವು ತರುತ್ತದೆ
- ಎಚ್ಚರಿಕೆಯು ಎದ್ದು ಕಾಣುವಂತೆ ಸ್ಫುಟವಾಗಿರಬೇಕು ಮತ್ತು ಬಿಳಿ ಹಿನ್ನೆಲೆಯಲ್ಲಿ ಕಪ್ಪು ಬಣ್ಣದ ಅಕ್ಷರಗಳಲ್ಲಿರಬೇಕು.
- ಫಲಕವು ಅಂಗಡಿಯಲ್ಲಿ ಲಭ್ಯವಿರುವ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪ್ರಕಾರಗಳನ್ನು ಮಾತ್ರ ಪಟ್ಟಿ ಮಾಡಬೇಕು. ಫಲಕದಲ್ಲಿ ಈ ಕೆಳಗಿನವುಗಳನ್ನು ಬಳಸುವ ಹಾಗಿಲ್ಲ:
    - ಬ್ರಾಂಡ್ ಚಿತ್ರ
    - ಬ್ರಾಂಡ್ ಹೆಸರು
    - ಬೆಂಬಲ ನೀಡುವ ಸಂದೇಶ ಅಥವಾ ಚಿತ್ರ
    - ಹಿನ್ನೆಲೆ ಬೆಳಕು ಅಥವಾ ಪ್ರಕಾಶಮಾನಗೊಳಿಸುವುದು

ತಂಬಾಕು ವಸ್ತುಗಳ ಪರೋಕ್ಷ ಜಾಹಿರಾತು

ಸಿನೆಮಾ ಹಾಗೂ ಟೆಲಿವಿಷನ್ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿ ತಂಬಾಕು ಜಾಹೀರಾತು ನಿಷೇಧ : ಟೀವಿ, ಸಿನೆಮಾ, ಮುದ್ರಣ ಹಾಗೂ ಎಲೆಕ್ಟ್ರಾನಿಕ್ ಮಾಧ್ಯಮಗಳಲ್ಲಿ ಯಾವುದೇ ವ್ಯಕ್ತಿ ಅಥವಾ ಪಾತ್ರಗಳು ತಂಬಾಕು ಉತ್ಪನ್ನ ಬಳಸುವುದನ್ನು ತೋರಿಸುವ ಹಾಗಿಲ್ಲ.



(ನಿಷೇಧಿಸಲ್ಪಟ್ಟ ಜಾಹಿರಾತು ಫಲಕ)

ಅನುಚ್ಛೇದ 5 ರ ಉಲ್ಲಂಘನೆಗಳ ಮೇಲೆ ನಿಗಾ ವಹಿಸುವ ಸಮಿತಿ: ಅನುಚ್ಛೇದ 5 ರ ಉಲ್ಲಂಘನೆಗಳನ್ನು ಗಮನಿಸಿ ತನಿಖೆ ನಡೆಸಲು ಒಂದು ಚಾಲನಾ ಸಮಿತಿಯನ್ನು ನವೆಂಬರ್ 30, 2005 ರಂದು ರಚಿಸಲಾಯಿತು. ಈ ಸಮಿತಿಯು ನಿಯಮ ಉಲ್ಲಂಘನೆ ಪ್ರಕರಣಗಳಲ್ಲಿ ದೂರುಗಳನ್ನು ಪರಿಗಣಿಸಿ ಕ್ರಮ ಕೈಗೊಳ್ಳುತ್ತದೆ. ದೂರುಗಳನ್ನು ಆರೋಗ್ಯ ಕಾರ್ಯದರ್ಶಿ, ಆರೋಗ್ಯ ಹಾಗೂ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಮಂತ್ರಾಲಯ, ನಿರ್ಮಾಣ ಭವನ, ನವ ದೆಹಲಿ 110011 ಇವರಿಗೆ ಕಳುಹಿಸಬಹುದು. ರಾಜ್ಯ ಹಾಗೂ ಜಿಲ್ಲಾ ಮಟ್ಟಗಳಲ್ಲಿಯೂ ಇಂತಹ ಸಂಚಾಲನಾ ಸಮಿತಿಗಳನ್ನು ರಚಿಸಿ, ಅನಚ್ಛೇದ 5 ರ ಉಲ್ಲಂಘನೆಯಾಗದಂತೆ ನೋಡಿಕೊಳ್ಳಲು ಕೇಂದ್ರ ಸರ್ಕಾರವು ಆದೇಶಿಸಿದೆ.

ಇದಲ್ಲದೇ, ಟೆಲಿವಿಷನ್ ಹಾಗೂ ಮುದ್ರಣ ಮಾಧ್ಯಮಗಳಿಗೆ ವಿದಿಸಲಾದ ನಿಯಮಗಳ ಉಲ್ಲಂಘನೆಯಾಗಿರುವುದು ಕಂಡು ಬಂದರೆ ಆ ಕುರಿತು ದೂರುಗಳನ್ನು ಸಹ ಕಾರ್ಯದರ್ಶಿ, ಮಾಹಿತಿ ಹಾಗೂ ಪ್ರಚಾರ ಮಂತ್ರಾಲಯ, ಶಾಸ್ತ್ರಿ ಭವನ್, ನವದೆಹಲಿ,110001, ಇವರಿಗೆ ಕೊಡಬಹುದ. ಕೇಬಲ್ ಟೆಲಿವಿಷನ್ ನೆಟ್‌ವರ್ಕ್ಸ್ ಕಾಯ್ದೆ (ನಿಯಂತ್ರಣ), 1995 ಅಡಿಯಲ್ಲಿ ಡಿಸ್ಟ್ರಿಕ್ಟ್‌ಮ್ಯಾಜಿಸ್ಟ್ರೇಟ್/ಪೊಲೀಸ್ ಕಮಿಶನರ್ ನೇತೃತ್ವದಲ್ಲಿ ಜಿಲ್ಲಾ ಮಟ್ಟದ ಸಮಿತಿಯನ್ನು ರಚಿಸಲಾಗಿದ್ದು, ಇದು ಖಾಸಗಿ ಟೀವಿ ಚಾನಲ್‌ಗಳು ನಿಯಮ ಉಲ್ಲಂಘನೆ ಮಾಡಿದರೆ ಕ್ರಮ ಕೈಗೊಳ್ಳುತ್ತದೆ.

ನ್ಯಾಯಾಲಯದ ವರ್ತಮಾನ ಮಹೇಶ್ ಭಟ್ ಮೊಕದ್ದಮೆಯಲ್ಲಿ ದೆಹಲಿ ಉಚ್ಚ ನ್ಯಾಯಾಲಯದ ಚಲನಚಿತ್ರ ಮತ್ತು ಟೆಲಿವಿಷನ್‌ನಲ್ಲಿ ತಂಬಾಕು ಬಳಕೆಯ ವಿರುದ್ಧ ಇರುವ ನಿಯಮಗಳನ್ನು ಹೊಡೆದುಹಾಕಿತು. ದೆಹಲಿ ಉಚ್ಚನ್ಯಾಯಾಲಯದ ಈ ಆದೇಶವನ್ನು ಪ್ರಶ್ನಿಸಿ, ಭಾರತ ಸರ್ಕಾರದ ಆರೋಗ್ಯ ಹಾಗೂ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ ಸುಪ್ರೀಂ ಕೋರ್ಟ್ ಮೊರೆಹೋಯಿತು. ಇದರ ಪರಿಣಾಮ ಸುಪ್ರೀಂ ಕೋರ್ಟ್, ದೆಹಲಿ ಉಚ್ಚನ್ಯಾಯಾಲಯದ ಆದೇಶಕ್ಕೆ ತಡೆಯಾಜ್ಞೆ ತಂದಿತು.

COTPA ಹೊರತಾಗಿ ತಂಬಾಕು ಜಾಹೀರಾತು ನಿಯಂತ್ರಣಕ್ಕೆ ಇರುವ ಕಾನೂನು

1. ಛಾಯಾಗ್ರಹಣ ಕಾಯ್ದೆ 1952, ಅಡಿಯ ನಿಯಮ ಛಾಯಾಗ್ರಹಣ ಕಾಯ್ದೆ 1952 ರ ಸೆಕ್ಷನ್ 5 ಬಿ ಯ ಉಪಸೆಕ್ಷನ್ (2) ರಂತೆ ಸೆನ್ಸಾರ್ ಮಂಡಳಿಯು ಚಲನಚಿತ್ರಗಳಲ್ಲಿ ತಂಬಾಕು ಸೇವನೆ ಅಥವಾ ಸಿಗರೇಟು ಸೇವನೆಯನ್ನು ಉತ್ತೇಜಿಸುವ,

ಸಮರ್ಥಿಸುವ ಮತ್ತು ವಿಜೃಂಭಿಸುವ ದೃಶ್ಯಗಳನ್ನು ತೋರಿಸದಂತೆ ನಿಗಾವಹಿಸಲು ಭಾರತ ಸರ್ಕಾರದಿಂದ ನಿರ್ದೇಶನ ಪಡೆದಿರುತ್ತದೆ.

2. ಆಕಾಶವಾಣಿ ಮತ್ತು ದೂರದರ್ಶನಗಳಲ್ಲಿ ಬಿತ್ತರವಾಗುವ ಜಾಹೀರಾತಿಗೆ ಸಂಹಿತೆ ವಾಣಿಜ್ಯ ಲಾಭ ಪಡೆಯುವುದೇ ಪ್ರಸಾರ ಭಾರತಿಯ ಏಕೈಕ ಉದ್ದೇಶವಲ್ಲ. ಹಾಗಾಗಿ ಜಾಹೀರಾತು ಬಿತ್ತರಕ್ಕಾಗಿ ಕಟ್ಟುನಿಟ್ಟಿನ ಸಂಹಿತೆ ಜಾರಿಯಲ್ಲಿದೆ. (ಎ) ಪಾನ್ ಮಸಾಲ ಒಳಗೊಂಡಂತೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು ಮತ್ತು ಪಾನೀಯಗಳ ಕುರಿತು ಜಾಹೀರಾತು ಪ್ರಸಾರವಾಗುವಂತಿಲ್ಲ.

3. ಕೇಬಲ್ ಟೆಲಿವಿಷನ್ ನೆಟ್‌ವರ್ಕ್ (ನಿಯಂತ್ರಣ) ಕಾಯ್ದೆ, 1995

ಈ ಕಾಯ್ದೆಗೆ 2000 ರಲ್ಲಿ ತಿದ್ದುಪಡಿ ತರಲಾಯಿತು. ಅದರಡಿಯಲ್ಲಿ ಜಾಹೀರಾತು ಸಂಹಿತೆಯ ನಿಯಮಗಳನ್ನು ರೂಪಿಸಲಾಯಿತು. ನಿಯಮ 7ರ ಪ್ರಕಾರ ಸಿಗರೇಟು, ಇತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು, ಮದ್ಯ, ಶಿಶು ಆಹಾರ, ಮಕ್ಕಳಿಗಾಗಿ ಸಿದ್ಧಪಡಿಸಿದ ಹಾಲು, ಅಥವಾ ಹಾಲು ಕುಡಿಸುವ ಬಾಟಲಿ ಮುಂತಾದವುಗಳ ಉತ್ಪಾದನೆ, ಮಾರಾಟ ಹಾಗೂ ಬಳಕೆಯನ್ನು ಪ್ರತ್ಯಕ್ಷವಾಗಿ ಅಥವಾ ಪರೋಕ್ಷವಾಗಿ ಬೆಂಬಲಿಸುವುದು ಸೂಕ್ತವಲ್ಲ. ಆದರೆ ಆಗಸ್ಟ್ 6, 2006 ರ AG ನಿಯಮ 7ಕ್ಕೆ ತಿದ್ದುಪಡಿ ತಂದು, ಮತ್ತು ಫೆಬ್ರುವರಿ 27, 2009 ರಂದು ಮತ್ತೊಂದು ತಿದ್ದುಪಡಿ ತಂದು ಈ ಕೆಳಗಿನ ವಿನಾಯತಿಯನ್ನು ಸೇರಿಸಲಾಗಿದೆ:

ಈ ಕೆಳಗಿನ ಷರತ್ತುಗಳಿಗೆ ಒಳಪಡುವಂತೆ ಸಿಗರೇಟು, ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು, ವೈನ್, ಮದ್ಯ ಮುಂತಾದ ಮಾದಕ ವಸ್ತುಗಳ ಬ್ರಾಂಡ್ ಹೆಸರು ಮತ್ತು ಲೋಗೊ ಹೊಂದಿರುವ ಇತರ ಪದಾರ್ಥಗಳ ಜಾಹೀರಾತುಗಳನ್ನು ಕೇಬಲ್ ಸೇವೆಯಲ್ಲಿ ಪ್ರಸಾರ ಮಾಡಬಹುದು.

- ಜಾಹೀರಾತಿನಲ್ಲಿ ತೋರಿಸುವ ವಸ್ತುವನ್ನು ಮಾತ್ರ ಬೆಂಬಲಿಸುವಂತೆ ಚಿತ್ರ ಮತ್ತು ದೃಶ್ಯಗಳು ಇರಬೇಕು. ನಿಷೇಧಿತ ವಸ್ತುಗಳನ್ನು ಯಾವುದೇ ರೂಪದಲ್ಲಿ ತೋರಿಸಬಾರದು.
- ಜಾಹೀರಾತಿನಲ್ಲಿ ನಿಷೇಧಿತ ವಸ್ತುಗಳ ಕುರಿತ ಪ್ರತ್ಯಕ್ಷ ಅಥವಾ ಪರೋಕ್ಷ ಉಲ್ಲೇಖ ಇರಬಾರದು.
- ನಿಷೇಧಿತ ವಸ್ತುಗಳನ್ನು ಬೆಂಬಲಿಸುವ ಯಾವುದೇ ನುಡಿಗಟ್ಟುಗಳು, ಸಂಕೇತಗಳು ಜಾಹೀರಾತಿನಲ್ಲಿ ಇರಬಾರದು.
- ನಿಷೇದಿತ ವಸ್ತುವಿನ ನಿರ್ದಿಷ್ಟ ಬಣ್ಣ, ಅಥವಾ ವಿನ್ಯಾಸ ಅಥವಾ ರೂಪವನ್ನು ಜಾಹೀರಾತು ಹೊಂದಿರಬಾರದು.
- ಇತರ ವಸ್ತುಗಳ ಜಾಹೀರಾತಿನ ನೆಪದಲ್ಲಿ ನಿಷೇದಿತ ವಸ್ತುಗಳನ್ನು ಬೆಂಬಲಿಸುವ ಸನ್ನಿವೇಶಗಳನ್ನು ತೋರಿಸಬಾರದು.

ನಿಷೇಧಿತ ವಸ್ತುಗಳ ಪರೋಕ್ಷ ಜಾಹೀರಾತನ್ನು ನಿಯಂತ್ರಿಸುವ ಸಲುವಾಗಿ ಫೆಬ್ರವರಿ 27, 2009 ರಂದು ಈ ನಿಯಮಗಳಿಗೆ ಎರಡು ವಿಧಿಗಳನ್ನು ಸೇರಿಸಲಾಯಿತು.

- ಜಾಹೀರಾತುದಾರನು ನಿಷೇಧಿತ ಉತ್ಪನ್ನದ ಹೆಸರಿರುವ ವಸ್ತುವಿನ ಪ್ರಸ್ತಾವಿತ ಜಾಹೀರಾತಿನ ಪ್ರತಿಯೊಂದಿಗೆ ಚಾರ್ಟರ್ಡ್ ಅಕೌಂಟಂಟ್ ಪ್ರಮಾಣಪತ್ರ ಹೊಂದಿರುವ ಅರ್ಜಿಯನ್ನು ಸಲ್ಲಿಸಬೇಕು.
- ಕೇಂದ್ರ ಸೆನ್ಸಾರ್ ಮಂಡಳಿಯು ಅಂತಹ ಜಾಹೀರಾತುಗಳನ್ನು ವೀಕ್ಷಿಸಿ ನಂತರ ಪ್ರಮಾಣಿಸಬೇಕು.
- ಕೇಬಲ್ ಟೆಲಿವಿಷನ್ ನೆಟ್‌ವರ್ಕ್ (ನಿಯಂತ್ರಣ) ಕಾಯ್ದೆ 1995 ರ ಅನ್ವಯ ಜಿಲ್ಲಾ ಮೆಜಿಸ್ಟ್ರೇಟ್ ಅಥವಾ ಉಪ-ವಿಭಾಗೀಯ ಮೆಜಿಸ್ಟ್ರೇಟ್ ದೂರಿನ ಆಧಾರದ ಮೇಲೆ ಕೇಬಲ್ ಆಪರೇಟರ್‌ಗಳ ಮೇಲೆ ಕ್ರಮ ಜರುಗಿಸುವ ಅಧಿಕಾರ ಹೊಂದಿರುತ್ತಾರೆ. ಜಾಹೀರಾತು ಕುರಿತು ಸಂಹಿತೆಯನ್ನು ಉತ್ತಮ ರೀತಿಯಲ್ಲಿ ಜಾರಿ ಮಾಡುವ ಸಲುವಾಗಿ 2005 ರಲ್ಲಿ ಸುತ್ತೋಲೆಯ ಮೂಲಕ ಜಿಲ್ಲಾ ಮಟ್ಟದ ನಿಗಾ ಸಮಿತಿಯನ್ನು ರಚಿಸಲಾಯಿತು. ಈ ಸಮಿತಿಯಲ್ಲಿ ಮಹಿಳೆ ಮತ್ತು ಮಕ್ಕಳ ಕಲ್ಯಾಣಕ್ಕಾಗಿ ದುಡಿಯುವ NGOಗಳು, ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಕಾರ್ಯನಿರ್ವಹಿಸುವ ಸರ್ಕಾರಿ ಇಲಾಖೆಗಳ ಪ್ರತಿನಿಧಿಗಳು ಇರುತ್ತಾರೆ. ಈ ಸಮಿತಿಯು ಜಿಲ್ಲಾ ಮೆಜಿಸ್ಟ್ರೇಟರ ಜ್ಞಾನ ಭಾಂಡಾರದಂತೆ ವರ್ತಿಸುತ್ತ, ದೂರುಗಳ ಮೇಲೆ ಕ್ರಮ ಕೈಗೊಳ್ಳಲು ಅವರಿಗೆ ಸಹಾಯಕವಾಗಿರುತ್ತದೆ.

4. ಭಾರತೀಯ ಜಾಹೀರಾತು ಮಾನಕಗಳ ಪರಿಷತ್ತು 1998 ರ ಭಾರತೀಯ ಜಾಹೀರಾತು ಮಾನಕಗಳ ಪರಿಷತ್ತಿನ

ಸ್ವಯಂಪ್ರೇರಿತ ಸಂಹಿತೆಯಂತೆ ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರನ್ನು ಗುರಿಯಾಗಿಸಿದ ನಿಷೇಧಿತ ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು ನಿಷೇಧಿಸಲ್ಪಟ್ಟಿದೆ.

5. ಪ್ರಸರಣ ಸೇವೆಗಳ ನಿಯಂತ್ರಣ ಮಸೂದೆ, 2007

2.2 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು ನಿಷೇಧಕ್ಕಿರುವ ತರ್ಕ

1. ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ತಂತ್ರಗಳು ಆ ಉತ್ಪನ್ನಗಳ ಮಾರಾಟವನ್ನು ಅತಿಯಾಗಿ ಉತ್ತೇಜಿಸುತ್ತವೆ. ತಂಬಾಕು ಕೈಗಾರಿಕೆಯು ಆಧುನಿಕ ಮತ್ತು ಯುಕ್ತಿಯ ಮಾರಾಟ ತಂತ್ರವನ್ನು ಅನುಸರಿಸುತ್ತದೆ.ತಂಬಾಕು ಕಂಪನಿಗಳು ನಿರ್ದಿಷ್ಟ ಗ್ರಾಹಕರನ್ನು ಗುರಿಯಾಗಿಸಿಕೊಂಡು ಜಾಹೀರಾತು ರೂಪಿಸುತ್ತವೆ. ಇದರಿಂದ ಬೇಡದ ರೀತಿಯಲ್ಲಿ ಮಕ್ಕಳಿಗೆ ಈ ಉತ್ಪನ್ನಗಳ ಪರಿಚಯ ಉಂಟಾಗಿ ಅವು ದೊರೆಯುವಂತಾಗುತ್ತವೆ.

2. ಜಾಹೀರಾತುಗಳು ಮತ್ತು ಪ್ರಾಯೋಜಿತ ಒಪ್ಪಂದಗಳು ಉತ್ಪನ್ನಗಳ ಬ್ರಾಂಡ್ ಮತ್ತು ಅವುಗಳ ವರ್ಚಸ್ಸನ್ನು ವೃದ್ಧಿಸುತ್ತವೆ. ಅಧ್ಯಯನವೊಂದರ ಪ್ರಕಾರ ತಂಬಾಕು ತಯಾರಕರಿಂದ ಪ್ರಾಯೋಜಿತಗೊಂಡ ಕ್ರೀಡಾ ಕಾರ್ಯಕ್ರಮವನ್ನು ವೀಕ್ಷಿಸಿದ ಮಕ್ಕಳು ಧೂಮಪಾನ ಆರಂಭಿಸುವ ಸಾಧ್ಯತೆ ಇದೆ.

3. ಭಾರತದಲ್ಲಿ ಮಕ್ಕಳು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತಿಗೆ ಹೆಚ್ಚು ಮರಳಾಗುತ್ತಾರೆ. ಭಾರತದಲ್ಲಿ ನಡೆಸಲಾದ ಸಮೀಕ್ಷೆಯಂತೆ ಮಕ್ಕಳು ಮತ್ತು ಯುವಕರು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ, ವಿಶೇಷವಾಗಿ ಸಿಗರೇಟು ಮತ್ತು ಗುಟ್ಕಾ ಜಾಹೀರಾತುಗಳಿಂದ ಹೆಚ್ಚು ಪ್ರಭಾವಿತರಾಗುತ್ತಾರೆ. 2001–04 ರಲ್ಲಿ ನಡೆಸಲಾದ ಸಮೀಕ್ಷೆಯಂತೆ 8–10 ನೇ ತರಗತಿಯಲ್ಲಿ ಓದುವ (13–15 ಪ್ರಾಯದ) 42 ಪ್ರತಿಶತ ಮಕ್ಕಳು ತಂಬಾಕು ಜಾಹೀರಾತನ್ನು ನೋಡಿದ್ದಾರೆ. ಮಕ್ಕಳಿಗೆ ಹಾಗೂ ಯುವಕರಿಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು ಕೈಗೆ ನಿಟುಕಬಾರದು ಎಂಬುದಕ್ಕೆ ಮೇ 31, 2005 ರಂದು ಅಧಿಸೂಚಿತ ನಿಯಮಗಳಿವೆ.

4. ಜಾಹೀರಾತು ನಿಷೇಧದಿಂದ ತಂಬಾಕು ಬಳಕೆ ಕಡಿಮೆಯಾಗುತ್ತದೆ ಎಂಬುದನ್ನು ಸಿದ್ಧಪಡಿಸಲು ಸಾಕಷ್ಟು ಪುರಾವೆಗಳಿವೆ.1999 ರ ವಿಶ್ವ ಬ್ಯಾಂಕ್ ವರದಿ ಇವುಗಳಲ್ಲಿ ಮಹತ್ವದ್ದು. ಆದರೆ ತಂಬಾಕು ನಿಷೇಧವನ್ನು ಭಾರತೀಯ ಹಾಗೂ ಜಾಗತಿಕ ತಂಬಾಕು ಉದ್ದಿಮೆಯು ಬಲವಾಗಿ ವಿರೋಧಿಸುತ್ತದೆ.

5. ಮಕ್ಕಳು ತಂಬಾಕು ಜಾಹೀರಾತಿಗೆ ಸುಲಭವಾಗಿ ಬಲೆ ಬೀಳುತ್ತಾರೆ. ಇಂತಹ ಯುಕ್ತಿಗಳಿಂದ ಅವರನ್ನು ರಕ್ಷಿಸಬೇಕಾದ ಅವಶ್ಯಕತೆ ಇದೆ. ಮಕ್ಕಳ ಹಕ್ಕು ನಿಯಮಾವಳಿ (convention on the Rights of the Child- CRC) ಯ 17ನೇ ಅನುಚ್ಛೇದವು ಇದನ್ನು ಒತ್ತಿ ಹೇಳುತ್ತದೆ. ಅನುಚ್ಛೇದ 13 ಹಾಗೂ 18 ಮಕ್ಕಳ ಹಕ್ಕು ಹಾಗೂ ಹಿತಾಸಕ್ತಿಯನ್ನು ಒತ್ತಿ ಹೇಳುತ್ತವೆ.

2.3 ಜಾರಿ ಅಧಿಕಾರಿಗಳ ಪಾತ್ರ ತಂಬಾಕು ಕಾಯ್ದೆಯ ಉಲ್ಲಂಘನೆಯಾಗಿದ್ದು ಕಂಡುಬಂದಲ್ಲಿ ಸಾರ್ವಜನಿಕರು ಸಂಬಂಧಪಟ್ಟ ಅಧಿಕಾರಿಗಳ ಗಮನಕ್ಕೆ ತರುವಂತೆ ರಾಜ್ಯವು ಪ್ರೋತ್ಸಾಹಿಸಬೇಕು.

- ಅಧಿಕೃತ ಅಧಿಕಾರಿಗಳು ಸಂಚಾಲನಾ ಸಮಿತಿಗೆ ದೂರುಗಳನ್ನು ಒಪ್ಪಿಸಬಹುದು. ಟೆಲಿವಿಷನ್ ಹಾಗೂ ಮುದ್ರಣ ಮಾಧ್ಯಮಗಳಲ್ಲಿ ಉಲ್ಲಂಘನೆ ಕಂಡುಬಂದರೆ ಭಾರತ ಸರ್ಕಾರದ ಮಾಹಿತಿ ಹಾಗೂ ಪ್ರಸರಣ ಇಲಾಖೆಗೆ ದೂರು ನೀಡಬಹುದು. ಕೇಬಲ್ ಟೀವಿ ಆಪರೇಟರ್‌ಗಳು ನಿಯಮ ಉಲ್ಲಂಘಿಸಿದರೆ ಜಿಲ್ಲಾ ಮೆಜಿಸ್ಟ್ರೇಟ್‌ಗಳ ಗಮನಕ್ಕೆ ತರಬಹುದು.
- ಇದಲ್ಲದೇ, COTPA ಸೆಕ್ಷನ್ 22 ಹಾಗೂ 23 ರ ಪ್ರಕಾರ, ಜಾಹೀರಾತು ವಸ್ತುಗಳನ್ನು ಹುಡುಕುವ ಹಾಗೂ ವಶಪಡಿಸಿಕೊಳ್ಳುವ ಹಂತದಲ್ಲಿ, ಪುರಾವೆಗಳು ನಾಶಗೊಳ್ಳದ ಹಾಗೆ ನೋಡಿಕೊಳ್ಳುವುದು ಅತ್ಯವಶ್ಯ.

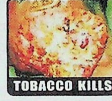
ಅಧ್ಯಾಯ-3

ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ಮತ್ತು ಅವರಿಂದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ನಿಷೇಧ

3.1 ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ಮತ್ತು ಅವರಿಂದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ನಿಷೇಧ ಕುರಿತು ಕಾನೂನು

ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ (18 ವರ್ಷಕ್ಕಿಂತ ಕೆಳಗಿನ ವಯಸ್ಸಿನವರು) ಯಾವುದೇ ವ್ಯಕ್ತಿಯು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರಬಾರದು ಹಾಗೂ ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ನಿಭಾಯಿಸದಂತೆ ಮತ್ತು ಮಾರಾಟ ಮಾಡದಂತೆ ಎಲ್ಲಾ ತಂಬಾಕು ಮಾರಾಟಗಾರರು ಖಚಿತಪಡಿಸಿಕೊಳ್ಳಬೇಕು. ಮತ್ತು ಯಾವುದೇ ವ್ಯಕ್ತಿಯು ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಗಳ ಸುತ್ತಮುತ್ತ ನೂರು ಗಜ/ಯಾರ್ಡ್ ಅಂತರದ ಒಳಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರುವಂತಿಲ್ಲ.

Sale of tobacco products to a person below the age of eighteen years is a punishable offence.



Sale of tobacco products to a person below the age of eighteen years is a punishable offence.

(ತಂಬಾಕು ಉತ್ಪನ್ನ ಪ್ಯಾಕುಗಳ ಮೇಲೆ ಪ್ರದರ್ಶಿಸಬೇಕಾದ ಆರೋಗ್ಯ ಸಂಬಂಧ ಎಚ್ಚರಿಕೆ ಚಿತ್ರ)

ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಯ ವ್ಯಾಖ್ಯೆ [ನಿಯಮ 2(ಬಿ)]

ಶಿಕ್ಷಣ ಸಂಸ್ಥೆ ಎಂದರೆ ನಿಗದಿತ ನಿಯಮಾವಳಿಗಳಂತೆ ಶೈಕ್ಷಣಿಕ ಸೂಚನೆಗಳನ್ನು ನೀಡುವ ಸ್ಥಳ /ಕೇಂದ್ರ, ಇದು ಯೋಗ ಅಧಿಕಾರದಿಂದ ಮಾನ್ಯತೆ ಪಡೆದ ಶಾಲೆಗಳು, ಕಾಲೇಜುಗಳು, ಮತ್ತು ಇತರ ಉನ್ನತ ಕಲಿಕೆಯ ಸಂಸ್ಥೆಗಳನ್ನು ಒಳಗೊಳ್ಳುತ್ತದೆ.

ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ಮತ್ತು ಅವರಿಂದ ತಂಬಾಕು ಮಾರಾಟಕ್ಕೆ ಶಿಕ್ಷೆ (S.24)

ನಿಯಮವನ್ನು ಉಲ್ಲಂಘಿಸಿದ ವ್ಯಕ್ತಿಯು ರೂ. 200 ರವರೆಗೆ ಜುಲ್ಮಾನೆಗೆ ಗುರಿಯಾಗುತ್ತಾನೆ.

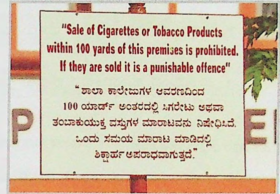
ನಿಷೇಧವನ್ನು ಜಾರಿಗೊಳಿಸುವುದು (S.25,28) ಕೇಂದ್ರ ಸರ್ಕಾರ ಅಥವಾ ರಾಜ್ಯ ಸರ್ಕಾರ ಸೆಕ್ಷನ್ 6ರ ಅನ್ವಯ ಅಪರಾಧ ಎಸಗಿದ ವ್ಯಕ್ತಿಯ ವಿರುದ್ಧಕ್ರಮ ಕೈಗೊಳ್ಳಲು ಒಬ್ಬ ಅಥವಾ ಹೆಚ್ಚಿನ ವ್ಯಕ್ತಿಗಳನ್ನು ನಿಯೋಜಿಸಬಹುದು. ಅಪರಾಧವು ಒಪ್ಪಂದದ ಮೂಲಕ ಪರಿಹರಿಸಿಕೊಳ್ಳಬಹುದಾದ ಬಗೆಯದ್ದಾಗಿರುವದರಿಂದ ಜಾರಿ ಅಧಿಕಾರಿಯು ಸ್ಥಳದಲ್ಲಿಯೇ ಬಗೆಹರಿಸಬಹುದು ಮತ್ತು 1973 ಅಪರಾಧ ಸಂಹಿತೆಯಂತೆ ಆದ್ಯಂತವಾಗಿ ವಿಚಾರಣೆ ನಡೆಸಬಹುದು. COTPA ಅಡಿಯಲ್ಲಿ ಮಾನ್ಯತೆ ಪಡೆದ ಅಧಿಕಾರಿಯು ತಾನು ಕರ್ತವ್ಯ ನಿರ್ವಹಿಸುತ್ತಿರುವಾಗ ಸಾರ್ವಜನಿಕ ಸೇವಕನಾಗಿ ಪರಿಗಣಿಸಲ್ಪಡುತ್ತಾನೆ.

COTPA ಹೊರತಾಗಿ ಬಾಲಕಾರ್ಮಿಕರ ನಿಷೇಧ ಮತ್ತು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆ 1986 ಕೂಡ ಹಾನಿಕಾರಕ ಚಟುವಟಿಕೆಗಳಿಂದ ಮಕ್ಕಳನ್ನು ರಕ್ಷಿಸುವುದನ್ನು ಕಡ್ಡಾಯಗೊಳಿಸುತ್ತದೆ. ಮಕ್ಕಳು ಬೀಡಿ ಕಟ್ಟುವುದನ್ನು ಕಾಯ್ದೆಯು ನಿರ್ದಿಷ್ಟವಾಗಿ ನಿಷೇಧಿಸುತ್ತದೆ. ಬೀಡಿ ಉದ್ದಿಮೆಯಲ್ಲಿ ಕೆಲಸ ಮಾಡುವ ಮಕ್ಕಳಿಗೆ ಅದು ಸುಲಭವಾಗಿ ದೊರೆಯುತ್ತದೆ. ಹಾಗಾಗಿ ಕಾಯ್ದೆಯು ಮಕ್ಕಳನ್ನು ಬೀಡಿ ಸೇವನೆಯಿಂದ ರಕ್ಷಿಸುತ್ತದೆ ಮತ್ತು COTPA ಸೆಕ್ಷನ್ 6ರ ಉದ್ದೇಶವನ್ನು ಸ್ವಲ್ಪಮಟ್ಟಿಗೆ ಪೂರೈಸುತ್ತದೆ.

ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ನಿಷೇಧ ಕುರಿತ ನಿಯಮಗಳು : ಆರಂಭಿಕವಾಗಿ ನಿಯಮಗಳನ್ನು 2004 ಫೆಬ್ರುವರಿಯಲ್ಲಿ ಅನುಸೂಚಿಸಲಾಯಿತು. ಇದರ ಪ್ರಕಾರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು ಮಾರಾಟವಾಗುತ್ತಿರುವ ಸ್ಥಳದ ಮಾಲೀಕ ಅಥವಾ ವಾರಸುದಾರ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆ ಹೊಂದಿರುವ ಫಲಕವನ್ನು ಪ್ರದರ್ಶಿಸಬೇಕು.

(ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ದುಷ್ಪರಿಣಾಮಗಳ ಬಗ್ಗೆ ಅರಿವಿನ ಕಾರ್ಯಕ್ರಮ)

- **"18 ವರ್ಷದೊಳಗಿನವರಿಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರಾಟ ಮಾಡುವುದು ಅಪರಾಧ" ಭಾರತದಲ್ಲಿ ಅನೇಕ ಮಕ್ಕಳು ತಮ್ಮ ಬಾಲ್ಯಾವಸ್ಥೆಯಲ್ಲೇ ತಂಬಾಕು ಸೇವನೆ ರುಚಿ ನೋಡಿ ಗೀಳು ಹತ್ತಿಸಿಕೊಂಡಿದ್ದಾರೆ.**
    - ಫಲಕದ ಕನಿಷ್ಠ ಗಾತ್ರ 60 ಸೆ.ಮೀ. X 30 ಸೆ.ಮೀ.
    - ಎದ್ದುಕಾಣುವ ಸ್ಥಳದಲ್ಲಿ ಫಲಕವನ್ನು ಪ್ರದರ್ಶಿಸಬೇಕು.
    - ಎಚ್ಚರಿಕೆಯು ಅನ್ವಯಿತ ಭಾರತೀಯ ಭಾಷೆಯಲ್ಲಿರಬೇಕು.



(ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಪ್ರವೇಶ ದ್ವಾರದ ನಾಮಫಲಕ)

ಸೆಪ್ಟೆಂಬರ್ 1, 2004 ರ ಅಧಿಸೂಚನೆಯ ನಿಯಮದಂತೆ ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಸುತ್ತಮುತ್ತ ಸಿಗರೇಟು ಮತ್ತು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರಾಟ ಮಾಡುವಂತಿಲ್ಲ. 18 ವರ್ಷಕ್ಕಿಂತ ಕೆಳಗಿನವರು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಕೊಡುವುದು, ವೈಯಕ್ತಿಕವಾಗಿ ಮಾರಾಟ ಮಾಡುವುದು ನಿಷೇಧಿತ.

ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಮಾಲೀಕ ಅಥವಾ ಅದರ ಜವಾಬ್ದಾರಿ ವಹಿಸಿದವರು ಈ ಕೆಳಗಿನಂತೆ ಪ್ರಮುಖ ಸ್ಥಳದಲ್ಲಿ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಿಸಬೇಕು "ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಸುತ್ತಮುತ್ತ 100 ಗಜಗಳ ಒಳಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟವನ್ನು ಕಟ್ಟುನಿಟ್ಟಾಗಿ ನಿಷೇಧಿಸಲಾಗಿದೆ. ಮತ್ತು ಇದನ್ನು ಉಲ್ಲಂಘಿಸಿದ ಅಪರಾಧವು ರೂ. 200 ವರೆಗಿನ ಜುಲ್ಮಾನೆಗೆ ಅರ್ಹವಾಗಿರುತ್ತದೆ."

ನ್ಯಾಯಾಲಯದ ವರ್ತಮಾನ : ಈ ನಿಯಮಗಳನ್ನು ಮುಂಬೈ ಉಚ್ಚನ್ಯಾಯಾಲಯದಲ್ಲಿ ಪ್ರಶ್ನಿಸಲಾಗಿತ್ತು. ಇತರ ವಿಷಯಗಳ ಹೊರತಾಗಿ ಫಿರ್ಯಾದುದಾರರು ಸೆಕ್ಷನ್ 6 (ಬಿ) ಯಲ್ಲಿರುವ ನಿಯಮಗಳನ್ನು ಆರೋಗ್ಯ ಹಾಗೂ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಮಂತ್ರಾಲಯವು ಅಧಿಸೂಚಿಸಿಲ್ಲ ಎಂದು ವಾದಿಸಿದ್ದಾರೆ. ಜುಲೈ 9, 2009 ರ ತನ್ನ ಆದೇಶದಲ್ಲಿ ಉಚ್ಚನ್ಯಾಯಾಲಯವು ಸೆಕ್ಷನ್ 6 (ಬಿ) ಗೆ ಸಂಬಂಧಿಸಿದ ಎಲ್ಲಾ ವಿಷಯಗಳನ್ನು ಇತ್ಯರ್ಥಗೊಳಿಸಿತು. ಭಾರತ ಸರ್ಕಾರವು ಈ ಸಂಬಂಧ ಅಧಿಸೂಚನೆ ಹೊರಡಿಸುವುದಾಗಿ ನ್ಯಾಯಾಲಯಕ್ಕೆ ಭರವಸೆ ನೀಡಿ ಆರೋಗ್ಯ ಹಾಗೂ ಕುಟುಂಬ ಕಲ್ಯಾಣ ಮಂತ್ರಾಲಯದ ಅಧಿಸೂಚನೆಯ ಕೊರತೆ ನೀಗಿಸಿ ಸೆಕ್ಷನ್ 6 (ಬಿ) ಸೆಪ್ಟೆಂಬರ್ 18, 2009 ರಂದು ಅನುಷ್ಠಾನಕ್ಕೆ ಅರ್ಹವಾಯಿತು.

3.2 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪರಿಚಯದಿಂದ ಯುವಕರು ಮತ್ತು ಮಕ್ಕಳನ್ನು ರಕ್ಷಿಸುವ ಸಕಾರಣತೆ

ತಂಬಾಕು ಸೇವನೆ ಆರೋಗ್ಯಕ್ಕೆ ಹಾನಿಕಾರಕ ಎಂಬುದು ತಿಳಿದ ವಿಷಯವಾಗಿರುವುದರಿಂದ ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರು ಅದರ ಪರಿಚಯಕ್ಕೆ ಒಳಗಾಗುವುದನ್ನು ತಡೆಯುವುದು ಇದರ ಉದ್ದೇಶ. COTPA ಅಡಿಯಲ್ಲಿನ ಈ ಕ್ರಮಗಳು ಮಕ್ಕಳು ಮತ್ತು ಯುವಕರು ಜೀವನದಲ್ಲಿ ಬೇಗನೇ ತಂಬಾಕು ಸೇವನೆ ಆರಂಭಿಸುವುದನ್ನು ತಡೆಯುತ್ತವೆ.

- ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ಮಾರಾಟ ನಿಯಂತ್ರಣಕ್ಕೆ ಕಾರಣಗಳು
    - ಭಾರತದಲ್ಲಿ ಅನೇಕ ಮಕ್ಕಳು ತಮ್ಮ ಬಾಲ್ಯಾವಸ್ಥೆಯಲ್ಲೇ ತಂಬಾಕು ಸೇವನೆ ರುಚಿ ನೋಡಿ ಗೀಳು ಹತ್ತಿಸಿಕೊಂಡಿದ್ದಾರೆ.
    - ಬಾಲ್ಯದಲ್ಲಿ ತಂಬಾಕು ಸೇವನೆ ಆರಂಭಿಸಿದವರು ಇತರರಿಗಿಂತ ಬೇಗನೇ ರೋಗಗಳಿಗೆ ತುತ್ತಾಗಿ ಅಕಾಲ ಮರಣ ಹೊಂದುತ್ತಿದ್ದಾರೆ. ಶ್ವಾಸಕೋಶ ಕ್ಯಾನ್ಸರ್‌ನಂತಹ ರೋಗಗಳು ತಂಬಾಕು ಸೇವಿಸುವ ಮಕ್ಕಳನ್ನು ಕಾಡುತ್ತಿವೆ. ಸಿಗರೇಟಿನಲ್ಲಿರುವ ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಯುವಕರಲ್ಲಿ ಬಾಯಿ ಕ್ಯಾನ್ಸರ್ ಹೆಚ್ಚಾಗುತ್ತಿದೆ.

(ಅಪ್ರಾಪ್ತ ವಯಸ್ಕ ಮಾರಾಟ ಮಾಡುವುದನ್ನು ನಿಷೇಧಿಸಿರುವ ಚಿತ್ರ)

- ಅಪ್ರಾಪ್ತವಯಸ್ಕರು ಮಾರಾಟ ಮಾಡುವುದನ್ನು ನಿಷೇಧಿಸಲು ಕಾರಣಗಳು
    - ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರು ಮಾರಾಟ ಮಾಡುವುದರಿಂದ ಯುವಕರಲ್ಲಿ ತಂಬಾಕು ಮಾರಾಟ ಉತ್ತಮ ವ್ಯಾಪಾರವೆಂಬ ತಪ್ಪು ಸಂದೇಶ ರವಾನೆಯಾಗುತ್ತದೆ.
    - ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರು ಮಾರಾಟ ಮಾಡುವುದರಿಂದ ಅವರು ಮತ್ತು ಇತರ ಮಕ್ಕಳು ತಂಬಾಕು ಸೇವಿಸುವುದು ಸರಿ ಎಂಬ ಭಾವನೆ ಬೆಳೆಯುತ್ತದೆ.
    - ಶಾಲೆಯಿಂದ ಹೊರಬೀಳುವ ಪ್ರೌಢರು ಇತರ ಯುವಕರಿಗಿಂತ ಹೆಚ್ಚಾಗಿ ಮಾರಾಟದಲ್ಲಿ ತೊಡಗುವ ಸಾಧ್ಯತೆ ಇದೆ.

3.3 ಜಾರಿ ಅಧಿಕಾರಿಗಳ ಪಾತ್ರ

ಜಾರಿ ಇಲಾಖೆ, ಪೋಲೀಸ್ ಇಲಾಖೆ, ಆಹಾರ ಮತ್ತು ಔಷಧ ಆಡಳಿತ ಮತ್ತು ಇತರ ಇಲಾಖೆಗಳು ಕೇಂದ್ರ ಅಥವಾ ರಾಜ್ಯ ಸರ್ಕಾರದಿಂದ ಈ ನಿಯಮಗಳನ್ನು ಜಾರಿಗೊಳಿಸಲು ಮಾನ್ಯವಾಗಿರುತ್ತವೆ. ಈ ಇಲಾಖೆಯ ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಸುತ್ತಮುತ್ತ 100 ಗಜಗಳ ಒಳಗಿನ ಅಂತರದಲ್ಲಿ ತಂಬಾಕು ಉತ್ಪನ್ನ ಮಾರಾಟವಾಗದಂತೆ ತಡೆಯಬೇಕು. ಈ ಪ್ರದೇಶದಲ್ಲಿ ಮತ್ತು ಹೊರಗೆ ವ್ಯಾಪಾರಿಗಳು ಅಪ್ರಾಪ್ತವಯಸ್ಕರಿಗೆ ಮಾರಾಟ ಮಾಡದಂತೆ ನಿಗಾ ವಹಿಸಬೇಕು.

ಪ್ರಾಧಿಕೃತ ಅಧಿಕಾರಿಗಳು ಇದನ್ನು ಖಚಿತಪಡಿಸಿಕೊಳ್ಳಲು ಆಗಾಗ ಪರಿವೀಕ್ಷಣೆ ಮತ್ತು ಅನಿರೀಕ್ಷಿತ ಭೇಟಿಯಿಂದ ಪರಿಶೀಲಿಸಬೇಕು.

ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಆವರಣವು ತಂಬಾಕು ಮುಕ್ತವಾಗಿರುವಂತೆ ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ ಆಡಳಿತಗಾರರು ನೋಡಿಕೊಳ್ಳಬೇಕು. ಮುಖ್ಯವಾಗಿ ಶಿಕ್ಷಕರು ಮತ್ತು ಆಡಳಿತ ಸಿಬ್ಬಂದಿಗೆ ಈ ಕುರಿತ ಕಾನೂನಿನ ಅರಿವು ಇರಬೇಕು. ಮತ್ತು ವಿದ್ಯಾರ್ಥಿಗಳಲ್ಲಿ ಈ ಕುರಿತು ಜಾಗೃತಿ ಮೂಡಿಸಬೇಕು.

ಅಧ್ಯಾಯ-4

ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಕುರಿತ ನಿರ್ದಿಷ್ಟ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಸಂಬಂಧಿತ ಕಾನೂನು

4.1 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪೊಟ್ಟಣಗಳ ಮೇಲೆ ಚಿತ್ರವತ್ತಾದ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಿಸುವುದನ್ನು ಕಡ್ಡಾಯಗೊಳಿಸುತ್ತದೆ.

ಸಿಗರೇಟು (ಉತ್ಪಾದನೆ, ನಿಯಂತ್ರಣ, ಪೂರೈಕೆ ಮತ್ತು ಸರಬರಾಜು) ಕಾಯ್ದೆ 1975: ಮೊಟ್ಟಮೊದಲು ಕಾಯ್ದೆಬದ್ಧ ಎಚ್ಚರಿಕೆ **'ಸಿಗರೇಟು ಸೇವನೆ ಆರೋಗ್ಯಕ್ಕೆ ಹಾನಿಕಾರಕ'** ಇದನ್ನು ಸಿಗರೇಟು ಕಾಯ್ದೆ 1975 ರ ಸೆಕ್ಷನ್ 2(m) ಮತ್ತು ಸೆಕ್ಷನ್ 3ರ ಅನ್ವಯ ವಿಧಿಸಲಾಯಿತು. ಅದರನ್ವಯ ಸಿಗರೇಟು ಪೊಟ್ಟಣಗಳ ಮೇಲೆ ಮತ್ತು ಅವುಗಳ ಜಾಹೀರಾತಿನಲ್ಲಿ ಬ್ರಾಂಡ್‌ನಲ್ಲಿ ಬಳಸಿದ ಭಾಷೆಯನ್ನು ಬಳಸಿ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯನ್ನು ಪ್ರಕಟಿಸಬೇಕು. ಬೀಡಿ, ಗುಟ್ಕಾ ಮತ್ತಿತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು ಇದಕ್ಕೆ ಒಳಪಟ್ಟಿರಲಿಲ್ಲ. ಬ್ರಾಂಡ್ ಹೆಸರನ್ನು ಬಳಸಲಾದ ವಿಸ್ತಾರ ಎಷ್ಟೇ ಇರಲಿ ಈ ಎಚ್ಚರಿಕೆಯ ಅಕ್ಷರಗಳು ಕನಿಷ್ಠ 3 ಮೀಮೀ ಎತ್ತರ ಇರಲೇಬೇಕು. ಸಿಗರೇಟು ಕಾಯ್ದೆ 1975ರ ಸೆಕ್ಷನ್ 3(3) ಈ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಿಸಿದ ಪೊಟ್ಟಣಗಳಲ್ಲಿ ಸಿಗರೇಟುಗಳ ಆಮದನ್ನು ನಿಷೇಧಿಸುತ್ತದೆ.

ಪೊಟ್ಟಣಗಳ ಮೇಲಿನ ಪರಿಣಾಮಕಾರಕ ಎಚ್ಚರಿಕೆಗಳು : COTPA ನಿಬಂದಿಸಿದಂತೆ ಸಿಗರೇಟು ಮತ್ತಿತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪ್ರತಿ ಪೊಟ್ಟಣವು ಚಿತ್ರವತ್ತಾದ ನಿಗದಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯನ್ನು ಪ್ರಕಟಿಸಬೇಕು.

ಚಿತ್ರವತ್ತಾದ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯನ್ನು ಹೊಂದಿರಬೇಕಾದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು (S.7)

- ಸಿಗರೇಟು ಮತ್ತಿತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪ್ರತಿ ಪೊಟ್ಟಣವು ಈ ಕೆಳಗಿನವುಗಳನ್ನು ಹೊಂದಿರಬೇಕು.
    - ನಿಗದಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಮತ್ತು ಅದರ ಪ್ರಾತಿನಿಧಿಕ ಚಿತ್ರ
    - ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆ ಇಲ್ಲದ ಪೊಟ್ಟಣಗಳಲ್ಲಿರುವ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ವ್ಯಾಪಾರ ಮತ್ತು ವಾಣಿಜ್ಯ ನಿಷೇಧ
    - ನಿಗದಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆಯನ್ನು ಪೊಟ್ಟಣದ ಮೇಲೆ ಹೊಂದಿದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಆಮದನ್ನು ಕಾಯ್ದೆ ನಿಷೇಧಿಸುತ್ತದೆ.
    - ತಂಬಾಕು ಉತ್ಪನ್ನದ ಪೊಟ್ಟಣದ ಮೇಲೆ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯು ಮುಖ್ಯ ಪಟ್ಟಿಗಿಂತ ಕಡಿಮೆ ಗಾತ್ರದಲ್ಲಿರಕೂಡದು.
    - ಪೊಟ್ಟಣದ ಮೇಲೆ ಪ್ರತಿ ತಂಬಾಕು ಉತ್ಪನ್ನದ ನಿಕೋಟಿನ್ ಮತ್ತು ಟಾರ್ ಅಂಶಗಳನ್ನು ಅವುಗಳ ಒಪ್ಪಬಹುದಾದ ಮಿತಿಯೊಂದಿಗೆ ಪ್ರಕಟಿಸಬೇಕು.

ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆಯು ಸ್ಫುಟವಾಗಿ, ಪ್ರಮುಖವಾಗಿ ಮತ್ತು ಕಾಣುವಂತೆ ಸ್ಪಷ್ಟವಾದ ಗಾತ್ರ, ಬಣ್ಣ ಮತ್ತು ಶೈಲಿಯಲ್ಲಿರಬೇಕು (S.8)

- ಎಚ್ಚರಿಕೆ ಅಕ್ಷರಗಳು ದಪ್ಪವಾಗಿ, ಹಿನ್ನೆಲೆ ಬಣ್ಣದಲ್ಲಿ ಎದ್ದು ಕಾಣುವಂತೆ ಸ್ಪಷ್ಟವಾಗಿರಬೇಕು.
- ಗ್ರಾಹಕನು ಪೊಟ್ಟಣವನ್ನು ಬಿಚ್ಚುವ ಮೊದಲು ಅವನಿಗೆ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆ ಕಾಣುವಂತಿರಬೇಕು.

ಪೊಟ್ಟಣದ ಮೇಲಿನ ಭಾಷೆ	ಎಚ್ಚರಿಕೆಯ ಭಾಷೆ
ಇಂಗ್ಲೀಷ್	ಇಂಗ್ಲೀಷ್
ಭಾರತೀಯ ಭಾಷೆ ಅಥವಾ ಭಾಷೆಗಳು	ಅದೇ ಭಾರತೀಯ ಭಾಷೆ ಅಥವಾ ಭಾಷೆಗಳು
ಇಂಗ್ಲೀಷ್ ಮತ್ತು ಭಾರತೀಯ ಭಾಷೆ ಅಥವಾ ಭಾಷೆಗಳು	ಇಂಗ್ಲೀಷ್ ಮತ್ತು ಅದೇ ಭಾರತೀಯ ಭಾಷೆಗಳು
ಭಾಗಶಃ ಇಂಗ್ಲೀಷ್ ಮತ್ತು ಭಾಗಶಃ ಭಾರತೀಯ ಭಾಷೆ ಅಥವಾ ಭಾಷೆಗಳು	ಇಂಗ್ಲೀಷ್ ಮತ್ತು ಅದೇ ಭಾರತೀಯ ಭಾಷೆಗಳು
ವಿದೇಶೀ ಭಾಷೆ	ಇಂಗ್ಲೀಷ್
ಭಾಗಶಃ ವಿದೇಶೀ ಭಾಷೆ ಮತ್ತು ಭಾಗಶಃ ಇಂಗ್ಲೀಷ್ ಅಥವಾ ಯಾವುದೇ ಭಾರತೀಯ ಭಾಷೆ	ಇಂಗ್ಲೀಷ್ ಮತ್ತು ಭಾರತೀಯ ಭಾಷೆ ಅಥವಾ ಭಾಷೆಗಳು

- ನಿಗದಿತ ಎಚ್ಚರಿಕೆಗೆ ವ್ಯತಿರಿಕ್ತವಾಗುವಂತೆ ಮತ್ತು ಹೊಂದದಂತೆ ಇರುವ ಯಾವುದೇ ಹೇಳಿಕೆ ಅಥವಾ ವಿಷಯ ಪೊಟ್ಟಣದ ಮೇಲೆ ಇರಬಾರದು.

COTPA ಸೆಕ್ಷನ್ 10–11 ರ ಅನ್ವಯ, ನಿಗದಿತ ಎಚ್ಚರಿಕೆಯನ್ನು ಪೊಟ್ಟಣದ ಮೇಲೆ ಪ್ರಕಟಿಸಲು ಭಾರತ ಸರ್ಕಾರವು ಅಕ್ಷರಗಳ ಗಾತ್ರ ಮತ್ತು ರೂಪವನ್ನು ನಿರ್ಧರಿಸಿ ಸೂಚಿಸುತ್ತದೆ. ಮತ್ತು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳಲ್ಲಿರುವ ನಿಕೋಟಿನ್ ಮತ್ತು ಟಾರ್ ಅಂಶಗಳನ್ನು ಪರೀಕ್ಷಿಸುವ ಪ್ರಯೋಗಾಲಯಗಳಿಗೆ ಮಾನ್ಯತೆ ನೀಡುತ್ತದೆ.

ಉತ್ಪಾದಕರು ಮತ್ತು ತಯಾರಕರಿಗೆ ಶಿಕ್ಷೆ (S.20)

- ನಿಗದಿತ ಎಚ್ಚರಿಕೆಯ ಪ್ರಕಟಣೆ ಹೊಂದಿಲ್ಲದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಉತ್ಪಾದಿಸಿದ ಯಾವುದೇ ಉತ್ಪಾದಕ ಅಥವಾ ತಯಾರಕನು ಮೊದಲ ಬಾರಿ ತಪ್ಪಿತಸ್ಥನಾಗಿದ್ದರೆ ಎರಡು ವರ್ಷದವರೆಗೆ ಜೈಲುವಾಸ ಅಥವಾ ರೂ. 5000 ಜಲ್ಮಾನೆ ಅಥವಾ ಎರಡೂ ಶಿಕ್ಷೆಗಳಿಗೆ ಅರ್ಹನಾಗಿರುತ್ತಾನೆ. ಎರಡನೇ ಬಾರಿ ತಪ್ಪಿತಸ್ಥನಾಗಿದ್ದರೆ ಸೆರೆವಾಸದ ಅವಧಿ 5 ವರ್ಷ ಮತ್ತು ಜುಲ್ಮಾನೆಯ ಮೊತ್ತ ರೂ. 10,000.

ಚಿಲ್ಲರೆ ವ್ಯಾಪಾರಿಗಳಿಗೆ ಶಿಕ್ಷೆ (S.20)

- ನಿಗದಿತ ಎಚ್ಚರಿಕೆಯ ಪ್ರಕಟಣೆ ಹೊಂದಿಲ್ಲದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರಾಟ ಮಾಡುವ ಅಥವಾ ಸರಬರಾಜು ಮಾಡುವ ಯಾವುದೇ ವ್ಯಕ್ತಿಯು ಮೊದಲ ಬಾರಿ ತಪ್ಪಿತಸ್ಥನಾಗಿದ್ದರೆ ಒಂದು ವರ್ಷದವರೆಗೆ ಜೈಲುವಾಸ ಅಥವಾ ರೂ. 1,000 ಜುಲ್ಮಾನೆ ಅಥವಾ ಎರಡೂ ಶಿಕ್ಷೆಗೆ ಗುರಿಯಾಗುತ್ತಾನೆ. ಎರಡನೇ ಅಥವಾ ಹೆಚ್ಚಿನ ಬಾರಿಗೆ ತಪ್ಪಿತಸ್ಥನಾಗಿದ್ದರೆ ಎರಡು ವರ್ಷದವರೆಗಿನ ಜೈಲು ವಾಸ ಮತ್ತು ರೂ. 3,000 ಜುಲ್ಮಾನೆಗೆ ಗುರಿಯಾಗುತ್ತಾನೆ.

ಕಂಪನಿಗಳಿಂದಾಗುವ ಅಪರಾಧಗಳು (S.26)

- ಕಂಪನಿಯೊಂದು ಅಪರಾಧವೆಸಗಿದರೆ, ಆ ಸಮಯದಲ್ಲಿ ಕಂಪನಿಯ ಮೇಲ್ವಿಚಾರಕ ಅಥವಾ ಜವಾಬ್ದಾರಿ ವ್ಯಕ್ತಿಯನ್ನು ಮತ್ತು ಕಂಪನಿಯನ್ನು ಶಿಕ್ಷಾರ್ಹ ಎಂದು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ. ಆದರೆ ವ್ಯಕ್ತಿಯು ತನ್ನ ಅರಿವಿಲ್ಲದೇ ತಪ್ಪು ಜರಗಿದೆ ಅಥವಾ ಆ ತಪ್ಪನ್ನು ತಡೆಯಲು ತಾನು ಎಲ್ಲಾ ರೀತಿಯ ಎಚ್ಚರಿಕೆ ವಹಿಸಿದ್ದೆ ಎಂದು ಸಿದ್ಧಮಾಡಿ ತೋರಿಸಿದರೆ ಆತ ಶಿಕ್ಷೆಯಿಂದ ವಿನಾಯಿತಿ ಪಡೆಯುತ್ತಾನೆ.

ಜಾಮೀನಿಗೆ ಅರ್ಹವಾಗುವ ಅಪರಾಧಗಳು (S.27) ಅಪರಾಧ ಸಂಹಿತೆ, 1973 ಗೆ ಹೊರತಾಗಿ COTPA ಅಡಿಯಲ್ಲಿ ಯಾವುದೇ ಅಪರಾಧವು ಜಾಮೀನಿಗೆ ಅರ್ಹವಾಗಿದೆ.

ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಕುರಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಬಗೆಗಿನ ಅಧಿಸೂಚಿ ನಿಯಮಗಳು: 2006 ರ ಜುಲೈನಲ್ಲಿ ಚಿತ್ರಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಬಗೆಗಿನ ಮೊದಲ ಕಂತಿನ ನಿಯಮಾವಳಿಯನ್ನು ಅಧಿಸೂಚಿಸಲಾಯಿತು. ಈ ನಿಯಮಗಳು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪೊಟ್ಟಣ ಕಟ್ಟುವಿಕೆ ಮತ್ತು ಅದರ ಮೇಲೆ ಹಣೆಪಟ್ಟಿ ಹಚ್ಚುವ ಬಗೆಯನ್ನು ಸೂಚಿಸುತ್ತವೆ. ಎಚ್ಚರಿಕೆಯು ನಿಯಮಗಳಿಗೆ

ಸೇರಿಸಲಾದ ಅನುಬಂಧದಲ್ಲಿ ಹೇಳಿರುವುದಕ್ಕೆ ಸರಿಯಾಗಿ ಪ್ರಕಟಿತವಾಗಿರಬೇಕು. ಈ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆ ಕುರಿತು ಸಾಕಷ್ಟು ವಿಳಂಬದ ನಂತರ ಈಗ ಪ್ರತಿ ತಯಾರಕ ಮತ್ತು ಮಾರಾಟಗಾರನು ನಿಗದಿತ ರೂಪದಲ್ಲಿ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಿಸತಕ್ಕದೆಂದು ನಿರ್ಧಸಲಾಗಿದೆ. ನಿಗದಿತ ಎಚ್ಚರಿಕೆಯು ಈ ಕೆಳಗಿನ ಅಂಶಗಳನ್ನು ಹೊಂದಿರಬೇಕು.

- ಪೊಟ್ಟಣದ ಮುಂದುಗಡೆಯ ಪಟ್ಟಿಯ ಶೇ 40 ರಷ್ಟು ಭಾಗವನ್ನು ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಆವರಿಸಿರಬೇಕು.
- ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಗಳನ್ನು 12 ತಿಂಗಳಿಗೊಮ್ಮೆ ಕೇಂದ್ರ ಸರ್ಕಾರದ ತೀರ್ಮಾನದಂತೆ ಬದಲಾಯಿಸುತ್ತಿರಬೇಕು.
- ಧೂಮಪಾನ ಸಾವು ತರುತ್ತದೆ. ಅಥವಾ ತಂಬಾಕು ಮಾರಕ ಎಂಬ ನಿಗದಿತ ಎಚ್ಚರಿಕೆಯನ್ನು ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಹೊಂದಿರುತ್ತದೆ. ಮತ್ತು ತಂಬಾಕಿನ ದುಷ್ಪರಿಣಾಮಗಳ ಕುರಿತ ಚಿತ್ರದ ಕೆಳಗೆ ಪ್ರಕಟವಾಗಿರುತ್ತದೆ.
- ಇದು ತಂಬಾಕಿನಿಂದ ಕ್ಯಾನ್ಸರ್ ಬರುತ್ತದೆ. ಎಂಬ ಎಚ್ಚರಿಕೆಯನ್ನು ಒಳಗೊಂಡಿರಬೇಕು.
- ಈ ಎಚ್ಚರಿಕೆ ಅಸ್ಪಷ್ಟವಾಗಿರುವುದು, ಮರೆಮಾಚಿರುವುದು, ಬದಲಾವಣೆಗೆ ಅಥವಾ ತಿರುಚುವಿಕೆಗೆ ಒಳಗಾಗುವುದು ಸಲ್ಲ.
- ಪೊಟ್ಟಣ ಮತ್ತು ಹಣೆಪಟ್ಟಿಯು ಸುಳ್ಳು, ದಾರಿ ತಪ್ಪಿಸುವ, ಅಥವಾ ವಂಚಿಸುವ ಮಾಹಿತಿಯನ್ನು ಹೊಂದಿರಬಾರದು.
- ಎಚ್ಚರಿಕೆಯು ಎರಡಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಭಾಷೆಯಲ್ಲಿರಬಾರದು. ಈ ಎರಡು ಭಾಷೆಗಳಲ್ಲಿ ಒಂದು ಬ್ರಾಂಡ್ ಹೆಸರಿನಲ್ಲಿ ಬಳಸಲಾದ ಭಾಷೆಯಾಗಿರಬೇಕು ಮತ್ತು ಎಚ್ಚರಿಕೆಯು ಸ್ಫುಟವಾಗಿ ಮತ್ತು ಪ್ರಮುಖವಾಗಿ ಕಾಣುವಂತೆ ಬಳಕೆಯಾಗಿರಬೇಕು.

ನ್ಯಾಯಾಲಯದ ವರ್ತಮಾನ : ನಿಗದಿತ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆ ವಿರುದ್ಧ ತಂಬಾಕು ಉದ್ಯಮ ಹಠಮಾರಿ ಧೋರಣೆ ತಳೆದಿದ್ದು, ಸರ್ಕಾರದ ಅಧಿಸೂಚನೆ ಪ್ರಶ್ನಿಸಿದ ಹಲವು ಮೊಕದ್ದಮೆಗಳು ದೇಶದ ನಾನಾ ಉಚ್ಚನ್ಯಾಯಾಲಯಗಳಲ್ಲಿ ಬಾಕಿ ಉಳಿದಿವೆ. ಹಲವು ಮೊಕದ್ದಮೆಗಳನ್ನು ನಿರ್ವಹಿಸಲಾಗಿದೆ ಮತ್ತು ನ್ಯಾಯಾಲಯಗಳ ವ್ಯತಿರಿಕ್ತ ಅಭಿಪ್ರಾಯಗಳಿಂದಾಗಿ ಭಾರತ ಸರ್ಕಾರ ಸರ್ವೋಚ್ಚನ್ಯಾಯಾಲಯದ ಮೊರೆ ಹೋಗಿ ಎಲ್ಲಾ ವ್ಯಾಜ್ಯಗಳನ್ನು ಒಂದೇ ಬಾರಿಗೆ ಇತ್ಯರ್ಥವಾಗುವಂತೆ ಒಂದೇ ನ್ಯಾಯಾಲಯಕ್ಕೆ ವರ್ಗಾವಣೆಯಾಗುವಂತೆ ಮಾಡಿತು. ಇದೇ ವೇಳೆ, ನಾಗರಿಕ ಸಮಾಜ ಕೂಡ ಸುಪ್ರೀಂ ಕೋರ್ಟ್ ಮೊರೆ ಹೋಗಿ ಚಿತ್ರಿತ ಎಚ್ಚರಿಕೆಯನ್ನು ತಕ್ಷಣ ಜಾರಿಗೊಳಿಸುವಂತೆ ಮನವಿ ಮಾಡಿದ್ದರಿಂದ ಮೇ 31, 2009 ರಂದು ಚಿತ್ರಿತ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಿಸುವುದನ್ನು ಕಡ್ಡಾಯಗೊಳಿಸಲಾಯಿತು.

ಮಾನ್ಯತೆ ಪಡೆದ ಅಧಿಕಾರಿಗಳು ಜುಲೈ 30, 2009 ರ ನಿಯಮಗಳ ಪ್ರಕಾರ ಈ ಕೆಳಗಿನ ಐದು ಬಗೆಯ ಮಾನ್ಯತೆ ಪಡೆದ ಅಧಿಕಾರಿಗಳು ಸೆಕ್ಷನ್ 12 ಮತ್ತು ಸೆಕ್ಷನ್ 13ರ ಅನ್ವಯ ಕಾಯ್ದೆಯ ಸೆಕ್ಷನ್ 5 ಮತ್ತು 7ರ ಅನುಷ್ಠಾನಕ್ಕೆ ಅಧಿಕಾರ ಪಡೆದಿರುತ್ತಾರೆ.

ಅಧಿಕಾರಿ ಶಿರೋನಾಮೆ	ಇಲಾಖೆ
ಕಸ್ಟಮ್ಸ್ ಮತ್ತು ಕೇಂದ್ರ ಅಬಕಾರಿ ಸುಪರಿಂಟೆಂಡೆಂಟ್ ದರ್ಜೆಗೆ ಮೇಲ್ಪಟ್ಟ ಎಲ್ಲಾ ಅಧಿಕಾರಿಗಳು	ಕಂದಾಯ ಇಲಾಖೆಯಲ್ಲಿ ನೊಂದಾಯಿಸಲ್ಪಟ್ಟ ಎಲ್ಲಾ ಆವರಣಗಳು
ಮಾರಾಟ ತೆರಿಗೆ / ಆರೋಗ್ಯ / ಸಾರಿಗೆ ಇನ್ಸಪೆಕ್ಟರ್ ದರ್ಜೆಗೆ ಮೇಲ್ಪಟ್ಟ ಎಲ್ಲ ಅಧಿಕಾರಿಗಳು	ರಾಜ್ಯ ಸರ್ಕಾರದ ಕಂದಾಯ / ಆರೋಗ್ಯ /ಸಾರಿಗೆ
ಕಿರಿಯ ಕಾರ್ಮಿಕ ಕಮಿಶನರ್	ಕಾರ್ಮಿಕ ಇಲಾಖೆ
ಜಂಟಿ ನಿರ್ದೇಶಕ	ಬೃಹತ್ ಕೈಗಾರಿಕೆ, ಸಣ್ಣ ಕೈಗಾರಿಕೆ ಕಚೇರಿ
ಪೋಲಿಸ್ / ರಾಜ್ಯ ಅರೋಗ್ಯ ಇಲಾಖೆ / ಔಷಧ ಆಡಳಿತದ ಸಬ್-ಇನ್‌ಸ್ಪೆಕ್ಟರ್ ಮತ್ತು ಹೆಚ್ಚಿನ ದರ್ಜೆಯ ಅಧಿಕಾರಿಗಳು	ಆಹಾರ / ಔಷಧಿ /ಗೃಹ

4.2 ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮೇಲೆ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯ ಚಿತ್ರವತ್ತಾದ ಪ್ರಕಟಣೆಯ ಸಕಾರಣತೆ

ಹಲವಾರು ದೇಶಗಳಲ್ಲಿ ಈಗಾಗಲೇ ಚಿತ್ರವತ್ತಾದ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಿಸುವ ಪರಿಪಾಠವಿದೆ. ಸಾರ್ವಜನಿಕರ ಆರೋಗ್ಯದ ದೃಷ್ಟಿಯಿಂದ ಈ ಕ್ರಮವು ಅತ್ಯಂತ ಮಹತ್ವದ್ದು ಎಂಬುದು ಇದರಿಂದ ತಿಳಿದುಬಂದಿದೆ. ಚಿತ್ರರೂಪದ ಎಚ್ಚರಿಕೆಯು ಅಕ್ಷರ ರೂಪದಲ್ಲಿರುವ ಎಚ್ಚರಿಕೆಗೆ ಪೂರಕವಾಗಿರುತ್ತದೆ. ಒಂದು ಚಿತ್ರವು ಸಾವಿರ ಪದಗಳಿಗೆ ಸಮ ಎಂಬ ಮಾತಿನಂತೆ ಗ್ರಾಹಕನು ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಬರುವ ರೋಗಗಳ ಬಗ್ಗೆ ತಿಳಿದುಕೊಳ್ಳುತ್ತಾನೆ ಮತ್ತು ಇದರಿಂದ ತಂಬಾಕು ಸೇವನೆ ಕಡಿಮೆ ಮಾಡಿಕೊಳ್ಳುವ ಸಾಧ್ಯತೆ ಇರುತ್ತದೆ.

ಗ್ರಾಹಕನನ್ನು ತಂಬಾಕು ಸೇವನೆ ಬಿಡುವಂತೆ ಪ್ರೇರೇಪಿಸುವುದು ಚಿತ್ರಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯ ಉದ್ದೇಶ. ತಂಬಾಕು ಸೇವನೆಯು ಜನರಲ್ಲಿ ಗಂಭೀರ ಕಾಯಿಲೆ ಉಂಟು ಮಾಡುತ್ತದೆ. ಮತ್ತು ಸಾವಿಗೆ ಕಾರಣವಾಗುತ್ತದೆ ಎನ್ನುವುದು ಅರ್ಥವಾಗುವಂತೆ ಈ ಎಚ್ಚರಿಕೆಯ ಪ್ರಕಟಣೆಯನ್ನು ವಿನ್ಯಾಸಗೊಳಿಸಬೇಕು. ತಂಬಾಕು ಸೇವಿಸುವವರಿಗೆ ಇರುವ ಆರೋಗ್ಯದ ಅಪಾಯಗಳನ್ನು ತಿಳಿಸಲು ಇವು ಪರಿಣಾಮಕಾರಿ ಸಾಧನಗಳಾಗಿರುತ್ತವೆ. ಇವು ತಂಬಾಕು ಸೇವನೆಯನ್ನು ಬಿಡುವ ಇಂಗಿತ ಮತ್ತು ಸಾಮರ್ಥ್ಯದ ಮೇಲೆ ಪ್ರಭಾವ ಬೀರುತ್ತವೆ. ಅಕ್ಷರಗಳಲ್ಲಿರುವ ಎಚ್ಚರಿಕೆಗಳಿಗಿಂತ ಚಿತ್ರಿತ ಎಚ್ಚರಿಕೆಗಳು ತಂಬಾಕು ಸೇವಿಸುತ್ತಿರುವವರು ಅದನ್ನು ಬಿಡುವಂತೆ ಮತ್ತು ತಂಬಾಕು ಸೇವಿಸದೇ ಇರುವವರು ಹೊಸದಾಗಿ ಆರಂಭಿಸದಿರುವಂತೆ ಮಾಡುವಲ್ಲಿ ಹೆಚ್ಚು ಪರಿಣಾಮಕಾರಿಯಾಗಿರುತ್ತದೆ. ಅನಕ್ಷರಸ್ಥರು ಮತ್ತು ಆ ಭಾಷೆಯನ್ನು ಓದಲು ಬಾರದೇ ಇರುವವರಿಗೂ ಚಿತ್ರಿತ ಎಚ್ಚರಿಕೆಯು ತಂಬಾಕಿನ ಹಾನಿಕಾರಕ ವಿಷಯಗಳನ್ನು ತಿಳಿಸುವಂತಿರುತ್ತದೆ.

4.3 ಜಾರಿ ಅಧಿಕಾರಿಯ ಪಾತ್ರ

ರಾಜ್ಯ ಸರ್ಕಾರ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರದಿಂದ ಮಾನ್ಯತೆ ಪಡೆದ ಜಾರಿ ಅಧಿಕಾರಿಗಳಿಗೆ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ಪ್ರಕಟಣೆ ಇಲ್ಲದೇ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರಾಟ ಮಾಡುತ್ತಿರುವ ಬಗ್ಗೆ ಅನುಮಾನವಿರುವ ಯಾವುದೇ ಕಟ್ಟಡ ಅಥವಾ ವಾಣಿಜ್ಯ ಆವರಣವನ್ನು ಪ್ರವೇಶಿಸಿ ಹುಡುಕಾಟ ನಡೆಸುವ ಅಧಿಕಾರ ಇರುತ್ತದೆ. ಸ್ವಾಧೀನಪಡಿಸಿಕೊಂಡ ಪದಾರ್ಥಗಳನ್ನು ನ್ಯಾಯಾಲಯದ ಮುಂದೆ ಹಾಜರುಪಡಿಸುವವರೆಗೂ ಜೋಪಾನವಾಗಿ ಇಟ್ಟಿರಬೇಕು. ಅದನ್ನು ಮುಟ್ಟುಗೋಲು ಹಾಕಿಕೊಳ್ಳುವ ಮತ್ತು ತಪ್ಪಿಗೆ ದಂಡ ವಿಧಿಸುವ ಆದೇಶವನ್ನು ನೀಡುವ ಅಧಿಕಾರ ಸಂಬಂಧಿಸಿದ ನ್ಯಾಯಾಲಯಕ್ಕೆ ಮಾತ್ರ ಇರುತ್ತದೆ ಎಂಬುದನ್ನು ತಿಳಿದುಕೊಳ್ಳುವ ಅಗತ್ಯವಿದೆ. ನಿಗದಿತ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಯನ್ನು ಹೊಂದಿರದ ತಯಾರಿಕೆ ಹಂತದಲ್ಲಿರುವ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಸ್ವಾಧೀನಪಡಿಸಿಕೊಳ್ಳುವ ಅಧಿಕಾರ ಮಾನ್ಯತೆ ಪಡೆದ ಅಧಿಕಾರಿಗಳಿಗೆ ಇರುತ್ತದೆ. COTPA ಸೆಕ್ಷನ್ 12–19 ರಲ್ಲಿ ನಮೂದಾಗಿರುವಂತೆ ಪದಾರ್ಥಗಳ ಹುಡುಕಾಟ, ಸ್ವಾಧೀನತೆ ಸಂಬಂಧಿಸಿದ ನಿಯಮಗಳನ್ನು ಅಧಿಕಾರಿಗಳು ಚೆನ್ನಾಗಿ ತಿಳಿದಿರತಕ್ಕದ್ದು. ಉದಾಹರಣೆಗೆ, ಸೆಕ್ಷನ್ 18 ರ ಅನ್ವಯ, ಅಧಿಕಾರಿಯು ಪದಾರ್ಥದ ಸ್ವಾಧೀನತೆಗೆ ಅಥವಾ ದಂಡ ಪಾವತಿಯ ಹಣ ವಸೂಲಿ ಮಾಡುವ ಮುನ್ನ ಬರಹ ರೂಪದಲ್ಲಿ ಪದಾರ್ಥದ ಸ್ವಾಧೀನತೆ ಆಧಾರದ ಮೇಲೆ ನೋಟೀಸು ನೀಡಬೇಕು. ಸ್ವಾಧೀನಪಡಿಸಿಕೊಂಡ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಅದರ ಒಡೆಯರಿಗೆ ಅಥವಾ ಯಾರಿಂದ ಅದನ್ನು ಸ್ವಾಧೀನಪಡಿಸಿ ಕೊಂಡಿರಲಾಗುತ್ತದೆಯೋ ಅವರಿಗೆ ಹಿಂದಿರುಗಿಸಬೇಕು.

ನಿಗದಿತ ಎಚ್ಚರಿಕೆ ಹೊಂದಿದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪೊಟ್ಟಣಗಳನ್ನು ಸ್ವಾಧೀನಪಡಿಸಿಕೊಳ್ಳುವುದು ಸಾರ್ವಜನಿಕ ಹಿತದೃಷ್ಟಿಯಿಂದ ಮಾತ್ರ ಮುಖ್ಯವಾಗಿಲ್ಲ. ನ್ಯಾಯಾಲಯದ ಮುಂದೆ ಆರೋಪಿಗಳ ತಪ್ಪನ್ನು ಸಾಬೀತುಪಡಿಸಲು ಅದು ಆಧಾರ ಒದಗಿಸುತ್ತದೆ.

ಸೆಕ್ಷನ್ 15 ರಲ್ಲಿರುವ ವಿನಾಯತಿಯ ಪ್ರಕಾರ, ಒಂದು ವೇಳೆ ಸ್ವಾಧೀನಪಡಿಸಿಕೊಂಡ ವಸ್ತುಗಳ ಮಾಲೀಕ ನ್ಯಾಯಾಲಯದಲ್ಲಿ ದಂಡ ಮೊತ್ತವನ್ನು ಪಾವತಿಸಿದರೆ, ಆ ಪದಾರ್ಥವನ್ನು ಆತನಿಗೆ ಹಿಂದಿರುಗಿಸಬಹುದು. ಸ್ವಾಧೀನಪಡಿಸಿದ ವಸ್ತುಗಳನ್ನು ಮಾಲೀಕರಿಗೆ ಹಿಂದಿರುಗಿಸುವ ಮುನ್ನ ಅವುಗಳನ್ನು ನ್ಯಾಯಾಲಯದ ಮುಂದೆ ಹಾಜರುಪಡಿಸಬೇಕು ಮತ್ತು ನಿಗದಿತ ಎಚ್ಚರಿಕೆಯನ್ನು ಪ್ರಕಟಿಸಿ ಪದಾರ್ಥಗಳನ್ನು ಮಾರಾಟ ಮಾಡಬಹುದು. ಜಾರಿ ತರುವ ಅಧಿಕಾರಿಗಳು ಈ ಕುರಿತು ನಿಗಾ ವಹಿಸಬೇಕು. ಸ್ವಾಧೀನಪಡಿಸಿಕೊಳ್ಳಲಾದ ವಸ್ತುಗಳು ಕೆಟ್ಟುಹೋಗುವ ಸಾಧ್ಯತೆ ಇದೆ. ಆದ್ದರಿಂದ ನ್ಯಾಯಾಲಯದ ಕಲಾಪಗಳಿಗೆ ಅಧಿಕಾರಿಗಳು ಹೆಚ್ಚಿನ ಆದ್ಯತೆ ನೀಡಬೇಕು.

ಸೆಕ್ಷನ್ 16 ರ ಅನ್ವಯ, ಪದಾರ್ಥದ ಸ್ವಾಧೀನ ಮತ್ತು ದಂಡ ಪಾವತಿಯ ನಂತರವೂ ತಪ್ಪಿತಸ್ಥರನ್ನು ಶಿಕ್ಷಿಸುವ ಅಧಿಕಾರವಿದೆ.

ಬೆಂಗಳೂರು ರೈಲ್ವೆ ನಿಲ್ದಾಣದಲ್ಲಿ ಪ್ರದರ್ಶಿಸಲಾದ ನಾಮಫಲಕ

ತಂಬಾಕು ನಿಯಂತ್ರಣಕ್ಕೆ ಇತರ ಪ್ರಸ್ತುತ ಕಾನೂನುಗಳು

ತಂಬಾಕು ನಿಯಂತ್ರಣಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಕಾಯ್ದೆಗಳು ಹಾಗೂ COTPA ಅನುಷ್ಠಾನಕ್ಕೆ ಈ ಕಾನೂನುಗಳಲ್ಲಿರುವ ಅವಕಾಶಗಳನ್ನು ಈ ಭಾಗವು ವಿಶ್ಲೇಷಿಸುತ್ತದೆ.

ಅಧ್ಯಾಯ-5

ಸಂಬಂಧಪಟ್ಟ ಭಾರತೀಯ ಕಾನೂನುಗಳು

5.1 ಭಾರತದ ಸಂವಿಧಾನ

ಸಂಸತ್ತು ಅವಗಾಹಿಸುವ ಮತ್ತು ಜಾರಿಗೆ ತರುವ ಪ್ರತಿಯೊಂದು ಕಾನೂನಿಗೂ ಭಾರತೀಯ ಸಂವಿಧಾನವೇ ಮೂಲಭೂತ ಆಧಾರ. ಹೀಗಾಗಿ ಪ್ರತಿಯೊಂದು ಕಾನೂನು ಸಂವಿಧಾನಕ್ಕೆ ಬದ್ಧವಾಗಿಯೇ ಇರಬೇಕು. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾಯ್ದೆಗಳ ಮೂಲ ಕೂಡ ಸಂವಿಧಾನದಲ್ಲಿ ಅಡಕವಾಗಿದೆ:

ಸಂವಿಧಾನಕ್ಕೆ ಪ್ರಸ್ತಾವನೆ

ಉತ್ತಮ ನಾಗರಿಕರು ಹಾಗೂ ಅವರಿಂದ ಚುನಾಯಿತವಾದ, ಸಮಾಜಕ್ಕೆ ಬದ್ಧವಾದ ಸರ್ಕಾರವನ್ನು ಹೊಂದಿರುವ ಒಂದು ಸಾಮಾಜಿಕ ವ್ಯವಸ್ಥೆಯನ್ನು ರೂಪಿಸುವುದು ಸಂವಿಧಾನದ ಪ್ರಸ್ತಾವನೆಯ ಉದ್ದೇಶ. ಸಂವಿಧಾನದಲ್ಲಿ ಕಲ್ಪಿಸಿದಂತೆ, ಸರ್ಕಾರದ ಅಧಿಕಾರವು ನಾಗರೀಕರ ಹಕ್ಕುಗಳಿಂದ ನಿಯಂತ್ರಿತವಾಗಿದೆ. ಸಂವಿಧಾನದ ಪ್ರಸ್ತಾವನೆಯಲ್ಲಿ ಈ ಮೂಲಭೂತ ಉದ್ದೇಶವು ಸ್ಪಷ್ಟಗೊಂಡಿದೆ.

ಸಿಗರೇಟ್ ಹಾಗೂ ಇತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಕಾಯ್ದೆ, 2003 ಇದೊಂದು ಸಾಮಾಜಿಕ ಕಾನೂನು. ಸಾರ್ವಜನಿಕರ ಆರೋಗ್ಯವನ್ನು ಗಮನದಲ್ಲಿಟ್ಟುಕೊಂಡು ರೂಪಿಸಲಾದ ಈ ಕಾನೂನು, ಸಂವಿಧಾನದ ಪ್ರಸ್ತಾವನೆಯಲ್ಲಿ ಉದ್ದೇಶಿಸಲಾದ ಸಾಮಾಜಿಕ ನ್ಯಾಯಕ್ಕೆ ಬದ್ಧವಾಗಿದೆ. ತಂಬಾಕಿನ ಉತ್ಪಾದನೆ ಹಾಗೂ ತಯಾರಿಕೆಯಿಂದ ದೇಶದ ಆರ್ಥಿಕ ವ್ಯವಸ್ಥೆಯ ಮೇಲೆ ಭಾರೀ ಹೊಡೆತ ಬೀಳುತ್ತದೆ. ಏಕೆಂದರೆ ತಂಬಾಕು ಮಾರಾಟದಿಂದ ಬರುವ ಆದಾಯ ಹಾಗೂ ಆ ಉದ್ದಿಮೆಯ ಸೃಷ್ಟಿಗೊಳಿಸುವ ಉದ್ಯೋಗಗಳಿಂದ ಆಗುವ ಆರ್ಥಿಕ ಲಾಭಕ್ಕಿಂತ, ತಂಬಾಕು ಸೇವನೆಯ ದುಷ್ಪರಿಣಾಮಗಳಿಂದ ಆಗುವ ಆರೋಗ್ಯ ಹಾನಿ ಹಾಗೂ ಆರ್ಥಿಕ ಹಾನಿಯ ಪ್ರಮಾಣ ಬಲು ದೊಡ್ಡದು. ಸಮಾಜದಲ್ಲಿ ಗೌರವದಿಂದ ಬಾಳುವ ಹಕ್ಕು ಪ್ರತಿ ವ್ಯಕ್ತಿಗೂ ಇದೆ. ಸಿಗರೇಟು ಸೇದುವ ವ್ಯಕ್ತಿ ಆತ್ಮ ಗೌರವಕ್ಕೆ ಅಷ್ಟೇ ಅಲ್ಲ, ಅದರ ಹೊಗೆಯನ್ನು ಪರೋಕ್ಷವಾಗಿ ಸೇದುವಂತೆ ಮಾಡಿ ಇತರರ ಗೌರವಕ್ಕೂ ಧಕ್ಕೆ ತರುತ್ತಾನೆ.

COTPA ಮೂಲಕ ಈ ಉಲ್ಲಂಘನೆಯನ್ನು ನಿಯಂತ್ರಿಸಲಾಗುತ್ತದೆ. "ಸ್ಥಾನಮಾನದಲ್ಲಿ ಸಮಾನತೆ" ಇದರ ಅರ್ಥ ಪ್ರತಿ ವ್ಯಕ್ತಿಯೂ ಇನ್ನೊಬ್ಬ ವ್ಯಕ್ತಿಯಂತೆಯೇ ಹಕ್ಕು ಹಾಗೂ ಸ್ವಾತಂತ್ರ್ಯ ಹೊಂದಿರುತ್ತಾನೆ . ಸಿಗರೇಟು ಸೇದುವುದು ಒಬ್ಬ ವ್ಯಕ್ತಿಯ ಹಕ್ಕು ಎಂದು ಭಾವಿಸುವುದಾದರೆ, ಸಿಗರೇಟಿನ ಹೊಗೆಯನ್ನು ಪರೋಕ್ಷವಾಗಿ ಸೇವಿಸುವುದನ್ನು ವಿರೋಧಿಸುವುದು ಇತರರ ಹಕ್ಕು ಎಂಬುದನ್ನು ಗಮನಿಸಬೇಕಾಗುತ್ತದೆ. ಏಕೆಂದರೆ ಭಾರತದ ಸಂವಿಧಾನವು ಕಾನೂನಿನ ದೃಷ್ಟಿಯಲ್ಲಿ ಎಲ್ಲರೂ ಸಮಾನರು ಎಂದು ಘೋಷಿಸುತ್ತದೆ.

ಮೂಲಭೂತ ಹಕ್ಕುಗಳು

ಜೀವನ ಹಾಗೂ ವೈಯಕ್ತಿಕ ಸ್ವಾತಂತ್ರದ ರಕ್ಷಣೆ: (ಅನುಚ್ಛೇದ 21) ಕಾನೂನಿನ ಪ್ರಕ್ರಿಯೆಯನ್ನು ಹೊರತುಪಡಿಸಿ, ಯಾವುದೇ ವ್ಯಕ್ತಿ ತನ್ನ ಜೀವನ ಹಾಗೂ ವೈಯಕ್ತಿಕ ಸ್ವಾತಂತ್ರ್ಯದಿಂದ ವಂಚಿತನಾಗುವ ಹಾಗಿಲ್ಲ.

ಪರೋಕ್ಷ ಧೂಮಪಾನದ ಪರಿಣಾಮವಾಗಿ ಸೇವಿಸಲಾಗುವ ವಾಯುವಿನಲ್ಲಿ ಸಾಮಾನ್ಯ ವಾಯುವಿನಲ್ಲಿರುವುದಕ್ಕಿಂತ ಮೂರು ಪಟ್ಟು ಹೆಚ್ಚು ನಿಕೋಟಿನ್, ಮೂರು ಪಟ್ಟು ಹೆಚ್ಚು ಟಾರ್ ಹಾಗೂ 50 ಪಟ್ಟು ಹೆಚ್ಚು ಅಮೋನಿಯಾ ಇರುತ್ತದೆ. ಹೀಗಾಗಿ ಧೂಮಪಾನಿಗಳು ಪರಿಸರವನ್ನು ಕಲುಷಿಗೊಳಿಸುತ್ತಾರೆ. ಇತರರ ಆರೋಗ್ಯಕ್ಕೆ ಕುತ್ತು ತರುತ್ತಾರೆ ಎಂಬುದರಲ್ಲಿ ಯಾವುದೇ ಸಂದೇಹವಿಲ್ಲ.

ಸ್ವಚ್ಛ ಗಾಳಿ ಜೀವನಾವಶ್ಯಕ. ಅದನ್ನು ಸಿಗರೇಟಿನ ಹೊಗೆಯಿಂದ ಕಲುಷಿತಗೊಳಿಸುವುದು ಜೀವನಕ್ಕೆ ಮಾರಕ. ಪರಿಚ್ಛೇದ 21 ರ ವ್ಯಾಪ್ತಿಗೆ ಇದು ಒಳಪಡುತ್ತದೆ. ವಾತಾವರಣದಲ್ಲಿ ಸೇರುವ ಸಿಗರೇಟು ಹೊಗೆಯು ನಿಧಾನ ವಿಷದಂತೆ ಆವರಿಸಿ, ಜನರ ಜೀವನಾವಧಿಯನ್ನು ಮೊಟಕುಗೊಳಿಸುತ್ತದೆ. ಧೂಮಪಾನಿಗಳು

ವಾತಾವರಣವನ್ನು ಕಲುಷಿತಗೊಳಿಸುವುದರಿಂದ, ಮುಗ್ಧ ಜನರನ್ನು ಪರೋಕ್ಷ ಧೂಮಪಾನಕ್ಕೆ ಗುರಿಯಾಗಿಸಿ, ಅವರ ಜೀವವನ್ನೇ ಬಲಿ ತೆಗೆದುಕೊಂಡಂತಾಗುತ್ತದೆ.

21 ನೇ ಅನುಚ್ಛೇದವು ಅಪ್ರಾಪ್ತವಯಸ್ಕರು ಹಾಗೂ ಮಹಿಳೆಯರನ್ನು ವಿಶೇಷ ಗುಂಪು ಎಂದು ಪರಿಗಣಿಸುತ್ತದೆ ಹಾಗೂ ಈ ಮೂಲಕ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಹಾಗೂ ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ಮತ್ತು ಶೈಕ್ಷಣಿಕ ಸಂಸ್ಥೆಗಳ 100 ಗಜ ಅಡಿಯಲ್ಲಿ ಯಾವುದೇ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರುವುದನ್ನು ವಿರೋಧಿಸುತ್ತದೆ..

ಸಾರ್ವಜನಿಕ ಹಿತಾಸಕ್ತಿ ದೃಷ್ಟಿಯಿಂದ ಕೆಲವು ಸ್ವಾತಂತ್ರ್ಯಗಳ ಮೇಲಿನ ನಿರ್ಬಂಧ

ಅನುಚ್ಛೇದ 19ರ ಅನ್ವಯ ಸಂವಿಧಾನಿಕ ಸ್ವಾತಂತ್ರ್ಯಗಳನ್ನು ಸಾರ್ವಜನಿಕ ಹಿತದೃಷ್ಟಿಯಿಂದ ನಿಯಂತ್ರಿಸಬಹುದಾಗಿದೆ. ಅನುಚ್ಛೇದ 19 (2) ರಿಂದ (6) ಕೂಡ ಇದನ್ನೇ ಹೇಳುತ್ತವೆ.

ಮಾತನಾಡುವ ಹಾಗೂ ಅಭಿವ್ಯಕ್ತಿ ಸ್ವಾತಂತ್ರ್ಯದ ಹಕ್ಕು ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಪರೋಕ್ಷ ಜಾಹೀರಾತಿಗೆ ನೆಪವಾಗಲು ಸಾಧ್ಯವಿಲ್ಲ. ಹಾಗೆಯೇ, ಯಾವುದೇ ಉದ್ಯೋಗ ಮಾಡುವ, ಯಾವುದೇ ಕ್ಷೇತ್ರದಲ್ಲಿ ವೃತ್ತಿ ಹೊಂದುವ ಅಥವಾ ಯಾವುದೇ ವ್ಯಾಪಾರ ಮಾಡುವ ಹಕ್ಕನ್ನು ಕೂಡಾ, ಸಾರ್ವಜನಿಕ ಹಿತದೃಷ್ಟಿಯಿಂದ ಸರ್ಕಾರವು ಪ್ರಜೆಗಳ ಅಭಿಪ್ರಾಯ ಪಡೆಯದೇ, ಅಥವಾ ಪಡೆದು ನಿಯಂತ್ರಿಸಬಹುದು. ಇದರ ಆಧಾರದ ಮೇಲೆಯೇ ಸಂಸತ್ತು COTPA ಮೂಲಕ ತಂಬಾಕು ಸೇವನೆಯ ಹಾನಿಕಾರಕ ಪರಿಣಾಮಗಳನ್ನು ತಡೆಯುವುದಕ್ಕೋಸ್ಕರ, ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತನ್ನು ಸಂಪೂರ್ಣ ನಿಷೇಧಿಸಿ, ಅವುಗಳ ವ್ಯಾಪಾರ, ವಾಣಿಜ್ಯ, ಉತ್ಪಾದನೆ, ಪೂರೈಕೆ ಮತ್ತು ಸರಬರಾಜನ್ನು ನಿಯಂತ್ರಿಸುವ ನಿರ್ಧಾರ ತೆಗೆದುಕೊಂಡಿದ್ದು. ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯಕ್ಕೆ ವಿರುದ್ಧವಾಗಿ ತಂಬಾಕು ಉದ್ಯಮವು ತನ್ನ ವಾಣಿಜ್ಯ ಹಿತಾಸಕ್ತಿಗಳನ್ನು ಬೆಳೆಸಿಕೊಳ್ಳುವುದನ್ನು ತಡೆಯುವುದು ಇದರ ಉದ್ದೇಶ.

ಮೂಲತಃ ಸಂವಿಧಾನವು ಪ್ರತಿಯೊಬ್ಬ ನಾಗರೀಕನಿಗೂ ನೈಸರ್ಗಿಕ ಪರಿಸರವನ್ನು ರಕ್ಷಿಸುವ ಕರ್ತವ್ಯವನ್ನು ವಿಧಿಸುತ್ತದೆ. ತಂಬಾಕಿನ ಹೊಗೆಯು ಮಲಿನಕಾರಿಯಾಗಿರುವುದರಿಂದ ಪ್ರತಿಯೊಬ್ಬ ನಾಗರೀಕನೂ ಧೂಮಪಾನದಿಂದ ಪರಿಸರ ಮಲಿನಗೊಳಿಸುವುದು ಹಾಗೂ ಜನರ ಆರೋಗ್ಯಕ್ಕೆ ಧಕ್ಕೆ ತರುವುದರಿಂದ ದೂರವಿರಬೇಕು.

ನಿರ್ದೇಶಿತ ತತ್ವಗಳು

ಸರ್ಕಾರಿ ನಿರ್ಣಯಗಳ ನಿರ್ದೇಶಿತ ತತ್ವಗಳು ದೇಶಾಡಳಿತದ ಅಡಿಗಲ್ಲಾಗಿದ್ದು, ಅವುಗಳನ್ನು ಕಾನೂನು ರೂಪಿಸುವಲ್ಲಿ ಅಳವಡಿಸುವುದು ಸರ್ಕಾರದ ಕರ್ತವ್ಯ. COTPA ಇದು ಸಾರ್ವಜನಿಕ ಹಿತದೃಷ್ಟಿಯಿಂದ ಮತ್ತು ಸಾರ್ವಜನಿಕರ ಆರೋಗ್ಯವನ್ನು ರಕ್ಷಿಸುವ ಉದ್ದೇಶದಿಂದ ರೂಪಿಸಲಾದ ಸಾಮಾಜಿಕ ಶಾಸನ. ಇದು ಸಾಮಾಜಿಕ ಆರೋಗ್ಯ ಸುಧಾರಣೆಯನ್ನು ಸಾಧಿಸುವ ಸಲುವಾಗಿ ಸೇರಿಸಲಾದ ಭಾರತೀಯ ಸಂವಿಧಾನದ ಭಾಗ ivರ ಆದೇಶವನ್ನು ಪ್ರತಿಧ್ವನಿಸುತ್ತದೆ.

ಸಂವಿಧಾನದ ದೂರದೃಷ್ಟಿಯಲ್ಲಿ ಪ್ರಮುಖ ವಿಷಯವಾಗಿರುವ ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಮಟ್ಟವನ್ನು ಹೆಚ್ಚಿಸುವ ಉದ್ದೇಶವನ್ನು COTPA ಹೊಂದಿದೆ. ಅನುಚ್ಛೇದ 39 ರ ಅನ್ವಯ, ಸರ್ಕಾರವು ನೀತಿಗಳನ್ನು ಮಕ್ಕಳು ಮಹಿಳಾ ಕೆಲಸಗಾರರ ಆರೋಗ್ಯ ಮತ್ತು ಶಕ್ತಿಯನ್ನು ರಕ್ಷಿಸುವ ಮತ್ತು ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಂದ ಅಪಬಳಕೆಯನ್ನು ತಪ್ಪಿಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ರೂಪಿಸಬೇಕಾಗಿದೆ. ಪ್ರಸ್ತಾವನೆಯ ಘೋಷಣೆಯಲ್ಲಿ ಸಾಬೀತಾಗಿರುವಂತೆ, ಸಂವಿಧಾನದ 47 ನೇ ಅನುಚ್ಛೇದವು ಸರ್ಕಾರದ ಮೇಲೆ ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಸುಧಾರಿಸುವ ಪ್ರಾಥಮಿಕ ಕರ್ತವ್ಯವನ್ನು ವಿಧಿಸುವ ಉದ್ದೇಶ ಹೊಂದಿದೆ.

5.2 ಭಾರತೀಯ ದಂಡ ಸಂಹಿತೆ (IPC)

ಇದು ಅಪರಾಧಿಗಳನ್ನು ನಿಯಂತ್ರಿಸುವ ಮತ್ತು ದಂಡನೆ ವಿಧಿಸಲು ಅನುಸರಿಸಬೇಕಾದ ಸಾಮಾನ್ಯ ಸಂಹಿತೆ, ಸ್ಥಳೀಯ ಕಾನೂನುಗಳು ಅಥವಾ ವಿಶೇಷ ಕಾನೂನುಗಳಲ್ಲಿ ನಿರ್ದಿಷ್ಟ ತತ್ವಗಳ ಉಲ್ಲೇಖ ಇಲ್ಲದೇ ಇರುವಾಗ, ಐಪಿಸಿಯನ್ನು ಬಳಸಬಹುದು. COTPA ವನ್ನು ಅರ್ಥಪೂರ್ಣವಾಗಿ ಜಾರಿ ಮಾಡಲು, ಜಾರಿ ಅಧಿಕಾರಿಯು ಸಂಹಿತೆಯಲ್ಲಿ ವಿಧಿಸಲಾಗಿರುವ ಸಾರ್ವಜನಿಕ ಸೇವಕ, ಅಪರಾಧ, ಹಾಗೂ ಶಿಕ್ಷೆ ಮುಂತಾದವುಗಳ ಅರ್ಥ ತಿಳಿದಿರಬೇಕು.

ಜಾರಿ ಅಧಿಕಾರಿಗಳ ಬಾಧ್ಯತೆ

COTPA ಅಡಿಯಲ್ಲಿ ಪ್ರತಿ ಜಾರಿ ಅಧಿಕಾರಿಯು ಸಾರ್ವಜನಿಕ ಸೇವಕ ಎಂದು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ. ಎಂಬುದನ್ನು ಗಮನಿಸಬೇಕು. ಮತ್ತು ಪ್ರಜ್ಞಾಪೂರ್ವಕವಾಗಿ ಕಾನೂನಿನ ನಿರ್ದೇಶನವನ್ನು ಉಲ್ಲಂಘಿಸುವ ಸಾರ್ವಜನಿಕ ಸೇವಕನು ಶಿಕ್ಷೆಗೆ ಅರ್ಹನಾಗಿರುತ್ತಾನೆ. ಶಿಕ್ಷೆಯು ಒಂದು ವರ್ಷ ಜೈಲು ಅಥವಾ ದಂಡ ಅಥವಾ ಎರಡನ್ನೂ ಒಳಗೊಂಡಿರಬಹುದು.

ತನ್ನ ಸಮ್ಮುಖದಲ್ಲಿ ಸಾರ್ವಜನಿಕ ಸ್ಥಳದಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವ ವ್ಯಕ್ತಿಯ ವಿರುದ್ಧ ಕ್ರಮ ಜರುಗಿಸದಿದ್ದರೆ, ಅಥವಾ ಆ ಕುರಿತು ಮಾಹಿತಿ ಇದ್ದರೂ ಸ್ಪಂದಿಸದಿದ್ದರೆ, ಅಂತಹ ಜಾರಿ ಅಧಿಕಾರಿಯು ಐಪಿಸಿ 166 ಅಡಿಯಲ್ಲಿ ತಪ್ಪಿತಸ್ಥನಾಗಿರುತ್ತಾನೆ. ಏಕೆಂದರೆ ಆತ, COTPA ನಿರ್ದೇಶನವನ್ನು ಉಲ್ಲಂಘಿಸಿದ್ದಲ್ಲದೇ, ತನ್ನ ವರ್ತನೆಯು ಪರೋಕ್ಷ ಧೂಮಪಾನ ಮಾಡುತ್ತಿರುವವರ ಆರೋಗ್ಯಕ್ಕೆ ಹಾನಿಕಾರಕ ಎಂದೂ ತಿಳಿದಿರುತ್ತಾನೆ.

ಶಿಕ್ಷೆ ಮತ್ತು ದಂಡ

COTPA ಸೆಕ್ಷನ್ 4 ಮತ್ತು 6 ರ ಪ್ರಕಾರ, ಇನ್ನೂರು ರೂಪಾಯಿಯವರೆಗೆ ದಂಡ ವಿಧಿಸಬಹುದು. ಅಪಾದಿತನಿಗೆ ದಂಡ ಕಟ್ಟುವ ಚೈತನ್ಯವಿಲ್ಲದಿದ್ದರೆ, ಅಂಥವನಿಗೆ ಐಪಿಸಿ ಸೆಕ್ಷನ್ 67 ರ ಅನ್ವಯ, 6 ತಿಂಗಳವರೆಗೆ ಸರಳ ಸೆರೆವಾಸ ವಿಧಿಸಬಹುದು. ಆದರೆ ದಂಡ ತೆತ್ತರೆ ಈ ಸೆರೆವಾಸ ಕೊನೆಗೊಳ್ಳುತ್ತದೆ.

ಹಾಗೆಯೇ, ಸೆರೆವಾಸ ಮತ್ತು ದಂಡ ಎರಡಕ್ಕೂ ಗುರಿಯಾಗಿದ್ದ ಸಂದರ್ಭದಲ್ಲಿ, ದಂಡ ತೆರಲು ಸಾಧ್ಯವಾಗದಿದ್ದರೆ, ಅದಕ್ಕೆ ವಿಧಿಸಲಾಗುವ ಸೆರೆವಾಸವು COTPA ಸೆಕ್ಷನ್ 20 ಮತ್ತು 22 ರಲ್ಲಿ ಹೇಳಿರುವ ಗರಿಷ್ಠ ಸೆರೆವಾಸದ ನಾಲ್ಕನೇ ಒಂದು ಭಾಗಕ್ಕಿಂತ ಹೆಚ್ಚಿರಬಾರದು.

ಅಪರಾಧಿಗಳಿಗೆ ಒತ್ತಾಸೆ

ಅಪರಾಧಕ್ಕೆ ಅವಕಾಶ ನೀಡಿ ಕೊಡುವ, ಸಹಾಯ ಮಾಡುವ ಅಥವಾ ಅಪರಾಧದ ವಿರುದ್ಧ ಕ್ರಮ ಕೈಗೊಳ್ಳಲು ಸಾಧ್ಯವಿದ್ದರೂ ಉದ್ದೇಶಪೂರ್ವಕವಾಗಿ ನಿರ್ಲಕ್ಷಿಸುವುದು ಐಪಿಸಿ ಸೆಕ್ಷನ್ 107 ರ ಪ್ರಕಾರ ಅಪರಾಧ. ಸೆಕ್ಷನ್ 110 ಈ ರೀತಿ ಅಪರಾಧಿಗಳಿಗೆ ಒತ್ತಾಸೆ ನೀಡುದುದಕ್ಕೆ ಶಿಕ್ಷೆ ವಿಧಿಸುತ್ತವೆ.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳ ಮಾಲೀಕರು 'ಇದು ಧೂಮಪಾನ-ಮುಕ್ತ ಸ್ಥಳ, ಇಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವುದು ಅಪರಾಧ'ಎಂಬ ಫಲಕವನ್ನು ಕಾನೂನಿನ ಪ್ರಕಾರ ಪ್ರದರ್ಶಿಸಬೇಕು. ಹಾಗೆ ಮಾಡದೇ ಇದ್ದರೆ, ಅದು ಅಪರಾಧಿಗಳಿಗೆ ಒತ್ತಾಸೆ ನೀಡಿದಂತಾಗುತ್ತದೆ ಹಾಗೂ ಐಪಿಸಿಯ 290 ನೇ ಅನುಚ್ಛೇದದ ಪ್ರಕಾರ ಶಿಕ್ಷಾರ್ಹವಾಗಿರುತ್ತದೆ. ಇದೇ ರೀತಿ, ಶಾಲೆ ಕಾಲೇಜುಗಳ 100 ಗಜ ಆವರಣದಲ್ಲಿ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರುವಂತಿಲ್ಲ, ಮಾರಿದರೆ ರೂ. 200 ದಂಡ ಎಂಬ ಫಲಕವನ್ನು ಪ್ರದರ್ಶಿಸಬೇಕು. ಹಾಗೆ ಪ್ರದರ್ಶಿಸದೇ ಇದ್ದರೆ, ಅದು ಅಪರಾದಿಗಳಿಗೆ ಒತ್ತಾಸೆ ನೀಡಿದಂತಹ ಅಪರಾಧವಾಗುತ್ತದೆ.

ಸಾಮಾನ್ಯವಾಗಿ ತಂಬಾಕು ಉತ್ಪಾದನೆ ಹಾಗೂ ಮಾರಾಟ ಕಂಪನಿಗಳು, ಆ ಉತ್ಪನ್ನದ ಜಾಹೀರಾತು ಫಲಕ ಹಾಗೂ ಇತರ ವಸ್ತುಗಳನ್ನು ಅಂಗಡಿಗಳಿಗೆ ನೀಡುತ್ತವೆ. ಈ ಜಾಹೀರಾತು, ಕಾಯ್ದೆಯ ನಿಯಮಗಳಿಗೆ ಅನುಸಾರವಾಗಿ ಇಲ್ಲದಿದ್ದರೆ, ಜಾಹೀರಾತನ್ನು ಒದಗಿಸಿದ ಕಂಪನಿ ಹಾಗೂ ಅದನ್ನು ಬಳಸಿದ ಅಂಗಡಿಯ ಮಾಲೀಕ ಇಬ್ಬರೂ ಈ ತಪ್ಪಿಗೆ ಹೊಣೆಗಾರರಾಗುತ್ತಾರೆ.

ಪರೋಕ್ಷ ಧೂಮಪಾನದಿಂದ ಸಾರ್ವಜನಿಕರಿಗೆ ತೊಂದರೆ

ಧೂಮಪಾನಿಗಳು ಇತರರಿಗೂ ಅಪಾಯ ಹಾಗೂ ತೊಂದರೆ ಉಂಟು ಮಾಡುತ್ತಾರೆ ಎಂಬುದು ಅಧ್ಯಯನಗಳಿಂದ, ವೀಕ್ಷಣೆಯಿಂದ ತಿಳಿದುಬಂದಿದೆ. ಇದು ಐಪಿಸಿ ಸೆಕ್ಷನ್ 290 ಪ್ರಕಾರ ಅಪರಾಧ. ಇಲ್ಲಿ ಗಮನಿಸಬೇಕಾದುದು ಏನೆಂದರೆ ಯಾವ ರಾಜ್ಯಗಳಲ್ಲಿ COTPA ಅಡಿಯಲ್ಲಿ ರಾಜ್ಯ ಸರ್ಕಾರವು ಅಧಿಕಾರಿಗಳನ್ನು ಅಧಿಸೂಚಿಸಿಲ್ಲವೋ, ಅಲ್ಲಿ ಐಪಿಸಿ ಅಡಿಯಲ್ಲಿ ಪೊಲೀಸ್ ಅಧಿಕಾರಿಯು ಕ್ರಮ ಕೈಗೊಳ್ಳಬಹುದು.

ಹಾಗೂ, ಅಪರಾಧಿಯು ಅಪರಾಧವನ್ನು ಪುನಃ ಮಾಡಿದರೆ, ಅದಕ್ಕೆ ಐಪಿಸಿ 291 ರ ಪ್ರಕಾರ ಆರು ತಿಂಗಳುವರೆಗೆ ಜೈಲು, ದಂಡ ಅಥವಾ ಎರಡನ್ನೂ ವಿಧಿಸಬಹುದು.

5.3 ಅಪರಾಧ ಸಂಹಿತೆ (Criminal Procedure Code)

ಬೇರೆ ಕಾಯ್ದೆಗಳು ಜಾರಿ ಇಲ್ಲದ ಸಮಯದಲ್ಲಿ ಅಪರಾಧ ಸಂಹಿತೆ, 1973 ರ ಅಡಿಯಲ್ಲಿ ಕೂಡ ಈ ಅಪರಾಧಕ್ಕೆ ಶಿಕ್ಷೆ ವಿಧಿಸಬಹುದು. ಅಪರಾಧಿ ಕೆಲವೊಮ್ಮೆ ದಂಡ ಕಟ್ಟುವ ಪರಿಸ್ಥಿತಿಯಲ್ಲಿ ಇಲ್ಲದೇ ಇರಬಹುದು. ಅಂತಹ ಸಂದರ್ಭಗಳಲ್ಲಿ ಆತನ ಹೆಸರು, ವಿಳಾಸಗಳನ್ನು ಸಂಗ್ರಹಿಸಲಾಗುತ್ತದೆ. ಒಂದು ವೇಳೆ ಅಪರಾಧಿಯು ಈ ವಿವರಗಳನ್ನು ನೀಡಲು ನಿರಾಕರಿಸಿದರೆ, ಆತನನ್ನು ವಾರಂಟ್ ಇಲ್ಲದೇ ಬಂಧಿಸಿ, ಮೆಜಿಸ್ಟ್ರೇಟ್ ಬಳಿ ಕರೆದೊಯ್ಯುವ ಅಧಿಕಾರ, ಅಧಿಸೂಚಿತ ಇದೆ. ಅಪರಾಧ ಸಂಹಿತೆಯ 42 ನೇ ಸೆಕ್ಷನ್ ಹಾಗೂ COTPA ಸೆಕ್ಷನ್ 25 (1) ರ ವ್ಯಾಪ್ತಿಗೆ ಇದು ಬರುತ್ತದೆ.

ಜಾಮೀನಿಗೆ ಅರ್ಹ

ಸೆಕ್ಷನ್ 27 ರ ಪ್ರಕಾರ ಈ ಅಪರಾಧಗಳಿಗೆ ಕಾನೂನು ಪ್ರಕಾರ ಜಾಮೀನು ಇದೆ. ಸಂಕ್ಷಿಪ್ತ ವಿಚಾರಣೆ

ಸೆಕ್ಷನ್ 4 ಹಾಗೂ 6 ರ ಪ್ರಕಾರ ಸಂಕ್ಷಿಪ್ತ ವಿಚಾರಣೆಗೆ ಅನುಮತಿ ಇದೆ, ಅದರಂತೆ, ಮೆಜಿಸ್ಟ್ರೇಟ್ ಬಳಿ ಅಪಾಧಿತನನ್ನು ಕರೆದೊಯ್ದಾಗ, ಈ ಕೆಳಗಿನ ಮಾದರಿಯಲ್ಲಿ ಮೆಜಿಸ್ಟ್ರೇಟ್ ವಿವರಗಳನ್ನು ಸಂಗ್ರಹಿಸಬೇಕಾಗುತ್ತದೆ–

- ಪ್ರಕರಣ ಸಂಖ್ಯೆ
- ಅಪರಾಧ ಎಸಗಿದ ದಿನಾಂಕ
- ದೂರು ದಾಖಲಿಸಿದ ದಿನಾಂಕ
- ದೂರು ದಾಖಲಿಸಿದವರ ಹೆಸರು (ಯಾರಾದರೂ ಇದ್ದರೆ)
- ಅಪಾದಿತನ ಹೆಸರು, ತಂದೆಯ ಹೆಸರು, ವಿಳಾಸ
- ಅಪರಾಧದ ವಿವರ
- ಅಪಾದಿತನ ಮನವಿ ಮತ್ತು ಆತನ ತಪಾಸಣೆ
- ಅಪರಾಧದ ಕುರಿತು ತಿಳಿದುಬಂದ ವಿಷಯ
- ವಿಧಿಸಲಾದ ಶಿಕ್ಷೆ ಅಥವಾ ಕೈಗೊಂಡ ಅಂತಿಮ ತೀರ್ಮಾನ
- ಕಾನೂನು ಪ್ರಕ್ರಿಯೆ ಅಂತಿಮಗೊಂಡ ದಿನಾಂಕ

ಅಪರಾಧಿಯು ತನ್ನ ತಪ್ಪನ್ನು ಒಪ್ಪಿಕೊಳ್ಳದೇ ಇದ್ದರೆ, ಮೆಜಿಸ್ಟ್ರೇಟ್ ತನ್ನ ಪರಿವೀಕ್ಷಣೆ ಆಧಾರದ ಮೇಲೆ ನಿರ್ಣಯ ಕೈಗೊಳ್ಳಬಹುದು.

ಶಿಕ್ಷೆಯ ಮೊತ್ತ

COTPA ಸೆಕ್ಷನ್ 20 ಹಾಗೂ 22 ಅಡಿಯಲ್ಲಿ ಅಪರಾಧಿಯ ಹಿಂದಿನ ಪ್ರಕರಣಗಳನ್ನು ದಾಖಲಿಸುವುದು ಅವಶ್ಯವಾಗಿದೆ. ಅಪರಾಧ ಮರುಕಳಿಸಿದ ಸಂದರ್ಭದಲ್ಲಿ ಶಿಕ್ಷೆಯ ಅವಧಿ ಹಾಗೂ ಮೊತ್ತ ಹೆಚ್ಚಾಗುತ್ತದೆ.

ಸಾರ್ವಜನಿಕರಿಗೆ ತೊಂದರೆ

ಸಾರ್ವಜನಿಕರಿಗೆ ತೊಂದರೆ ಉಂಟುಮಾಡುವುದು ಐಪಿಸಿ 290 ರ ಪ್ರಕಾರ ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ.

ಸಿಆರ್‌ಪಿಸಿ (ಅಪರಾಧ ಸಂಹಿತೆ)ಯ 133 ನೇ ಸೆಕ್ಷನ್ ಪ್ರಕಾರ, ರಾಜ್ಯ ಸರ್ಕಾರದಿಂದ ಮಾನ್ಯತೆ ಪಡೆದ ಜಿಲ್ಲಾ ಮ್ಯಾಜಿಸಿಸ್ಟ್ರೇಟ್, ಉಪ ವಿಭಾಗೀಯ ಮೆಜಿಸ್ಟ್ರೇಟ್ ಅಥವಾ ಇನ್ನಾವುದೇ ಕಾರ್ಯನಿರ್ವಾಹಕ ಮೆಜಿಸ್ಟ್ರೇಟ್ ಈ ವಿಷಯದಲ್ಲಿ ಆದೇಶ ಹೊರಡಿಸಬಹುದು. ಸೆಕ್ಷನ್ 133 ಪ್ರಕಾರ ಮೆಜಿಸ್ಟ್ರೇಟ್ ಹೊರಡಿಸಿದ ಆದೇಶವನ್ನು ಯಾವುದೇ ಸಿವಿಲ್ ನ್ಯಾಯಾಲಯದಲ್ಲಿ ಪ್ರಶ್ನಿಸುವ ಹಾಗಿಲ್ಲ.

ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳ ಪಟ್ಟಿಯಲ್ಲಿ ಸರ್ಕಾರಕ್ಕೆ ಸೇರಿದ ಆಸ್ತಿ ಹಾಗೂ ಯಾವುದಾದರೂ ಉದ್ದೇಶಕ್ಕೆ ಕಾಯ್ದಿರಿಸಿದ ಖಾಲಿ ಮೈದಾನಗಳೂ ಸೇರಿರಬಹುದು. ಕಾಯ್ದೆಯ ಪ್ರಕಾರ ಜಾರಿ ಅಧಿಕಾರಿಗಳು ಈ ಸ್ಥಳಗಳ ಪರಿಶೀಲನೆ ನಡೆಸಲು ಅನುಮತಿ ಇದೆ.

ವಶಪಡಿಸಿಕೊಳ್ಳುವಿಕೆ

COTPA ಸೆಕ್ಷನ್ 12 ಜಾರಿ ಅಧಿಕಾರಿಗಳಿಗೆ ಆಯಾ ಸ್ಥಳಗಳನ್ನು ಪ್ರವೇಶಿಸುವ ಹಕ್ಕು ನೀಡುತ್ತದೆ ಹಾಗೂ ಸೆಕ್ಷನ್ 13 ರ ಅಡಿಯಲ್ಲಿ ಅವರು ಉತ್ಪನ್ನ, ವಸ್ತುಗಳನ್ನು ವಶಪಡಿಸಿಕೊಳ್ಳಬಹುದು.

ವಾರೆಂಟ್ ನಂತರ ತಪಾಸಣೆ (S-93): ಯಾವುದೇ ಸ್ಥಳದಲ್ಲಿ ಕಾಯ್ದೆ ಉಲ್ಲಂಘನೆಯ ಅನುಮಾನವಿದ್ದರೆ, ಅಥವಾ ಸಾಮಾನ್ಯ ಪರೀಕ್ಷಣೆಗಾಗಿ ನ್ಯಾಯಾಲಯವು ಆ ಸ್ಥಳದ ಶೋಧನೆಗೆ ವಾರೆಂಟ್ ಹೊರಡಿಸಬಹುದು.

ಮೆಜಿಸ್ಟ್ರೇಟ್ ಸಮ್ಮುಖದಲ್ಲಿ ತಪಾಸಣೆ (S 103) : ಯಾವುದೇ ಮೆಜಿಸ್ಟ್ರೇಟ್ ತನ್ನ ಸಮ್ಮುಖದಲ್ಲಿಯೇ ನಿರ್ದಿಷ್ಟ ಸ್ಥಳದ ಶೋಧನೆಗಾಗ ಎಂಬ ಆದೇಶ ಹೊರಡಿಸಬಹುದು.

ಪೊಲೀಸ್ ಅಧಿಕಾರಿಯಿಂದ ಶೋಧನೆ (S 165) : ತನ್ನ ವ್ಯಾಪ್ತಿಗೆ ಬರುವ ಸ್ಥಳಗಳಲ್ಲಿ ಯಾವುದೇ ಪೊಲೀಸ್ ಅಧಿಕಾರಿ ಶೋಧನೆ ನಡೆಸಬಹುದು, ಅಥವಾ ಶೋಧನೆಗೆ ಆದೇಶ ನೀಡಬಹುದು. ಶೋಧನೆಯ ವಿವರಗಳನ್ನು ಮೆಜಿಸ್ಟ್ರೇಟ್‌ಗೆ ಕಳುಹಿಸಬೇಕು. ಮೆಜಿಸ್ಟ್ರೇಟ್ ಇದರ ಒಂದು ಪ್ರತಿಯನ್ನು ಅಪಾದಿತ ವ್ಯಕ್ತಿ ಅಥವಾ ಕಂಪನಿಗೆ ಕಳುಹಿಸಬೇಕು.

ತಪಾಸಣೆಗೆ ಅನುಮತಿ ನೀಡುವುದು (S 100) : ಶೋಧನೆಗೆ ಅಧಿಕಾರಿ ಹಾಗೂ ತಂಡವು ಬಂದಾಗ ಆಯಾ ಸ್ಥಳದಲ್ಲಿ ವಾಸವಿರುವ ಅಥವಾ ಅದರ ಮೇಲ್ವಿಚಾರಣೆವಹಿಸಿದ ವ್ಯಕ್ತಿಗಳು ಶೋಧನೆ ಅವಕಾಶ ಹಾಗೂ ಅನುಕೂಲ ಒದಗಿಸಿಕೊಡಬೇಕು.

ಒಂದು ವೇಳೆ ಈ ರೀತಿಯ ಅನುಕೂಲ ಹಾಗೂ ಅನುಮತಿ ದೊರೆಯದಿದ್ದರೆ, ಅಧಿಕಾರಿಗಳಿಗೆ ಬಾಗಿಲು ಅಥವಾ ಕಿಟಕಿ ಮುರಿದು ಒಳಗೆ ಹೋಗುವ ಹಕ್ಕು ಇದೆ.

ಒಂದು ವೇಳೆ ಯಾವುದೇ ವ್ಯಕ್ತಿ ವಸ್ತುಗಳನ್ನು ತನ್ನಲ್ಲಿ ಮುಚ್ಚಿಟ್ಟುಕೊಂಡಿದ್ದಾನೆ ಎಂದು ತಿಳಿದರೆ ಆತನ ದೇಹ ತಪಾಸಣೆ ಮಾಡಬಹುದು. ಅಪಾದಿತೆಯು ಮಹಿಳೆಯಾಗಿದ್ದಾರೆ, ಮರ್ಯಾದೆ ಉಲ್ಲಂಘನೆಯಾಗದ ರೀತಿಯಲ್ಲಿ ಮಹಿಳಾ ಪೊಲೀಸರಿಂದ ತಪಾಸಣೆ ಮಾಡಿಸಬೇಕು. ಇಂತಹ ಶೋಧ ನಡೆದಾಗ ಇಬ್ಬರು ಅಥವಾ ಮೂವರು ಮರ್ಯಾದಸ್ಥ ವ್ಯಕ್ತಿಗಳು ಸಾಕ್ಷಿಯಾಗಿ ಅಲ್ಲಿ ಉಪಸ್ಥಿತರಿರಬೇಕು. ಸಾಕ್ಷಿಗಳು ನ್ಯಾಯಾಲಯಕ್ಕೆ ಹಾಜರಾಗುವ ಅವಶ್ಯಕತೆ ಇಲ್ಲ. ವಿಶೇಷ ಸಂದರ್ಭಗಳಲ್ಲಿ ಮಾತ್ರ ನ್ಯಾಯಾಲಯವು ಕರೆ ಹೇಳಿದರೆ ಅವರು ಹಾಜರಾಗಬೇಕಾಗುತ್ತದೆ.

ಆಸ್ತಿ ವಶಪಡಿಸಿಕೊಳ್ಳಲು ಪೊಲೀಸ್ ಅಧಿಕಾರಿಗೆ ಇರುವ ಅಧಿಕಾರ (S 102) : ಯಾವುದೇ ಸ್ಥಳದಲ್ಲಿ ಅಪರಾಧ ನಡೆದಿದೆ ಎಂಬ ಅನುಮಾನ ಬಂದರೆ ಆ ಆಸ್ತಿಯನ್ನು ಪೊಲೀಸ್ ಅಧಿಕಾರಿಯು ಕಾನೂನು ರೀತಿ ವಶಪಡಿಸಿಕೊಳ್ಳಬಹುದು. ಈ ರೀತಿ ವಶಪಡಿಸಿಕೊಂಡಿರುವುದನ್ನು ತಕ್ಷಣವೇ ಮೆಜಿಸ್ಟ್ರೇಟ್‌ಗೆ ವರದಿ ಒಪ್ಪಿಸಿ, ಆ ನಂತರದ ನ್ಯಾಯಾಲಯದ ಪ್ರಕ್ರಿಯೆಗೆ ಅನುವು ಮಾಡಿಕೊಡಬೇಕು.

ಮೆಜಿಸ್ಟ್ರೇಟ್‌ನಿಂದ ಅಪರಾಧಕ್ಕೆ ತಕ್ಕ ಕ್ರಮ (S 190) : ಪ್ರಥಮ ದರ್ಜೆಯ ಅಥವಾ ಎರಡನೇ ದರ್ಜೆಯ ಮೆಜಿಸ್ಟ್ರೇಟ್ ಅಪರಾಧದ ಕುರಿತು ದೂರು ಬಂದ ಮೇಲೆ, ಘಟನೆಯ ಕುರಿತು ಪೊಲೀಸ್ ವರದಿ ದೊರೆತ ಮೇಲೆ ಅಥವಾ ಇಂತಹ ತಪ್ಪು ನಡೆದಿದೆ ಎಂದು ಬೇರೆ ಅಧಿಕಾರಿಗಳಿಂದ ಅಥವಾ ಸ್ವತಃ ಗಮನಕ್ಕೆ ಬಂದ ಮೇಲೆ ಅಪರಾಧಕ್ಕೆ ತಕ್ಕ ಕ್ರಮ ಕೈಗೊಳ್ಳುತ್ತಾರೆ.

ಪ್ರಕಟಣೆ
ಅಭಿಯಾನ ನಿರ್ದೇಶಕರು (ಎನ್‌ಆರ್‌ಹೆಚ್‌ಎಂ)
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳ ನಿರ್ದೇಶನಾಲಯ, ಬೆಂಗಳೂರು.

PH-20

Are you being manipulated ?

BAN TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP

WORLD NO TOBACCO DAY 31 MAY

www.who.int/world-no-tobacco-day

World Health Organization

Publishers: Society for Community Health Awareness Research and Action (SOCHARA) and State Anti Tobacco Cell (SATC)

Opinions and views expressed in this booklet are those or the authors themselves and not of the publishers or editors.

Editors:
Mr. S J Chandedr& Dr. Prem Mony

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From the Editors' Desk

Tobacco use is the single most preventable cause of death globally. Every year, **May 31st is observed as World No Tobacco Day (WNTD)**, to highlight the health burden associated with tobacco use and advocating for effective policies to reduce tobacco use. A comprehensive ban of all tobacco advertising, promotion and sponsorship is required under the World Health Organization's Framework Convention on Tobacco Control (FCTC). Yet, only 19 countries, representing 6% of the world's population, have comprehensive national bans. India's Cigarettes and Other Tobacco Products Act (COTPA) 2003, under section 5, clearly articulates the following:

- Both direct & indirect advertisement of tobacco products prohibited in all forms of audio, visual and print media
- Total ban on sponsoring of any sport and cultural events by cigarette and other tobacco product companies
- No trade mark or brand name of cigarettes or any tobacco product to be promoted in exchange for sponsorship, gift, prize or scholarship
- No person, under contract or otherwise, to promote or agree to promote any tobacco product.

While the laws are in place, enforcement leaves a lot to be desired in India. On a scale of 1 to 10 (1 being least compliant and 10 being most compliant) for compliance with the provisions, **India scored 4 out of 10** according to a recent survey in 2009. It's appropriate that the theme for WNTD 2013 is: **ban tobacco advertising, promotion and sponsorship (TAPS).**

The ban on direct advertising of tobacco products is implemented effectively in urban pockets of the country. Nevertheless, direct advertising, particularly of smokeless tobacco products like gutkha and pan masala, feature in newspapers, public transport, kites, calendars, and at the tobacco vendors. The ban on indirect advertisements of tobacco products has suffered serious setback due to legal challenges and poor enforcement. Indirect advertising of tobacco products is rampant in all forms of media and feature regularly in newspapers, television, public transport, billboards, magazines, and in market places. In India, cigarette companies engage heavily in using surrogate advertising and brand stretching -- the proverbial "wolf in sheep's clothing". Tobacco companies, through their surrogate products, sponsor events such as fashion shows, music, sports events, and bravery awards which are in turn promoted through the mass media.

To mark the WNTD 2013 activities in Karnataka, partners in health from across different organizations in Bangalore, have come together to improve public awareness on tobacco control in general, and banning TAPS, specifically, through this informative booklet. Mr Madan Gopal, I A S, Secretary-Health, Govt of Karnataka, in the foreword to this booklet, provides a crisp note on tobacco-attributable ill-health and appeals for tobacco control for a healthy India. Mr V,B.Patil, I A S ,the Health Commissioner, Govt of Karnataka, highlights the opportunity provided by WNTD to wean youth away from initiation of tobacco use. Dr Prashantha Kumari, Secretary to the State Anti-Tobacco Cell, shines a light on the close link between tobacco and poverty that is very contextual for our nation.

Drs Hebbar and Bhojani, present a state-of-the-art situational analysis of TAPS presently in India and are upbeat about the potential opportunities for avoiding manipulation by the tobacco industry in the future. Dr Pradyumna, provides a scholarly account of the harmful effects of 'second-hand smoking' or 'passive smoking'. Dr Vishal Rao, draws from his clinical experience as a cancer specialist to draw our attention at a personal level to the major problem at hand – that of prevention by tackling tobacco as the root cause, rather than trying to treat the myriad health problems that arise from tobacco use. Dr Vanishree, offers a simple do-it-yourself (DIY) guide on conducting an examination of the mouth for those who are or who may have someone close being a smoker or tobacco chewer, in the belief that early detection and treatment improve quality of life and longevity. Mr. Chander, in his inimitable style, provides an historical account of the Consortium for Tobacco-Free Karnataka (CFTFK), a network of about a dozen organizations from Bangalore working on tobacco control. Lastly, Drs Murthy and Chand, give an insight into the development of tobacco addiction and also offer useful tips on how to quit tobacco use including tips on handling withdrawal.

Somewhere in between are interesting first-person accounts of 'the discomfiture of a passive smoker' and a 'positively inspiring story of an active smoker who successfully quit smoking'... Evidence of the energy of school and college students....Positive role of famous personalities like sportspersons and filmstars...motivating individuals and inspiring organizations...collaboration of governments and NGOs...stories from India and China....plain language and medical jargon....sad stories and hope for the future! All in all, a smorgasbord of information!
Here's to a tobacco-free future!

Editors
Mr. S J Chander, SOCHARA-SOPHEA, Bangalore
Dr Prem Mony, MD, St John's Medical College, Bangalore

31st May 2013

M. Madan Gopal, I.A.S.,
Principal Secretary to Government
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Government of Karnataka

Department of Health & Family Welfare Services
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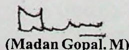
Foreword

Karnataka being the seventh largest State in India geographically has achieved great endeavours in the field of health, family welfare, maternal and child health and communicable diseases. However, non-communicable diseases have been a great challenge to mankind owing to its burden on human life. In this context, tobacco control plays a pivotal role in improving people's health and quality of life.

Tobacco kills around 10 lakh people in India every year. This is more than the combined deaths due to HIV/AIDS, malaria and tuberculosis. To combat the public health challenge posed by tobacco, there is an urgent need to have a strong and effective tobacco control measures in the State of Karnataka.

The World Health Organization's initiative of celebrating World No Tobacco Day on 31st of May every year is a step taken to promote a tobacco- free world and educate people especially youths on the ill effects of tobacco consumption. This booklet released on World No Tobacco Day conveys a message to the people of Karnataka on the ill effects of tobacco consumption and various control measures available to combat tobacco related diseases. In this regard, I appeal all the readers to pledge to live a tobacco-free life and thereby build a stronger and healthier nation.



(Madan Gopal. M)

V. B. Patil, I.A.S.,
Commissioner
Department of Health & Family Welfare
Government of Karnataka

Directorate of Health & Family Welfare Services
Anand Rao Circle, Bangalore- 560009

Message

Every year, on 31st May, World Health Organization and partners everywhere mark World No Tobacco Day, highlighting the risks associated with tobacco use and advocating for effective policies to reduce tobacco consumption. Tobacco use is the single most preventable cause of death globally and is currently responsible for killing one in 10 adults worldwide. More than 80% of these preventable deaths will be among people living in low and middle income Countries.

The ultimate goal of World No Tobacco Day is to contribute to protect present and future generations not only from these devastating health consequences, but also against the social, environmental and economic scourges of tobacco use and exposure to tobacco smoke.

The theme for World No Tobacco Day 2013 is **"Ban on Tobacco Advertising, Promotion and Sponsorship".** Evidence shows that comprehensive advertising bans lead to reductions in the numbers of people starting and continuing smoking. Banning tobacco advertising and sponsorship is one of the most cost-effective ways to reduce tobacco demand.

This year's World No Tobacco Day celebration is a great opportunity to create awareness among various sections of the community on the need to ban tobacco advertising, promotion and sponsorship in order to prevent youths from being attracted to tobacco consumption. I wish all success to the Directorate of Health and Family Welfare Services to celebrate World No Tobacco Day 2013.

Vbpatil
(V. B. Patil)

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Ban on TAPS! Past, present and future.

Dr. Pragati B Hebbar, Dr. Upendra Bhojani
Institute of Public Health Bangalore.

According to a World Health Organization (WHO) report on the global tobacco epidemic, 2011 - only 6% of the world's population was fully protected from exposure to the tobacco industry advertising, promotion and sponsorship tactics in 2010 which shows that much needs to be done on this front. The WHO marks 31st of May each year as the 'World No Tobacco Day'. This year aptly the theme of celebration proposed by WHO is 'Ban on Tobacco Advertising Promotion and Sponsorship' (TAPS). Evidence suggests that comprehensive advertising bans lead to reductions in the numbers of people initiating and continuing smoking. The article 13 of Framework Convention on Tobacco Control (FCTC) obligates its Parties to implement, within five years, a comprehensive ban on tobacco advertisement, promotion and sponsorship including cross-border advertising. Very few countries have lived up to implementing strict ban on TAPS within five years of agreeing to Framework Convention on Tobacco Control. India was one of the first few countries to sign (10 September 2003) and ratify (5 February 2004) the WHO Framework Convention for Tobacco Control, hence it is all the more important to strictly implement a ban on TAPS.

The Indian Act termed Cigarette and Other Tobacco Products Act (COTPA) 2003 prescribes for a complete ban on all forms of tobacco advertisements, promotions and sponsorships. However, in and on pack advertisements and point of sale (POS) advertisements are still permitted - with some restrictions. According to COTPA board specifications for POS advertisements, it should not exceed 60x45cm and should bear a health warning covering 20x15cm area and saying "Tobacco Causes Cancer" or "Tobacco Kills", no brand pack shot, brand name of tobacco product or other promotional messages are allowed to be displayed.

Some of the Common violations of TAPS are as follows

ADVERTISING:

Indirect/ surrogate advertisements, (brand stretching/brand sharing) Eg: Use of similar imagery, logos etc. for tobacco products (gutka) and non-tobacco products (pan masala)

Point of sale (POS) advertisements – Commonly entire kiosks/small shops are seen bearing famous tobacco company brand names and logos.
Direct advertisements - The enforcement of ban on direct advertisements is also occasionally violated by pasting advertisements on private vehicles and autos etc.

PROMOTION and SPONSORSHIP:

A conflict of interest exists here as Indian Tobacco Board a Government of India body has a mission of "To strive for the overall development of tobacco growers and the Indian Tobacco Industry" which is in contrast with the article 13 of FCTC regarding promotion of tobacco.

Some examples for sponsorship include

- Red and White Bravery awards, now renamed as Godfrey Phillips Bravery awards as part of company 'CSR initiatives' wherein often Government officials hand over the awards.
- ITC Milky Magic Contest in Tamil Nadu targeting 4th to 9th std children. Award distribution by famous sports celebrities.
- Four Square Cigarette singing competition in Tamil Nadu, which was later banned.

Issues relating to ban on TAPS in the State:

Global Tobacco Networking Forum in Bangalore was sponsored by Indian Tobacco Board a Government of India body. The Karnataka High Court ruled in favour of Institute of Public Health (IPH) by ordering the Tobacco Board to stop its sponsorship of GTNF 2010 and banned all government officials from attending the conference. IPH also developed and presented a code of conduct (Public Policies and the Tobacco Industry - Upendra Bhojani, Vidya Venkataraman, Bheemaray Manganawar, Economic and Political Weekly Vol - XLVI No. 28, July 09, 2011) to the Karnataka High Court focusing on primarily bringing about transparency in the interactions of Government officials with tobacco industry members. The other aspects that the code of conduct touches upon is regarding partnerships or contribution of government officials in

tobacco industry events, declaration of any affiliations with tobacco industry, denormalizing the so called 'Corporate Social Responsibility' CSR activities of tobacco industry and avoiding preferential treatment to the tobacco industry. The state is yet to accept and implement this code of conduct and hence advocacy efforts are on for the same.

The way forward:

The other sections of COTPA such as section 4 addressing prohibition of smoking in public places and section 6 addressing limiting access of tobacco to minors subdivided into section 6a and 6b have received substantial attention. IPH has closely worked in the past and continues to do so with the Home department for strict implementation of COTPA section 4. Through sustained advocacy efforts the COTPA violations of section 4, 5, 6a, 6b and 7 has been included into the monthly crime record (MCR) by the home department. The education department has also started an online reporting system where section 6b violations are reported.

Somehow section 5 of COTPA pertaining to TAPS has not received the similar attention as the other sections. Through this World No Tobacco Day awareness needs to be spread among the civil society as well as the media regarding what is allowed and what is not allowed as per the national and international laws and Acts with regard to tobacco advertising promotion and sponsorships. Advertising is a very powerful tool to attract the youth to take up tobacco habits. If children initiate such harmful habits at younger age the addiction is much stronger and quitting becomes all the more difficult. Still a lot needs to be done to make the state and the nation tobacco free but with sustained efforts of the consortium in this direction a tobacco free future is something that we all can surely hope for.

Hardly a personal thing – impacts of tobacco on "others"

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If you're not a smoker, you may remember many instances that made you uncomfortable around people smoking. I do. For instance, that one time when a cute German exchange student inadvertently blew some smoke in my direction and I almost fell back in repulsion, surprising her in the process.

Discomfort may be overtly expressed by vigorously shaking your hands to shoo the smoke away or by covering your nose and throwing a dirty stare at the smoker, but "discomfort" is only the superficial aspect. There is a health impact of environmental tobacco smoke (ETS), commonly known as passive smoking, which is rarely acknowledged. ETS contributes to the negative health externalities of tobacco consumption – that is, the smoke generated by cigarette/beedi consumption also impacts other persons besides the consumer. There are also indirect health impacts of tobacco consumption arising from the massive environmental impact of growing and processing tobacco, which will be discussed later.

Several studies have been conducted over the years to estimate the health effects of passive inhalation of ETS at homes and workplaces. These show that ETS increases the risks among non-smokers for the same health conditions that smokers are prone to, but at relatively lower levels. The health problems include the increased risk of lung cancer (by up to 30%), heart disease (up to 30%), stroke (up to 82%), chronic respiratory symptoms and low birth weight . These become significant because of the size of the exposed population which includes vulnerable groups such as children and pregnant women. Non smoking women exposed chronically to ETS showed a 15% increase in dying of heart disease compared to non smoking women not exposed to ETS . In the UK it was seen that 40-60% of children were exposed to ETS, making them vulnerable to exacerbation of asthma (9% of cases), middle ear disease and lower respiratory infections (25% of cases), among other things . These stats wouldn't be very different in India as the prevalence of smoking is 30% among adults . There is a need for persistent efforts to stop exposure to ETS, especially for children.

And this is not all. What is perhaps the greater impact is the indirect one, affecting people far removed from ETS. Globalisation has led to the shift of tobacco industry (cultivation and processing) to developing countries,

which have made cigarettes available at relatively low costs. These relatively low costs are made possible through the subsidies provided by tobacco workers (by loss of health), by the local communities (loss of forest resources), and by people worldwide (who are impacted by climate change due to deforestation). Tobacco cultivation and processing is associated with deforestation and soil degradation. There is pressure to expand into forest lands, and the demand for wood for the tobacco curing process is also on the rise. Forest fires are not the only way cigarettes destroy forests after all! And as tobacco is a plantation crop, a heavy dose of chemicals is used to maintain it, leading to soil degradation too. Workers do not regularly use safety equipment while handling chemicals (during cultivation) or tobacco (during processing) leading to harmful exposure. In several instances, children are involved in rolling beedis which impacts the physical and mental health of this vulnerable group in many ways. These are just some examples.

While these health impacts are not immediately apparent, they very much exist and it is something that smokers should acknowledge. It is the demand for tobacco that drives these impacts. And it is important that non smokers too are aware of these effects they face, which should hopefully encourage them to advocate for their health and environment through demand reduction and better regulation of tobacco production and consumption for a smoke-free world tomorrow.

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Tobacco and Poverty- A vicious circle

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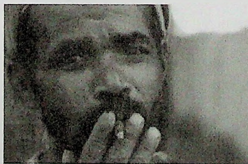
Tobacco and poverty create a vicious circle. Studies have shown that in the poorest households in many low-income countries, spending on tobacco products often represent more than 10% of total household expenditure. As a result, these families have less expendable income for necessities such as food, education and health care. Thus, in addition to its direct health effects, tobacco leads to malnutrition, increased health-care costs and premature death. Viewed from this perspective, tobacco may also contribute to a higher illiteracy rate, since money is spent on tobacco instead of education. Some street children and other homeless people in India spend more on tobacco than on food, education or savings.

Tobacco and poverty is a vicious circle, through which tobacco exacerbates poverty and poverty is also associated with higher prevalence of tobacco use. Studies from different parts of the world have shown that smoking and other forms of tobacco use are much higher among the poor.
(Source: Tobacco free initiative-WHO)



If a person spends Rs 10 per day for purchasing tobacco products, they are losing Rs 300 per month and Rs 3650 per year. If saved, this lost money could bring them wealth of Rs 80,000 in 10 years and Rs 3 lakhs in 20 years.

If one uses tobacco, treatment of tobacco-related diseases may cost them lakhs of rupees. One can eat nutritious food and educate their child by saving the money spent on tobacco products. They can even buy a dream vehicle and house with that money. On an average, the wealth loss due to a monthly expenditure of Rs 100 for tobacco products over 10, 20, 30 and 45 years could be Rs 26,000, Rs 97,000, Rs 2.78 lakh, and Rs 10 lakh respectively.(Source: STEPS Tobacco Control Program)

In many countries, workers spend a significant portion of their salaries on tobacco. The following table shows the amount of time that workers in selected countries would have to work in order to pay for a pack of Marlboro or local brand cigarettes and the equivalent amount of time that it would take to buy bread or rice instead.

Required work time to buy cigarette pack Vs bread or rice (selected countries)

Country	Marlboro	Local brand	Bread (1kg)	Rice (1 kg)
Brazil	22 min	18 min	52 min	13 min
Canada	21 min	17 min	10 min	11 min
Chile	38 min	33 min	19 min	25 min
China	62 min	56 min	103 min	47 min
Hungary	71 min	54 min	25 min	42 min
India	**102 min**	**77 min**	**34 min**	**79 min**
Kenya	158 min	92 min	64 min	109 min
Mexico	49 min	40 min	49 min	25 min
Poland	56 min	40 min	21 min	23 min
United Kingdom	40 min	40 min	6 min	8 min

Source: Guindon GE et al. Special Communication. Trends and affordability of cigarette prices: ample room for tax increases and related health gains. *Tobacco Control*. 2002,

As per the table mentioned above, a cigarette smoker in India has to work for nearly 77 minutes a day to buy just a local brand of cigarette pack which is much higher work time when compared to other Countries except for Kenya. At the same time, the money earned during this work time can be diverted to purchase a kilogram of rice which can feed the smoker's entire family for a day.

India is a developing country and most of its citizens do not have adequate resources to spend on tobacco products on a daily basis and to further spend on related costs such as sickness absenteeism and health expenditure incurred due to tobacco related diseases. One of the most effective ways to prevent our people from being poverty stricken is to enable them stay away from the dreadful habit of tobacco consumption.

Tobacco or health – A change in perspectives for Indian health care

Dr. Vishal Rao,
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Over the decades much has been heard and spoken on tobacco and its ill effects time and again. Now let me put across my perspectives on this problem as a head and neck cancer surgeon.

The question a lot of readers may wonder is - Why is this doc so concerned about tobacco issues? *Well, a doctor may save more lives by indulging in tobacco control for several hours than by treating the diseases caused by tobacco for a lifetime!*

Although most of us are quite aware of the perils of tobacco consumption, today in India we have close to 300 million tobacco consumers. Every year more than 30-40 lakh people in India fall prey to diseases of the heart, lung or cancer owing to this deadly habit. Is this number not large enough for us as citizens to wake up and ask ourselves and government to take necessary steps to curb this?

The health care system in India is largely governed by the private sector (80%) which means a person who reaches out to embrace these habits, eventually ends up spending from his own pocket to treat the illnesses caused by this substance abuse. This further leads to increase in the financial burden to him and his family. Let's stop here and look into what costs does the common man bear as a price of his addiction.

Although tobacco affects every cell of the body, the 3 main illness caused by tobacco consumption are heart diseases, lung disorders and cancer. Rath and chaudhry way back in 1999 through an ICMR study showed that the average cost incurred to treat these disease were rupees 3,50,000, 29,000 and 23,300 respectively. This is a serious concern for the citizens of this country where 80% of our population resides in villages and 75% of our population has a PPP (purchase power parity) of less than 2$ per day. How do we expect this common man to bear with the increasing costs of health care and why should he pay this price?

Well the government says the economy needs tobacco! Revenue from taxation, exports and employment (agriculture, advertisement, vendors)

are important for fiscal gains. The government on an average earns 9000 crores from taxes and exports on tobacco, but the expenditure on health diseases caused by tobacco is of the order of 30,000 crores (taking only 3 main diseases into consideration!). This comprises $1/4^{th}$ of India's expenditure on health.

As a doctor, we often observe, that it is not only the patient who undergoes the treatment but also his entire family which bears the brunt both emotionally and financially. Furthermore, lots of these patients do not have accessible health care in the villages and hence need to move to town or cities with better facilities. Annually, India registers 1 lakh new cases of cancer and tobacco consumption is implicated in almost 50% of these cancers in general and 95% of head and neck cancers. Cancers of the head and neck include areas of the body such as mouth, throat, voice box or food pipe which take care of vital functions such as speech, swallowing, breathing and also maintain cosmesis. Hence cancer afflicting these areas kills the very life force of existence. As a cancer surgeon, dealing with these cases on a daily basis, involves surgically removing a patients jaw, tongue, throat or voice box, which may not be gratifying, more so when the thought crosses your mind that these cancers were caused voluntarily. The fact remains that these mutilating surgeries could have been avoided. Despite advances in technology science has not been able to significantly improve the cure rates or add years to life, in these cancers caused by tobacco. Yes, this is true! Some may ponder, why so, even after man has scientifically advanced in this jet age? Well, expecting any technological advancement to improve outcomes is like letting a man consume poison and then looking for a new antidote. Isn't this imprudent? Precisely, that is we have been witnessing all these years. **"Trying to find a new antidote –**

Rather than quitting the poison!"

Have always practiced a simple principle in medicine, "Treat the cause and not only the effect". Thats right!! For instance, if any one of you is diagnosed with fever, would treatment with paracetamol only suffice? Naturally NO. Fever is the effect, the cause of which may be malaria, typhoid, dengue, H1N1 etc. Hence it is mandatory to treat the cause too. Similarly, treatment for these cancers, whatever is the modality; surgery, chemotherapy or radiotherapy, aim at treating the effect- CANCER after the cause has played its role. That is why the scientific world has moved from - trying to improve survival to improving quality of life for these patients. However, what could yield more gratifying results is **"preventing cancers"**.

Similarly why not look at the lakhs of heart diseases, lung disorders or several such diseases caused by tobacco and develop the same preventive outlook. Rather than treat these diseases by medications, surgery or other treatments, let us say no to tobacco and embrace life!
One of my patients a 30 year old gentleman, working in a software company was diagnosed with tongue cancer owing to tobacco consumption. The diagnosis of cancer came in as a shock to his family and his wife whom he was married to for a year. The patient was diagnosed at such an advance that despite chemotherapy and radiotherapy the tumour spread could not be controlled. Towards the end, the tumor has spread to the neck and started to show in his skin over the neck. All we could do w helplessly watch the young man go into the jaws of death. He bled to death in the hospital room on one fateful day. I still recall his words to me – Doctor, I got cancer because I consumed tobacco, but I quit the habit a year back after I was married. What wrong did I do to deserve this? He left behind him a devastated family and a young widow. This was the story of one of the million bread winners.

Here is a good old Chinese story that I came across in an article called 'Reconnecting with peace' by **Marguerite Theophil in the times of Ideas** which may be relevant:

Long ago, there lived a man with three sons, who all became doctors, but only the youngest son became famous throughout the land. Patients from far and wide, considered to be beyond hope, would go to him and be cured.

Someone asked their father, "All three of your sons are doctors, yet how come only the youngest has become so famous?"

He replied, "This son of mine can cure people even at the point of death, so naturally, everyone knows him. But, my middle son can detect and cure sickness before it grows too serious, so there are only few who know him. And my eldest son takes such good care of people's health that they rarely get sick at all, so he remains unknown.
My youngest son's name may be better known than the other two, but I believe the skill of my other two children is equal to if n not far greater than his."

Effects of tobacco on oral health and importance of self examination

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Introduction:

Tobacco is derived from the species of the plant of genus Nicotina. Use of tobacco has been a part of Indian cultural system. Tobacco leaves are subjected to different types of curing and are processed into various forms of smoked and smokeless tobacco like bidi, cigarettes, zarda, mawa, gutka, mishri, khaini, gudakhu etc. In certain areas of Andhra Pradesh, Vishakapatnam etc reverse smoking is practiced where in the lit end of the cigarette is placed within the mouth. This is more detrimental to oral health. Other than this tobacco is also used along with hookah especially in areas where there is mughal influence.

Epidemiology:

It has been reported that the consumption of tobacco has reached the proportions of an epidemic. WHO reports suggest that tobacco kills nearly 6 million people each year, of whom more than 5 million are from direct tobacco use and more than 600 000 are nonsmokers exposed to second-hand smoke. Approximately one person dies every six seconds due to tobacco and this accounts for one in 10 adult deaths. In men, oral cancer is the eighth most common cancer type globally. Tobacco smoke is known to contain more than 43 cancer producing agents. Nevertheless smokeless tobacco like snuff and chewable tobacco also contains high amounts of cancer producing agents. In the present days the use of smokeless tobacco has increased as compared to use of smoked form of tobacco. Tobacco use in the past decades was observed only in males, however in the recent

Effects on Oral Health

Tobacco use promotes the development of gum diseases where in there is loss of supporting bone due to which teeth may become mobile and be lost at earlier age resulting in disturbance of the masticatory function of the mouth. Smoker is 5-20 times at higher risk of developing gum disease as compared to a non smoker. Gum disease in later stages results in exposure of root which in turn may increase risk of root decay. Nicotine present in tobacco weakens the defense system of the person thus increasing the risk of bacterial infections from microorganisms in plaque (deposit on tooth). Halitosis (foul smell in the mouth) is another problem faced due to use of tobacco. Both smoked and smokeless form of tobacco are the agents responsible for the development of cancers of the mouth and pharynx. Tobacco use also causes a delay in healing of wounds like extraction socket, surgical wounds in the mouth etc mainly as it affects the salivary and serum immunoglobulin and also because of reduced oxygenation to tissues in case of smokers.

Smoking of cigarettes can result in failure of treatments like dental implants mainly due to inflammation in the area surrounding the implants. Smoking during pregnancy increases the risk of development of cleft lip and cleft palate. Long term smoking can result in a condition known as smokers palate where there are changes in the skin of palate, which appears diffuse white having red dots present on elevated nodules in the lesion. Another condition commonly seen in tobacco and betel nut users is the occurrence of stiffness in the oral mucosa (skin of the mouth) resulting in reduced opening. This condition is accompanied by burning sensation in the mouth. There can also be reduction in the movements of tongue. In addition tobacco use may result in development of white patches in the oral cavity called leukoplakia which is a precancerous lesion (lesion preceding the development). The lesion may be smooth, fissured or nodular. The white lesions may at times be interspersed with red lesion and the condition is known as erythroplakia which carries more risk of turning into oral cancer. The risk of mouth cancer is still higher when the person uses alcohol along with smoked form of tobacco. Smoking leads to mouth cancer mainly due to carcinogens (cancer causing agents) present in cigarette, drying of the mucosa by the high intra-oral temperature, pH change, alteration in immune response, or altered resistance to fungal or viral infections.

Pipe smoking has been associated with wear of tooth (loss of the surface layer of the tooth). Smokers melanosis can be seen in smokers which results in pigmentation of the skin of the mouth due to increase in production of melanin. Smoking also results in black/brown discolouration of teeth, restorations and dentures. There can be alteration in the taste sensation. Smokers are also more prone for fungal infection known as candidiasis which presents as white scrapable patch in the mouth.

IMPORTANCE OF SELF-EXAMINATION:

Thousands of Indians are diagnosed every year with life threatening oral cancer. On a positive note, when detected early, this disease has an estimated 80 per cent survival rate. Learning to recognize abnormal conditions in your mouth and performing routine self-examinations are important detection measures and could even save your life. It's important to learn to recognize the normal healthy condition of your own mouth so that you can detect abnormal conditions and report anything unusual to a dental professional or a medical specialist.

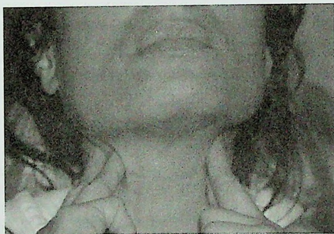
MONTHLY SELF-EXAMINATION ROUTINE

Perform oral cancer self-examination if any of the following symptoms are present:

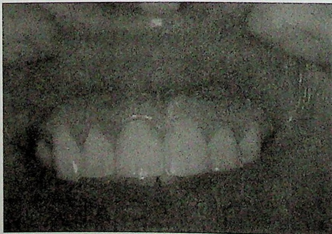
1. Difficulty in chewing or swallowing.
2. A chronic sore throat or hoarse voice that does not heal.
3. Red patches in the mouth or on the tongue.
4. White patches in the mouth or tongue.
5. A lump or overgrowth of tissue anywhere in the mouth.

Supplies needed: flashlight, small mirror (optional), piece of gauze, wall mirror

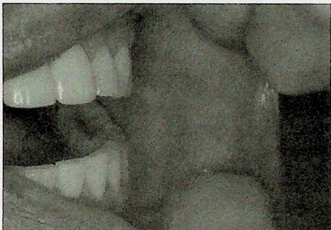
Look at yourself in the mirror – both sides of your face and neck should look the same. Press along the sides and front of the neck and feel for any tenderness or lumps. Do the same on your face. Normally, your face and neck are symmetrical so notice any bumps or swelling.



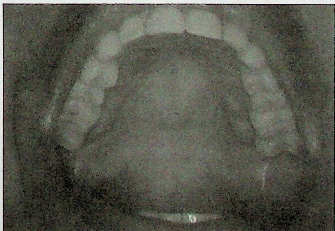
Pull your upper lip up and look for any sores and color changes on your lips and gums. Repeat this on your lower lip.



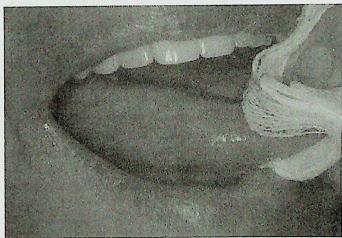
Use your fingers to pull out your cheeks and look for any color changes such as red, white, or dark patches. Put your index finger on the inside and your thumb on the outside of your cheeks to feel for any lumps. Repeat on other cheek.

* 

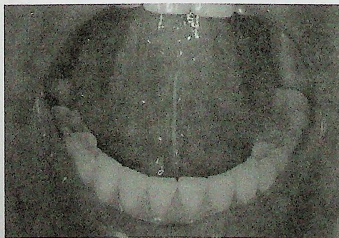
Tilt your head back and open your mouth wide to see is there are any lumps or color changes.

* 

Grab your tongue with cotton gauze and examine for any swellings or color changes. Look at the top, back and each side of your tongue



Touch the roof of your mouth with your tongue and look at the underside of your tongue and the floor of your mouth.



See if there are any color changes or lumps. Use one finger inside your mouth and one finger on the outside corresponding to the same place and feel for any unusual bumps, swelling, or tenderness.

The story of a network working towards a tobacco free Karnataka

S J Chander, SOCHARA- SOPHEA

The World Health Organization (WHO) has organized 'World No Tobacco Day' since 1989, with various themes every year. The preparatory process for developing a Framework Convention on Tobacco Control (FCTC) commenced in 1995, and in 1999 the WHO began negotiations with the member countries. The FCTC was adopted by the World Health Assembly in 2003 and came to force in 2005. This led to greater awareness generation on ill effects of tobacco among various sections of the society, particularly among the health care professionals.

In Karnataka various community health organizations; institutions including medical, dental and other health science colleges; and professional associations worked on tobacco control in diverse ways. SOCHARA was involved with the WHO efforts since the late 1990s. This linkage moved us beyond health education alone to understanding the entire 'Tobacco Cycle' from cultivation to consumption. Since 1999 collective efforts were made by a few health institutions in Bangalore for awareness raising events in different parts of the city and the state around World No Tobacco Day. The Karnataka Task Force on Health and Family Welfare deliberated on the issue in 2000-1 and held discussions with several government departments including that of Agriculture. The women's health empowerment program working in parts of 11 districts of the state through partner NGOs and self help groups with the Community Health Cell (CHC) as the state nodal organisation included a section on tobacco in 2001-2. Creative posters were developed by students from Karnataka Chitrakala Parishad in collaboration with the Community Health Cell and donors. These were used extensively for exhibitions and talks with students. Public rallies were conducted. Participating institutions reviewed and reflected about their work and the annual campaigns and this led to the birth of the Consortium for Tobacco Free Karnataka (CFTFK). In view of the alarming ill effects of tobacco; the following institutions expressed the need to form a network and carry out action to address the various issues related to demand and supply of tobacco: Society for Community Health Awareness Research and Action (SOCHARA), Bangalore Institute of Oncology (BIO) National Institute of Mental Health and Neuro Sciences (NIMHANS) and the Indian Medical Association-Karnataka Chapter. Later on many more institutions have joined the CFTFK.

Advocacy issues addressed

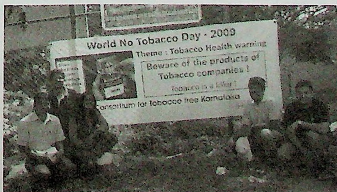
While the negotiation process for FCTC was being carried out by the WHO, the Karnataka government initiated the process for THE KARNATAKA PROHIBITION OF SMOKING AND PROTECTION OF HEALTH OF.NON-SMOKERS ACT, 2001 which was notified in 2003. CFTFK wrote to the health minister for framing rules for implementation of the Act. In the same year Government of India announced 'THE CIGARETTES AND OTHER TOBACCO PRODUCTS (prohibition of advertisement and regulation of trade and commerce, production, supply and distribution) Act 2003' (COTPA) following which CFTFK wrote to the union health minister urging her to ban all forms of advertisement of tobacco products especially those targeting children. A memorandum was also submitted to all the Members of Parliament in Karnataka to support the safe passage of the above Act in Rajya Sabha. CFTFK facilitated the process of 'Students Action Against Tobacco' by college students in Bangalore to appeal to the minister for education to take action to protect them from aggressive marketing strategies of tobacco companies. In the year 2004 CFTFK mobilized over 10000 signatures and submitted a memorandum to the Governor of Karnataka for urging the state government to implement both the Acts mentioned above. In the year 2006 CFTFK organized a panel discussion with senior officers from police, law and health department, focusing on lapses in implementing the COTPA Act. Justice Malimath was the chief guest for this event.

Awareness campaigns

Bangalore city witnessed for the first time tobacco awareness banners and wall posters in some of the prime localities during the 2001 campaign. Theses banners carried messages such as 'Tobacco Kills- Don't be duped' and 'Tobacco Contains over 4000 poisonous substances'. The public awareness rallies always included celebrities from the film industry and sports.Some of the movie stars who supported the campaign are: Late Shri , Vishnuvardha and his actress wife Smt. Bharathi, comedian Shri, Shivram, Mrs. Jayanthi and Mr. Narendra Babu. Sports stars who supported the campaign are: swimmer Ms. Nisha Millet, Ms.Ashwini Nachappa, and Cricketer Rahul Dravid.

The year 2002 focused more on mobilization of students' body across the city. St Joseph, Christ and Baldwin PU colleges played a key role in organizing public rallies and awareness programs within the colleges. The campaign in 2003 was supported by the network of organizations working with street children. Rag pickers Development Education Society (REDS) played the lead role. The children gathered on M G Road and appealed to the leading film actors who were promoting tobacco advertisement to abstain from it.

The 2004 campaign was unique as CFTFK organized many public awareness programs preceding the WNTD program. First time people at the railway stations and bus stations in Bangalore and Mysore witnessed public awareness program on tobacco. A special program was street children in the city were organized through a magic show and puppet show.



Untouched agenda

The efforts by the government to implement various provisions in COTPA seem reasonably good in terms of displaying the key messages of the Act such as: ban of smoking in public places and ban on sale of tobacco products to minors and within 100 meters from educational institutions. Violators have been penalized in a few places, though not all of them. Despite all these efforts it appears that the consumption of tobacco products in India does not indicate a declining trend. This is evident for the information furnished in websites of tobacco companies which reports increase in both production and sales. It has been observed that the COTPA does not fully comply with FCTC recommendations. One of the key measures recommended by FCTC for supply reduction is to shift tobacco cultivation to other economically viable crops in a phased manner. The work of the Center for Multidisciplinary Development Research (CMDR) in Dharwad and other institutions across the globe shows that there exists the possibility of tobacco farmers shifting to alternate crops or finding alternate livelihood options. It is evident that no efforts are taken to implement this measure and there is a need for advocacy towards it. Tobacco consumption has gained wide social acceptance for many years now. While the information on harmful effects of tobacco is reaching the public, it is important that we further engage society through social mobilization to reject tobacco and to put pressure on the regulatory systems for effective implementation of COTPA.

I would like to close with the words of Dr. C M Francis, founder president of SOCHARA 'if tobacco is allowed to grow, there will be pressure to sell it hence, reduction in tobacco cultivation is an important step towards changing the trends in both demand and supply of tobacco'.

Why and How I Quit Tobacco

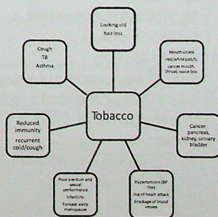
Dr. Prabhat Chand and Prof. PratimaMuthy
Tobacco Cessation Clinic, Centre for Addiction Medicine, NIMHANS, Bangalore

"I used to work for a big company and used to travel frequently. The work stress was very high. With work stress and travel, my smoking increased rapidly. It became three packets per day and continued till till I was45 years old. One evening while watching television, I had sudden chest pain and breathlessness. The pain was very much and I could not breathe. I did not know what happened after that. When I woke, I was in hospital with so many tubes, needles around me. The doctor told me Ihad a massive heart attack. I could not believe him as I am neithera hypertensive (BP) nor diabetic nor obese and I have been physically fit. Then the doctor asked me "do you smoke?". He also advised me to quit smoking completely or else the chance of another attack would bevery high. I stopped from that day onwards. I stayed in hospital for a bypass operation (open heart) as there were seven blocks in my heart vessel. Now I am 84 year and healthy. I wish I had not started smoking or that someone had advised to stop smoking.Still I feel proud that I could kick the habit." (A True story)

Tobacco is the most addictive substance known to mankind. Its use, either as smoking or in the smokeless form, is common among both men and women. In view of its chemical nature, its regular use leads to nicotine addiction. When a person gets addicted, there is a constant urge to smoke or chew and feeling of uneasiness, restlessness in the person upon stopping use. Some people use tobacco in certain situations like after coffee/lunch/dinner, while driving, when tense or angry etc. Use of tobacco provides a sense of short-lived relaxation. The use increases over time and person develops physical problems.

What will happen if I continue using tobacco?

It is an irony that tobacco related advertisement is popular every where whereas its harmful effects are not. People may know that tobacco use is harmful but are often ignorant about the range of health hazards.Tobacco use can involve all the systems of the body and can cause serious harm.



What benefit will I get if I quit tobacco?

A person often thinks, "I don't have any physical problem or illness... what is the benefit I will get from quitting tobacco. In fact, using tobacco improves my mood and is helping me to work better". It is important that quitting tobacco at any point of time is beneficial In fact, the best benefit is probably got by such a person who has not developed any tobacco related problems and can prevent such problems in the future. It is also better to quit before addiction develops, as the struggle to quit is much more once addiction develops. The benefits of quitting occurs not just in physical health but also in psychological health i.e. there is a feel good factor that the person has been able to overcome tobacco use. At the same time, immediate family members and friends are also saved from the dangerous effects of passive smoking.

By quitting smoking	By quitting chewing
By 1 day BP and heart rate become normal. Carbon monoxide (toxin) reduces. Chance of heart attack reduces *By 3 months* Breathlessness decreases Fertility improves *By 5 to 15 years* Risks of lung cancer, coronary artery disease and stroke reduce to levels of that of a non-smoker.	Dental staining and mouth ulcer comes down Opening of mouth becomes normal There is no further tooth decay Risk for pre-cancerous lesions like leukoplakia or erythroplakia reduces

How do I quit tobacco?

There are various ways in which a person can quit tobacco. These approaches are used regularly and found to be useful.

1. Understanding that nicotine is addictive.
2. Fixing a Quit date: Fix a date from when you want to quit completely. It can be from the present day itself. Do not fix a date which is too far. Once you quit there are chances of nicotine withdrawal symptoms like irritability, restlessness, sleep disturbance etc. These are normal in nicotine withdrawal and very mild. These will go way in a few days. These withdrawal symptoms will be more intense in the first two to three days and gradually come down. At this time there will be an increased urge to use tobacco. One can fight these urges with simple techniques that are described below.

3. Handling the urge (craving): It is important to understand that the urge for tobacco will remain for the next 3-6 months and perhaps even longer. In the first three months it will be most intense. Each time the urge for tobacco appears, you need to learn the technique to handle it. Also remember that the intensity will come down with time as one remains tobacco free.

Techniques to help withdrawal and urges after you stop tobacco

- Remind yourself that withdrawal will last only a few days. The symptoms will appear like a mild flu and disappear by themselves.
- Take each day at a time.
- When the urge comes, remember it will stay only for a few minutes and then go away.
- For many, keeping something in the mouth, like a clove, cardamom, fennel seeds or chewing gum is very helpful when there is craving.
- Keep the hands busy – wash vessels, wash clothes, water the plants, squeeze a ball
- Eat a healthy diet; Get enough exercise and Learn to relax.
- Avoid situations that cause temptation. (i.e. tobacco user friends)
- Remind yourself the benefits that you have got or will get by quitting tobacco

Medications

- Nicotine replacement therapy i.e. nicotine gums
- Others : varenicline, bupropion, clonidine, nortryptiline etc.

1. Medication As mentioned before, nicotine use is very addictive. Use of medication facilitates the quitting process and in staying away from tobacco. The medications normally help people who are heavy tobacco users or need tobacco the moment they get up, or if they find it difficult to handle craving (urges).

   These medications need to be taken under advice of a doctor. The role of medications is to assist in the quitting process. They are not a substitute for your effort to quit. Studies show that the chance of successful quitting increases upto 5-6 times with medications. Your decision to quit, the lifestyle changes that you make to avoid tobacco use (avoiding alcohol, eating well, exercising, learning other ways of relaxation and stress reduction) are important in quitting and medications would further help you in your decision if you are addicted and your craving is strong.

Conclusion

Tobacco use normally starts as a temporary pleasure that becomes a costly and risky pastime when it ends up in addiction or with serious medical problems. The best success with quitting is when it occurs early. However, even addicted smokers CAN quit, with sustained effort. As in the person mentioned at the beginning of the article, every quitter should be proud of kicking the habit either by self or with help as well as encourage others to quit.

Please contact Tobacco Cessation Clinic (TCC), Centre for Addiction Medicine, NIMHANS in case you want any help in quitting tobacco. Phone number: 080 26995547 (OPD: Monday, Thursday, Saturday) email: tccbangalore@gmail.com

Save lives today

Implement the Framework Convention on Tobacco Control

MONITOR
tobacco use and prevention policies

PROTECT
people from exposure to tobacco smoke

OFFER
help to quit tobacco use

WARN
about the dangers of tobacco

ENFORCE
bans on tobacco advertising, promotion and sponsorship

RAISE
taxes on tobacco

The Union supports over 30 low-and middle-income countries to fulfil their obligations under the FCTC through grants and capacity building, which includes technical training based on the MPOWER package.

www.tobaccofreeunion.org, www.theunion.org

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Prohibition on Tobacco Advertising, Promotion and Sponsorship in India:

A Resource Kit

A Resource Kit developed by Health Related Information Dissemination Amongst Youth (HRIDAY) with support from Ministry of Health and Family Welfare, Government of India (MoHFW, GoI) and World Health Organization (WHO) Country Office for India.

Tobacco Advertising Promotion and Sponsorship (TAPS)

Tobacco manufacturers are some of the best marketers in the world and increasingly aggressive at circumventing prohibitions on advertising, promotion and sponsorship that are designed to curb tobacco use (World Health Organization, Report on The Global Tobacco Epidemic, 2008).

- Tobacco industry uses means such as television, print, radio, internet, Point of Sale (PoS) displays, product placement in films, brand stretching, and sponsorship of sports, cultural, fashion and music events.
- The pack in which tobacco products are sold itself is a strong vehicle for advertising.
- Cross-sectional and longitudinal studies conducted with school-going adolescents in India establish a causal relationship of TAPS with increased tobacco use.
- A study conducted with about 4000 school-going adolescents in Delhi concluded that students highly exposed to tobacco use in Bollywood films are at more than twice the risk of being ever tobacco users compared with the least exposed.
- This association suggests the need to strengthen policy and programme based interventions in India to reduce the influence of such exposure.

Project MYTRI: Mobilising Youth for Tobacco Related Initiatives in India

According to a study conducted by HRIDAY among 14,000 students in 32 schools of Delhi and Chennai, it was found that:

- Current use of tobacco was five times higher in students who were highly receptive to tobacco advertising than those who were least receptive.
- Tobacco use was also 12% higher in those exposed to tobacco advertising.
- Current tobacco use was almost twice as high in those students who were exposed to tobacco advertising in more than four places as compared to those who were not exposed to any.

Tools to curb TAPS

WHO Framework Convention on Tobacco Control

Article 1 (c) - *"tobacco advertising and promotion"* means any form of commercial communication, recommendation or action with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

Article 1 (g) - *"tobacco sponsorship"* means any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting a tobacco product or tobacco use either directly or indirectly;

The Cigarettes and Other Tobacco Products (Prohibition of Advertising and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA)

Section 3 (a) - *"advertising"* includes any visible representation by the way of notice, circular, label, wrapper or other document and also includes any announcement made orally or by any means of producing light, sound, smoke or gas;

Section 5 (1) – *"Indirect advertisement"* means:

- the use of a name or brand of tobacco products for marketing, promoting or advertising other goods, services and events;
- the marketing of tobacco products with the aid of a brand name or trademark which is known as, or in use as, a name or brand for other goods and service;
- the use of particular colours and layout and/or presentation those are associated with particular tobacco products; and
- the use of tobacco products and smoking situations when advertising other goods and services.

COTPA Section 5

The Indian law prescribes for a complete ban on all forms of TAPS with ban on the display of tobacco products at the PoS. However, in-and-on pack advertisements and PoS advertisements are still permitted - with some restrictions.

PoS rules under COTPA

- An advertisement board should not exceed 60 cms x 45 cms with a 20cms x 15cms health warning on the top edge.
- Each such board shall contain in an Indian language as applicable, one of the following warnings (i) Tobacco causes cancer, or (ii) Tobacco Kills.
- The health warning must be prominent, legible and to be in black colour with a white background.
- The board should only list the type of tobacco products available and shops cannot display any kind of tobacco products and no brand pack shot, brand name of the tobacco product or other promotional message and picture shall be displayed on the board.
- The display board should not be backlit or illuminated.

Penalties for violation

- First conviction: up to 2 years jail or up to Rs. 1,000 fine or both.
- Subsequent conviction: up to 5 years jail and up to Rs. 5,000 fine.
- Infringement of the law may lead to forfeiting of advertisements and advertising material.

Cable Television Network (Regulation) Act, 1995

An amendment to the Cable Television Network Rules 1994 was notified by the Ministry of Information and Broadcasting on February 27, 2009 which allowed the indirect advertising of prohibited products like cigarette, tobacco, liquor etc. with some restrictions. The letter by Director, Information and Broadcasting dated June 17, 2010 categorically directs all TV channels including news and current affairs channels to stop airing any advertisement of a product on their channel that uses a brand name or logo which is also used for cigarettes, tobacco products, wine, alcohol, liquor or other intoxicants and strictly follow the provisions of Rule 7 (2) (viii)(A) of Cable television rules, 1994.

The Broadcasting Services Regulation Bill, 2007

The Broadcasting Services Regulation Bill, 2007, Ministry of Information and Broadcasting, Government of India has provisions of a 'Content Code' and revoking of licenses of broadcasters, which would regulate inter alia, the broadcasting and advertisement of tobacco and other addictive products.

Broadcasting Content Complaints Council (BCCC)

BCCC's (a thirteen member body under Indian Broadcasting Foundation) Self Regulatory Content Guidelines for Non News & Current Affairs TV Channels has prohibition on smoking and tobacco as one of the principles and a complaint can be made against its violations.

The Advertising Standards Council of India

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

Current Situation in India

Print, Electronic and Outdoor Advertisements

- With a ban on direct advertisement of tobacco products in place since 2004, tobacco companies have used indirect and surrogate means to advertise their products on print, electronic and outdoor media.
- Tobacco companies have ubiquitously used television, radio, newspapers, billboards, hoardings, rain shelters and transport vehicles for advertising and promotion of their products.

Large outdoor hoarding of surrogate products

Advertising of surrogate products on transport facilities

Advertising in leading newspapers

Advertising of cigarette brands on carry bags

PoS and Product Display

- Tobacco companies in India provide lucrative incentives to retailers of their products for placing tobacco ads and other items promoting tobacco usage.
- Companies supply vendors with promotional materials, including LCD television, giant posters and refurbish their stores to make them more attractive and turn the stores into tobacco advertisements.
- The display of products at the PoS is a powerful advertising and promotion tactic especially to target youth.

Use of PoS colour combinations matching tobacco products

Use of LCD Television for PoS advertisements

Supreme Court of India clears the way for implementation of PoS Rules

The Hon'ble Supreme Court on January 3, 2013 directed the implementation of above mentioned PoS under Section 5 of COTPA.

Advertisements of Surrogate products

- Tobacco companies use their non-tobacco products having similar names, packaging, logos and labeling to indirectly advertise their tobacco products.
- These advertisements are present everywhere in Indian media and instances of such advertisements have increased after a majority of Indian states/union territories have banned Gutkha and other smokeless tobacco products under Regulation 2.3.4 of the Food Safety and Standards (Prohibition and Restrictions on Sales) Regulations, 2011.

Surrogate products resembling tobacco products

Brand Stretching

- The tobacco industry uses its brand names, logos, or visual brand identities on non-tobacco products including clothing and accessories to attract new consumers.
- This strategy turns customers into advertisement mediums.

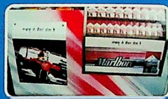
Range of body care products and clothing carrying the same name as cigarette brands

Sponsorship

- Tobacco companies in India have associated with popular sports and fashion events to promote their products.

Tobacco companies sponsoring fashion events

Tobacco companies advertising products during cricket matches



Tobacco companies associating with popular Grand Prix events

Competitions/Contests

- Tobacco companies flout Section 5 of COTPA by promoting tobacco product use through competitions targeted towards children/youth or providing financial benefits to tobacco users.

Contest schemes from tobacco companies

Industry sponsored competition canceled

Indian tobacco giant ITC Ltd's snack foods brand Sunfeast announced the 'Milky Magic All Rounder Competition' in nearly 500 schools across 10 cities in Tamil Nadu in January 2011. As a result of the strong advocacy by Indian tobacco control advocates, the Department of Education and State Tobacco Control Cell cancelled this competition for children on grounds of violation of COTPA.

Packaging as Advertisement

- Tobacco packages have always been an important part of the tobacco industry's marketing strategy.
- Tobacco product package design is used to reinforce brand imagery, to minimize perceptions of risk, and to contribute to the tobacco user's identity.
- Tobacco companies also use limited editions pack in conjunction with sports, festival/events.

Cigarette packs during cricket world

Kiddie packs of cigarette

International Best Practice: Australia adopts plain packaging of tobacco products

The Government of Australia took a momentous step forward by implementing plain packaging of tobacco products from December 1, 2012. With this, Australia has become the first country in the world to have brought in plain packaging of tobacco products. Plain packaging restricts tobacco industry logos, brand imagery, colours and promotional text appearing on packages, thus eliminating the "badge value" of all forms of tobacco product packaging. Brand and product names are allowed only in a standard colour, position, font style and size in a pre-defined area on the package. To enhance effectiveness of graphic warnings in India, researchers and tobacco control advocates are strongly proposing introduction of plain packaging of tobacco products. A Private Members' Bill has been introduced on this issue in the Indian Parliament, which remains to be discussed.

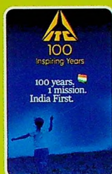
Australian plain pack

Corporate Social Responsibility (CSR)

- CSR is a strategy by which tobacco companies manipulate the public's attitude towards their reputation and send the message that they are looking out for the public's best interest.
- Tobacco companies have often engaged in such activities in order to promote their products while portraying a 'positive self image'.

Tobacco industry sponsored bravery awards

Tobacco industry's CSR initiatives targeted towards farmers



Tobacco industry's CSR initiatives

UNDP shocked over World Business Development Award presented to tobacco firm ITC at UN + 20 summit

After receiving a letter from various Indian tobacco control organizations, protesting the conferral of the World Business Development Award (WBDA) to Indian tobacco giant ITC Ltd. during the UN +20 Summit in Rio de Janeiro from June 13 -22, 2012, Ms. Helen Clark, Administrator of United Nations Development Programme (UNDP), responded several letters expressing shock and discontent over the issue. The letter stated that '*UNDP was shocked to learn that a company given an award through the WBDA derives a substantial proportion of its profits from tobacco. UNDP does not ever wish to be associated with awards which are presented to such companies.*'

Product Placement and Tobacco use Imagery in Films

- A number of actors from the Indian film industry have being found smoking/using tobacco in their films and films scenes displaying tobacco brand packages and logos for surreptitious promotion of products has also been observed.

Tobacco Imagery in Indian Movies

Protect youth from unnecessary exposure to tobacco usage through films and TV programmes

India is one of the first countries world-over to introduce stringent regulations on depiction of tobacco imagery in films and television programmes. Rules were amended and notified vide G.S.R. 708(E) dated September 21, 2012 and came into force from October 2, 2012. These rules mandate :

- Minimum 30 seconds health spots and static health warning message (beginning and middle)
- Minimum 20 seconds audio visual film on the ill effects of tobacco use (beginning and middle)
- Non-compliance may lead to suspension of license
- No films to be certified without compliance with the rules

Indian youth monitor, score and give a 'Thumbs Down' to tobacco imagery in Bollywood films!

In a unique ongoing monitoring campaign named *'Thumbs Up and Thumbs Down'*, HRIDAY has engaged school and college going youth from Delhi to monitor depictions of tobacco use and tobacco imagery in the newly released Bollywood films. Out of the 27 films reviewed so far, 15 have received a Thumbs Down! and only 12 films have received a Thumbs Up!, which means 56 percent of the films haven't complied with the rules regulating depiction of tobacco use in films.

Challenges in dealing with TAPS

- Almost all smokeless tobacco products have their identical non-tobacco brand extensions which are extensively advertised as surrogates for the tobacco products.
- In-and-on pack advertising gives much room to the tobacco industry to make its product visible in every corner of the country
- Despite of Hon'ble Supreme Court's new ruling tobacco industry is using several posters, boards and LCD screens within the kiosks to advertise at PoS.
- Tobacco companies make use of the loophole in the Trade Marks Act, 1999 which allows tobacco companies to register the same trademark for non-tobacco products. This allows the tobacco companies to advertise their non-tobacco products thus, resulting in indirect advertisement /promotion of tobacco products which is in gross violation to Section 5 of COTPA.
- Tobacco industry activities in the name of CSR are targeted to promote brand loyalty and create a positive image of the Industry.
- Excessive advertisement on internet and social networking sites e.g. Facebook, Twitter etc.
- Print, electronic and outdoor media see tobacco industry as their leading customers, hence contribute to increase in surrogate and indirect advertisements.
- When compared to other provisions of the law, there is a general lack of awareness among enforcement officers and the public on the extent of the advertising bans. This further leads to lack of action.
- Besides, steps should be taken to prohibit cross-border advertisements as recommended under FCTC. The bordering regions of the country experience free-flow of tobacco advertisements through both print and electronic media.
- The tobacco industry has ample financial resources to support development of advertising, promotion and sponsorship strategies and to challenge any bans in absence of proper enforcement.

Delhi Metro Rail Corporation (DMRC) urged to take off surrogate advertisements of tobacco products

Raising concern over display of tobacco product advertisements in Delhi Metro, HRIDAY urged the Delhi Metro Rail Corporation (DMRC), to remove all such advertisements from, metros, metro stations and metro feeder buses. Replying to this DMRC officials said that *"The Delhi Metro Rail Corporation follows the guidelines set by the Directorate of Audio Visual Publicity, Ministry of Information and Broadcasting, regarding the display of advertisements in its premises. Surrogate advertisements are allowed only if the requests are accompanied by an NOC from the Ministry of Information and Broadcasting, Government of India."*

Existing enforcement mechanisms

Role of enforcement officers

PoS

- Ensure complete ban on TAPS and implementation of Section 5 of COTPA within their jurisdiction.
- Conduct frequent raids and surprise checks to prevent TAPS including cross-border TAPS.
- Enter and search any premises if she/he suspects the existence of any material advertising tobacco products.
- Seize and confiscate such materials as per the provisions of Criminal Procedure Code.
- All materials so seized are forfeited to the government.
- Complain to the Steering Committee - all and any instance of tobacco advertisement.

Films and Television

- Ensure complete enforcement of October 2, 2012 regulations on depiction of tobacco imagery in films and television programmes.
- Monitor violations of the rules in films and television programmes and bring them in notice of the Steering Committee.

Tobacco product packaging

- Ensure that the tobacco products sold in their jurisdiction depict the notified pictorial health warnings, as per the size prescribed in the law.
- Monitor violations of in-and-on pack advertisements and bring them in notice of the Steering Committee.

Following categories of enforcement officers are authorized by the Government of India to implement the provisions of Sections 5 and 7 of COTPA:

S. No.	Designation	Department
1	All officers of the level of Superintendent and above of the Customs and Central Excise	All Premises registered under Department of Revenue
2	All officers of the rank of Inspectors and above of Sales Tax/Health/Transport	Department of Revenue/ Health/Transport of the State
3	Junior Labour Commissioner and above	Labour Department
4	Joint Director	Office of the Commissioner of Industries/Small Scale Industries
5	Sub-Inspector and above of Police/State Food and Drug Administration or any other officer holding the equivalent, rank of Sub-Inspector of Police	Department of Food and Drugs and Department of Home Affairs.

...g Committees to enforce ban on TAPS

...tate and District level Steering Committees have been constituted to guide monitor and ensure enforcement of ban on ...he Committees are empowered to take cognizance of TAPS violations under COTPA and look into specific instances of ...ation of Section-5 of COTPA and take suo-moto action. The Steering Committee consists of representatives from 3 Departments of ...vernment of India. In addition representatives from Press Information Council of India, Press Information Bureau, Advertising ...andards Council of India (ASCI) & from Civil Society Organizations are members of this Committee.

Proposed Recommendations to strengthen enforcement of TAPS ban in India

1. Regular meetings of the National, State and District level Steering Committees for Section 5.
2. Formation of raiding teams at state and district level for law enforcement.
3. Effective Government-NGO partnership for enforcement of TAPS ban.
4. Coordinated action among all concerned departments and ministries for meeting FCTC and COTPA mandates at all levels.
5. Strengthening COTPA and other related laws to encompass uncovered or under-covered areas, such as: CSR, advertising on internet and social platforms, in-and-on pack advertisements.
6. Advertisement materials to be handled carefully during search and seizure to ensure that relevant evidence remains intact (conviction for contravention as under COTPA Sections 22 and 23).
7. Active engagement of multi-sectoral partners such as: Central Board of Film Certification, Broadcast Content Complaints Council, under Indian Broadcasting Foundation, Advertising Standards Council of India, Ministry of Information and Broadcasting, Ministry of Health and Family Welfare, Ministry of Commerce and Industry, Ministry of Transport and Ministry of Finance.
8. Propose amendment in the Trade Marks Act to curb the use of tobacco products brands/trade marks for any other non-tobacco goods or services.
9. Specific violations of the advertising and programmme code of the Ministry of Information and Broadcasting (on TV and print media), must be reported to the Ministry of Information and Broadcasting. Likewise, violations by cable TV operators should be reported to the District Magistrates.
10. National Tobacco Control Helpline (1800-110-456) should be effectively utilized for reporting violations of TAPS ban.
11. Prohibition on in-and-on pack advertising and strengthening existing pictorial health warnings through strategies such as Plain Packaging of tobacco products should be considered.
12. Mobilization of civil society, media and general public to report violations to the concerned authorities and highlight the issue at various platforms.
13. Greater consumer awareness about tobacco industry tactics that counteract public health campaigns.

Global Best Practices on Prohibition of TAPS

- United Kingdom restricts internet advertising and promotion of all tobacco products.
- Sri Lanka completely prohibits Corporate Social Responsibility activities by tobacco industries.
- Myanmar banned tobacco advertisement on Satellite TV.
- Brazil and Thailand prohibit display and promotion of tobacco products at PoS.
- Nepal's tobacco control law imposed a total ban on TAPS in any form.
- Australia has implemented plain packaging of tobacco products to counter on-pack advertisements.
- Countries with the highest level of achievement against TAPS: Chad, Colombia, Djibouti, Eritrea, Iran, Jordan, Kenya, Kuwait, Madagascar, Montenegro, Myanmar, Niger, Norway, Panama, Qatar, Sudan, Syrian Arab Republic, Thailand and United Arab Emirates.

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PH-9

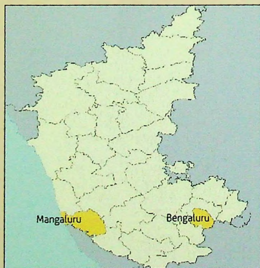
Examining the Impact of the Gutka Bans in Selected States in India

Karnataka- Summary Findings

According to the Global Adult Tobacco Survey India (2009-10), 28 per cent of adults (15 years and above) in Karnataka used tobacco. About 12 per cent of adults were smokers and 19 per cent used smokeless tobacco. Of the latter, 6 per cent were current users of gutka.

A study was jointly undertaken by the Johns Hopkins University Bloomberg School of Public Health's Institute of Global Tobacco Control (JHSPH-IGTC) and the World Health Organization Country Office for India, in collaboration with JHSPH Center for Communication Programs (JHSPH-CCP) and Centre for Communication and Change-India (CCC-I) to understand the impact of state laws that ban the sale and distribution of gutka.

Surveys were conducted with 1,001 current and former gutka users and 458 tobacco product retailers to gain insight into the effect of the bans on consumer use and product availability in seven states (Assam, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, and Odisha) and the National Capital Territory. Observations of 453 retail environments and 54 in-depth interviews with government officials, enforcement officials and citizens working with civil society groups were conducted to the same end.



Study jurisdictions in Karnataka

In Karnataka, surveys were conducted in the districts of Bengaluru and Mangaluru with current and former gutka users and tobacco product retailers to determine the impact and effectiveness of gutka ban. In addition, observation of 60 retail environments and in-depth interviews with government officials, enforcement officials and citizens working with civil society groups were conducted to find out different stakeholders' reaction to the ban.

The study is supported by JHSPH-IGTC and WHO Country Office for India and conducted in collaboration with JHSPH-CCP and CCC-I

Summary Findings

- Support for gutka ban is very high (94%) across the studied jurisdictions
- Almost universal agreement (99%) that gutka ban is good for the health of India's youth
- Product ban did impact use. None of the respondents use pre-packaged gutka since the ban
- Post-ban, manufacturers have started selling twin packs (pan masala and tobacco separately). All the respondents reported purchasing ingredients separately and combining/mixing them for consumption
- A large percentage of dual users (64%) reduced the use of smokeless tobacco products after the ban
- Eighty five per cent of respondents agreed that the government should ban the manufacturing, sale and distribution of other forms of smokeless tobacco
- Interest in quitting is high with approximately half of the respondents (45%) reported attempting to stop using gutka in the last year. Approximately seventy three per cent of respondents agree that the gutka ban will help people to quit
- Of the respondents that quit since the ban, a substantial proportion in Karnataka (92%) reported that they quit because "gutka was not available"
- There was virtually no retail outlet where pre-packaged gutka was on display
- A very small percentage (8%) of tobacco product retailers interviewed reported that they had been approached post-ban by a supplier to continue selling pre-packaged gutka
- A very small percentage (7%) of outlets observed displayed a board declaring that "sale of tobacco products to minors is prohibited"
- Twenty two per cent of the retail outlets observed were located within 100 yards of an educational institute

Recommendations

The study *Impact and Effectiveness of ban on Gutka* yielded significant insights. These are presented as recommendations here:

- Policy measures need to be adopted to curb the sale and purchase of all other smokeless tobacco products including products that can be bought separately and mixed to be consumed as gutka or a product similar to gutka (by whatever name it be called).
- Enforcement mechanisms need to be strengthened to ensure complete compliance of the ban.
- Provision for tobacco cessation services to be scaled up to cater to the unmet need for tobacco cessation.
- Smokeless tobacco products are freely available at a very low price near educational institutions leading to easy access of these products by youth. The boards declaring that "sale of tobacco products to minors is prohibited" were not displayed at all outlets as per the law. This calls for a stronger monitoring of tobacco control laws.

The study is supported by JHSPH-IGTC and WHO Country Office for India and conducted in collaboration with JHSPH-CCP and CCC-I

PH-9.

Examining the Impact of the Gutka Bans in Selected States in India

Karnataka

Study conducted by
Johns Hopkins University Bloomberg School of Public Health's
Institute of Global Tobacco Control
World Health Organization Country Office for India
JHSPH Center for Communication Programs
Centre for Communication and Change-India

Examining the Impact of the Gutka Bans in Selected States in India

Karnataka – Abstract of Findings

Tobacco use patterns in Karnataka

According to the Global Adult Tobacco Survey (GATS) India report-2009-10, current smokeless tobacco users comprise 19 per cent of the total adult population of Karnataka. About 23 per cent of males and 16 per cent of females above 15 years of age, fall in the current user category.

Twenty eight per cent of adults (15 years and above) in Karnataka used tobacco. About 12 per cent of adults were smokers and 19 per cent used smokeless tobacco. Of the latter, 6 per cent were current users of gutka (GATS).

The total percentage of daily adult users of smokeless tobacco comprises 17 per cent of the total adult population. Almost 20 per cent of males and 14 per cent of females above 15 years of age, fall in the daily current user category.

The Karnataka state government imposed a ban on gutka, joining the group of 25 States and five Union Territories that had already banned it.[1] With this, Karnataka became the 26th State to ban gutka in May, 2013.

Methodology

In Karnataka surveys were conducted in the districts of Bengaluru and Mangaluru with current users[2], dual users[3] and former gutka users[4] and tobacco product retailers to determine the impact and effectiveness of Gutka ban. In addition, observation of 60 retail environments and in-depth interviews with government officials, enforcement officials and citizens working with civil society groups were conducted to find out different stakeholders' reaction to the ban.

[1] The Hindu - www.thehindu.com

[2] Current users were defined as those gutka consumers who have used gutka or something similar-to-gutka by mixing tobacco at least once in last one month, and have not used any other tobacco product in the last one month

[3] Dual users were defined as those gutka consumers who have used gutka or something similar-to-gutka by mixing tobacco at least once in the past month, and have also used any other tobacco product (smoked and/or smokeless) at least once in the past month

[4] Quitters were those gutka consumers who have used gutka in the past but have not used something similar-to-gutka even once in the past month, and have stopped using gutka since the ban of gutka

Study findings

Age at initiation:- Twenty to twenty three per cent had initiated gutka consumption when they were below 20 years of age (20% of current users, 22% dual users and 23% of quitters).

Status of gutka use: - All consumers of gutka had switched over to something similar – to- gutka because it was not available after the ban.

Comparison of usage before and after the ban: - A large percentage of dual users reduced the use of smokeless tobacco products and cigarettes respectively (64% and 62%).

Opinion on the state enforced ban: - There was almost universal (94%) support for the ban even by those who were currently consuming tobacco products in any form. When asked about the reasons for the ban, almost 51 per cent of the current users, 58 per cent of the dual users and 37 per cent of quitters reported that they were not aware of the reasons for the ban.

Extension of ban to other smokeless tobacco products: - Eighty five per cent of the respondents were in favor of the ban being extended to all other smokeless tobacco products.

Effect on health of children: - All the respondents reported that the ban on gutka was good for the health of children

Quitting behavior: - People feel that gutka ban will definitely help in quitting consumption of gutka or a similar product. However, only 45 per cent of the respondents have made serious efforts to quit gutka or similar product.

Information regarding prohibition of sale of tobacco products to minors: - Section 6 (a) of Tobacco Control Act, 2003 states that the sale of tobacco products to persons under the age of 18 is prohibited. Further, the shop should display a board declaring that "sale of tobacco products to minors is prohibited". Out of 60 outlets, only 4 outlets had such messages displayed.

Information regarding prohibition of sale of tobacco products to minors: - Section 6 (a) of Tobacco Control Act, 2003 states that the seller should not sell tobacco to a minor. In Karnataka, minors were observed purchasing gutka/tobacco products from 4 outlets.

Location of outlets in the proximity of educational institutions: - Section 6 (b) of Tobacco Control Act, 2003, states that the sale of the tobacco products is prohibited within a radius of 100 yards of any educational institution. Observation shows that out of 60 outlets, 13 were located within 100 yards of any school or college.

Display of gutka packets for sale: - None of the outlets observed was found displaying pre-packaged gutka packets.

Observation of vendors: - None of the vendors was found consuming gutka.

Manufacture's, supplier's and retailer's response: - The retailers were asked about the manufacturers' and distributors' response to the gutka ban. They were also asked whether retailers still stock it

- Nearly 66 per cent of the retailers said that gutka was not being manufactured
- About 58 per cent said that gutka was not available with the retailers.
- Nearly one-fourth (26%) of retailers mentioned that consumers have approached them to buy gutka.
- Only 8 per cent of the retailers were approached by suppliers to store gutka
- About 37 per cent of the retailers were approached to store something similar-to-gutka products.

Monitoring of gutka availability: - The retailers were asked several questions on their response to the ban

- Nearly 90 per cent of the retailers have started selling gutka ingredients separately post the ban.
- About 85 per cent of the retailers sell smokeless tobacco products and 92 per cent sell smoked tobacco products
- Ninety eight percent retailers were in the favor of the ban.

Recommendations

The study *Impact and Effectiveness of ban on Gutka* yielded significant insights. These are presented as recommendations here:

- Policy measures need to be adopted to curb the sale and purchase of all other smokeless tobacco products including products that can be bought separately and mixed to be consumed as gutka or a product similar to gutka (by whatever name it be called).
- Enforcement mechanisms need to be strengthened to ensure complete compliance of the ban.
- Provision for tobacco cessation services to be scaled up to cater to the unmet need for tobacco cessation.
- Smokeless tobacco products are freely available at a very low price near educational institutions leading to easy access of these products by youth. The boards declaring that "sale of tobacco products to minors is prohibited" were not displayed at all outlets as per the law. This calls for a stronger monitoring of tobacco control laws.

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Examining the Impact of the Gutka Bans in Selected States in India

A study was conducted by the Johns Hopkins University Bloomberg School of Public Health and the World Health Organization Country Office for India to understand the impact of state laws that ban the sale and distribution of gutka.

Surveys were conducted with 1,001 current and former gutka users and 458 tobacco product retailers to gain insight into the effect of the bans on consumer use and product availability in seven states (Assam, Bihar, Gujarat, Karnataka, Madhya Pradesh, Maharashtra, and Orissa) and the National Capital Territory. Observations of 450 retail environments and 54 in-depth interviews with government officials, enforcement officials and citizens working with civil society groups were also conducted to the same end.

Summary Findings:

- Support for gutka bans is very high (92%) across the studied jurisdictions
- Almost universal agreement (99%) that gutka bans are good for the health of India's youth
- Product bans did impact use. Of the respondents who continue to use pre-packaged gutka, half (49%) reported they consume less since the bans
- Ninety per cent of respondents agreed that the government should ban the manufacturing, sale and distribution of other forms of smokeless tobacco
- Post-bans, most gutka users report purchasing ingredients separately and combining/mixing their own gutka. However, 15 per cent of respondents continue to purchase pre-packaged gutka
- Interest in quitting is high-approximately half of respondents reported attempting to stop using gutka in the last year. Approximately 80 per cent of respondents agree that the gutka bans will help people to quit
- Of the respondents that quit since the bans, a substantial proportion in each state (from 41-88%) reported that they "quit using gutka because of the ban"
- The cost of pre-packaged gutka increased following the bans
- There was virtually no retail outlet where pre-packaged gutka was on display
- More than one-quarter of tobacco product retailers interviewed reported that they had been approached post-ban by a supplier to continue selling pre-packaged gutka

Limitations:

- Sample is not nationally representative
- Sample only includes adults
- Responses are self-reported and are not corroborated with any biological measures to confirm gutka or tobacco use

The study was supported by WHO Country Office for India and JHSPH-IGTC in collaboration with JHSPH-CCP and CCC-I

ಕರ್ನಾಟಕ ಸರ್ಕಾರ

The Union
International Union Against Tuberculosis and Lung Disease

ಎಚ್ಚರ..! ಎಚ್ಚರ..!

ತಂಬಾಕು ಸೇವನೆ ಆರೋಗ್ಯಕ್ಕೆ ಹಾನಿಕರ

SMOKING Kills

LIFE

ತಂಬಾಕು ಕೊಲ್ಲುತ್ತದೆ

SMOKING KILLS

ರಾಜ್ಯ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಘಟಕ:

ರಾಜ್ಯ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಘಟಕವು ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆಯ ಒಂದು ಅಂಗ ಸಂಸ್ಥೆಯಾಗಿದೆ. ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾರ್ಯಕ್ರಮದ ಸಮಗ್ರ ಯೋಜನೆ, ಅನುಷ್ಠಾನ ಮತ್ತು ಅವಲೋಕನ ಇದರ ಪ್ರಮುಖ ಜವಾಬ್ದಾರಿಯಾಗಿದೆ. ಇದು ರಾಷ್ಟ್ರೀಯ ತಂಬಾಕು ನಿಯಂತ್ರಣದ ಮಾರ್ಗದರ್ಶಿಯಂತೆ ರಾಜ್ಯದಲ್ಲಿ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾರ್ಯಕ್ರಮವನ್ನು ಅನುಷ್ಠಾನಗೊಳಿಸುತ್ತಿದೆ.

ತಂಬಾಕಿನ ಬಗೆಗಿನ ಸತ್ಯಾಂಶಗಳು :

ಜಾಗತಿಕ

- ವಿಶ್ವದಾದ್ಯಂತ ತಡೆಗಟ್ಟಬಹುದಾದ ಖಾಯಿಲೆ ಮತ್ತು ಮರಣಗಳಿಗೆ ಉದಾ : ಕ್ಯಾನ್ಸರ್, ಹೃದಯ ಸಂಬಂಧಿ ಕಾಯಿಲೆಗಳು, ಶ್ವಾಸಕೋಶದ ಖಾಯಿಲೆಗಳಿಗೆ ತಂಬಾಕು ಸೇವನೆಯೇ ಪ್ರಮುಖ ಕಾರಣವಾಗಿದೆ.
- ಪ್ರತಿ ವರ್ಷ ವಿಶ್ವದಾದ್ಯಂತ 60 ಲಕ್ಷಕ್ಕಿಂತ ಹೆಚ್ಚು ಜನರು ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಉಂಟಾಗುವ ಖಾಯಿಲೆಗಳಿಂದ ಸಾವನ್ನಪ್ಪುತ್ತಿದ್ದಾರೆ.
- ತಂಬಾಕು ಸೇವನೆ ಮಾಡುವವರು ತಂಬಾಕು ಸೇವನೆ ಮಾಡದವರಿಗಿಂತ 10 ವರ್ಷ ಹೆಚ್ಚು ವಯಸ್ಸಾದವರಂತೆ ಕಾಣುತ್ತಾರೆ.
- ಪ್ರತಿ 6 ಸೆಕೆಂಡಿಗಳಿಗೊಮ್ಮೆ ಒಬ್ಬ ವ್ಯಕ್ತಿ ತಂಬಾಕು ಸೇವನೆಯಿಂದ ಉಂಟಾಗುವ ಖಾಯಿಲೆಗಳಿಂದ ಸಾವನ್ನಪ್ಪುತ್ತಿದ್ದಾರೆ

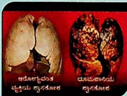
GATS- INDIA 2009-10 (ಗ್ಲೋಬಲ್ ಅಡಲ್ಟ್ ಟೊಬ್ಯಾಕೋ ಸರ್ವೆ ಇಂಡಿಯಾ):

- 14.6% ಯುವಕರು(13-15 ವರ್ಷದೊಳಗಿನ)ಯಾವುದಾದರೂ ಒಂದು ರೀತಿಯ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಸೇವನೆಯನ್ನು ಮಾಡುತ್ತಾರೆ. ಇದರಲ್ಲಿ 19% ಹುಡುಗರು ಮತ್ತು 8.3% ಹುಡುಗಿಯರಾಗಿರುತ್ತಾರೆ.
- ದೇಶದ 21.9% ಯುವಕ ಯುವತಿಯರು ತಮ್ಮ ಮನೆಯಲ್ಲಿಯೇ ಇತರರು ಧೂಮಪಾನ ಮಾಡುವುದರಿಂದ ಪರೋಕ್ಷವಾಗಿ ಇತರರು ಧೂಮಪಾನಕ್ಕೆ ಒಳಗಾಗುತ್ತಾರೆ.
- ಭಾರತದಲ್ಲಿ 26.4% ಪೋಷಕರು ಧೂಮಪಾನಿಗಳಾಗಿದ್ದಾರೆ.

ಕರ್ನಾಟಕದ ಅಂಕಿ ಅಂಶಗಳು

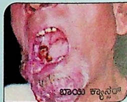
- ಕರ್ನಾಟಕದಲ್ಲಿ ಶೇ. 28 ರಷ್ಟು (15 ವರ್ಷಕ್ಕಿಂತ ಮೇಲ್ಪಟ್ಟ) ವ್ಯಕ್ತಿಗಳು ಯಾವುದಾದರು ಒಂದು ರೀತಿಯ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಸೇವನೆ ಮಾಡುತ್ತಾರೆ.
- 11.9% ಧೂಮಪಾನಿಗಳಿದ್ದು ಹಾಗೂ 19.4% ಜಗಿಯುವ ತಂಬಾಕುಗಳ ಸೇವನೆ ಮಾಡುತ್ತಾರೆ.
- ಸರಿಸುಮಾರು 18 ವಯಸ್ಸಿನಲ್ಲಿ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಸೇವನೆಯನ್ನು ಆರಂಭಿಸುವುದಾಗಿ ಅಂದಾಜಿಸಲಾಗಿದೆ.
- 42% ರಷ್ಟು ಜನ ಕೆಲಸದ ಸ್ಥಳದಲ್ಲಿ, 44.3% ರಷ್ಟು ಮನೆಯಲ್ಲಿ ಮತ್ತು 37.2% ರಷ್ಟು ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಇತರರು ಧೂಮಪಾನ ಮಾಡುವುದರಿಂದ ಪರೋಕ್ಷ ಧೂಮಪಾನಕ್ಕೆ ಒಳಗಾಗುತ್ತಿದ್ದಾರೆ.

ಧೂಮಪಾನ ಮಾಡುವುದರಿಂದ ಆರೋಗ್ಯದ ಮೇಲೆ ಆಗುವ ದುಷ್ಪರಿಣಾಮಗಳು :



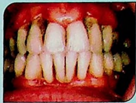
ತಂಬಾಕಿನಿಂದ ಕಾನ್ಸರ್, ಹೃದಯ, ಶ್ವಾಸ ಸಂಬಂಧಿ ಇತ್ಯಾದಿ ಮಾರಣಾಂತಿಕ ಖಾಯಿಲೆಗಳು ಬರುತ್ತದೆ.

- ತಂಬಾಕು ವಸ್ತುಗಳಲ್ಲಿ (ಸಿಗರೇಟ್, ಬೀಡಿ, ಸಿಗ್ಯಾರ್ ಇತ್ಯಾದಿ) 7000 ರಾಸಾಯನಿಕ ವಸ್ತುಗಳಿದ್ದು, ಅದರಲ್ಲಿ 69ರಷ್ಟು ಕ್ಯಾನ್ಸರ್‌ಕಾರಕ ವಸ್ತುಗಳಾಗಿವೆ. ಧೂಮರಹಿತ (ಜಗಿಯುವ ತಂಬಾಕುಗಳು) ತಂಬಾಕು ಉತ್ಪನ್ನಗಳಲ್ಲಿ 3095 ರಾಸಾಯನಿಕಗಳಿದ್ದು, ಅದರಲ್ಲಿ 28ರಷ್ಟು ಕ್ಯಾನ್ಸರ್‌ಕಾರಕ ವಸ್ತುಗಳಿವೆ.



ಗರ್ಭಪಾತ

ಗರ್ಭಧಾರಣೆಯಲ್ಲಿ ಕುಂಠಿತ



ತಂಬಾಕು ಸೇವನೆಯಿಂದ ದಂತ ಕ್ಷಯ ಉಂಟಾಗುತ್ತದೆ

ತಂಬಾಕು ನಿಯಂತ್ರಣ ಕಾನೂನು - ಕೋಟ್ಪಾ 2003

The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act – COTPA 2003

ಸೆಕ್ಷನ್ 4 : ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವುದು ನಿಷೇಧ.

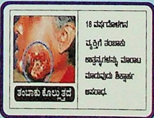
- ಸಾರ್ವಜನಿಕ ಸ್ಥಳದ ಮಾಲೀಕರು 60 x 45 ಸೇ.ಮೀ ಇರುವ ಈ ಚಿತ್ರದಲ್ಲಿ ತೋರಿಸಿರುವಂತೆ ನಾಮಫಲಕವನ್ನು ಪ್ರದರ್ಶನ ಮಾಡುವುದು.
- ಸಾರ್ವಜನಿಕ ಸ್ಥಳದಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡಲು ಅವಕಾಶ ನೀಡದೆ ಇರುವುದು.
- ಸಾರ್ವಜನಿಕ ಸ್ಥಳದಲ್ಲಿ ಧೂಮಪಾನ ಮಾಡುವುದು ಕಂಡು ಬಂದಲ್ಲಿ ಹತ್ತಿರದ ಪೋಲೀಸ್ ಠಾಣೆಗೆ ದೂರು ನೀಡುವುದು.
- ಬೆಂಕಿಪೊಟ್ಟಣ, ಆ್ಯಷ್‌ಟ್ರೇ, ಲೈಟರ್ ಮುಂತಾದ ಧೂಮಪಾನಕ್ಕೆ ಉತ್ತೇಜಿಸುವ ವಸ್ತುಗಳನ್ನು ತಂಬಾಕು ಮಾರಾಟ ಮಾಡುವ ಅಂಗಡಿಗಳಲ್ಲಿ ಮತ್ತು ಇತರೆ ಸಾರ್ವಜನಿಕ ಸ್ಥಳಗಳಲ್ಲಿ ಇಡದಿರುವುದು.

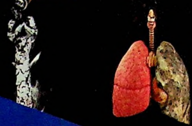
ಸೆಕ್ಷನ್ 5: ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ನೇರ ಹಾಗೂ ಪರೋಕ್ಷ ಜಾಹೀರಾತು, ಉತ್ತೇಜನ, ಪ್ರಾಯೋಜಕತೆ ನಿಷೇಧ.

ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ಮಾಡುವ ಅಂಗಡಿಗಳಲ್ಲಿ (Point of Sale) ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಶೋಕೇಸ್‌ಗಳ ಮೂಲಕ ಪ್ರದರ್ಶನ ಮಾಡುವಂತಿಲ್ಲ. ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತುಗಳನ್ನು ಬೋರ್ಡ್, ಚಿತ್ರಿ ಪತ್ರ, ಎಲ್.ಸಿ.ಡಿ. ಟಿ.ವಿ ಗಳ ಮೂಲಕ ಮಾಡುವಂತಿಲ್ಲ. ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಗೋಡೆ ಬರಹ, ಹೋರ್ಡಿಂಗ್ಸ್‌ಗಳ ಮೂಲಕ ಜಾಹೀರಾತುಗಳನ್ನು ಮಾಡುವಂತಿಲ್ಲ. ದೃಶ್ಯ ಹಾಗೂ ಮುದ್ರಣ ಮಾಧ್ಯಮದ ಮೂಲಕ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಜಾಹೀರಾತು ಮಾಡುವಂತಿಲ್ಲ.

ಸೆಕ್ಷನ್ 6: ತಂಬಾಕು ಉತ್ಪನ್ನಗಳು ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ (18 ವರ್ಷದೊಳಗಿನ ಮಕ್ಕಳು) ಸಿಗದಂತೆ ನಿಯಂತ್ರಣ ಮಾಡುವುದು.

ಸೆಕ್ಷನ್ 6a ಪ್ರಕಾರ, ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ಮಾಡುವುದು ಹಾಗೂ ಅಪ್ರಾಪ್ತ ವಯಸ್ಕರಿಂದ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟ ಮಾಡುವುದು ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ. ತಂಬಾಕು ಮಾರಾಟ ಮಾಡುವ ಅಂಗಡಿ ಮಾಲೀಕರು ಚಿತ್ರದಲ್ಲಿ ತೋರಿಸಿರುವಂತೆ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆ ನಾಮ ಫಲಕವನ್ನು ಕಡ್ಡಾಯವಾಗಿ ಅಂಗಡಿ ಮುಂದೆ ಪ್ರದರ್ಶನ ಮಾಡುವುದು.





ಸೆಕ್ಷನ್ 6b

ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಗಳ 100 ಗಜದ ಒಳಗೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳನ್ನು ಮಾರಾಟ ಮಾಡುವುದು ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ. ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಯ ಮುಖ್ಯಸ್ಥರು ತಮ್ಮ ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಯನ್ನು ಸಂಪೂರ್ಣವಾಗಿ ತಂಬಾಕು ಮುಕ್ತವನ್ನಾಗಿಸುವ ಜವಾಬ್ದಾರಿಯುನ್ನು ಹೊಂದಿರುತ್ತಾರೆ. ಶಿಕ್ಷಣ ಸಂಸ್ಥೆಯ ಮುಖ್ಯಸ್ಥರು ಚಿತ್ರದಲ್ಲಿ ತೋರಿಸುವ ನಾಮ ಫಲಕವನ್ನು ಕಡ್ಡಾಯವಾಗಿ ಸಂಸ್ಥೆಯ ಮುಂದೆ ಪ್ರದರ್ಶನ ಮಾಡುವುದು.

ಈ ವಿದ್ಯಾ ಸಂಸ್ಥೆಯ ಆವರಣದಿಂದ 100 ಯಾರ್ಡ್ (ಗಜ) ಅಂತರದಲ್ಲಿ ಸಿಗರೇಟು ಅಥವಾ ಇತರೆ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮಾರಾಟವನ್ನು ನಿಷೇಧಿಸಿದೆ. ಉಲ್ಲಂಘನೆಯು ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧವಾಗಿದ್ದು ರೂ.200ರ ವರೆಗೆ The Cigarettes & Other Tobacco Products Act (COTPA)-2003 ರ ಕಾಯ್ದೆ ಅಡಿಯಲ್ಲಿ ದಂಡ ವಿಧಿಸಲಾಗುವುದು.

Sale of Cigarettes & other Tobacco Products within [illegible] Yards of this Education Institution is Prohibited. It is a punishable offence with a fine which may extend to Rs. 200 under The Cigarettes & Other Tobacco Products Act (COTPA)-2003.

ಸೆಕ್ಷನ್ 7

ಸಿಗರೇಟ್ ಮತ್ತು ಇತರ ತಂಬಾಕು ಉತ್ಪನ್ನಗಳ ಮೇಲೆ ನಿರ್ದಿಷ್ಟ ಆರೋಗ್ಯ ಎಚ್ಚರಿಕೆಗಳ ಸಂದೇಶಗಳಿಲ್ಲದೆ ಮಾರಾಟ ಮಾಡುವುದು ಶಿಕ್ಷಾರ್ಹ ಅಪರಾಧ.

ತಂಬಾಕು ತ್ಯಜಿಸುವುದು ಹೇಗೆ ?

- ತಂಬಾಕಿನಲ್ಲಿರುವ ನಿಕೋಟಿನ್ ಎಂಬ ರಾಸಾಯನಿಕ ವಸ್ತು ವ್ಯಸನವಾಗಿಸುತ್ತದೆ ಎಂಬ ಕಟು ಸತ್ಯ ಅರ್ಥಮಾಡಿಕೊಳ್ಳುವುದು.
- ತಂಬಾಕು ತ್ಯಜಿಸುವ ದಿನಾಂಕ ನಿಗದಿ ಮಾಡಿಕೊಳ್ಳುವುದು ಮತ್ತು ಅದಕ್ಕೆ ಬದ್ಧರಾಗಿರುವುದು.
- ತಂಬಾಕು ಸೇವಿಸುವ ವ್ಯಕ್ತಿಗಳಿಂದ, ಪರಿಸರದಿಂದ ಸಾಧ್ಯವಾದಷ್ಟು ದೂರವಿರುವುದು.
- ತಂಬಾಕು ತಿನ್ನಬೇಕಿನಿಸಿದಾಗ, ಮನಸನ್ನು ನಿಗ್ರಹಿಸಲು ನಿಮಗೆ ಖುಷಿ ನೀಡುವ ಇತರೆ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ತೊಡಗಿಸಿಕೊಳ್ಳುವುದು.
- ಪೌಷ್ಟಿಕ ಆಹಾರ ಸೇವಿಸುವುದು.
- ಅಗತ್ಯವಿದ್ದಲ್ಲಿ ನುರಿತ ವೈದ್ಯರನ್ನು ಸಂಪರ್ಕಿಸಿ ಮಾಹಿತಿ/ಚಿಕಿತ್ಸೆ ಪಡೆಯುವುದು.

ತಂಬಾಕು ತ್ಯಜಿಸುವುದರಿಂದ ಆಗುವ ಪ್ರಯೋಜನ :

- ರಕ್ತದ ಒತ್ತಡ ಮತ್ತು ಹೃದಯ ಬಡಿತ ಸಾಮಾನ್ಯ ಹಂತಕ್ಕೆ ಬರುತ್ತದೆ.
- ದೇಹದಲ್ಲಿ ಕಾರ್ಬನ್ ಮೊನಾಕ್ಸೈಡ್ (ಟೊಕ್ಸಿನ್) ಪ್ರಮಾಣ ಕಡಿಮೆ ಆಗುತ್ತ್ದೆ.
- ಹೃದಯಾಘಾತ ಕಡಿಮೆಯಾಗುತ್ತದೆ.
- ಬಾಯಿ ಅಲ್ಸರ್ ಕಡಿಮೆಯಾಗುತ್ತದೆ.
- ಹಣದ ಉಳಿತಾಯ ಆಗುತ್ತದೆ.

COTPA : 2003 ಕಾಯ್ದೆಯ ನಿಯಮಗಳ ಉಲ್ಲಂಘನೆ ಬಗ್ಗೆ ದೂರು ಸಲ್ಲಿಸಲು ಉಚಿತ ಸಹಾಯವಾಣಿ ಸಂಖ್ಯೆ 1800110456

ಪ್ರಕಟಣೆ : ಬ್ಲೂಮ್ ಬರ್ಗ್ ಇನಿಷಿಯೇಟಿವ್ ಯೋಜನೆ, ರಾಜ್ಯ ತಂಬಾಕು ನಿಯಂತ್ರಣ ಘಟಕ, ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ, ಬೆಂಗಳೂರು.
www.stoptobacco.in / www.satc.karnataka.in