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RESEARCH ARTICLE

Tobacco Control Law Enforcement and Compliance in Odisha, India - Implications for Tobacco Control Policy and Practice

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Abstract

Introduction: Tobacco use is a leading cause of deaths and disabilities in India, killing about 1.2 lakh people in 2010. About 29% of adults use tobacco on a daily basis and an additional 5% use it occasionally. In Odisha, non-smoking forms are more prevalent than smoking forms. The habit has very high opportunity cost as it reduces the capacity to seek better nutrition, medical care and education. In line with the WHO Framework Convention on Tobacco Control (FCTC), the Cigarettes and Other Tobacco Products Act (COTPA) is a powerful Indian national law on tobacco control. The Government of Odisha has shown its commitment towards enforcement and compliance of COTPA provisions. In order to gauge the perceptions and practices related to tobacco control efforts and level of enforcement of COTPA in the State, this cross-sectional study was carried out in seven selected districts. **Materials and methods:** A semi-structured interview schedule was developed, translated into Odiya and field-tested for data collection. It mainly contained questions related to knowledge on provisions of section 4-7 of COTPA 2003, perception about smoking, chewing tobacco and practices with respect to compliance of selected provisions of the Act. 1414 samples were interviewed. **Results:** The highest percentage of respondents was from the government departments. 70% of the illiterates consumed tobacco as compared to 34% post graduates. 52.1% of the respondents were aware of Indian tobacco control laws, while 80.8% had knowledge about the provision of the law prohibiting smoking in public places. However, 36.6% of the respondents reported that they had 'very often' seen tobacco products being sold 'to a minor', while 31.2% had seen tobacco products being sold 'by a minor'. In addition, 24.8% had 'very often' seen tobacco products being sold within a radius of 100 yards of educational institutions.

Keywords: Tobacco control policy - tobacco control law - compliance - enforcement - Odisha - India

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Introduction

Use of tobacco has been proven to be one of the leading causes of preventable premature deaths and diseases across the globe (WHO, 2008). Worldwide, it kills more than 5.4 million people, every year, out of which more than 1.3 million deaths occur in the South East Asia Region (Singh et al., 2011). WHO predicted that nearly one million Indians will die from smoking alone in 2010 and 70% of these deaths will be premature (Chaturvedi, 2007). It is estimated that if current trends of tobacco use persist, by 2030, it would take more than 8 million lives, every year - 80% of these are expected to occur in low and middle-income countries. A recent study reveals, in India, the burden of tobacco related cancer was alarmingly high, contributing to almost 120,000 deaths in 2010 - over 40% of male, and nearly 20% of female cancers (Centre for Global Health Research, 2012). By 2020 it is predicted that tobacco will account for 13% of all deaths in the country. With respect to smoking, India contributes to approximately 10% of total smokers in the

world - the second largest group, first being China (Singh et al., 2011).

The Global Adult Tobacco Survey (GATS) India Report 2009-10 estimates 34.6% of India's adult population (aged 15 years and above) use tobacco in some form or other. About 29% of adults use tobacco on a daily basis and an additional 5% use it occasionally. The prevalence of tobacco use among males is 48% as compared to 20% among females. About two in five adults from rural areas and one in four from urban areas use tobacco (GATS, 2010). The prevalence of tobacco use in Odisha is higher than the national average and most Indian states, with 46.2% of the population using tobacco in some form or the other. Smokeless forms of tobacco like pan, zarda and gutkha are more commonly used than smoking forms like beedi and cigarettes. Three percent population uses smoking forms of tobacco, while 36%, smokeless forms (GATS, 2010).

The economic costs of tobacco use are devastating. Direct medical costs of treating tobacco related diseases in India in year 2004 amounted to \$907 million for smoked

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tobacco and \$285 million for smokeless. The indirect morbidity costs, including the cost of caregivers and value of work loss due to illness, amounted to \$398 million and \$104 million for smoked and smokeless tobacco, respectively (Jandoo and Mehrotra, 2008). At individual level, spending on tobacco consumption can have a very high opportunity cost as it could reduce the capacity to seek better nutrition, medical care and education. Studies suggest that families with low socio-economic status incur additional expenditure because of consumption of tobacco and related products (John et al., 2004). The average monthly expenditure incurred by a cigarette and a beedi smoker in Odisha is INR 203.30 (\$4.06) and INR 59.40 (\$1.18), respectively (GATS, 2010).

The WHO Framework Convention on Tobacco Control (FCTC) was a response to the global tobacco epidemic. It is an all-powerful global instrument that contains binding provisions on member countries. The FCTC provided a comprehensive direction for tobacco control at all levels and has become one of the most widely ratified treaties, covering more than 87.8% of the world's population with 175 countries as signatories. It focuses on both demand reduction strategies and supply side issues, including regulation of trade and commerce (WHO FCTC, 2003).

To counter the pandemic of tobacco, even before and parallel to the FCTC, the government of India notified a comprehensive tobacco control legislation titled "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act in 2003. Though the national law came into force on May 1, 2004 and the Treaty obligations became effective from February 27, 2005. COTPA like FCTC gives priority to protection of public health and requires effective steps for its implementation to meet different objectives (GOI, 2003).

COTPA banned smoking at public places (Section 4: came into effect in May 2004, revised rules in October 2008), sponsorship of any sport/cultural events by cigarette and other tobacco product companies (Section 5: implemented in May 2004), sale of tobacco products to and by minors (Section 6: implemented in December 2004), sale of tobacco products within 100 yards of educational institutions (Section 6b: implemented in December 2004), and provision of specified and mandatory pictorial warnings, including in imported products (Section 7: implemented on 31 May 2009). Pictorial warnings on all tobacco products were made mandatory following the Supreme Court directives (GOI, 2003).

The State government of Odisha in 2005 notified officers of the concerned departments, such as, Health, Home, Food and Drugs, etc for enforcement of COTPA. A state level monitoring committee and a task force were formed under the chairmanship of the Commissioner-cum-Secretary, Department of Health and Family Welfare (DOH and FW) for implementation of tobacco control programmes. On November 10, 2009, the DOH&FW in collaboration with civil society organizations officially declared its commitment to implementing COTPA in the state. It is one of the 21 states included in the National Tobacco Control Programme (NTCP) for piloting. As per the 11th Five year plan the total financial outlay of NTCP

is INR 1.82 billion. Setting up of a national regulatory authority (NRA), implementation of state tobacco control programme and district tobacco control programme, launching of anti-tobacco public awareness campaigns and establishment of tobacco testing laboratories are the main components of this programme.

Taking into account India's comprehensive tobacco control law and its active role in FCTC negotiations, immediate follow-up action are crucial from key stakeholders for its enforcement. Therefore, concerned ministries and departments responsible for meeting the FCTC objectives and enforcing COTPA at all levels should in coordination on priority basis. This highlights an urgent need for continuous capacity building capsular training of stakeholders, strong government-nongovernment partnership, simple reporting mechanisms and early response systems to deal with violations.

Recognizing the urgent need to curb the tobacco epidemic and to strengthen enforcement of COTPA, as a part of Bloomberg Initiatives to Reduce Tobacco Use (BI) grant to Health Related Information Dissemination Among Youth (HRIDAY), in which Public Health Foundation of India (PHFI) and its constituent Indian Institute of Public Health Bhubaneswar (IIPHB) were partners, state and district level sensitization workshops were planned on enforcement of and compliance with COTPA provisions. The activities planned under this project, entitled "Awareness to Action through Multi-Channel Advocacy for Effective Tobacco Control in India: Capacity Building in Five Indian States", aimed to strengthen and augment the ongoing tobacco control advocacy in states of Odisha, Bihar, Haryana, Karnataka and Uttarakhand. The project activities included active advocacy and capacity building of state and district level law enforcers, encouragement with civil society organizations to complement governmental efforts on tobacco control, while monitoring progress and reporting violations. The project also focused on bolstering government-NGO partnership at all levels in order to complement and upscale implementation of the NTCP of the Ministry of Health and Family Welfare, government of India.

In order to gauge the perceptions and practices of stakeholders from different walks of life on tobacco control efforts and enforcement of the tobacco control law at the district level, this cross-sectional study was carried out in the selected seven districts of the state. Stakeholders included in the study were ranging from diverse socio-economic background. Homemakers to salaried professionals, uneducated and highly educated professionals were interviewed. Refer to Table 1 for list of respondents.

Materials and Methods

Study Setting

There are 30 districts in the State with district-wise urban population ranging from 4.3%-42.9%. Seven districts (Angul, Bhadrak, Kalahandi, Nayagarh, Gajapati, Puri and Rayagada) were chosen for the study. Prior to the selection of the districts, a comprehensive needs assessment exercise was conducted in the state to collect

data on key indicators reflective of the tobacco control scenario. A tool was developed to understand the context-specific needs of tobacco control in the state. The needs assessment broadly covered questions on the state level tobacco control policy, economy, and demography. It focused in particular on specific issues of tobacco control, including burden of tobacco, prevalence of its use, production and control, targeted health services, communication media, public education, health budget and infrastructure, and control priorities of the state. The district selection was based on a two-day consultation in which state level officials of DoH&FW and NGOs were actively involved. A total of 1400 interviews (200X7=1400) in the state were planned to be conducted with a pre-determined category of respondents. The participants were briefed about the project and were given an information sheet before conducting the interview. They were free not to respond to a particular question or to leave the interview at any stage. The study was conducted during May-Dec, 2011. Collected data was entered into a data entry interface prepared in MS-Access and subsequently transported to SPSS 16.0.

Data Collection Tools

A semi-structured interview schedule was developed jointly by HRIDAY and IIPHB, translated into Odiya and field-tested for data collection. It mainly contained questions related to knowledge on provisions of section 4-7 of COTPA 2003, perception about smoking, chewing tobacco and practices with respect to compliance of

selected provisions of the Act. In order to ensure quality and uniformity in data collection, six field investigators were hired, trained on the questionnaires. The supervisory team from IIPHB monitored the data collection process.

Results

Profile of the respondents

As reflected in Table 2, Data was collected from 1414 respondents in total; of which 998 (70.57%) respondents were males and 402 (28.42%) were females. The mean age of the respondents was 35.12±11.64. People with no formal education, college students, college staff, children, school children, professionals, homemakers, health personnel, NGO personnel, municipality officials, police department and education department officials participated in the study. The highest percentage of respondents was from the government departments.

Tobacco Use Pattern

On tobacco consumption behavior, majority 60.6% of '>50 years' age group were consuming it, followed by 55.1% of '41-50 years' and 47.2% of '31-40 years' age groups. In terms of tobacco habits within educational groups, 70% of the illiterates consumed it as compared to 34% post graduates.

Knowledge about COTPA

Findings revealed that 52.1% of the respondents were aware of Indian tobacco control laws, while 80.8% of

Table 1. Clinical and Pathologic Characteristics of the 356 CRC Cases in this Study

S.No	Category	Age Group	Officials
1	People with no Formal Education	16 years and above	
2	Home Makers	Adults	
3	College Students	16-24 years	
4	College Staff	Adults	Head of the Institution/HR-Manager/Head of Administration/ College Principal/Teacher
5	Children from Schools	13-16 years	
6	School Staff	Adults	School Headmaster/ Principal/Teacher
7	Professionals	Adults	
8	Health Professionals /ASHAs/Health Workers	Adults	ASHAs/Chief Medical Officer / Medical Officer at PHC
9	NGO personnel	Adults	
10	Village Panchayat and Zilla Parishad	Adults	Sarpanch / Panchayat Secretary
11	Municipality	Adults	Inspectors of Health
12	Department of Health	Adults	District Health Society Program/ Finance Manager
13	Police Department	Adults	Police Officials not below Sub - Inspector
14	Education department	Adults	District Educational Officer/ Inspector of School
15	State Transport Department/Public Conveyances	Adults	Traffic Superintendents/Bus Station Officer/ Ticket Collector
16	Excise Department	Adults	Inspectors of Central Excise/Income-tax Customs/Sales Tax
17	Forest and environment	Adults	District Forest officer
18	Other government departments	Adults	See List of Other Department*
19	Shopkeepers	Adults	
20	Media Persons	Adults	Print, Electronic, T.V, Radio, etc
21	Public Place Managers	Adults	Hotels, Restaurants, Amusement Parks, Cinema Halls etc.

Table 2. Profile of Respondents by Socio-economic Status

Educational Status	N	%	Occupation	N	%	Monthly Income	N	%
Illiterate	61	4.3	Student	193	13.6	>2500	237	16.8
No formal education	114	8.1	Government service	350	24.8	2500-10000	657	46.5
Class 1-8	255	18	Panchayat	34	2.4	10001-25000	327	23.1
Class 9-12	338	23.9	Municipality	78	5.5	25001-50000	127	9
Graduate	329	23.3	NGO personnel	70	5	50001-100000	35	2.5
Post graduate	248	17.5	Professionals and private service	260	18.4	100001-200000	19	1.3
PhD degree and above	48	3.4	Others	403	28.8	<200000	0	0

Table 3. Knowledge about COTPA, 2003

Sl No	Rayagara	Puri	Bhadrak	Kalahandi	Nayagarh	Angul	Gajapati
1. Are you aware about the indian Tobacco control law?							
	N=200	N=197	N=203	N=201	N=202	N=201	N=201
Yes	68.70%	85.70%	56.90%	6.50%	73.80%	29.70%	42.80%
No	25.00%	8.40%	20.60%	66.70%	25.20%	19.30%	56.70%
Don't Know	6.50%	3.00%	22.10%	26.90%	1.00%	50.50%	0.50%
2. In your district is there any village/panchayat/tehsils/town/city/ward/institution which is smoke free.							
	N=198	N=193	N=202	N=200	N=202	N=202	N=200
Yes	1.00%	7.40%	1.50%	0.50%	2.50%	7.40%	0.50%
No	70.60%	45.30%	33.80%	69.70%	85.60%	23.30%	99.00%
Don't know	27.40%	42.40%	63.70%	29.40%	11.90%	69.30%	0.00%
3. Are you aware of any fine being imposed on people smoking in public places?							
	N=198	N=192	N=201	N=199	N=202	N=298	N=200
Yes	1.00%	17.20%	2.50%	5.60%	11.40%	8.90%	0.50%
No	77.60%	37.90%	20.60%	24.40%	79.20%	23.30%	96.50%
Don't know	20.40%	39.40%	75.50%	69.70%	9.40%	65.80%	2.50%

the respondents had knowledge about the provision of the law prohibiting smoking in public places (Table 3). However, the knowledge about ‘penalty’ on smoking in public places was very limited as only 6.7% respondents reported so. 24.9% of the survey respondents were aware about tobacco control projects/programmes being implemented in their state/district. However there was limited or no knowledge about villages/panchayats/tehsils/towns/cities/wards/institutions being “smoke-free” and only 3% reported the existence of such area in reality.

Compliance with COTPA Provisions

As shown in Table 4, 35% of the respondents reported very often seeing ashtrays, matches, lighters or things that facilitate smoking in public places. Regarding mandatory signboards required at the point of sale, 66.6% of the respondents reported to have never seen such boards. 36.6% of the respondents reported that they had ‘very often’ seen tobacco products being sold ‘to a minor’, while 31.2% had seen tobacco products being sold ‘by a minor’ 24.8% had ‘very often’ seen tobacco products being sold within a radius of 100 yards of educational institutions. Around 77.7% of the respondents had never seen a sign saying “Sale of cigarettes and other tobacco products within the radius of 100 yards of this educational institution is a punishable offence with a fine up to Rs. 200”. With respect to Section 7 of COTPA, 2003, it was found that 36.2% of the respondents had ‘never seen’ tobacco products being sold with ‘pictorial health warnings’. Further, 84.3% respondents reported seeing the mandatory health warnings in English, while 58.3% reported seeing these health warnings in Hindi and 37.1% had seen such warnings in their local language.

Opinion about Awareness and Enforcement of COTPA 11.6% respondents were of the opinion that the current level of awareness and enforcement of ban on smoking in public places could motivate people to quit tobacco use (Table 5). Similarly, 9.5% respondents felt that the current level of awareness and enforcement of prohibition on advertisement of tobacco products in the district could create such motivation. Further, 14.2% of the respondents

Table 4. Level of Compliance of COTPA, 2003

Sl No	Rayagara	Puri	Bhadrak	Kalahandi	Nayagarh	Angul	Gajapati
1. How often do you see ashtrays, matches, lighters or the things facilitating smoking in public places?							
	N=198	N=192	N=201	N=199	N=202	N=198	N=200
Never	85.10%	16.30%	3.40%	1.50%	38.10%	14.40%	21.40%
Rarely	7.00%	3.90%	14.70%	0.50%	13.90%	55.00%	1.00%
Sometimes	4.50%	21.20%	39.20%	10.90%	38.60%	25.20%	27.90%
Very often	2.50%	53.20%	41.20%	86.10%	9.40%	3.50%	49.30%
2. How often do you see tobacco products being sold to a minor?							
	N=199	N=194	N=201	N=199	N=201	N=198	N=200
Never	0.50%	3.90%	5.40%	23.40%	4.50%	0.50%	20.70%
Rarely	1.50%	37.40%	1.00%	34.80%	9.40%	5.00%	1.50%
Sometimes	31.80%	36.50%	2.90%	39.80%	60.90%	88.60%	23.90%
Very often	65.50%	17.70%	89.20%	1.00%	24.80%	4.00%	53.20%
3. How often do you see tobacco products being sold by a minor?							
	N=199	N=195	N=201	N=199	N=201	N=198	N=200
Never	2.00%	3.00%	4.40%	23.90%	3.50%	4.50%	27.40%
Rarely	3.00%	41.40%	1.50%	32.30%	15.30%	32.20%	1.00%
Sometimes	62.20%	35.00%	5.40%	41.80%	52.50%	56.40%	23.90%
Very often	32.30%	16.70%	87.30%	1.00%	28.20%	5.00%	47.30%
4. How often do you see warning boards banning sale of tobacco products to minors, placed at the point of sale in shops, kiosks etc?							
	N=199	N=191	N=201	N=199	N=201	N=198	N=200
Never	97.50%	30.00%	46.60%	88.10%	36.10%	71.80%	97.00%
Rarely	0.50%	38.40%	10.80%	9.50%	21.30%	24.30%	0.50%
Sometimes	1.50%	16.30%	27.00%	1.50%	35.10%	2.00%	1.50%
Very often	0.00%	9.40%	14.20%	0.00%	6.90%	0.00%	0.50%
5. How often do you see tobacco products being sold within the radius of 100 yards of any educational institution?							
	N=199	N=190	N=201	N=199	N=201	N=198	N=200
Never	7.00%	23.20%	26.50%	92.50%	40.60%	41.10%	19.50%
Rarely	3.50%	37.90%	5.40%	6.50%	13.40%	50.50%	0.00%
Sometimes	68.50%	16.30%	16.20%	0.00%	30.20%	5.90%	10.00%
Very often	20.40%	16.30%	50.50%	0.00%	15.30%	0.50%	70.10%
6. How often do you see display boards displayed outside educational institutions?							
	N=199	N=189	N=201	N=200	N=199	N=198	N=200
Never	97.00%	36.50%	71.60%	96.00%	72.80%	71.10%	99.00%
Rarely	0.50%	34.50%	9.30%	3.50%	12.90%	25.70%	0.00%
Sometimes	2.00%	10.80%	9.30%	0.00%	11.40%	0.50%	0.00%
Very often	0.00%	11.30%	8.30%	0.00%	1.50%	0.00%	0.50%
7. How often do you see tobacco products being sold with pictorial health warnings?							
	N=199	N=191	N=200	N=202	N=200	N=197	N=198
Never	6.50%	26.10%	56.90%	94.00%	9.90%	58.90%	1.00%
Rarely	6.50%	40.90%	15.20%	5.00%	15.80%	34.70%	0.00%
Sometimes	37.30%	19.20%	16.70%	0.00%	34.20%	4.00%	0.50%
Very often	49.30%	7.90%	9.30%	0.00%	39.10%	0.00%	97.00%

felt that the current level of awareness and enforcement of pictorial health warnings on tobacco products in their districts could motivate people to quit tobacco use.

Discussion

Intensification of ongoing tobacco control efforts in India, with special focus on the effective implementation

Table 5. Opinion about Awareness and Enforcement of COTPA, 2003

Sl No	Rayagara N=200	Puri N=202	Bhadrak N= 204	Kalahandi N=200	Nayagarh N=201	Angul N=201	Gajapati N=200
1 The current level of enforcement of pictorial health warnings on tobacco products in your district can motivate people to quit tobacco use?							
Yes	8.00%	50.00%	14.70%	0.50%	18.90%	3.50%	4.00%
No	87.50%	30.70%	26%	68.50%	78.10%	79.60%	94.00%
Don't Know	4.00%	14.4. %	57.80%	30.50%	2.00%	12.40%	1.00%
2 The current level of enforcement of ban on smoking in public places in your district can motivate people to quit tobacco use?							
Yes	3.00%	40.10%	9.80%	1.50%	18.90%	1.50%	4.00%
No	87.50%	39.10%	39.20%	71.00%	79.10%	83.10%	94.00%
Don't know	9.00%	15.80%	49.50%	27.00%	1.50%	10.90%	1.00%
3 The current level of enforcement of prohibition on advertisement of tobacco products in your district can motivate people to quit tobacco use?							
Yes	3.50%	39.10%	5.90%	2.50%	12.40%	0.50%	2.50%
No	91.50%	38.60%	25.50%	53.00%	83.60%	85.60%	95.00%
Don't know	4.50%	16.80%	67.20%	44.00%	3.50%	9.50%	1.50%

of, and compliance with, Section 4-7 of COTPA through development and demonstration of effective and sustainable state- district- and local-level enforcement mechanisms is the immediate need, as has been reflected out of the results of the this study. Building tobacco control capacity of Civil Society Organizations (CSO), policy makers, government officials, Panchayati Raj Institution (PRI) members, Accredited Social Health Activists (ASHA) under the National Rural Health Mission (NRHM), Non-Government Organizations (NGO) and key stakeholders involved in tobacco control activities would be critical for better implementation of law at the grassroots. This would not only strengthen compliance with COTPA provisions at village, panchayat and block level but also encourage violation reporting.

Low level of compliance with the Section 4 of COTPA remains a major challenge in the state; absence of a coordinated reporting and monitoring mechanism leaves the notified officers unaccountable for, on the issue of non-compliance with law. As recommended by the WHO and the Guidelines to Article 8 of FCTC, 100% smoke-free environment is imperative to address the problem of second hand smoking.

In Tamil Nadu, the concept of smoke free educational institute proved to be a major success in implementing Section 6 of COTPA Act. Studies point declaration of all education / institutional areas as 'smoke free' is critical in reducing the tobacco selling outlets and, in turn, its consumption (Selvavinayagam, 2010). Another study found that there was a major decline in percentage of smokers in the bus before and after implementation of the COTPA 2003, due to strict regulation by Bangalore Metropolitan Transport Corporation (BMTC). Such type of models could be an effective measure in other cities also to ensure the successful implementation of COTPA 2003 (Nayak et al., 2010). These recent success stories of smoke-free jurisdictions in India encourage states and cities / towns to act fast towards 'smoke-free' goals. Sensitization and capacity building of all notified enforcement officers and other key stakeholders is a pre-

requisite for realization of this goal.

COTPA provides for a complete prohibition on direct advertisement, promotion and sponsorships of tobacco products. However, in India surrogate advertisements on print and electronic media, both indoors and out-doors are in abundance. One study in Murad Nagar on samples of different tobacco brands found that out of 37 brands under study, fifteen tobacco brands (40%) had pictorial health Warnings (PHW) smaller than stipulated principal display area; 6 brands of beedis had PHWs on deceptive backgrounds, 3 of which were placed on a curved axis. Misleading descriptors and promotional messages were also present (Aruna et al., 2010). Constitution of national, state and district level Steering Committees to take cognizance of such violations and to effectively enforce Section 5 is a commendable initiative of the government. However, actual constitution of such Committees in all districts and making them functional is still in infancy phase that requires strong political will and administrative acumen to take a definite shape.

In order to restrict youth access to tobacco products, Section 6 of the COTPA prohibits sale of tobacco products to and by any person below the age of 18 years while clause (b) of the same Section prohibits sale of tobacco products within the radius of 100 yards of any educational institution. However, there are no set guidelines for tobacco sellers to establish the age of their young customers and it seems difficult to displace tobacco vendors from the immediate vicinity of educational institutions. While many states have issued effective directives to the concerned officials to enforce Section 6b of the law, a comprehensive mechanism with a time-bound roadmap need to be developed by the enforcement agencies to expedite its implementation.

Adolescents in the age group of 14-19 years are the most susceptible to initiate use of tobacco use in both rural and urban areas. An effective school level tobacco control policy would play a vital role in deterring tobacco experimentation among adolescents. Schools with tobacco control policies have reduced tobacco use as compared to those without such policy, both in rural and urban areas. Societal influences, such as, parents' and closest friend's tobacco use, lack of knowledge on harmful effects of tobacco, positive attitude towards tobacco use by family members and viewing of tobacco advertisements are strongly associated with tobacco use. To counter development of such pro-tobacco attitude, teaching and training to students should be mandated in all schools. School teachers and counselors ought to be oriented on the facts related to tobacco production, distribution channels and consumption patterns amongst adolescents so that they could play a deterrent role for those initiating this and could help the users give up this habit (Pednekar and Gupta, 2004; Sinha and Gupta, 2004).

As per Section 7 of the COTPA, Since 31 May 2009, all tobacco products in India are required by law to display pictorial health warnings. However, changing political context and industry interference has pressurized the government to delay introduction of strong and tested pictorial health warnings. Over the recent years, advocacy and support around this issue has gained momentum, but

far from being satisfactory. There is still a dearth of district and state level initiatives on pictorial health warnings. Policy makers and media at the local levels need to be informed and sensitized on this. Vigorous advocacy by CSOs and NGOs will be critical in fulfilling this agenda.

While the positive trade-off of restricting tobacco use without any immediate danger to the existing economic interests of the country is well known by now, the conflict between pro-tobacco actors and public health advocates continue to be major bottleneck in implementation of COTPA. This paradoxical proposition continues to control the contour of anti-tobacco measures in the State. A remarkable increase in the tax base of tobacco and covering all types of tobacco products, irrespective of the turnover, is essential to stop product substitution. Moreover, there should not be significant differences between the tax policies for various types of tobacco products. Raising taxes on all tobacco products to act as a disincentive for purchase, especially for youth on the threshold of tobacco experimentation, generation of additional tax revenue for tobacco control, curbs on smuggling and programmes to aid tobacco farmers for alternative livelihood are the interventions that would provide the backbone for tobacco control in the country. The district team in charge of enforcement of COTPA in the grass root level must play a positive and receptive role for violation reporting. Similarly, active advocacy at the village, block and district level is a pre-requisite for improving the compliance with COTPA.

One cross-sectional survey among 300 adults revealed that low public support, lack of information and awareness, low political commitment, cultural acceptability of tobacco and less priority for tobacco control are the main barriers to successful implementation of COTPA (Sharma et al, 2010).

In conclusion, overcome policy enforcement weaknesses: The weak enforcement of provisions of COTPA demand an urgent action by the state government for informing the bureaucrats, policy makers and opinion leaders about the provisions of COTPA and ensuring its effective implementation. A comprehensive mechanism for monitoring and evaluation of the compliance with COTPA and FCTC needs to be developed and put in place. The law enforcement agencies of the State ought to take this up on priority.

The government may consider establishing a Steering Committee Task Force at the state level and corresponding structure in the district and block level to monitor the progress with respect to tobacco cessation. Given the fact the average age of initiation of tobacco is about 17 years; the long-term benefits to the society could be imminent after mainstreaming tobacco into medical and dental curriculum.

In order to implement the NTCP, the option of establishing and training a motivated workforce as frontline workers may be considered, especially since tobacco chewing is found to be rampant than smoking and it would need a great deal of interpersonal counseling for quitting efforts to be successful. Tobacco Cessation Centres (TCC) will play a crucial role in this direction.

Improve coordination: In order to effectively

implement the law in India, active engagement and cooperation of the state and district level administrative is imperative. Though the Union Ministry of Health is the nodal agency for implementation of COTPA, it alone cannot handle all issues related to effective enforcement of the Act. It is essential that all related Ministries, central and state governments, district administration and CSOs play their role in facilitating implementation and monitoring of its enforcement and compliance. Underlying causes of illiteracy, poverty and addiction: This is being cited as an excuse for labourers resorting to work in tobacco production companies. The government of India has realized this. Alternative livelihood for tobacco cultivators has to be explored and offered to them.

Medical graduates, Dentists and Nurses have a critical role to play role in success of COTPA. Since doctors and nurses interface with the community and dentists have expertise in dental as well as oral care, so they can contribute to smoking withdrawal program. Oral health professional should include counseling practices in their routine practices (Chaly, 2007). In a study conducted in 600 people in Karnataka it was observed that awareness and impact of pictorial warning on tobacco consumption are poor among the population and hence more effective pictorial warning should be introduced to have a successful implementation of COTPA act 2003 (Karinagannanavar et al., 2011).

Mass media activities, advocacy through the existing structures, such as, Rogi Kalyan Samitis (RKS), Gaon Kalyan Samitis (GKS) and aligning the role of ASHA in identifying and referring tobacco abuse cases to TCCs, and incentivizing early detection of tobacco initiators for speedy quitting, offer as much opportunities as challenges to the NRHM. Civil societies will have to play a larger role in tobacco control campaign. It needs, in fact, to become an integral part human resource strategy in every non-governmental organization.

Both HRIDAY and IIPHB are contemplating targeted interventions on tobacco control in the State of Odisha that would involve extensive work down below to block and village level for creation of mass awareness, effective advocacy at Gram Panchayat level and strengthening implementation of COTPA 2003 across the seven districts. Percolation of tobacco control measures down to grassroots and strengthening Government-NGO partnership, policy-maker advocacy and media mobilization will be the prime aim of all future initiatives. IIPHB conducted a series of advocacy and capacity building workshops during July 2011 - Feb 2012 and conducted a post-intervention survey - data are being analyzed and the results are awaited. Further study should be undertaken to find out general perceptions and practices of tobacco users regarding tobacco-related hazards, more so because a large proportion of population consumes tobacco, being poorly informed about its traumatic effects. The general understanding about health threats associated with chewing and smoking is sparse and, like other developing countries, our youth is least hesitant in picking up the habit. Thus the State government may consider taking steps for complete ban of gutkha and ban of smoking in public places with utmost urgency &

widespread advocacy.

The results should be cautiously interpreted given the limitations of this study. Since the questionnaire was administered in the district headquarters of all seven districts, it doesn't represent the rural population. The short duration of data collection may have restricted the possibility of getting the views of other potential respondents at data collection sites.

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