POLICY CONTEXT AND SOCIAL CORRELATES OF TOBACCO USE: A CASE STUDY OF DISTRICT JALANDHAR, PUNJAB

Thesis submitted to Jawaharlal Nehru University in fulfillment of the requirements for the award of the degree of

DOCTOR OF PHILOSOPHY

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DECLARATION

I hereby declare that this thesis entitled **"Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab"**, submitted to Jawaharlal Nehru University for the award of Degree of Doctor of Philosophy, is my original work. This thesis has not been previously submitted for the award of any other degree of this or any other university.

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Shaveta Menon

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

ACF	Advocacy Coalition Framework
AFTC	Advocacy Forum for Tobacco Control
AIIMS	All India Institute of Medical Sciences
BAT	British American Tobacco
BCC	Behaviour Change Communication
BED	Basic Excise Duty
BPL	Below Poverty Line
CHC	Community Health Centre
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
COTPA	Cigarettes and other Tobacco Products Act
CVD	Cardiovascular Disease
DALY	Disability Adjusted Life Years
DEO	District Education Officer
DLCC	District Level Coordination Committee
DSP	Deputy Superintendent of Police
DTCC	District Tobacco Control Cell
ETS	Environmental Tobacco Smoke
EVD	Electronic Vaping Devices
FCTC	Framework Convention on Tobacco Control
FCV	Flue Cured Virginia
FDI	Foreign Direct Investment
FGD	Focus Group Discussion
FSA	Food Safety Act
FSO	Food Safety Officer
FSSAI	Food Safety and Standards Authority of India
FSSR	Food Safety and Standards Regulation

GATS	Global Adult Tobacco Survey
GATT	General Agreement on Tariffs and Trade
GHW	Graphic Health Warnings
GPI	Godfrey Philips India
GST	Goods and Service Tax
GTC	Golden Tobacco Company
GYTS	Global Youth Tobacco Survey
HOT	Health or Tobacco
ICMR	Indian Council of Medical Research
ICTC	Indian Central Tobacco Committee
IEC	Information, Education and Communication
IHD	Ischemic Heart Disease
ILTD	Indian Leaf Tobacco Development
IMF	International Monetary Fund
ITC	Indian Tobacco Company
ITGA	International Tobacco Growers Association
MONICA	Monitoring of Trends and Determinants in Cardiovascular Diseases
MDGs	Millennium Development Goals
MLG	Multi Level Governance
MMPCRKS	Mukh Mantri Punjab Cancer Rahat Kosh Scheme
NCCD	National Calamity Contingency Duty
NCD	Non Communicable Disease
NEP	New Economic Policy
NHSDAA	National Household Survey of Drug and Alcohol Abuse use in India
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NMHP	National Mental Health Program

NPCDCS	National Program for Prevention and control of Cancer, Diabetes, Cardiovascular diseases
NRHM	National Rural Health Mission
NSDP	Net State Domestic Product
NSS	National Sample Survey
NSSO	National Sample Survey Organisation
NTCC	National Tobacco Control Cell
NTCP	National Tobacco Control Program
PCOL	Parliamentary Committee on Subordinate Legislation
PHC	Primary Health Centre
PMI	Phillip Morris International
POS	Point of Sale
PSNTD	Punjab State No Tobacco Day
RCH	Reproductive and Child Health
RMP	Registered Medical Practitioner
RNTCP	Revised National Tuberculosis Control Program
SAD	Shrimoni Akali Dal
SAP	Structural Adjustment Program
SDGs	Sustainable Development Goals
SLB	Street Level Bureaucrat
SLT	Smokeless Tobacco
SMO	Senior Medical Officer
STCC	State Tobacco Control Cell
TB	Tuberculosis
TBT	Technical Barrier on Trade
TCC	Tobacco Cessation Centre
TII	Tobacco Institute of India
TPPA	Trans Pacific Partnership Agreement
TRCC	Trans National Risk Commodity Corporation
TRIPS	Trade Related Aspects of Intellectual Property Rights

TTC	Transnational Tobacco Company
VAT	Value Added Tax
VST	Vazir Sultan Tobacco
WHO	World Health Organization
WTO	World Trade Organisation

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

GLOSSARY

Amritdhari Sikh	Sikhs initiated into Khalsa
Anna	Amounts to one sixteenth of a rupee
Bhaiyaas	Local language in Punjab used for migrant labourers
Bhogas	Sanskrit word meaning enjoyment
Bidi	Sun dried flake tobacco put into a conical shape of temburni leaf and the roll is secured with a thread.
Challan	Fine imposed in Punjabi language
Cheroots	Small cigarette made of rolled leaves
Chutta	Homemade cigar whose ignited end is placed in the mouth
Doaba	The area between Beas and Sutlej River
Gurudwaras	Religious place of worship of Sikhs
Gutka	Chewing tobacco preparation made of tobacco, crushed areca nut, catechu, paraffin wax, slaked lime and sweet or savory flavours
Hookah	Indian water pipe used for smoking tobacco
Jat	A traditional agricultural community in Punjab which follows Sikh religion
Khaini	Prepared tobacco leaves and is mixed with small amount of lime stone powder and few drops of water
Majha	Covers the area between Beas and Ravi River in Punjab
Malwa	The region of Punjab south to river Sutlej

Mazhabi Sikh	Members of the untouchable cast who have rejected Hinduism in the favour of the Sikh religion.
Maund	Equals to 37 kilogram
Paan	Preparation combining betel leaf with areca nut
Paan masala	A mixture of areca nut with slaked lime, catechu and other flavoring agents.
Sikh Rehat Maryada Code	Code of conducts and conventions which a created to standardize practical and functional aspects of Gurudawars.
Tehsil	An administrative division which consists of some villages and towns.
Zamindars	Persian word meaning land owner
Zarda	Moist or dry chewing tobacco mixed with variety of colours and spices

INTRODUCTION

Health experts have discovered detrimental effects of tobacco use and documented them for more than half of the century. For years together tobacco companies created a myth that the relationship between tobacco use and ill health is controversial. But in the recent times industry has given up on these claims. If there is evidence on use of tobacco being harmful then why is it that tobacco control continues to pose a challenge? The answer is very complex and numerous factors play an important role to influence people in consuming tobacco. Tobacco policy is itself complex and possesses some unique features. First, tobacco use is considered legal but it is seen as a risk factor for various diseases causing premature deaths in the world. Second, it provides one of the most important examples of change in the policy globally. Third, it lays out an important example of corporate power and policy in contemporary times. Lastly, it provides important information on the processes of policy in different environment and their outcomes (Cairney, Studlar & Mamudu, 2012, p.2).

In addition health behaviour (tobacco use in this case) is not solely individualistic in nature and any effort to change this behaviour must take into account social context and political and economic forces which act directly on people's health regardless of any individual choices they make (Kelly & Barker,2016). In public health research the use of tobacco and its health effects have always been the focus of discussions; tobacco being a risk factor to many diseases. These diseases caused by use of tobacco impact nearly every organ of the human body. It includes various types of cancers, lung diseases and heart diseases. World Health Organisation (WHO) reports that around 5 million people die prematurely every year globally due to tobacco use and divides these deaths between the developed and developing countries. More importantly the deaths and disease due to the use of tobacco are currently increasing (Reddy &Gupta, 2004, p.2).

India's problem is more complex than any other country in the world with a large burden of tobacco related diseases and deaths. The most prevalent and most studied form of tobacco use globally is cigarette smoking. However, global literature cannot be relied upon for calculating the problem of tobacco use in India since the most commonly consumed tobacco product is in smokeless form and *bidi* is most commonly smoked product (Reddy &Gupta, 2004). Further, the role of various

agencies in the process of tobacco use and its control takes advantage of the fragmented institutional structures and resistance from concentrated groups which compel the policy makers to adapt international policy changes, ignoring the domestic consumption patterns as well as the demography of the problem. Nevertheless, public health actions taken by the government are important to construct outcomes which the individuals are not able to do it themselves. The individual and the institutional actions often produce spillovers which are called externalities some of which may be harmful and some beneficial. To compensate for the private actions such as smoking, requires strict policy decisions about how to bring under control commercial interests and impose restrains on individual autonomy (Oliver, 2006).

The broad theme of the research is derived out of several unanswered questions raised during the study examining the provisioning of oral health services in public health setting in district Jalandhar. The previous research established that Punjab was reeling under the burden of cancers, oral cancer being one of them. The changes in lifestyle and use of tobacco as well as alcohol have been seen as risk factors for increase in cancers in Punjab. The earlier research did not study the subject of risk factors for oral cancer but was limited to the availability of treatment for oral cancer patients in public health settings in district Jalandhar. Smokeless tobacco which has been considered the biggest risk factor for oral cancer caught the attention of the researcher and guided us in the subject of tobacco use and its control. The researcher wanted to explore various forms of tobacco being consumed in the district but as far as health implication of tobacco use is concerned she was particularly interested in the subject of oral cancer due to her training as an oral health expert.

In regard to Punjab, the use of tobacco in the state is below the national statistics. It is one of the states of northern India which is relatively small in terms of geographical boundaries and population but holds high importance in the social, economic and political spheres of the country due to which it has always received special attention from the researchers throughout the world. The developmental history of the state has been of significance in shaping the present social, economic as well as political architecture of the region. This social architecture has not remained untouched by the use of various forms of substance abuse including tobacco. The use of tobacco in the state has been present throughout years of its evolution and development. But what sets it apart from rest of the nation is the cultural as well as the religious taboo

associated with tobacco use in Punjab. Being a Sikh dominated state the prohibitions on the use of tobacco in the past have been more due to religious reasons than its harmful effects on health. The interesting and rich historical revelations compelled the researcher to find meaning to place of tobacco in the history of Punjab to serve as important background for the present tobacco consumption patterns in Punjab.

Another important aspect of the state of Punjab has been the stagnation in its economy and the associated implications of the same for youth in Punjab. The lack of employment opportunities has made them fall prey to various forms of substance abuse, tobacco being one of them. There are few research articles which blame the migrant labourers in Punjab for increased tobacco use in the state. However, there have been no state level surveys on tobacco in Punjab which can provide claim to this indictment of influence of migrants on tobacco consumption patterns in the state. This is to say that when the problems in public health are divided according to variables of income, age, gender, race and geographical set up, the problem of one group may not be same as the problem of another group. Instead the place of the affected individuals in the social set up, the professional groups or industry will probably control the type of action government takes (Morone, 1997). This dearth of comparative studies highlighting the tobacco use associated with migrant and local population raised few interesting questions for us to explore in our study.

In addition, Punjab was applauded for its role in tobacco control in the initial years of conception of Tobacco Control Program but within years of introduction control program got confined to papers. When the tobacco control machinery in the state was wasting no time in patting its back for smallest of the events, the role of politics in putting the tobacco industry ahead of the control measures was being reported. Various newspapers during the period of year 2012 -2015 which put Punjab on national front for being a pioneer on tobacco control also criticised it for the role the political environment played in providing advantages to tobacco industry. In contrast, robust writings by academicians or health officials focusing on tobacco industry in Punjab were nowhere to be found.

Also, there was a lack of uniform data on use of tobacco across various religions and age groups in the state of Punjab. The department of health and other departments associated with tobacco control gave incremental updates and notifications on tobacco

control in local newspapers. Moreover, the news reports highlighted the raids being conducted by Health department in Punjab on various kiosks in order to restrict the sale of tobacco. These reports were of extreme significance for us to investigate what place do the sellers of tobacco at a local level find in tobacco use and its control? Were they sensitised regarding various tobacco laws? In what numbers were they selling tobacco products? Did they know about the various effects of tobacco use? Which products of tobacco were being sold and to which age groups? These questions informed a vital part of the study which gave researcher clarity on inclusion of various stakeholders in the study to get a holistic perspective on subject of tobacco.

The literature on social context of tobacco use and political economy of tobacco in Punjab is virtually absent. As a result, tobacco laws in Punjab have been rarely tailored to meet the demographics of the local population. Moreover, training of the workforce in health and various related departments of Punjab as far as tobacco control is concerned is not thoroughly documented. Although training manuals have been released and instructions given, any in depth study of the knowledge of these workers on tobacco has been limited to the various legislative measures being taken by the government. In order to handle the cases of tobacco use, the sensitisation of the fraternity to look beyond the usage of tobacco stands questioned. Considering the tobacco users in a compartmentalised manner and offering help limited to the health implications of tobacco use, reflects the policy frame and its translation in the field. The political context of health, the need to engage all the stakeholders in the fight against tobacco and looking for novel approaches to build a holistic approach in the field finds little mention in Punjab.

Throughout the process of constant reporting of tobacco use and its control, the researcher tried to decipher connections between policy and the individual's use of tobacco. Despite the available evidence, the question on why was there a gap between the tobacco problem and the response of the government to it needed further exploration. Also at the heart of tobacco use stories, is the subject of personal independence which goes on to say that the people who act reluctantly either through coercion or out of sheer ignorance should not be blamed for their actions (Leichter, 2003).On the contrary, health related behaviours can be seen as a matter of personal responsibility and the individual can defend its freedom to make choices even if they are the unhealthy ones (Beauchamp, 1980). These dichotomies on use of tobacco,

where on one side the government is running a control program but on the other side the individuals talk of personal freedom for consuming tobacco, forms an important part of our debate in the thesis.

There were various questions to guide the course of our study in district Jalandhar, Punjab. These questions helped us to approach the study and frame its contribution to the existing body of knowledge on tobacco. Does the use of tobacco in varied forms inform policy decisions? What are the various forms of tobacco used in district and how is tobacco control manipulated by the industry? How can individual level use of tobacco be seen as an important determinant to make policy changes? This study attempts to examine the area of tobacco use which is ruled not only by the individual choices and free will but also through various attempts made by the industry to keep the addiction going. The policies so made for controlling the menace of tobacco and its translation into the national level programs do not seem to be enough, given the role of industry in manipulating the tobacco control measures. The researcher has attempted to answers these questions through theoretical, conceptual and empirical construction in various sections of this thesis. The present study focuses its attention to tobacco use examining it in the broader context of tobacco policy and the social correlates of its use in district Jalandhar. It locates the use of tobacco within the social, economic and political system of Punjab and localises these approaches to district Jalandhar.

STRUCTURE OF THE THESIS

Chapter 1: Review of literature

The chapter lays out the literature relevant to the topic which guided the researcher throughout the research period. It helps us to describe, evaluate and clarify the existing literature on the topic of tobacco. It also elucidates how the proposed study is related to the already established literature. In addition, it highlights the gaps which are present in the literature or not adequately addressed justifying the relevance of the proposed research.

Chapter 2: Research Methodology

The chapter on research methodology conceptualises and discusses the methodological approach adopted by the study. It lays down the objectives which

guided the study and helped researcher to segregate the findings as per the objectives. It also details the limitation of the study and its methods and provides a detail map of the study subjects, the study area and various tools used to reach the study objectives.

Chapter 3: State, market, tobacco industry and public health debates

This chapter provides information on the history of cultivation of tobacco in India and associated expansion of the industry. The opening of the markets for trade and associated growth of tobacco industry form an important part of this chapter. Also various ways in which the tobacco industry manipulates legislation to enter new markets and allure new age groups have been documented in detail. Finally, it also churns out the agitations from the public health advocates in response to the strategies adopted by industry in India.

Chapter 4: Contexualising tobacco in historical development of Punjab

This chapter assembles together the events which led to introduction of tobacco in Punjab and its consumption in the state. It elaborates the change in the economic, social and political scenario of Punjab from the mid sixteenth century to contemporary Punjab. It places the use of tobacco within these historical events that ensued during various periods in the state. The change in Punjab's economy and its effect on the social structure of Punjab form an important background in studying tobacco use in the state.

Chapter 5: Tobacco Control Policies and law: Translation in Jalandhar, Punjab

This chapter provides information about the translation of tobacco control policies and laws in district Jalandhar. It details various Acts which control the use as well as tobacco sales in the state. The translation of these Acts into tobacco control measures in the state placing Jalandhar in these debates lays out the barriers faced in the implementing the Tobacco Control Program in the district. In addition, it highlights the role of tobacco industry in manipulating these control measures in the district.

Chapter 6: Tobacco users in district Jalandhar: Oral cancer and its social correlates

The chapter studies the social correlates of tobacco use and its health implication in form of oral cancer in the district. It outlines how various social correlates of tobacco use play a role in the health behaviour of the individuals in the district. It goes on to

investigate several dimensions of tobacco use which helps to establish a strong understanding of its consumption as a collective social practice as well as its translation into disease, oral cancer in this case.

Chapter 7: Discussion and Conclusion

This chapter weaves together the various findings and helps in analysis of tobacco use contexualising it in policy as well as its social correlates. It helps to relate various arguments presented in the chapters with the findings of the studies. We argue that the use of tobacco and tobacco control policy are fluid in nature and any change in one leads to the change in other. That being said the role of market forces to allure tobacco users as well as the economy of tobacco in the state cannot be ruled out in our discussion.

CHAPTER 1

REVIEW OF LITERATURE

INTRODUCTION

Tobacco control is an important subject for health advocates as well as those who see it as political agenda. Although relatively new, it has gained importance has grown tremendously in the past few decades of the century. Before the period of 80's relatively few countries had government legislations on Tobacco Control Policy as one of its subject. Further the governments encouraged the growth of tobacco leaves by providing various subsidies, assistance for research and loans. However, this situation has changed spectacularly in the past quarter century due to political advocacy by health professionals as well as voluntary health organisations. Furthermore, the acceptance of scientific findings on the deleterious effects of smoking has made government more active on the issues of tobacco control. It is more willing to take necessary actions to limit the use of tobacco through various measures as taxation, education and restrictions on tobacco advertisements and smoking areas (Studlar, 2006).

In order to understand how much policy has been influenced by the evidence generated on the subject of tobacco use, the review of literature examines tobacco consumption patterns as well as its control through legislative measures taken in India. The review is divided into five sections which throw light on the frequency of various types of tobacco use and its control and lay out a broad framework on why the subject is important in present times and what is the response of the government of India in dealing with it. It also highlights various conceptual issues of health behaviour and response of policy to this behaviour.

The first section provides details on the burden of tobacco use in India and how the use of tobacco renders into various forms of diseases and its associated economic costs. In addition, the role of health professionals in addressing this burden of tobacco has been mentioned in the section. This burden of tobacco made the government vigilant, which then formulated legislation for control of tobacco which is focus of the second section. It not only talks of the Indian and International legislation but also

underlines the loopholes in the Indian legislation which compromises the processes of tobacco control.

The third section puts together the various determinants of tobacco use responsible for initiation of its use as well as its continuation. These include socio economic differences, gender based differences, external influences to tobacco use in adolescents and addiction to tobacco. This section holds extreme importance because these determinants are an important driving force for the changes in legislations in tobacco control. The fourth section brings Punjab into focus and addresses the gaps and questions which arise from literature in the context of the state. The last section highlights conceptual issues on tobacco use and policy and how vital is it to address tobacco in a holistic manner.

1.1. BURDEN OF VARIOUS TYPES OF TOBACCO USE IN INDIA

The use of tobacco and its detrimental effects on health advocated the need for tobacco control throughout the globe, ripples of which reached India too. In order to understand the birth of legislation for controlling the use of tobacco, it becomes extremely significant to note the prevalence of tobacco use globally and in India. It also becomes important to lay down the implications of tobacco use, related to health and otherwise.

1.1.1. Prevalence of tobacco use

In order to estimate this burden of tobacco use, there have been surveys which are population based in India to study risk factors for various ailments such as heart and lung diseases for which tobacco is a risk factor. These have been state specific local studies and occupational group surveys which provide limited information on tobacco use. Three main national surveys have gathered restricted information on prevalence of tobacco use in India. The National Household Survey of Drug and Alcohol Abuse use in India (NHSDAA), National Sample Survey Organisation (NSSO) and National Family Health Survey (NFHS) have been conducted for determining the prevalence of tobacco use (Reddy & Gupta, 2004). The prevalence studies in India for tobacco use have shown the variations in tobacco use across different regions, education, religions, gender and other variables of socio demographic importance across the country. The major limitation of these surveys was that they were not meant to gather

data on use of tobacco. The responses used were surrogate which could be erroneousness and biased. Moreover, due to use of household as a sampling unit instead of individual, it did not likely make necessary statistical adjustments at the time of estimating the results (Soni & Raut, 2012).

In order to get comprehensive and comparable statistics across countries, a global standard for monitoring the use of tobacco smoking as well as smokeless tobacco and tracking indicators of tobacco control, Global Adult Tobacco Survey (GATS) 2009-10 India, was done as a household survey of persons aged 15 and above. It was carried out in 29 states and two union territories of Chandigarh and Pudduchery and covered about 99.9% of the population. The major objectives of the study were to obtain the prevalence of tobacco, second hand smoking, economics of tobacco use and knowledge and perception of people towards tobacco use (GATS India, 2009-10).

GATS 2009-10 India has revealed that more than one third of the adults consume tobacco in some form. "Of the total of 35% of adults, 21% use only smokeless tobacco, 9% only smoke and 5% use both forms of smoke. Converting these percentages into numbers the people smoking were found to be 274.9 million with 163.7 million using smokeless form, 68.9 million using smoking and 42.3 million using both the forms of tobacco. The prevalence of tobacco use among males is 48% and among female is 20%. Nearly two in five adults in rural area and one in four in the urban areas make use of tobacco in some form. Prevalence of smoking in males is 24% and in females is 3% and prevalence of smokeless forms is 33% in males and 18% in females" (GATS India, 2009-10, p.43).

The consumption of tobacco in India is in varied forms. In India, the most commonly used smokeless tobacco product is "*khaini* or tobacco-lime mixture (12%), followed by *gutka* and areca nut mixture (8%), betel quid with tobacco (6%) and applying tobacco as dentifrice[1] (5%). The use of each of the smokeless tobacco products, except dentifrice, is higher among males than females. Among smoking tobacco products, *bidi* (9%) is used most commonly followed by cigarette (6%) and *hookah* (1%). The prevalence of cigarette smoking is higher in urban areas among both males and females whereas prevalence of other smoking products is higher in rural areas. The use of smokeless tobacco product is higher in rural than urban areas, however,

[1] Dentifrice is a paste or powder used for cleaning teeth.

gutka is almost equally consumed in both urban and rural areas" (GATS India, 2009-10, p.72).

Tobacco not only affects the people who smoke but also those who inhale the tobacco smoke and second hand smoking has been a matter of concern for these persons. The persons who are exposed to second hand smoking are about 52%. In rural areas 58% and in urban areas 39% are exposed to second hand smoking at home (GATS India, 2009-10, p .128). The use of tobacco and the type of tobacco being consumed can be attributed to the levels of literacy and economic status. GATS 2009-10 established that the use of any type of tobacco decreased with increased level of education and cigarette smoking had a positive association with wealth while *bidi* smoking had inverse associations for the same (GATS India, 2009- 10, p.81).

In order to track the use of tobacco in adolescents, Global Youth Tobacco Survey India (GYTS) 2008-09 was conducted in school going children of 8^{th} to 10^{th} standard. 14.6% in this age group used tobacco in any form, consisting of 19% boys and 8.3% girls. It is a school based cross sectional survey carried out in different states of India using a uniform methodology. Currently the use of smokeless form of tobacco use is more prevalent than smoking in the age group of 10 to 15 years. Most of the students were under this misconstruction that tobacco use is fine for teeth and health. The initiation of tobacco use before the age of ten is rising and the states where the levels of counselling on tobacco by teaching is high tobacco use among the students is less prevalent. This means that the states where teachers inform the students about the ill effects of tobacco use and engage them in extracurricular activities; the use of tobacco is less. There is no statistical difference between the use among the students in rural and urban area (GYTS, 2009, p.1).

However, the latest report released by the government on GATS 2016-17 India shows that the prevalence of tobacco use has decreased from the last GATS by six percentage points to 28.6 % of tobacco users using tobacco in any form. "Moreover the use of tobacco among minors has also decreased to 4 % in GATS 2 from 10 % in GATS 1. Although the numbers in GATS 2 are encouraging but the average monthly expenditures on cigarette and *bidis* have increased which could be attributed to the increased taxation on these products in those six years gap between GATS 1 and GATS 2. Also the most commonly used tobacco product in India is *khaini* (11.2%)

which is followed by *bidi* (7.7%), *gutka* (6.8%) and betel quid with tobacco (5.8%). In the urban areas *khaini* and *gutka* are the most commonly used products whereas in rural areas *khaini* and *bidi* are the most commonly used tobacco products. The mean age of starting the tobacco use has increased from 17.9 from GATS 1 to 18.9 in GATS 2" (GATS India, 2016-17, p.xxxv).

1.1.2. Implications of tobacco use

The use of tobacco comes with health as well as economic issues of tobacco purchase due to its continuous consumption. The health issues associated with tobacco decrease the economic productivity of the user and lead to economic burden. This economic burden is not only harmful to the individual but to the nation on the whole as it loses a section of its productive workforce as most of the tobacco users as seen in the above section belong to the productive age group. The consumption of tobacco not only causes psychological and physical dependence but is also a reason for the growing poverty and decreased intake of nutrients.

1.1.2.1. Economic implications of tobacco use

The reduction in poverty was one of the goals in Millennium Development Goals(MDGs) set out by United Nations and the developing countries have been measured in their progress by poverty alleviation. Tobacco use leads to poverty in many ways. Since in poor households most of the share of their incomes is spent on food, money spent on tobacco compromises their resources that would otherwise be available for food. This causes a difference between a sufficient diet and leads to malnutrition. Apart from food, it also reduces consumption of other goods and services. Moreover, spending on tobacco shrinks expenditure on education continuing the cycle of poverty. It is undoubtedly acceptable that it raises health costs which magnify into taxing health budget for poor households. In addition, it decreases productivity when a person is absent from work because of tobacco related diseases and the majority of deaths related to tobacco use are in the male members who are the earning heads of the family. This loss of earning male members can increase the probability of the whole family moving below the poverty line as a typical household uses 3% of the household budget for tobacco purchase (John RM as cited in John et al., 2011, p. 1). The recently introduced Sustainable Development Goals (SDGs) also

lay stress on ending poverty in all forms and reducing the economic inequalities within the countries (United Nations, 2015). A study where tobacco expenditure and associated medical expenditure were subtracted from the household monthly expenditure revealed that 15 million people in India fall below poverty line accounting to tobacco use. Of this, tobacco pushed 14 million people into poverty due to direct spending and tobacco related medical care affected another one million (John et al., 2011, p. 3).

In order to measure the costs of diseases for smoked and smokeless tobacco consumed in India using data on health care expenditure from National Sample Survey (NSS), it was found that "direct medical costs accounted for $907 million for smoked tobacco and $285 million for smokeless tobacco" (John, Sung & Max, 2009, p.142). WHO estimates suggested that Disability Adjusted Life Years (DALYs) attributed to tobacco use in 1990 were 1719 which increased to 24024 by 2002 (Rani et al., 2003, p.8). It was found that in India ,economic costs of tobacco related diseases were five times higher than the excise tax revenue earned from tobacco sales in year 2011(MOHFW,2017,p.30).

These negative effects of tobacco use led 50 countries to ban indoor smoking in pubs, bars and lounges. This increased the environmental impact of tobacco use because people started to come out and smoke. Smoke and cigarette butts affect the environment leading to air, water and land pollution. The presence of around 4000 chemicals in cigarettes which are exhaled and passed in the atmosphere, cause injurious effects on humans effecting their productivity and health (Venkatesh, 2013, p.47). The diseases caused by tobacco use are seen as life threatening and efforts are being made to spread awareness against the use of tobacco in various forms. The section on health implications of tobacco use provides information on the severity of problem of tobacco use on general as well as oral health.

1.1.2.2. Health implications of tobacco use

The global tobacco burden says that tobacco causes one in ten deaths in the world and 5.4 million deaths per year due to consumption of tobacco. The increase in the developed and the developing world will not be shared equally as the deaths are expected to increase to 2.4 million in the developed region from 1.6 million in 1990

whereas deaths in Asia alone will increase from 1.1 million in 1990 to 4.9 million in 2030 (Asma et al., 2004, p.253). The following sub section will focus on three major diseases which increase the tobacco care costs, namely Cardiovascular diseases (CVDs), Chronic Obstructive Pulmonary Diseases (COPD) and cancers.

1.1.2.2.1. Tobacco and overall bodily health

Around the globe tobacco use is the primary risk factor for chronic diseases either independently or in combination with other risk factor which are causative agents for diseases of cancer, CVDs, diabetes, respiratory diseases and other chronic diseases. The burden of these diseases is expected to rise from 43% in 1998 to 73% by 2020 and this increase is expected to be more in the developing world (Murray & Lopez as cited in Asma et al., 2004, p. 254).Cardiovascular diseases are a group of diseases which are leading cause of deaths in the world and in many countries deaths due to CVDs is more than the than deaths related to cancers, CVDs accounting for 45% of all NCD deaths (World Health Organisation, 2017, p.31).

The WHO Monitoring of Trends and Determinants in Cardiovascular Diseases (MONICA),a surveillance for CVD carried out from early 1980s to mid 1990s was done in 21 countries and it showed that the risk of cardiovascular diseases in men and women aged 35-39 years who smoked was five times than the non smokers in the same age group. In about 50% of the men and women younger than 50 years of age, CVDs were attributed to smoking (Leupker, 2012, p.386). During the period of 2000 to 2030, "35% of the deaths due to CVDs in India are projected to occur in the age group of 35 to 64 years" (Leeder et al., 2004, p. 31).

Apart from the cardiovascular diseases, there is convincing evidence to show strong association between smoking and different types of lung diseases. Tobacco use not only leads to lung cancer but also causes different types of lung diseases as Chronic Obstructive Pulmonary Disease (COPD), some interstitial lung diseases and bronchial asthma (Murray & Lopez as cited in Reddy & Gupta, 2004, p.100). When respiratory illnesses are a concern, TB remains most important cause of death particularly in men who smoke in India. The occurrence of TB is three times higher in smokers than in non smokers. More the use of cigarette, the greater is the prevalence of TB and smoking contributes to half of male deaths from TB (Reddy & Gupta, 2004, p. 107).

It is due to this increase in the Non Communicable Diseases (NCDs) burden that the Government of India launched National Programme for prevention and control of Cancer, Diabetes, Cardiovascular diseases (NPCDCS) in 2007. Overall NCDs are emerging as the leading cause of death accounting for over 42% deaths in India. The main preventable risk factors for NCDs are tobacco consumption, stress, sedentary lifestyle and poor dietary habits. The report on NCDs shows that out of all the cancers in India, the occurrence of tobacco related cancers is 48% in males and 20% in females which are totally avoidable. NPCDCS aims at integration of services for optimise use of resources and long term sustainability of interventions. It also aims at providing wider coverage by converging ongoing interventions at National Rural Health Mission (NRHM) with National Tobacco Control Program (NTCP) (NPCDCS, n.d. p. 2).

The various measures were taken by the Government of India to control tobacco use due to the fact that the pattern of diseases as discussed earlier is dependent on the type of tobacco product used. It is a well established that the mortality for cigarette smokers is higher than the non smokers. But there are differences in health effects of *bidi* and cigarette smoking. For example cancer deaths due to lung cancer are more due to cigarette smoking. In India due to *bidi* smoking and tobacco chewing the main effects are seen in the pharynx and oral cavity, which contribute to a large share of tobacco related cancers in the country (Reddy & Gupta, 2004). The health effects of tobacco consumption on oral cavity are equally deleterious to the human body. The section on tobacco use and oral health discusses the various side effects of tobacco consumption in the oral cavity. Apart from life threatening condition of oral cancer, restriction of function occurs in the oral cavity due to various dental diseases caused by the use of tobacco.

1.1.2.2.2. Tobacco use and oral health

In order to control the increasing diseases of oral cavity due to tobacco use, WHO Oral Health Program "aims to reduce tobacco related oral diseases and adverse conditions through several strategies. Within WHO, Oral Health Program forms an important part of the WHO tobacco free initiative. Externally the Oral Health Program encourages the adoption and use of various tobacco cessation activities laid down by WHO at national and international level. The integrated information system

provides an important new platform for public health initiatives in tobacco control. The program provides assistance to countries in risk behaviour analysis and surveillance to include oral health in tobacco prevention programs". It also promotes the translation of knowledge into action by involvement of oral health professionals into the program at national and international level encouraging information exchange among the countries to actively work for curbing the menace of tobacco. The program gives guidelines on health providers' involvement in treatment of tobacco addiction, including the dentists in the community, as they reach a large section of the healthy population. Of all the oral health goals, the aim to reduce mortality from cases of oral cancer and provide proper treatment for the patients suffering from the same find an important mention (Hobdell, Petersen, & Clarkson, 2003).

In spite of the efforts and initiatives taken at the international level, the deleterious effects of use of tobacco seen in the oral cavity are a big concern for health professionals. Smokeless tobacco delivers as much or more nicotine to the body as does cigarette smoking. Most smokeless products in India use alkalinising agents such as calcium hydroxide. These can irritate the mucosa of mouth and oesophagus, promote nicotine absorption by the mucosa and increase the pH[2] dramatically and absorption of nicotine into blood stream. *Bidi* smoking delivers more nicotine per gram of tobacco than the cigarette despite containing much less of tobacco per stick. This is due to type of tobacco used and the non porous leaf wrapper that does not permit much dilution of smoke during puffing causing it to be more harmful for the oral cavity (Cecily & Gupta, 2009). The prolonged use of tobacco causes discoloration of teeth and is considered to be cause of halitosis[3] in the users. A clear association has been found between tobacco use and severity of the periodontal diseases[4]. Periodontal bone loss, periodontal pockets and periodontal attachment loss are all associated with tobacco use. It also affects the outcome of the periodontal therapy as tobacco is a peripheral vasoconstrictor which influences rate of healing within mouth, causing the delay in healing of the wounds (Beaglehole &Benzian, 2005).

[2] pH also called power of hydrogen is a measure of how acidic or basic is water. pH of more than 7 indicates a base and of less than 7 indicates acidity. It ranges from 0-14.
[3] Halitosis called bad breath is a symptom in which an unpleasant odor is present on exhaled breath.
[4] Periodontal diseases are the diseases of the supporting tissues of teeth namely bad breath, mobility of teeth and gap formation between teeth and supporting tissues.

But the most threatening of the detrimental effects of tobacco use is the occurrence of cancer. The Indian Council of Medical Research (ICMR) reports of 2006 and 2009 have reported rising cases of cancers in India (Ali, Waseem & Saleem, 2011). Rates of death from cancer are expected to rise due to risk of tobacco use which increases the risk for cancers (Dikshit et al., 2012). "The common sites for cancers in India are oral cavity, lungs, oesophagus and stomach in males and cervix, breast and oral cavity among females" (Dinshaw & Patil, 2004). The use of smokeless tobacco has been seen to increase the risk for oral cancer. In a study done in southern India to study the effect of tobacco use, oral cancer cases were identified at three centres in southern India. Chewing of *paan* and use of other forms of smokeless tobacco was seen as an important factor leading to causation of oral cancer (Alaram et al., 2002). The National Cancer Registry of India's report from 2012 to 2014 on the use of tobacco and cancer causation, showed that out of 29 Population Based Cancer Registries in India, lung cancer is leading site for cancer in 11 registries, oesophageal cancer in 8 registries and mouth cancer for 7 registries (National Cancer Registry of India, 2015b, p. 27).

This widespread body of evidence on adverse health effects of tobacco makes the role of health professionals very important in limiting the occurrence of these diseases at early stages. The subsequent section emphasises how the health professionals can help an addict in the initial stages of tobacco use and prevent him from progressing to serious disease condition.

1.1.3. Role of health professionals in tobacco control

Physicians are not only health professionals but also educators and role models. They can help a patient change his behaviour and act as a motivation for the same. During the time of visit they can act as counsellors to the patients and ask them about the history of tobacco use. Brief advise for quitting tobacco includes 5 A's for the health professionals helping tobacco users quit its use.

Table: 1.1.Five A's for helping quit tobacco by health professionals

Ask	Ask the patient if he or she is a tobacco user at every visit.
Advise	Advise them briefly against continuing the use of tobacco and link their current condition to the use of tobacco.
Assess	Assess their readiness to quick by asking them if they are ready to quit.
Assist and Arrange	Assist and arrange the various methods which would help the patient quit tobacco use.

Source: Srivastava, 2011, p .12

If the patient is not ready to quit using tobacco, five R approach of counselling is used which primarily prepares the tobacco users to quit the use of tobacco by explaining him the importance of a tobacco free life. It reinforces the deleterious effects of tobacco use every time the patient is counselled to quit the use of tobacco and identifies any roadblocks which prevent the users from quitting (Srivastava, 2011).

Table: 1.2.Five R approach of Behavioural Counselling

Relevance	The patient should be explained the relevance of quitting tobacco and harmful effects of tobacco use.
Risks	The health hazards that are more relevant to individual tobacco user should be highlighted very vividly to influence the patient in a positive manner
Rewards	The tobacco user should be explained the benefits of quitting the use of tobacco and way it influence health in a positive manner
Roadblocks	Difficulty that the client may face in his or her attempt to quit should be recognized. The client may encounter fear and concern related to quitting, depression and lack of social support as well as withdrawal symptoms.
Repetition	The patient should be reminded about the harmful effects of tobacco time and again and asked to quit the use of tobacco with help of outreach workers.

Source: Srivastava, 2011, p .11

Inclusion of tobacco in the training curriculum of the health professionals has been considered of vital use to curb the tobacco use at early stages (Mckay, Patel & Majeed, 2015). Moreover, 13 Tobacco Cessation Centres (TCC) in India were set up in 2002 to provide first formal tobacco cessation services. Although encouraging results were experienced for those receiving behavioural therapy as well as pharmacotherapy, the major limitations are that these cessation services reach a limited number of urban users. Moreover the lack of trained human resources to provide these services is still a challenge in India. Including tobacco in medical curriculum is considered to be of extreme importance as the doctors who use tobacco pick this habit during their training as health professionals and act as negative role models. In addition, asking for tobacco and alcohol use must be a routine part of the history taking and the doctors can use their consultation as behaviour change method (Murthy & Saddichha, 2010). However, there are various challenges faced by public hospitals in India which consist of deficient infrastructure, lack of manpower and unmanageable patient load to name a few (Bajpai, 2014). With these problems already burdening the public hospitals in India, tobacco cessation services to be provided by the doctors stand questionable.

1.2. LEGISLATION FOR TOBACCO CONTROL

Tobacco legislation is not only used as means of raising awareness among the population but also to reinforce and examine the social context of tobacco use. The present tobacco laws in Indian context and international recommendations have solutions to offer if implemented in full letter and spirit. The use of different types of tobacco has different effects on health but the question which arises is if approaches to these forms of tobacco are addressed in the legislative measures to control tobacco use.

1.2.1. Tobacco Control Policy and legislation in India

The key responsibility of legislation is to reduce health risks, establish defence mechanisms for sheltering of rights and furthering social consciousness as a vehicle of social change. The need of laws on tobacco control was felt in India around 1970s due to increasing morbidity and mortality due to tobacco use and growing demand for tobacco control worldwide. To regulate the trade of tobacco in India and production

and supply of cigarettes the Government of India passed the Cigarettes Act in 1975 that made it obligatory to display health warnings on advertisements and packets of cigarettes. The purpose of these warnings was to inform the citizens of damaging effects of cigarettes and reduce demand for the same. But the provisions in the Act were weak and it wasn't comprehensive in nature. The non cigarette tobacco products as *bidi, gutka* etc. were not included in the act. At the same time, Indian population was consuming more smokeless tobacco products as compared to cigarettes. In order to expand the jurisdiction of the Act, the passage of Cigarettes and Other Tobacco Products Act (COTPA) in 2003 saw the previous act of 1975 being repealed (Jhandoo & Mehrotra, 2008).

Also, international organisations such as World Health Organisation (WHO) proposed stronger action against the rising menace of tobacco at the national level. The developed countries took to stronger legislation and increased the scientific knowledge and social activism for tobacco control. In India too, media started playing an important role and demands for tobacco control were increasingly made in the Parliament. All these measures forced the government to take stricter actions and work towards comprehensive tobacco control. During the period of 80s and 90s, WHO asked its member states to prevent the non smokers from second hand smoke[5], to protect children from harmful effects of smoke, restrict the trade of tobacco products and regulate the advertisements promoting the use of tobacco. National Conference on Tobacco in India in 1991 recommended that tobacco should be included in the concurrent list of Government of India and States for proper resolution regarding tobacco economics, second hand smoke, advertisements and how to regulate them (Chaudary, n.d.).

But these attempts made by the Government in 1990s were resisted by tobacco industry and the proposal was postponed by appointing a committee to evaluate the financial impact of tobacco industry. In 1995, Central Ministry of Health constituted an expert committee on the economics of tobacco use. The committee also consisted of representatives from tobacco workers, trade unions, tobacco farmers' associations and employees' federation. However, after the committee started it work, the representation of tobacco industry increased in the committee by industry's political

[5] Side stream from the lighted end of cigarette,cigar bidi or hookah.

influence. It led to reconstitution of the committee which now accommodated representatives from the tobacco industry. On basis of the recommendations of the committee, the Union Ministry of Health and Family Welfare introduced the Tobacco Control Bill in Rajya Sabha in March 2001(Reddy & Gupta, 2004).

The Bill proposed the recommendations for tobacco control to be applicable to whole country. It was translated into Cigarettes and Other Tobacco Products Act (COTPA) 2003 which brought the entire range of tobacco products under the jurisdiction of Central Government and it is enforceable throughout India and on all tobacco products. "The key provisions of the act include prohibition of direct and indirect advertisements of tobacco, ban on smoking in public places, prohibition of sale of tobacco products to persons below 18 years of age and display of health warnings on the package of tobacco products". The owners of the restaurants, public places and hotels are required to display prohibitory signs against tobacco use as mentioned in the Act. They are also responsible for the segregation of the non smoking areas from the smoking areas in a manner that public reaches the non smoking area without having to enter smoking area. The persons engaged in trade of tobacco products and those having control over media should ensure that the ban is upheld. In addition under the Act, no person is allowed to sell tobacco products within 100 yards of educational institutions (Mathur & Shah, 2011).

In order to bring understanding about the harmful effects of tobacco and for effective implementation of tobacco laws, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Program (NTCP) in 2007-08 during the Eleventh Five Year Plan. The interventions listed under NTCP have been planned at the primordial and primary level. The main areas of thrust of NTCP include training of social workers, teachers, enforcement officers, and Information Education Communication (IEC) activities, school programs, monitoring the tobacco control laws, coordination with Panchayati Raj institutions at village level and strengthening the cessation activities at the district level. Under the National Tobacco Control Program, the National Tobacco Control Cell (NTCC) is responsible for all the activities envisaged under the NTCP (MOHFW, n.d.).

The harmful effects of tobacco on children and pregnant mothers are well established. Pregnant mothers exposed to smoke are at increased risk of delivering low birth

weight and pre term child. Children are also vulnerable to second hand smoke at home as well as public places (Goel et al., 2004). Therefore, steps have been taken to integrate the Reproductive and Child Health Program (RCH) with NTCP. Under the NTCP, as a part of the District Control Program, NGOs are involved in carrying the activities of awareness generation campaigns, training and capacity building program for school teachers, health workers etc. (FCTC India, 2010).

1.2.2. Global efforts for tobacco control

Tobacco companies have since long targeted youth as replacement smokers for those who quit tobacco use or those who die. Although anyone using tobacco can become addicted to nicotine but those who do not begin by the age of 21 are less likely to begin. Because of a loyal customer base and high profit margins, tobacco companies are flushed with cash which provides them a major incentive to exploit markets in the developing world. The triumvirate of objectives of tobacco control as preventing uptake, maximising cessation and prohibiting smoking in public places directly opposes the commercial interests of tobacco industry. Any success of Tobacco Control Program means the failure of tobacco industry. In 2000, the WHO Committee of Experts on tobacco industry published a report which showed that the tobacco industry used varied strategies to prevent or weaken advances in tobacco control which included establishing inappropriate relations with WHO staff, exercise financial power, using surrogates such as trade groups, distorting WHO research and staging media events to distract from tobacco control (Fooks & Gillmore, 2013).

In order to provide a comprehensive framework for checking the tobacco use as well as curbing the influence of industry on the legislative aspects, WHO adopted the Framework Convention on Tobacco Control (FCTC) at its 56th session in May 2003. India was the 8th and largest country to endorse it in October 2004. It was long time since WHO had been stressing the importance of adoption of national laws and tobacco regulations but through this treaty it was the first time that it focussed on global public health use of tobacco. The increasing use of tobacco worldwide as well as more of young population getting addicted to it set the alarm ringing for health experts and policy makers to regulate this tobacco epidemic (Mathur & Shah ,2011).

WHO, in 2003 mentioned that FCTC in itself doesn't lay down any laws which should be clearly acceptable but sets out guidelines for national and international measure that would encourage the smokers to quit and refrain people from taking up the habit of smoking. "It stresses the importance of various tobacco control measures and health benefits arising from the same. It visualises international cooperation which includes the support and transfer of technical, scientific and legal expertise for assisting in the developing strong legislative foundation for tobacco control and protection from tobacco smoke and other hazards. It is basically a standard document which identifies various measures that can help its member states to adopt an effective tobacco control strategy" (FCTC, 2003).

If we talk of India's role in FCTC negotiations, it emerged as a country whose strong position for tobacco control was widely appreciated by the international community. The strong stance of India for tobacco control was widely appreciated back home and parliamentary opinion crystallised in the favour of strong legislation overcoming the earlier doubts on the economic consequences of tobacco control. While judicial pronouncements at the centre and state level called for banning of smoking in the public places, there were various state governments which imposed a ban on the sale of oral tobacco products (FCTC India, 2010).

The objective of the Convention and its protocols is "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke"(FCTC, 2003, p.5).Certain guidelines were established to inform people of the health hazards of tobacco; bringing together joint political commitment on tobacco control; international cooperation; multi sector tobacco industry; technically and financially assisting the economies adversely affected by tobacco control. The various articles of FCTC lay stress on demand and supply reduction measures along with establishing and increasing international cooperation (FCTC, 2003, p.7).

To expand the fight against tobacco epidemic, in 2008 WHO introduced the MPOWER package of six proven policies. These policies were directed at monitoring

the tobacco use, protecting people from smoke, offering help for quitting tobacco use and keeping a check on the promotion and advertisement of tobacco products. These policies are included in the various articles of FCTC and they serve as guidelines for regulating the tobacco use, its trade and its abuse. Its main focus is on negating the harmful effects of tobacco through laid down rules on an international platform. The member countries are expected to follow these and replicate them in their national laws (World Health Organisation [WHO], 2008).

1.2.3. Additional legislative steps by Indian Government on tobacco control

The Indian government introduced the COTPA Amendment Bill in 2015 which proposes to bring changes in the existing act. This Bill has projected that brand name which was earlier being used for non-tobacco product promotion as a surrogate advertisement will be banned. Although it calls for removing the tobacco advertisements at the point of sale and lays stress on pictorial warnings on *bidi* packets in order to deter the buyers from using it but its implementation in case of small shops remains a concern. It also recommends declaring hotels, restaurants and airports as no smoking areas while smoking areas to be present at the international airports. Thereafter, the legislation also offers to increase the penalty in case of tobacco related offences and stricter ban on sale of loose cigarettes nationally. It proposes to prohibit spitting of tobacco products which will help to curb diseases like TB, H1N1 and Avian flu. It also suggests that no sale of tobacco products outside the premises of educational institutes should be increased to 100 meters from existing 100 yards. Lastly, constitution of a National Tobacco Organisation is also proposed in the Amendment Bill (COTPA Amendment Bill, 2015).

COTPA intersects with other laws in India which lay down certain rules pertaining to use of tobacco products. The use of tobacco as ingredients and its sale has been prohibited in food products and certain places. For example, the Drug and Cosmetic Act of 1940, bans the use of tobacco products in the toothpastes and allows the use of nicotine gums with 2/4 grams of nicotine in chewing gum. It was seen that in some part of the country tobacco formed an important constituent of the dentifrices used to clean teeth (Drugs and Cosmetics Act, 1940). Lal Dantmanjan, a dentifrice traditionally contained tobacco as an ingredient but after passing of the law banning tobacco in dental products it was stopped (Wahi, 1968).In order to prevent public

from getting influenced by the role models using tobacco in Indian cinema the Central Government in 1991 directed Central Board of Film Certification not to encourage the scenes which tend to justify, glorify or glamorise the consumption of tobacco (Cinematograph Act, 1952). Adding to it in 2000, the government prohibited any advertisements on cable television which directly or indirectly encouraged the production, sale or consumption of tobacco products (Cable Television Network (Regulation) Act, 1994).

It was from June 1999 that the Railway Ministry banned the sale of cigarettes and *bidis* on railway platforms as well as in passenger trains (Government of India [GOI], 1999).Further in interest of maintaining cleanliness of the railway platforms and health of the population, the sale of *gutka* was also banned on the railway station premises and reservation centres (GOI, 2001). Since chewed tobacco is categorised under food items, it declares the use of nicotine or tobacco in any food product as toxic and unfit for human consumption. But it does not ban the use of tobacco as it is a regulated product under Prevention of Food Adulteration Act 1954 (Prevention of Food Adulteration Act, 1954).It is also mentioned under Juvenile Justice (care and protection) Act 2015, that anyone found selling tobacco to juvenile (a child less than 18 years of age) can be punished for a term extending to seven years and a fine up to Rupees one lakh (Juvenile Justice (care and protection) Act, 2015).

1.2.4. Comparative analysis of WHO FCTC and Indian tobacco control laws

The FCTC called for an international collaboration on the multisectoral tobacco control strategy which required all the nations who are signatories to work for prevention of uptake of tobacco as well as reduction in the consumption of tobacco. It also appealed to the nations to keep tobacco industry at bay and increase partnership between government and civil society which helps to strengthen the strategy of tobacco control. Under WHO FCTC there are demand reduction provisions have been divided into “price and tax measures and non price measures”. The non price measures include protecting non smokers from second hand smoke, packaging and labelling of tobacco products, education, communication and training, tobacco content and product regulation, advertising and sponsorship and tobacco cessation (FCTC, 2003). Indian laws regulating tobacco are not comprehensively covered under COTPA, 2003 as different agencies and organizations are concerned with the

implementation of these laws which ask for a better synchronization among these departments. Few provisions under FCTC which are either not addressed in the COTPA or find an erroneous explanation to its implementation are discussed in this section.

Article 6 of WHO FCTC recognizes price and taxation as an important measure to reduce the consumption of tobacco especially among young people. This price and taxation measure is seen necessary not only to prevent tobacco uptake but also to prohibit the importation of the duty free products (FCTC, 2003, p.7). In India the price and taxation measures are controlled under the Annual Finance Act that is the Union Budget. There has been increase in the price of the cigarettes though *bidi* industry has been let off the hook. The Import Export Policy, Custom Act and Regulations put a limit on what could be imported through duty free import and sale in India. Imported tobacco products being cheaper than those available in the domestic market are alluring for the tobacco users (Reddy, Arora & Yadav, 2008).

As far as tobacco content and product regulation is concerned FCTC Article 9 and 10 outlines the protocol for it. The Article 9 requires the parties to propose guidelines in order to test and measure the contents and emissions of tobacco products so that they can be adopted by the signatories to the convention. Article 10 requires the manufacturers and exporters to disclose the information about the contents and emissions of tobacco products in addition to indicating its toxic constituents (FCTC, 2003, p.9). Similarly, Section 11 of COTPA requires the Central government to recognize laboratories which can test nicotine and tar in tobacco products. Section 10 requires Central government to prescribe health warnings or indicate the content of nicotine and tar with height of each letter or figure or both used on such specific warning. This provision in Indian Act seems more technical in nature as there is lack of studies on the individuals reading the content of tar and nicotine content on packets of tobacco products (COTPA, 2003, p.5).

In order to provide information to the consumers, Article 12 of FCTC requires the parties to make use of all possible communication tools in order to promote as well as strengthen public awareness on tobacco control issues. Besides implementing intersectoral Tobacco Control Programs and strategies, information should also be imparted on the unfavourable health, economic and environmental effects of tobacco

production as well as consumption (FCTC, 2003, p.10). The Indian counterpart to this is addressed in NTCP which includes IEC (Information, Education and Communication) as one of its five components to be initiated at the state and district level. Other than this the Health Ministry disseminates the messages through government as well as private media on ill effects of tobacco use. But these messages in the media are not innovative enough to catch the attention of the customers and the messages are not rotated, meaning the same warning is circulated in the form of advertisements or testimonials against tobacco use (Reddy, Arora & Yadav, 2008).

In order to restrict the advertisements by tobacco advocates, Article 13 of FCTC obligates its parties to implement within a period of five years a comprehensive ban on advertisement of tobacco and its sponsorship and promotion. It also requires portrayal of health warnings on all the advertisements which are permitted and disclosure of such advertisements by the industry which may be available for public use (FCTC, 2003, p.11). Although Section 5 of COPTA recommends complete ban on all forms of tobacco advertisements, sponsorships and promotions yet on pack advertisements and those at the point of sale are permitted with some restrictions (COTPA, 2003, p.5).

Supply reduction provisions in FCTC and COTPA

The supply reduction provisions include the regulation of illicit trade, prevention of access to tobacco by youth and supporting crop alternatives for tobacco farmers. Article 15 of FCTC recognizes the need for eliminating the illicit trade in tobacco products as essential for tobacco control. Monitoring and data collection, developing tracking and tracing systems, monitoring and controlling the transit of tobacco, enabling confiscation and controlling smuggling and taking other appropriate measures to control the illegal trade of tobacco (FCTC, 2003, p.13). COTPA India mainly deals with demand reduction measures. As mentioned earlier, the measures to control the illicit trade are included under Customs and Trade laws. There are strong legislative measures in India regarding smuggling of illicit tobacco product because 7% of the Central taxes come from taxes on tobacco products (Reddy, Arora & Yadav, 2008, p.12). In order to protect the health of adolescents, Article 16 of FCTC makes it a requisite for the parties to implement measures to prohibit the sale of products to minors, asking for proof from the minors, display the indicators of

prohibition at the point of sale, no visible display of tobacco products (FCTC,2003, p.15). COTPA Section 6 prescribes sale of tobacco products to minors but later it was amended in 2006 which says that sale both to and by minors is prohibited. A step ahead, the law bans the sale of tobacco products within a radius of 100 yards of any educational institutes (COTPA, 2003, p.4). But there is no provision to prevent the sale of loose cigarettes although some states ban its sale. Moreover at the point of sale the tobacco products are displayed in the kiosks which are visible to adolescents.

Also to discourage tobacco farming, the parties are to cooperate with other members as well as other international as well as regional organizations to promote economically viable alternatives of tobacco to farmers, workers and individual sellers as per Article 17 of FCTC (FCTC, 2003, p.16). COTPA doesn't include these details but the Ministry of Commerce is eager to reduce the Flue Cured Virginia (FCV) tobacco production to half in the next ten years. The Ministry of Health and Family Welfare with department of agriculture is to field test alternatives for the non FCV tobacco (chewing and *bidi* tobacco) (Reddy, Arora & Yadav, 2008). As far as protection of the environment is concerned Article 18 of FCTC lays obligations for the parties to protect the environment as well as the health of the persons in relation to environment in respect of tobacco cultivation and manufacture within their respective territories (FCTC, 2003, p.16). On the other hand the laws pertaining to environment protection in India are regulated by series of Environmental Acts enacted in pursuance of global commitment of India at the Stockholm Conference and thereafter (Reddy, Arora & Yadav, 2008).

1.3. DETERMINANTS OF TOBACCO USE

This section explains how various determinants of tobacco use affect the health of the population. A broad range of determinants such as social, psychological, gender, income, education etc. have been associated with the use of tobacco. These determinants not only lead to discrepancies in the use of tobacco but also affect the type of tobacco being used. It is important to draw attention to these determinants so that the policy is tailored to meet the requirements of particular group of tobacco users.

1.3.1. Socio economic determinants of tobacco use: income, occupation and social class

Individuals being a part of the society may start this habit as a means of socializing and being part of a group. Why do people smoke despite being informed of harmful effect of tobacco use is the question which has been raised throughout centuries. The scientific community has blamed the addictive nature of nicotine for any smoker to engage in smoking and continue the habit despite being aware of the negative consequences of their behaviour. There are various reasons of why people start smoking but most of them are associated with the psychosocial motives (Jarvis, 2004). Also, the use of tobacco is common in low income groups mainly for two reasons: firstly, poverty negatively correlates with power and the influence on policy making, leaving these people voiceless. Secondly, unplanned proliferation of slums due to poverty driven urbanisation has resulted in tobacco use as a norm in these areas (Arora, et al., 2010). This explains the fact that the most commonly used products in India are the cheapest varieties available in the market (smokeless tobacco and *bidi*) which is consumed by those from low income groups whose voice is not important to the policy makers. It also goes on to explain the reason for the near absence of stricter legislations on these products in India.

Beyond the tight connections of income levels with the use of tobacco, occupational status is more closely related to job security and insurance, hence access to health care. Moreover, work environment shapes the pro smoking or co -smoking culture which defines the acceptability of tobacco use (Marmot, et al., 2008). In addition, different social classes have different social networks which generate political empowerment and inclusion if upstream and social exclusion and isolation if downstream (Mentis, 2017).In India, irrespective of the type of tobacco use, education has been seen as an important determinant. Uneducated males and females in India are more vulnerable to use of tobacco due to less knowledge and awareness regarding the health effects of tobacco use. Being poor is highly associated with the risk of use of smokeless tobacco among the males and dual use in the females. The employment status is a clear indication of the patterns of tobacco use namely those working in the unorganised sector were more likely to use tobacco in any form than those working in the organised sector (GATS India, 2009-10; 2016-17).

Moreover, the non awareness of health hazards of tobacco use is an important factor in the use of tobacco. Population is more aware of the cancerous effect of smoking and has least knowledge regarding other non communicable diseases as stroke and heart attack (Reddy & Gupta, 2004). The reason for this can be attributed to the health warnings on tobacco products as well as those in the media which are concentrated on informing the population on linkages between tobacco use and cancer. Warnings related to loss of cosmetic appeal due to tobacco stains on teeth, early ageing and tobacco being a risk factor to various diseases other than cancer is completely missing in India. In addition, research indicates that the warning labels are more effective if they talk about the positive attitude towards quitting rather than negative consequences of smoking. It is important to review the social psychological principles for creating more effective health warnings (Strahan et al; 2002).

1.3.2. Gender based differentiation in tobacco use

Similarly, gender based social values and norms exert a great influence on the tobacco prevalence and global trends indicate that smoking is much more common in males than females in the age group of 15 years and above, while gender differences are less striking in adolescence (Okoli, Greaves & Fagyas, 2013). Contrary in India, in adolescents in age group of 13 to 15 years, the difference between males and females consuming tobacco is more pronounced. This difference is more in tobacco smoking than the use of smokeless form of tobacco (GYTS, 2009). For male adults, low education and reduced income and individual as well as transgenerational social psychology imposes smoking as a model of masculinity (Jha et al; 2006). Psychologists go on to say that having no control over one's life which is rooted in the aggregate social disadvantage may predispose men to tobacco initiation as well as continuation (Farrelly, Evans, & Sfekas, 1999).

For females apart from the factors shared as low education and income as their male counterparts, the use of tobacco has to do with the anxiety to earn money for their children which impacts them negatively, making them more vulnerable to tobacco use. In low income countries gender disparities have always remained which explain differences in tobacco consumption among different regions, cultural or religious norms (Thrift, Nancarrow & Bauman, 2011) as in India. For instance, both smoking and smokeless tobacco consumption is more in South Asian men than women. As far

as the type of tobacco consumed is concerned, the male female gap was lower in the case of smokeless tobacco and the use was equally high in middle age and elderly women in India. Smoking and dual use of tobacco was higher in the younger and middle age group men. There have been studies earlier which have found age as an important determinant of tobacco use (Rani et al; 2003).

1.3.3. Influences in tobacco use during adolescence

Usually youngsters experiment with smoking and this experimentation starts due to social pressure from the peer group or the older siblings. There are studies which suggest that those who experiment with four cigarettes become regular smokers (Salber, MacMahon & Harrison, 1963). From the perspective of psychology a number of explanations have been given for people's smoking. For instance in order to explain the initiation of smoking among the adolescents behavioural perspective has been applied (Akers 1977). But the most consistent and powerful predictor in an adolescent is urge to smoke is whether the friends smoke or not (Urberg, Shyu, & Liang, 1990). The next powerful influence is the family and adolescents are more likely to smoke if their parents smoke (Bricker et al., 2005).The most suitable explanation to this is that adolescent population is the most vulnerable in the use of tobacco as they undergo various biological and psychological changes. They are less critical in their thinking and are emotionally more impulse. The brains of the adolescents have a remarkable capacity to adapt to change; thus tobacco use during this period is perceived as normative while it is highly pathological in nature. On the contrary, the use of tobacco during young adulthood might be contributed to addiction to nicotine and barriers to cessation help which prevails in most of the countries (WHO, 2014). In addition, studies have indicated that youngsters estimate that they will quit before tobacco use behaviour does any harm to them (Arnett, 2005).

1.3.4. Addiction to Nicotine

The researchers of the late nineteenth century studied that nicotine produces a strong influence on the nervous system which is largely dose dependant. But they were quick to add that the repeated use of nicotine produces tolerance for which more doses are needed addicting the user to repeated consumption of tobacco products. However late twentieth century and early twenty first century put forward the research that nicotine produces similar behavioral and physical effects as that of the addicting drugs. These

include activating the brain reward systems that create behavioural effects and psychological cravings leading to chronic drug use and physical dependence which causes withdrawal systems upon its discontinuation. Subsequent research showed and confirmed that it was possible to become addicted to nicotine which led to development of nicotine chewing gums and nicotine patches to relieve the withdrawal symptoms and make quitting tobacco products easier (Henningfield & Santora, 2005, p.3).

These findings were reflected in 1988 Surgeon General's Report which said that cigarettes were addictive and nicotine caused addiction. It is obvious that all tobacco products contain nicotine which can lead to addictive patterns of tobacco use. But addictive risks depend on the type of tobacco products consumed. Oral smokeless products do not produce as rapid an effect on the brain as smoking does. Speed of delivery of nicotine is most remarkable with cigarettes which require smoke delivery to the lungs and nicotine hits the brain in seven seconds. The combination of chemicals which offers an addictive cocktail of substances to make it maximally addicting makes cigarette very much addictive (Hennigfield & Santora, 2005).

1.4. PLACE OF TOBACCO IN PUNJAB

The state of Punjab is known as the bread basket of India indicating high levels of productivity and growth in agriculture. But now the situation is different and income of the farmers has stagnated due to stagnation in production of rice, fall in the production of cotton and increase in the input use and their prices. Technology has shown the signs of fatigue, the income growth has slowed down and employment has shrunk (Sidhu & Bhullar, 2004). The regions capacity to absorb labour has shrunk and the availability of cheap migrant labourers both during and after the Green Revolution has contributed to the inability of the farms of Punjab to provide employment to the local youth (Singh, 2002).

The migrant labourers came to dominate the agricultural labour force in Punjab during 1990s when American bollworm attacked cotton and forcefully paddy cultivation was adopted. The local labour was not skilled in paddy cultivation and hence the labour from Bihar and Uttar Pradesh started dominating the agricultural market which left little for the local youth to look forward to. Although the growth rates in Punjab

slowed in recent years yet the state is still reaping the benefits of economic glory. It has poverty rates lower than the other states of India and the addiction of various forms in youth has been created out of tension of a relatively aspiring rural population with slowing agricultural economy. This stagnation in income with the expansion of higher education is Punjab made the matters worse. A wider gap has been created between the availability of labour and actual employment opportunities in the rural sector (Dutta, 2012).

While more youth are getting educated, they do not find the farm jobs lucrative and do not want to go to the old ways of tilling the land. But the problem which has arisen is that they do not find any jobs to absorb them (Singh, 2005). This leaves them with little to do and they start indulging in any form of addiction such as tobacco, alcohol or other drugs. This is because they enjoy fair degree of financial and cultural prosperity which makes it easy for them to procure the addictive material. The access to money and its exposure to different cultures through internet and television have lead to obsession with the idea of global lifestyle. This influences a young person's desire to purchase synthetic drugs from medical store and leads to various forms of addiction (Kaminsky & Long, 2011).

Although Punjab witnessed economic prosperity which brought financial freedom to explore various forms of addictives, the religious background of the state prohibits all forms of addiction. According to Census of 2011, majority of population of Punjab is of Sikhs. Smoking is banned in Sikh culture and use of tobacco is listed under Sikh Rheyat Maryayda (code of conduct) as one of the four transgressions.[6] In spite of the prohibition of use of tobacco in Sikh culture in Punjab, the use of tobacco in form of cigarette smoking from 1985 to 2015 in males in Punjab has increased (Misra et al., 2016). The use of tobacco in Punjab has increased from the year 2010 (GATS India, 2016-17). A study done in Punjab, Haryana, Himachal Pradesh and Chandigarh among school going children of 13 to 15 years of age found that the use of tobacco was lowest for Punjab amongst these regions. Within Punjab, the use of smokeless tobacco was less than smoked form of tobacco (Jindal et al., 2005). However, a change has been seen in the recent times. A study conducted in Ludhiana in age group of 13 to 19 years among 400 adolescents found tobacco use to be more than

[6] http://www.sikhs.org/art9.htm

some regions of India namely Jaipur and Noida. The use of smokeless tobacco was more in females and males smoked more (Saji, Jain & Pabla, 2014).

The increasing use of evidence of tobacco use in Punjab has seen the effects of tobacco use on the health of the population. A study done in two districts of Punjab revealed that not only the use of pesticides and heavy metals in drinking water but also the prolonged use of tobacco was a reason for increasing cancer cases in Punjab (Thakur et al., 2008). The National Cancer Registry of India's under ICMR report from 2012 to 2014 revealed that oesophagus, lung, tongue and mouth were leading sites of cancer due to tobacco use in district of Patiala in males (National Cancer Registry of India 2015a, p.26). The relative proportion of tobacco related cancer has been seen to be as high as 39 % in males which is more than some of the north eastern states in India (National Cancer Registry of India 2015, p.28).

The increased use of tobacco in the region of Punjab saw the government taking serious actions to curb the menace of tobacco. A news report stated that Punjab banned "the storage, sale or distribution of *gutka, paan masala,* flavoured /scented /processed chewing tobacco and any other food products containing tobacco or nicotine as ingredients" on 1st of January 2016 (The Hindu, 2016). The Hindustan Times also reported that Punjab government's finance department had decided to increase the Value Added Tax (VAT) on *bidi* and cigarette products in order to make them unaffordable for children and poor and reduce their prevalence. Necessary instructions had also been sent at the district level to officials for limit the number of tobacco vendors and reduce the availability of these products to children (The Hindustan Times, 2016).

Although these decisions received applause from the residents of Punjab yet the internal politics of tobacco control is being seen as a big hindrance in curbing the use of tobacco in the state. The Tobacco Control Program in Punjab came under a serious scrutiny when an article published in Punjabi newspaper Ajit ,dated 31 May 2016, stated that the banned tobacco products in Punjab were being sold due to lack of coordination between the Railway officials ,Punjab police and Excise and Taxation department. These tobacco products reached through rail parcels to the railway stations in Punjab and were allowed to move out of the railway stations without any checking by the Railway department. The officers at Excise and Taxation department

complained that the parcel department of railways did not provide enough cooperation to nab the culprits. This politics of tobacco control where on one side tobacco is being banned and on other side the tobacco industry is being favoured by those within the government provides a grim picture of tobacco control in Punjab.

1.5. CONCEPTUAL ISSUES OF TOBACCO USE AND POLICY

Most of the people are aware of the harmful effects of tobacco use still continue to consume it. There are broadly three pre disposing factors to this kind of continued behaviour namely biological, social and psychological. These factors can be seen as foundation which acts as a driving force for awareness, motivation and information factors that all result in intent and ultimately to the behaviour state (Segaar et al; 2007). The behaviour intent can be determined by three types of motivational factors namely attitude towards new behaviour, social influences and self efficacy explanations. These are influenced by distant factors, awareness and information as well as predisposing factors. The social factors (parents, siblings and peers) implicated in initiating smoking behaviour have an important role to play in maintenance of this behaviour. Although smoking is a social activity yet it can vary from individual to individual and cigarette to cigarette (Perkins,Conklin & Levinee, 2008).

For those at work it can mean a break from the monotonous routine, for those in club it can mean strengthening the ties with the friends and for low income mothers it can mean coping up with something gone wrong (Irwin, Johnson & Bottorff, 2005). An addition to social factors, the most successful approach in looking for the psychological factors leading to continuance of smoking is the Theory of Planned Behaviour. It says that the proximal determinants to engage in the behaviour are the intentions to engage in that behaviour. Intentions reflect the effort an individual puts in to perform behaviour in this case using tobacco. The perception of control of tobacco users over their behaviour becomes uncontrollable and hence difficult to change (Schachter et al., 1977).

However, there are people who quit smoking for a number of years but start smoking again. Furthermore there are smokers known as chippers who smoke a given number of cigarettes daily for a number of years and do not increase the amount they smoke. Smokers under estimate the risk of getting cancer relative to other smokers and non

smokers and demonstrate a lack of understanding of the negative consequences of smoking. Thus it is a matter of doubt if the smokers make their decision due to lack of understanding of the risks associated with smoking (Weinstein, Marcus & Moser, 2005).However, it is suggested that it is a risk denial rather than lack of information about the effects of smoking on health due to which people continue to smoke (Peretti Watel et al; 2007). It is advocated that smokers have an "unrealistic optimism" associated with their smoking behaviour and the risks involved in the same (Dillard Savageau & Fletcher, 2006).

Over the last few decades much research has been done on persuading the individuals to change their health behaviour in order to decrease their susceptibility to lifestyle diseases. Since the aetiology of these lifestyle diseases is deep-rooted in the daily lives of the people, the response to such behaviour does not seem to be inappropriate in nature. However, while it is easy to describe distal behaviour; routines, habits and established ways of life are not easily changed. Most behaviour change models limit themselves to presumptions that individuals are able to make healthier choices for themselves based on the information received and their well being is a part of the choices they make (Blue et al., 2016). This interpretation has been critiqued saying that individuals can partially calculate rational information and often respond mechanically to their environments (Marteau et al., 2011).

However, not all theories of health behaviour are based on individual choices. For instance the explanations that focus on the broader determinants draw attention to the social context and the impacts these have on the lives of the people (Marmot et al., as cited in Blue et al., 2016). Changing these conditions has been seen as a way of dealing with the epidemics of NCDs since these diseases show a strong social class inclination. However, while contextual approaches argue for different forms of intervention, many reproduce similar individualised methodological approaches which conceptualise the macro social structures as limiting or simply determining the health choices or behaviour of the individuals (Blue et al., 2016). Both the approaches do not provide much insight into the patterned routine and habitual ways of life.

A key challenge in the tobacco policies is its detachment from the micro level realities surrounding the individuals. The structuration theory given by Giddens suggests that there is a recursive relation between the structure (External forces as laws, resources,

and social systems) and the agency (capability to make a difference). He is trying to suggest that both structure and agency have an equal importance in their influence on individual. For example the poor health practices in a community (say tobacco use) are as important as understanding the absence of any knowledge provided on the same by the government in understanding why the health practices are poor. So it will not be wrong to say that there is a recursive relation between health outcome, health practices and facilities provided by the government (Bodolica et al; 2016). Having said that an explanation which is concentrated solely on the structure or the actions of the individual will be inadequate as the structuralists (who emphasise on structures of the society) and humanists (who empathise on the human agency) can very well provide an explanation to the poor health outcomes (example those related with tobacco) in a given community (Oppong, 2014).

However, Giddens criticised the dualism or compartmentalisation of the structure and agency and rather argued for the duality between the structure and agency (Giddens, 1984). Thus recognition of the duality of structure and agency is essential for us to report human actions and develop interventions for the same. It goes on to say that "individual choices are seen as partially constrained, but they remain choices nonetheless" (Bratton et al; 2010, p.373). This argument says that any understanding of the formulation of the policies will be completely skewed if we are unable to appreciate the duality of structure and agency. It becomes necessary to adopt a holistic approach to the subject of tobacco use as well as its control. Thus the actions of the individuals depend on the human agency while human agency is in turn dependant on the psychological and demographical attributes of the agents (individual). This behaviour is undoubtedly influenced by the micro environment (work environment, family, peers etc) which in turn depends on the structure (rules, social systems and resources) (Oppong, 2014).

As already mentioned in the structuration theory, the role of structures which in this case means regulations cannot be seen independent of the agencies which translate to various institutions in case of tobacco. In order to build complementary theoretical approach, the various theories in policy are broken into their component parts which explain the "relationship between the five core causal processes" which in turn work together to control the behaviour of tobacco use. The five core causal processes as

laid down by John are institutions, networks, socio economic process, choices and ideas (John, 2003).

The main question which needs an answer is that can the policy outcomes be linked to a single institution and the rules associated with it or can multiple institutions affect the progress of the policy? The rules associated with these institutions can be formal such as based on a political system or informal in which there is an understanding of how actors should behave. The formal institutions are first in which the power is concentrated in the hands of few who thereby claim to be representatives of majority (majoritarian) and second those who "share, disperse and limit power." In majoritarain system the policies are imposed from top down while in consensus there is a spirit of "inclusiveness, bargaining and compromise" where government is more willing to form corporatist alliances. A corporatist structure "enhances the institutional centralization of power which obstructs the process of new interest and outside agendas. If all cases agree on need for a change new policies can be put into order more swiftly than in the pluralist arrangement" (Green-Pederson & Wolf, 2009).

Historical institutionalism on the other hand focuses on path dependency and the arrangements and policies carved under them are increasingly difficult to change (Peirson, 2000). The variations in the tobacco policy across different systems may be explained by the comparative focus on the institutions. The institutional difference within a political system for policy differences or similarities may depend on the choice of institution within a political system. The responsibility of tobacco may extend across different institutions across different departments with each department having its own norms, clientele and behaviour. Also the shift in the policy responsibility from departments of trade and treasury to health calls for attention. These institutional characteristics and the shift in the policy are explained in various ways in nature through different theoretical frameworks (Cairney, Studlar & Mamudu, 2012, p.26).

First the Advocacy Coalition Framework (ACF) plants policy at the centre and locates all actors and types of government within realm of policy sub system (Weible et al; 2009). It is based on the critical assessment of the policy cycle saying that it artificially draws a distinction on the various stages of policy process and the construction of these boundaries where various actors get involved. Instead ACF

separates actors according to their beliefs which symbolise the base for their actions. For example Tobacco Control Policy may be divided into pro and anti tobacco actors or coalitions which have supports at multiple levels and in different types of government (Sato, 1999). Second, Punctuated Equilibrium Theory and Multi Level Governance (MLG) scrutinise the extent of involvement of different actors in controlling tobacco use and how this changes with time. The policy outcome results from interplay between governmental and nongovernmental actors at various levels (Baumgartner & Jones, 1993). Similarly a Street Level Bureaucracy approach can suggest that although the legislation is born at top of the hierarchy, it is influenced by the officials in public sector who deliver it. The bureaucrats at the bottom establish thumb rules and routines to satisfy what government lay down as objectives while defending a sense of professional independence necessary to maintain their morale (Lipsky, 1980).

However, the question which arises is why only some policy issues are at the peak of policy agenda ignoring other unlimited number of policy problems? Second, there are number of solutions to these problems yet only few are considered (Cairney, 2012). There are no objective markers to determine which problem is the most deserving of the attention of the policy makers. Instead this attention is defined by the negative feedbacks when the issues are ignored and positive feedbacks when issues receive too much attention (Baungartner & Jones, 2009). This attention is strongly linked to how to persuade people that the issues raised are worthy of receiving attention (Baungartner & Jones, 1993). A shift in the balance of power among the political sub systems can be responsible for change in the problem definition and attention. The shift in the policy network in the countries and how the dominance of tobacco industry has been confronted by the public health advocacy networks explains the shift (Cairney ,Studlar & Mamudu,2012 pp.31-32).

In addition, relevant contextual factors include a political system's size, demographics, mass attitude and behaviour, structure as well economics. While there are accounts suggesting that policy environment decides policy, there are various studies which point to the fact that socio economic factors produce demands which inform the political system. As far as Tobacco Control Policy is concerned a number of socio economic conditions may explain policy convergence and divergence globally. These factors may include public behaviour including prevalence of

smoking (but disaggregated by gender, class and age); the economic benefits of tobacco as well as economic burden caused by its use and public attitude to smoking, smokers and tobacco companies (Blomquist, 2007).

CONCLUSION

The use of evidence to inform tobacco policy decisions was likely to ensure most unbiased population health gains. This is to say that the use of varied forms of tobacco in Indian population in the form of smokeless and smoking tobacco should have fetched equal attention from the government. This relation between the health practises, the health outcomes and the response of government to it is fluid in nature. While tobacco use by individuals informs policy choice, the policy also determines the ways to contain the use of tobacco in the population. However, an analysis of legislation of tobacco control in India found that too much focus is laid on smoking tobacco (cigarettes to be precise) and smokeless products are suitably ignored. The debates on second hand smoke and passive smoking have been a crucial factor in pushing further the need for a stricter regulation as far as smoking is concerned. Moreover, there are no timely rotations of the health warnings which are present on the packets of tobacco use specially the smokeless tobacco. Same messages throughout the years without any creative approach are a big drawback of the crusade against tobacco. To add to the problem, there are various Ministries which work for tobacco and coordination between different Ministries in order to work for a tobacco free society is a mammoth task for the Indian government. Also, government has taken clues from the international control policies on tobacco but failed to recognise the local demography and diversity of tobacco products being consumed in the country. One must not forget the highly political nature of tobacco control in general and the complex vested interests of the lobby for tobacco industry. This influences the policy makers and the government to go lenient on the laws which could affect tobacco business. The location of various determinants of tobacco use within this policy takes a back seat while formulating the policies and addressing the problem of tobacco in India. The cheapest and most consumed tobacco products as well as those consuming them are completely ignored in policy making.

CHAPTER 2

RESEARCH METHODOLOGY

As far as tobacco is concerned India occupies a very special place globally as the second largest consumer of tobacco which makes it important to take it as a serious public health challenge and examine various measures taken by government to control the spread of tobacco induced diseases. The researcher conceptualised the research problem and dealt with the methodology which has been adopted in a comprehensive manner to address the subject of tobacco control in an exhaustive way in district Jalandhar, Punjab.

2.1. CONCEPTUAL FRAMEWORK

Tobacco in any form or type kills people and is seen as a risk factor for various non communicable diseases which are completely preventable. Tobacco control is very important public health goal as it protects people from mortality and morbidity. The tobacco control measures involve multiple stakeholders and coordinated efforts, which are a major requisite for controlling the epidemic of tobacco which is expected to kill 8 million people yearly worldwide and 80% of these deaths are likely to take place in developing countries by 2030 (WHO, 2008, p.6). In high income countries smoking related medical costs constitute 6 to 15% of all costs of healthcare. Roughly contributing to 10% of smokers in the world, India is next to China in tobacco consumption (John, Sung & Max, 2009, p.138). The mean age at initiation of smoking as well as use of smokeless tobacco in India among the age group of 20-34 years is 17.9 years in India (MOHFW, 2010, p.36).

But the use of tobacco in India is varied and is changing with the varying patterns of consumption as well as the age group consuming the same. The most consumed among the smoked tobacco products is *bidi* and only 20% of the total tobacco consumption is shared by cigarettes. The consumption of *hookah*, *khaini* and other forms of smokeless products varies within the regions of India (Jhandoo & Mehrotra, 2008, p.805).The prevalence of smoking among youth is also increasing. Data from the Global Youth Tobacco Survey (GYTS) 2009 shows that “one out of five children in the world smokes his or her first cigarette by age 10 years” (GYTS, 2009).

The review of literature makes it evident that the proportion of young people and women consuming tobacco products has been on increase in the recent years in India. The advertisements in media and on screen smoking by celebrities portray smoking as a way to liberate the youth. Also, young women are becoming financially independent and take it as an opportunity to free themselves from the social customs, norms and patriarchal mindset and flaunt their social status as well as independence. On the other hand, peer pressure has been seen as a major factor in initiating tobacco use. The young men and women to keep pace with the modernisation and westernisation of the Indian society, succumb to pressure from peer group. The various socio demographic and socio economic factors not only determine the initiation and continuation of tobacco use but also decide various types of tobacco products being consumed. The consumption of *bidi* and smokeless tobacco products is more in the users from lower socio economic background and those consuming cigarettes are in relatively higher socio economic conditions.

Review of literature showed that in India the number of those smoking *bidi* is more than those smoking cigarettes and smokeless form of tobacco is consumed most commonly. An important reason for this dissimilarity is the difference in the taxation systems in *bidis* and cigarettes. The last nineteen years have seen the taxes on cigarettes rise to 1606%. The tax on the cigarettes is a complex system and is based on the length and the filters of the cigarette stick. The companies take advantage of this puzzling tax procedure and manipulate it with relative ease keeping the demand intact. The biggest problem in curbing tobacco use is among those who manufacture the closest cousin of cigarette that is *bidi*. While WHO has suggested the taxes on tobacco to be 75% of the retail price those on a pack of *bidi* remains to be 7% of the retail price. A 20 stick cigarette pack is taxed around 60% of the retail price in India (The Wire, 2015).

In addition, the use of *bidi* is a major health risk because the loose packing of tobacco in *bidi* requires smokers to inhale the smoke more and puts them at a higher risk of developing Chronic Obstructive Pulmonary Disease (COPD) apart from other illnesses like oral cancer and lung cancer. But the industry is of the view that the illicit trade in *bidi* would rise if the taxes on *bidi* are to be increased, depriving the centre and state of the taxes. Moreover, *bidi* due to its inexpensive nature is consumed by those who have low socio economic background. This compromises their health by

not only consuming *bidi* but also spending the money to be spent on food for consumption of tobacco products. Intake of less food makes them more prone to malnourishment and diseases.

The use of different forms of tobacco products makes the pattern of tobacco-related diseases also different in various countries. For example, vascular disease and lung cancer for which tobacco is a risk factor, predominate in the United States, but in China, there are far more deaths from chronic respiratory diseases due to smoking than from CVDs. On the contrary, in India there is greater prevalence of oral cancer due to use of smokeless forms of tobacco. In addition, 12% of global tuberculosis deaths are caused by smoking and in India, where almost half the world's tuberculosis deaths take place, smoking increases this risk (Asma et al; 2004, p.254).

The use of tobacco, both in smoke and smokeless form, has a direct impact on the health of the individual involving respiratory system and oral cavity. The lesions developing in the oral cavity due to tobacco use include malignant disorders, squamous cell carcinoma, periodontal diseases, dental diseases, pigmentation, tooth loss and variety of other diseases (Pillai & Jagannathan, 2014). Oral cancer is caused by use of smokeless form of tobacco due to easy absorption of tobacco products in the oral mucosa. The patients consuming *gutka, khaini* and other forms of smokeless tobacco keep the quid in their buccal vestibule[7] which is absorbed through oral mucosa slowly and leads to release of carcinogens. This leads to various stages of malfunctioning of the oral cavity through stages of discoloration, mobile teeth and limited mouth opening. These patients coming with tobacco stains are to be seen as a potential threat which not only compromise on the cosmetic health but also stand the risk of getting oral cancer.

Not only tobacco induced diseases, tobacco consumption is also the cause of poverty. Apart from decreased expenditure on food, studies from India and China show that the expenditure on the tobacco products reduces investment in education which aggravates poverty. On top of that, increase in diseases due to tobacco consumption leads to increased expenditure on health care. It causes productivity to decrease and hence affects earnings and in turn pushes the family into poverty. Death due to tobacco use is mainly among males who are sole earning members and hence more

[7] The part of the mouth which is between the cheek and the teeth is called buccal vestibule.

economic burden on the family affects the welfare of entire family (John et al; 2011, p.3).

The rise in the diseases associated with consumption of tobacco is in the form of an epidemic, the vector being the tobacco industry. There are great linkages between the increasing incidences of tobacco use due to interference of the tobacco industry in the tobacco control. Some of these strategies range from direct and indirect political lobbying to campaigns, financing of research and influencing the policy machinery. Today, tobacco companies are shifting their business from developed countries to developing countries and India is a prime target due to its population of tobacco users. Nevertheless, both World Health Organization (WHO) and World Bank recommended that countries should prohibit all forms of tobacco advertising and promotion. Such bans, if adopted globally, could "reduce the worldwide demand of tobacco by around 7%". Despite denial by the tobacco industry, majority of literature shows that tobacco advertising leads to an increase in its consumption in population (Legresley et al; 2008, p.339).

A report by WHO also shows that cigarettes in India have become more affordable by 15% between 2008 and 2015 because taxes have not been able to contain the consumption of tobacco[8]. In addition, tobacco is seen as a public health threat to not only those who directly consume it, but also to the whole community. The children engaged in the tobacco industry are not able to visit schools and are deprived of formal education. Not only has the individual health been affected, use of tobacco has also caused degradation of environment due to deforestation done for tobacco cultivation. The effects of tobacco use on young people have a direct impact on the workforce of the country and indirectly affect the economy of the nation.

The health effects of tobacco use as mentioned earlier were influential in tobacco policy changes globally. These changes are limited to the use of policy instruments of tobacco control and ignore the changing patterns of environment; social political as well as economical. It has always been maintained that policy follows problems and changes with the nature and the severity of the problem. The factors outside the immediate policy troubles as social or political are not taken into consideration in

[8] http://thewire.in/2015/09/29/curious-bends-affordable-cigs-notes-from-fukushima-a-destructive-bladder-craze-and-more-11873/

order to offer explanation for non solution of the problems. However, the macro level changes such as globalisation have been offered as an explanation for some major tobacco policy changes in India.

The literature ascertains that the use of tobacco by an individual is not only dependant on individual's choice of a particular behaviour but also the factors which control that behaviour. This is to say that not only the immediate environment but also various agencies and institutions play an important role in the decision to consume tobacco. Simply put, if the taxes on tobacco products especially *bidi* and smokeless tobacco products are high; the behaviour of tobacco consumption will be contained. Moreover, if stricter rules as well as their implementation for sale of tobacco in adolescents are there, the age of initiation of tobacco and hence the associated health effects of its prolonged use can be prevented.

The use of various social correlates to enhance the effectiveness of the tobacco control program has not been found in the Indian literature. There are various gaps in the way research on tobacco is oriented which is in turn reflected in the policy. The interstate variations in tobacco consumption can be traced to their history and this exploration of the historical context is not part of the policy process. The subsequent tailoring according to the demography of the states is nowhere to be seen. It is to note further that an individual is the centre of approach in the policy but his interaction with different stakeholders and to and fro movement of these interactions are not developed; not to forget that health is a process of various social and political forces which are under the control of various political actors with their own interests. Although there are various instruments of tobacco control, their effective engagement with the individual in a social environment is a matter of question as well as concern.

The picture is no different in the state of Punjab where politics of tobacco industry and the laxity in implementation of tobacco control offers an interesting representation of the above raised concerns. Punjab is a state in India known for its agricultural produce as much as it is known for its extreme and exceptional case of various forms of addiction. When the exceptionalities and extremities of the problem exist, the linkages established present a complex problem which can be traced to the period of agricultural revolution in Punjab. The shift to paddy growing, migration of cheap labour from other states, increasing aspirations of Punjabi youth, lack of

employment opportunity and money through family's farmland are some of the reasons responsible for the rising addiction, tobacco being one of them. The failure of Punjab's industrial sector to effectively absorb the increasing number of youth from rural areas and the cultural attributes that inhibit them from taking certain kinds of employment especially in agriculture sector, have influenced the uptake of drug use including tobacco among the educated yet unemployed rural youth.

Although the culture and the predominance of Sikh religion in Punjab do not advocate use of tobacco products yet the use of these products is on rise. In spite of being low on tobacco use when compared to national statistics, the use of tobacco in adults in recent past has increased in Punjab as evident in GATS-2 report which found an increase in the percentage of those using tobacco from 11.7% in 2009-10 to 13.4% in 2016-17 (GATS India, 2017). The Punjab government is taking steps to control tobacco menace but the interference by tobacco industry creates obstacles in Tobacco Control Program. Although banning of loose cigarettes in Punjab fetched appreciation from international agencies like World Health Organisation (WHO), the loose cigarettes are easily available in the state due to which children easily get addicted to tobacco use. Additionally, there are studies which show that the use of tobacco is on increase in the school going children in Punjab predominantly the smokeless form. The alliance of some government officials with tobacco industry has seen banned tobacco products being openly sold in the state. The print media has been reporting the sale of these banned tobacco products and the negligence of the government but any convincing action on the part of authorities is missing. Drawing upon this conceptualisation, my study wants to look into the policy context and social correlates of tobacco use in district Jalandhar of Punjab and various factors responsible for the same.

2.2. RATIONALE OF THE STUDY

As per the Census Report of 2011, the population of Punjab consists of 57.6 % Sikhs and rest of the inhabitants belongs to other religions. Punjab was first among the states to ban production and sales of the harmful smokeless chewable form of tobacco in 2012 after the Union Health Ministry framed the new food adulteration rules in 2011(The Economic Times,2012). These rules by the Food Safety and Standards Authority of India (FSSAI) specified that tobacco and nicotine will not be used as

food products. Since *gutka, khaini, zarda*, toothpastes etc. were categorised as food products and consumed for flavour or use, they should not contain products as tobacco and nicotine which are proven carcinogens. However seven months after WHO appreciated the government of Punjab's control strategies for curbing use of tobacco, in January 2016, a newspaper report said that Punjab government made a crucial decision by lifting the ban on the manufacture of *gutka, pan masala* and other processed flavoured and scented products which have tobacco and nicotine as their ingredients. This meant that the manufacture of tobacco products would be allowable and their storage, sale and distribution would be banned in Punjab. The Punjab government was of the view that only a nationwide blanket ban on tobacco products can serve the purpose. So in order to alleviate the sufferings of tobacco industry, the Punjab government called for lifting the ban on tobacco manufacture (The Tribune, 2016).

Although Punjab banned the sale of loose cigarettes in January 2015, according to a report on 31st December 2015, in district Jalandhar all the products made of tobacco were being openly sold in public places. The kiosks selling these tobacco products were found outside the district courts and also in front of educational institutes including schools, colleges and universities. They were found to be selling banned loose cigarettes to the students. The administration had made various task forces in police, judicial and health departments. However the district had failed to go smoke free despite being declared a smoke free zone (Khaira, 2015).

In my research, I want to focus on the measures of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Indian Government has been trying to address the use of tobacco and related diseases in Indian population the approach to social, cultural and political factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The various factors responsible for use of tobacco and its translation into oral cancer in district Jalandhar will add thick description to the study. Moreover, any mention on tobacco in the thesis would include both smoking and smokeless forms of tobacco unless specified or segregated into various categories.

2.3. RESEARCH QUESTIONS

1. What is the history of tobacco cultivation, the corresponding growth of tobacco industry in India and the response of government to it?

2. How did the historical events in development of Punjab played an important role in tobacco introduction and its consumption?

3. What legislative measures have been taken by the Punjab government to address the use of tobacco?

4. How have been the Tobacco Control Policies and laws in district Jalandhar translated and what have been the barriers in implementing the same?

5. What are the social correlates of tobacco use and its health implication in the form of oral cancer in district Jalandhar?

2.4. BROAD OBJECTIVE

To study the Tobacco Control Policies and laws in Punjab with focus on their translation and health implication(oral cancer) as well as social correlates of tobacco use in district Jalandhar.

2.5. SPECIFIC OBJECTIVES

1. To trace the history of tobacco cultivation and the corresponding growth of tobacco industry in India and public health response to it.

2. To collate the events which played an important role in tobacco introduction and consumption in history of Punjab.

3. To study the translation of Tobacco Control Policies and laws in district Jalandhar, and the barriers in implementing the same.

4. To study the health implications of tobacco use in the form of oral cancer in district Jalandhar.

5. To study the social correlates of tobacco use in district Jalandhar.

2.6. RESEARCH DESIGN

The research is qualitative in nature and follows the Case Study design which helped the researcher to get a holistic view of Tobacco Control Policies in district Jalandhar. Various qualitative tools were used at different phases of research, thereby building better understanding of the relationship between ideas and helping in conceptual development. Moreover, the design was supportive in capturing a range of perspectives on tobacco control, consequently reducing bias in the study. A significant benefit of this approach was that the study could be deciphered from different vantage points using different methods and techniques. To put it more simply, the questions raised through review of literature and the context in which they were raised, helped to establish what is available in the literature on tobacco and what more can be added to it. The use of various tools, as enumerated later, for collecting data reflects an in depth understanding of the phenomenon being studied.

The design added value to the participants through discussions on subject of tobacco and helped in getting realistic responses rather than a pure statistical survey. In addition, it helped to simplify the subject of tobacco control as well as its use. The researcher taught herself to be open to observation, questioning and participation across all the stakeholders; policy implementers and those at the receiving end of the implementation. Localising the elaborate efforts of the Indian government to implement smoke free policies, to assist tobacco users to quit and prevent uptake of tobacco in the district was beneficial in outlining the similarities as well as elaborating the peculiarities of the same within the district. Besides, it was advantageous in addressing the mass reach communication interventions through adequately funded campaigns, cessation interventions in health care system and integrating these into routine clinical care, administration and management of program.

The use of tobacco across various groups and experiences of the oral cancer patients threw a light on the social correlates of tobacco use in the district and preparedness of government to address the use of tobacco as well as its health implications mainly in the form of oral cancer. The policy context was studied with the help of in-depth interviews of the officials involved in tobacco control which helped to establish the course of tobacco control measures in the district. The research was further enhanced by the analysis of what had been given in the policy documents regarding tobacco and

what was operational in the field. It helped the researcher to elaborate, clarify, or build on findings from other methods which seemed relevant for the study in the course of progress of the research.

The study gained reliability by thoroughly triangulating the descriptions and various interpretations not only in a single step but constantly throughout the study period. It paid close attention to the social, political and other contexts involved in tobacco use as well as control in the district through an addressal of the objectives laid down for the study. The process of case study informed the tobacco control measures being taken in the district which could help to curb tobacco use in its various forms. This was possible through engagement with the district officials across various departments as Health, Education, Municipal Corporation and Police involved in the Tobacco Control Program. They were able to provide an insight into the questions of how and why the tobacco control is running in the district the way it has been.

Equally enriching were the experiences of the sellers as well as users of tobacco which helped to understand tobacco use as a complex social phenomenon adding to the convoluted process of tobacco use as well as its control. The Case Study design specifically helped the researcher to explore the nuances of the program in the district and complicated context within which the selected variables operated, making the explanation dense. Nonetheless, there was difficulty in drawing the boundary of the study but the emphasis was more on the processes associated with tobacco use than the actual outcome of the policy. The researcher was not interested in the technical aspects of the development of the policy. Simply put, the active aspect of the policy was viewed as ongoing process which involved the articulation of various ideas and dialogues among various stakeholders in the district. The study was consciously designed to generate new insights into the existing body of research on the questions of tobacco use and control. In other words, the focus was not on mere frequencies or numbers but tracing the links of policy evolution and tobacco use over a period of time.

2.7. PROFILE OF THE STUDY AREA

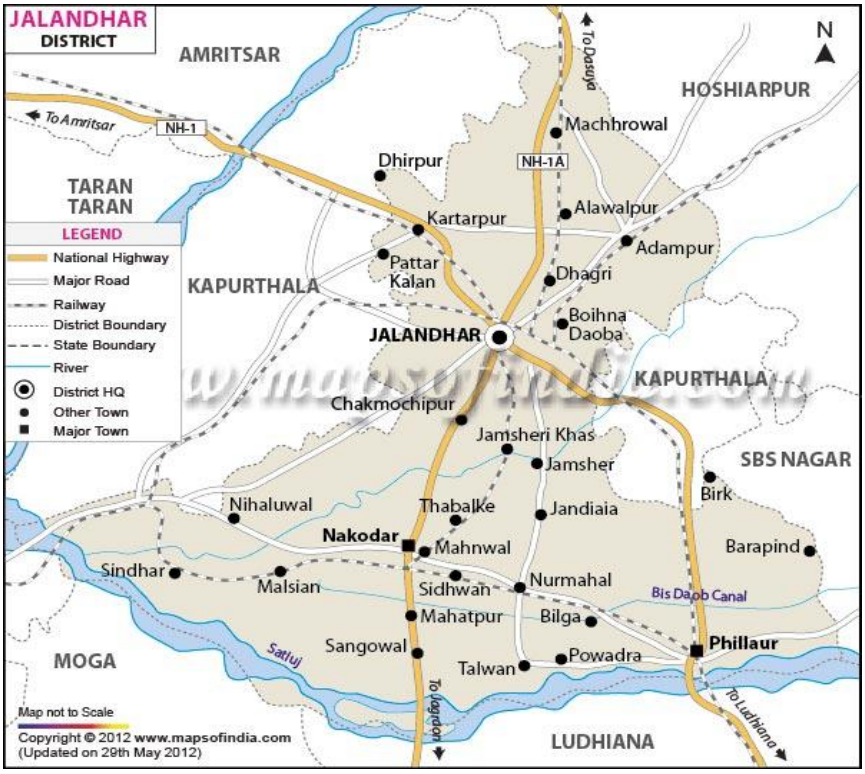
Jalandhar is a centrally located district which falls in the Doaba region of Punjab state and lies between the north latitude 30°-58’ and 31°-37’ and east longitude 75°-08’ and 76°-18’. The district on the south is bound by river Satluj which separates it from

Firozpur, on the northwest there is Kapurthala district intervening between Jalandhar and Beas River, on the north east it shares boundary with district of Hoshiarpur broken by area of Phagwara *tehsil* of district Kapurthala. For the purpose of administration Jalandhar is divided into five *tehsils* namely, Shahkot, Nakodar, Phillaur, Jalandhar I and Jalandhar II and ten development blocks. As per Census 2011, Jalandhar district is more urbanised (52.9%) than the state of Punjab (37.5%) with a sex ratio of 915 which is also higher than the state 895. The population of the district is 21, 93, 590 comprising 11, 45,211 males and 10, 48,379 females amounting to 7.9% of the total population of the state. Out of the total population of Jalandhar 31.4% of the population is the main workers and 3.87% is the marginal workers. However what is alarming is the number of non workers in the district amounting to 64.69% (District Census Handbook-A, 2011, pp.13-15).

Figure: 2.1. Map of Punjab[9]

[9] https://www.mapsofindia.com/maps/punjab/punjab-district.htm

Figure: 2.2. Map of District Jalandhar[10]



As enumerated in Census Handbook 2011, on 1st April 2010, there were 152 medical public institutions out of which 124 are rural and 28 are urban. Among these public institutions there are three hospitals, 10 Community Health Centres (CHC) (4 Rural and 6 Urban), 29 Primary Health Centres (PHC) and 110 dispensaries (District Census Handbook-B, 2011, pp.21-22). In Jalandhar, District Tobacco Control Cell (DTCC) is responsible for overall planning, implementation and monitoring of the different activities planned under Tobacco Control Program in the district. The role of the different functionaries under the NTCP in district for tobacco control is documented. The DTCC is responsible for developing generating awareness against the harmful effects of tobacco through use of mass media. In order to manage the enforcement of all these at district level, engagement of health workers and key decision makers is required. Under the Tobacco Control Act 2003, Punjab government involves the following officials to take action in cases of offence related to tobacco namely the Drug inspector, the Superintendent of Police , Civil Surgeons, all SMOs of CHCs and PHCs ,all Medical Officers in charge of dispensary, Food Inspectors, Principals, Headmasters and others educational heads. The various

[10] https://www.mapsofindia.com/maps/punjab/districts/jalandhar.htm

activities to be carried out under the program include arranging education campaigns at district level, lawful implementation of the anti- tobacco act, reporting the anti-tobacco activities at the district level to the State Headquarters, promoting IEC activities with the help of NGOs, the Local administration and various other departments of health, education and police"[11].

2.8. SAMPLING PROCEDURE

The sampling technique used in the study was purposive sampling with the hope that each participant would provide information which would add value to the study. Thus the members of the available population were unique in their characteristics and data saturation was used to determine sample size instead of using statistical power analysis.

Table: 2.1.Respondents of the study

Respondents	**Number**	**Area(in district Jalandhar)**
Officials involved in Tobacco Control Program		
Food Safety Officer	1	District Hospital
Health/Sanitary Inspector	1	District Hospital
Senior Medical Officers	4 (one in each CHC)	Kalabakra ,Shankar, Noormahal and Shahkot
Health/Sanitary Inspectors	2 (one in each CHC)	Kalabakra and Shahkot
Medical Officers	2 (one in each CHC)	Shankar and Noormahal
District Education Officer (Secondary)	1	In charge of all secondary schools of District Jalandhar
Health Officer in Municipal Corporation	1	Jalandhar city
Deputy Superintendent of Police(Urban)	1	Jalandhar city
Patients of oral cancer	10	Rolls Hospital
Kiosk Holders		
Rural	10	Pholriwala, and Lambra
Semi Urban	10	Mithapur
Urban	10	Jalandhar city
Labourers		
Migrant labourers group only	8-10	Jalandhar City(Urban Estate phase 2)
Punjabi labourer group only	8-10	Pholriwala
Mixed group of labourers	10-14	Khambra

[11] http://www.pbhealth.gov.in/pdf/tobaccoo.pdf

The universe of study were the officials involved in the Tobacco Control Program, groups of migrant and local labourers, the kiosk owners and patients of oral cancer in a private hospital (Rolls Hospital[12], Jalandhar) empanelled under District hospital in Jalandhar. Rolls Hospital is a superspeciality and multispecialty hospital 250 bedded (out of which 65 are for cancer patients) which was started in the year 1976 by the team of a surgeon and physician as a 20 bedded hospital. It has grown to be the first private cancer hospital to be fully functional in the North West region of India with all facilities of oncology as well as cancer surgery. The motto of the hospital is dedicated and effective patient care with the help of latest techniques. The hospital is located in the heart of the city and spread over an areas of 11000 square feet[13].

Officials involved in Tobacco Control Program in Jalandhar

During the study officials in the Health department were contacted and the researcher was referred by the officials in the District Hospital to different departments which were responsible for the subject of tobacco control. The district of Jalandhar is divided into ten blocks and the District Health Officer is the Nodal Officer entrusted with tobacco control in the district. Out of ten blocks four blocks namely Kala Bakra, Shankar, Noormahal and Shahkot were chosen for the study. The CHCs in each block has a Nodal Officer/Medical Officer who is responsible for the implementation of the program in the block. The Health Inspectors/Sanitary Inspectors in each CHC are entrusted with the duty of visiting the field and fining the offenders. The various respondents from the Health department were the Food Safety Officer and Health Inspector in the District Hospital, the Senior Medical Officers (one in each CHC) and the Health Inspectors (one in each CHC). In case of vacant posts for Health Inspector in CHC Shankar and Noormahal, a Medical Officer was entrusted with the duty of visiting the field for tobacco control.

The Municipal Corporation has been entrusted with random checks and imposing fines during checking for any water logging, garbage disposal or any other duties of the same. The Health Officer in Municipal Corporation who was responsible for the health related duties of the Corporation was interviewed. In order to prevent any untoward incident, police plays an important role in curbing the illegal activities

[12] Name of the private hospital withheld due to ethical reasons and renamed Rolls hospital by the researcher.
[13] As detailed in website of the hospital

related to tobacco in the district, collecting of fines and accompanying the health officials on special raids. The Deputy Superintendent of Police (DSP) was interviewed from to detail the role of police department. Furthermore, to prevent adolescents from falling prey to the use of tobacco, Education department is entrusted with the responsibility of keeping a check on mushrooming of tobacco kiosks within 100 yards of radius of the school. The District Education Officer (DEO) secondary, who works in collaboration with department of health to keep a check on the kiosks as well as provide counselling to the adolescents regarding the harmful effects of the tobacco use, was also interviewed.

Patients of oral cancer

The number of patients of cancer visiting Rolls Hospital in Jalandhar daily is 45 to 50 in number[14]. This includes new cases of cancer as well as those coming for follow up. Out of these daily, on an average two patients of oral cancer are examined in the hospital. The records of the hospital regarding the visits of the patients in the hospital were checked and patients were interviewed accordingly. The patients were confirmed cases of oral cancer of both sexes (18 years and above) at any stage of TNM classification[15]. Any newly diagnosed cases of oral cancer also formed a part of the study. The patients who were suffering from oral cancer but now declared cancer free were not included in the study. Interview with their spouse, friend and father was done in three patients who could not respond due to recent surgeries.

Although the initial research plan was to interview thirty patients of oral cancer, the ethical fall out with the hospital was a major reason for limiting the interview to ten patients. The oncologist was informed of that the objective was to study the social correlates of tobacco use rather than biomedical aspects of cancer. But as the study progressed the hospital environment turned hostile as the oncologist wanted the researcher to prepare a data base of two hundred patients and analyse it for them which was beyond the scope as well as the time frame of the research. Although researcher did not go with the bias of interviewing any particular sex yet the patients interviewed in the facility at that point of time were all males.

[14] As told by the hospital authorities
[15] TNM classification is a cancer staging notation system that describes the stage of a cancer.

The owners of kiosks selling tobacco products

There is no written record on the number of kiosks selling tobacco in the district as the registration for these kiosks had not been done till the time of data collection. The researcher found that the kiosks in the urban areas were congregated at a distance of 100 metre from each other while tobacco in the rural areas was being sold through the general stores which acted as tobacco kiosks. It was not possible to go to the kiosk holders in every block as the researcher was not familiar with their placement in each block. So a plan was devised to interview ten kiosk holders in the urban areas, ten in the semi urban areas and ten in the rural areas of the district. The rural area included in the study was Pholriwala, and Lambra (Jalandhar East block). There were no kiosks in the village and almost all the general stores selling items of daily use were selling tobacco products. Five shops from each village were chosen and owner of every fourth shop in the village was interviewed. The shops chosen in Lambra village were situated on the Jalandhar Nakodar road while those chosen in Pholriwala were within the village. The semi urban area chosen included in the study was Mithapur. There were a number of kiosks next to each other in this area. Attempt was made to choose every fourth kiosk in the area. Similarly within the Jalandhar city starting from Urban Estate phase 2, every fourth kiosk was chosen (Jalandhar West block).

Migrant and Local labourers

The migrant labourers in the urban area in Jalandhar city's Urban Estate phase 2, working in unorganised sector and the migrant as well as local farm labourer in the rural area Pholriwala and in Khambra were chosen to get an insight into the consumption patterns of tobacco as well as the cultural differences amongst these groups which affect tobacco use. Since the health officials repeatedly mentioned that the use of tobacco is more prominent in the migrant labourers than local population, the researcher conducted four Focus Group Discussions (FDGs) during the process of data analysis. There were four groups which included males in the age group of 18 and above who consumed tobacco in any form. These four groups consisted of two groups of migrant labourer in city, one group of agricultural labourer consisting of both migrant and local labourers in Khambra village and one Punjabi group working in unorganised sector in Pholriwala village.

2.9. SOURCES OF DATA COLLECTION

The data was collected from the primary as well as secondary sources. Primary data is based on facts present on the topic of tobacco and is original whereas secondary data is the scrutiny and analysis of the primary data. The primary sources were the interviews with the officials of District Tobacco Control Cell, with patients of oral cancer, kiosk owners, migrant and local labourers and data from the government officials relevant to the study. These also included the reports of the government reports and government bills on tobacco use as well as control in India and Punjab. The secondary sources of data collection were journal articles, books, book sections, newspaper reports and internet records.

2.10. TOOLS OF DATA COLLECTION

The research on the Tobacco Control Policy and the social correlates of tobacco use typically drew on the following tools of data collection which spoke to each other to add a comprehensive description to the study objectives.

2.10.1. Document reading

The first tool of data collection was documents of various kinds which included legislative records, debates on tobacco, annual reports, and correspondence. Newspaper correspondence although considered less worthy than scientific journals for research purpose because of their sensationalistic character yet contain unique information which cannot be found anywhere else. The critique of the Punjab government's Tobacco Control Program was not found in journals and researcher had to rely on the information of the newspapers.

Moreover the GATS report of 2009-10 and the latest report of 2016-17 were also read for comparing the national average of tobacco use with that of Punjab. Report on tobacco control in India, 2004, by Ministry of Health and Family welfare played a crucial role in understanding the evolution of the tobacco use and its control in the country. In addition, the Framework Convention on Tobacco Control (FCTC) 2003, by WHO was a crucial document to be read in order to provide the researcher a sense of the involvement of the international agencies in tobacco control. The changes in the social, economic and cultural history of Punjab was located with help of research articles as well as books based on these account. Gazetteers of Punjab, Early

European Accounts, and writings on Maharaja Ranjit Singh, Punjab under Mughals and textbooks on Punjab agriculture contributed importantly in locating tobacco within various changes in history of Punjab. Moreover, the duties and responsibilities laid down for tobacco control in the documents of National Tobacco Control Program (NTCP) aided the researcher in preparing the interview schedule for the officials involved in the program (Annexure A.1).

2.10.2. Observation

The degree of participation of researcher in the setting, acts, and events being observed was an important part of research on tobacco. The researcher tried to understand various stakeholders from their frame of reference, how they made sense of the situation and carried out research on the same. Non-participation, the first level of observation was when knowledge on tobacco control and implications of its use was acquired from print media, digital media, reading magazines, visual media or similar texts on tobacco and subjects related to it. The second level of observation was passive participation when the researcher was actually present at the kiosks and made observations acting as a pure observer. Some of these observations were contradictory to what the kiosk holders or the officials had said in their respective interviews. The sales of various kinds of tobacco products across various age groups and adherence to tobacco control laws at kiosks were observed through a checklist (Annexure A.2).

2.10.3. In depth interviews

Interviewing bears a resemblance to common conversation although the interviewer plays an active role in directing the topic of the conversation and making sense of the lived experiences of those involved in the tobacco control and those suffering from tobacco use.

Semi structured interview schedule

The interview technique included three types of questions; main questions follow up questions and probes. The main questions were designed to focus on various objectives of the study and to stay on target by addressing these objectives. The follow up and probe questions helped to ensure that researcher probes the stakeholders in detail in order to get acquainted with the nuances of the subject. It included semi structured interviews with the officials involved in the Tobacco Control

Program which provided information on the topic of interest. It was based on the activities being carried under the program and the hindrances being faced. It threw a light on the social, political and economic context of Tobacco Control Program (Annexure A.3).

It also included hospital based interviews with patients of oral cancer patients visiting the hospital at that point of time. The interview contained questions regarding their socio demographic profile and history of tobacco use. It indicated significant factors associated with tobacco use in any form. Age of the patients, marital status, education, religion, occupation, place of residence and access to information was included in the interview schedule. It was helpful in outlining the determinants of tobacco use in the patients of oral cancer (Annexure A.4). Semi structured interviews which explored the kind of tobacco products being sold, the profits being made, role of government in tobacco control, consumer base and the availability of tobacco products at sale were aimed at the kiosk holders selling tobacco products (Annexure A.5).

2.10.4. Focus Group Discussions

Focus Group Discussions (FGDs) are used for gathering information on views of a similar group and the meanings which attend to those views. Moreover, they are an important method in generating the experiences as well as beliefs of the participants. It has been used to extend the data which has been already collected through the methods mentioned above (Gill et al; 2008). The size of the group is an important concern in the FGDs. It is suggested to slightly over recruit and manage a large group than under recruit and not get answers leading to unsatisfactory discussion. The optimum size for the discussion should be six to eight participants (excluding the researchers) but the focus group can consist of as few as three participants and as many as fourteen participants. Small groups are a threat in limiting the discussion and large groups can be chaotic to manage frustrating the participants who do not get opportunity to speak (Bloor et al; 2001). The venue for the FGDs was accessible, private, comfortable and free from distractions. The researcher bore in mind to be positive and respectable of the views being presented by the participants which resulted in more fruitful discussions. A local person known to the group was present during the discussions in order to make the group more comfortable. Four FGDs with 8 to 10 participants in each group (as mentioned earlier) were conducted to get an

insight into tobacco use, different patterns of tobacco use as well as the associated culture of tobacco consumption in migrant as well as local labourers.

2.11. PROCESS OF DATA COLLECTION

The process of data collection meant collecting the information relevant to the course of study in various phases. It also established coherence between different aspects of research seeking answers from various respondents. The information so collected during this process was used to generate explanation for the objectives of the thesis.

2.11.1. Pilot study

Informal talks were carried out with those involved in Tobacco Control Program in the pre pilot phase to get preliminary information about the program in the district. It gave the researcher an idea of what is being done in the field and how to organise the main research. The researcher visited few government schools where the boards of no smoking were pasted and no kiosks could be seen in the vicinity of the schools. An informal interview with the psychiatrist working in the District Hospital was carried out which revealed that no de-addiction centres till then had started working on tobacco cessation. The researcher was also informed that no NGO in Jalandhar was working on tobacco control activities.

A pilot study was done before the main study in 2016 which helped the researcher to test the study tools and identify questions which did not make sense to the respondents or led to biased answers. The improvements in the study tools were based on the feedback of the respondents, meaning if they found the questions uncomfortable or did not understand the question it was either reframed or changed. The researcher got to know the difficulties to be encountered in accessing the government documents or obtaining permissions for the same. Pilot was done to save time for the main study and establish rapport and contacts with the respondents especially the government officials.

2.11.2. Main study

The data collection was planned and executed in such a manner that the researcher could collect necessary information in designated time frame. Permission from the Institutional Ethical Review board was obtained for the study (Annexure A.6).

Phase 1

Objective 1: To trace the history of tobacco cultivation and the corresponding growth of tobacco industry in India and public health response to it.

Objective 2: To collate the events which played an important role in tobacco introduction and consumption in history of Punjab.

This phase of the study was carried out with the help of newspaper reports or any document evidence available for the tobacco history in India and Punjab. This process of data collection started from the conceptualisation of the research in 2016 and continued till date not limiting it to any time frame. In the initial stages reports of the government on tobacco were read to know the statistics of tobacco use as well as the legislations linked with its control. The focus then shifted to Punjab and various documents across subjects of history, agriculture, industry and public health were read to build connections with tobacco use.

Phase 2

Objective 3: To study the translation of Tobacco Control Policies and laws in district Jalandhar, Punjab with focus on the barriers in implementing the tobacco control measures in the district.

Objective 4: To study the health implications of tobacco use in the form of oral cancer in district Jalandhar.

This was accomplished with the help of interviews with the officials involved in the Tobacco Control Program which was carried out in the month of December 2016 to January 2017. The interviews with the kiosk holders were done in the month of May 2017. It took time to convince the kiosk holders that the researcher was not from Health Department or to report their sales or profits to any government agency. The sensitive question on the profit involved in the sale of tobacco or their monthly income was left on the choice of the kiosk holders to answer.

The interviews with the patients of oral cancer were done in the month of February 2017. The patients of oral cancer and their family members had a number of queries regarding the prognosis of the disease and the associated risk in the future. The researcher patiently handled their questions as well as counselled them for a better and bright life ahead. The experience was emotional for the researcher when she heard about their physical, emotional and financial pain.

Phase 3

Objective 5: To study the social correlates of tobacco use in district Jalandhar.

After completion of the first two phases of data collection, the researcher started compiling the data and looking across various emerging themes. The themes though collected in separate phases were interlinked. The time period in between phase 2 and phase 3 was spent to make field notes for any scope of iteration. Moreover, the constant mention of migrant labourer in Punjab selling as well as using tobacco during interviews with Health Officials was another important reason to think about conducting FGDs with migrant as well as local labourers. It was equally important to compare the two groups of tobacco users one with the disease (oral cancer) and the other without the disease in order to draw out similarities as well as differences within and across the groups.

These FGDs with the migrant and the local labourer groups were done in the month of May 2018. It was taken care that during the discussions a local person who the group was comfortable remained present during the process. They were explained the importance of discussing tobacco use in group and how their discussion would bring out more questions either for future research or for a more elaborate discussion. The participation of the researcher was limited to introducing the topic and any digression from the topic was channelled back to the focus point of discussion. The information collected was sorted out on daily basis for better compilation of results after the completion of data collection process. These phases of data collection were flexible in nature and the respondents of one phase were extended to the next phase. Any referral provided by the authorities moved to and fro in each of these phases.

2.12. DATA ANALYSIS

The visible characteristic of data collection methods was word-based, from data "collection" instruments to data analysis tools. The researcher stuck close to the character of the data and rather than reading the documents as event evidence, they were read for a sense of the times, of how people responded at that time to particular events or ideas on tobacco use as well as control. The focus was on meaning making on how subject of tobacco evolved over time. In addition, themes from the interviews were extracted from all phases of data collection.

These themes captured something which was important about the data in relation to objectives of the research and provided some level of meaning within the data set. Some themes occupied considerable space within the data set and some appeared relatively less in data set. It was the researcher's judgement to determine what a theme was. The themes were not dependant on quantifiable measures but in terms of whether they captured the overall research questions or not.

Process of data analysis

The process of data analysis started when the researcher began to notice the patterns while reading the documents and collecting data in the field. These themes were broad which were polished during the data analysis procedure. Writing began during this phase in form of writing down of ideas and possible coding schemes which continued during the entire analytical process. The researcher familiarised herself with the length and the breadth of data. Since data collection involved verbal data collected through semi structured interviews in Punjabi, the data was translated and transcribed into written form for the purpose of conducting a thematic analysis. Although the process of transcription was time consuming yet it was the most important step in familiarising with the data.

It was important that the transcription retained the information obtained from verbal content and was true to its nature. The original audio recordings were checked time and again for accuracy. The data so transcribed was coded as a basic raw form, from which the data could be analysed. These codes were applied to short segments of data which is different from themes which are broader in nature. Coding was done manually and equal attention was given to each data item and interesting aspects of

data were identified for repeated pattern which were then converted into themes. The data was coded by writing notes on the texts (transcriptions) for potential patterns in the data. Various inconsistencies within and across the data set were recognised and were retained to look for any variation or interesting emergent themes. When data was coded and a long list of codes was available with the researcher, these various codes were sorted into potential themes and all the codes were collated within the identified themes. Some codes went to form themes, some sub themes and some were discarded. At this stage the researcher started getting sense of individual themes but the themes still needed to be refined, redefined or discarded.

The next stage involved the refinement of the themes which had been formulated during the previous steps. During this step it was seen that some themes were not actually themes as there was no enough data to support them while some themes collapsed into one another. Some of them were broken into other themes. "Patton's dual criteria for judging categories' internal and external homogeneity were considered in this step. It says that while data within the themes should be in meaningful coherence with each other, there should be clear and identifiable demarcations within the theme" (Patton, 2002).

All the codes for a theme were read to see if they formed a coherent pattern. When the researcher found a lack of coherence it was checked, the theme was reworked upon or discarded. Further the validity of the themes as compared to the whole data set was determined to see if it reflected the meanings evident in the data set. Secondly any additional data within the themes was coded which had been earlier missing in coding stages. The last step involved the defining of the themes which were to be presented for the analysis. It was taken care that the theme was not too complex or diverse in nature.

The researcher gave conceptual definitions to five major themes established around which the study revolves. Although these themes stand independent of one another yet they are interconnected because any change in one of these affects the other theme (Table 2.2).

Table: 2.2.Conceptual definitions of major themes

S. No.	Themes	Conceptual definition
1.	Politics of inter departmental coordination for tobacco control	The commitments or the political will of government to establish inter department coordination and employ any alternate employment for tobacco sellers as well as growers.
2.	Tobacco program's integration with other programs	The relation of tobacco control program with other health programs specially the mention it finds in oral health programs.
3.	Health department responsiveness to tobacco control	The response in the form of BCC, IEC, Fines, response to patients of oral cancer, public health services of cessation and counselling for tobacco users.
4.	Tobacco industry's influence on tobacco control measures	The profits earned, the kind of incentives provided to kiosk holders, the advertisements at point of sale and by passing laws to keep tobacco market going.
5.	Social Correlates of tobacco use	The socio demographic and socio economic profile, social support and behaviour of tobacco users

2.13. ETHICAL CONSIDERATIONS

The ethical considerations in the thesis were not only limited to the interviewing of the respondents but also included the researchers position in the whole process of data collection, analysis as well as writing which started before visiting the field. During the process of reading the literature about the subject of tobacco, the researcher kept in mind not to visit the field with any bias about Tobacco Control Program in district Jalandhar. The literature helped the researcher to expound gaps and concepts which then got translated in the form of semi structured interview schedules. A conscious effort was made to read the interview schedules repeatedly to remove any leading

questions in order to minimise bias in research. The study was carried out in field after being approved by Institutional Ethical Review Board of the University.

As the stakeholders were varied in their profiles as well as position in tobacco control, permission was obtained from the officials and prior appointments for the interview were taken through informed consent form (Annexure A.7). The officials were given a free hand to talk about tobacco in general and then come to specific questions directed to the program in district. Some officials were not comfortable with the audio recording of the interview; hence a written account of the interview was made. Transparency explaining the purpose of research was an important part of the informed consent and helped the respondents to make decisions as to what they were consenting to. The officials were explained that the study was not on the evaluation of the Tobacco Control Program but an in depth exploration of the questions of how the program has evolved.

The officials at the Rolls hospital were contacted before the study began and were given necessary documents required to start the process. The hospital authorities were informed that the questions were not directed at the medical aspects of oral cancer and the process associated with it but revolved around various correlates of tobacco use. The consent form for the oral cancer patient included the statement which will include the purpose of research and the expected duration of the participation and explaining risk or discomforts to the subject if any. A statement describing the extent to which privacy of records which could identify the study subjects was maintained (Annexure A.8).

In case of patients of oral cancer who have undergone surgeries, the family members were contacted for the patient related information. During the process of interview there were apprehensions in the patient regarding their disease and any questions raised by them were answered by the researcher. The training of researcher as an oral health expert helped her to guide them well and respond to their queries. Withdrawal at any time of the interview was permitted to patients of oral cancer. Care was taken not to administer any psychological trauma to these patients. The name of the private hospital (empanelled under District hospital Jalandhar for treating cancer patients) was changed to protect the identity of the hospital.

The kiosk holders were apprehensive regarding their interviews and the address of their kiosks. The researcher kept the names as well as the addresses of the kiosk holders confidential and obtained their consent. Consent forms were read out to the kiosk holders who could not read or write (Annexure A.9). No questions were forced and the silence of the kiosk holders on some questions was also recorded as a response. The interviews were conducted during the time of sale and the researcher did not interfere with the business of the kiosk holders and waited patiently for them to get back in case the interview was interrupted by the arrival of a customer. Most of the kiosk holders were not comfortable to be photographed and gave researcher the permission to click the photos of products being sold without identifying the kiosk in the photographs. The researcher took the photographs relevant to the objectives of the study.

2.14. LIMITATIONS OF THE STUDY

There are both internal formal and informal controls over the public sector. The latter are as important as the former. The public servant has to serve the government of the day and act in the public interest. The researcher faced problems in getting the access to government data on tobacco control in the district of Jalandhar. Moreover, officials did not share information in a non biased way regarding the Tobacco Control Program being carried out in the district. Repeated contacts (three times)with the then District Health Officer was met with failure as he directed the researcher to other officials and was not willing to talk or give any interview about the Tobacco Control Program in Jalandhar. Moreover, the researcher faced difficult behaviour in working with hospital authorities for interviewing the patients of oral cancer. The oncologist wanted the researcher to prepare a data base for their patients which was beyond the research objectives as well as capacity of the researcher. Moreover medical staff was very uncooperative when the researcher expressed inability to work for them.

The Medical College in Jalandhar was not willing to give permission because there was no co guide involved in the study from their institute. In addition, getting industry data from authentic sources was a big challenge. There is a limited open data on tobacco industry in India as well as in Punjab. Moreover, the recent reports on the Indian tobacco industry are highly paid and not freely accessible. The newspaper articles though were of great help in critically analysing the Tobacco Control Program

in Punjab yet the politics of newspapers in the state of Punjab cannot be ruled out. The researcher tried to delve into sources in history, agriculture and industry and played the role other than that of public health scholar. Even without any training in these subjects the researcher tried to do full justice to the objectives of the research. The researcher did not go in the field with any prejudice on the gender of respondents in case of tobacco users as well as patients of oral cancer. The respondents happened to be all males in these groups at the given point of time. The presence of females in any of these groups could have added more thickness or a different dimension to the study.

CHAPTER 3

STATE, MARKET, TOBACCO INDUSTRY AND PUBLIC HEALTH DEBATES

INTRODUCTION

Having outlined the available literature on tobacco, the objective of this chapter is to trace the history of tobacco cultivation and the corresponding growth of tobacco industry in India. The various market strategies adopted for maintaining the growth of tobacco in India as well as it exports to the outside world played a crucial role in establishing the tobacco industry. Moreover, the opening of markets and relatively fluid boundaries globally post liberalisation has been instrumental in the expansion of tobacco industry in India. The industry has responded to the approaches set up by government to check use of tobacco in the population by using various tactics and it is as serious for profits as the government is for checking its expansion. Campaigners of anti tobacco crusade in India have been vocal about the detrimental health effects of tobacco use, the connection of industry with politics and the huge political lobbying involved. This led to various tobacco control measures being set up by the government which industry tried to dilute by adopting various counter measures. The focus of Government of India and industry has been cigarette smoking, ignoring place of smokeless tobacco in legislation and trade.

The researcher has tried to bring the debates associated with smokeless tobacco within the sections of the chapter and reasoned for its blurred presence. In addition, the debates on health in the chapter do not quantify the disease pattern which already has been done in review of literature. Instead it places health within the boundaries of expansion of industry and the associated struggles of Indian government to limit its spread. The chapter is divided into six sections and corresponding sub sections which historically trace the expansion of tobacco industry from colonial to post independence era in the country. It emphasizes that the evolution of tobacco industry and trade of tobacco as well as its use with resultant health effects have been a process of constant development. The first section deals with the cultivation of tobacco and its expansion in the country in the colonial and post colonial period. It draws on production of tobacco in India and evolution of tobacco industry in Colonial and post

independence period. The second section of the chapter details favourable geographical conditions and encouraging institutional environment to tobacco farmers as incentives which accelerate the process of industry's growth in India.

The third section brings out how post liberal era led to tobacco liberalization and global trade agreements which lead to expansion of tobacco industry in India. This spread of the industry was curtailed through complex tobacco taxation system by the Government of India and how the industry's defended increased tobacco taxation which forms a part of section four. Also, the health debates associated with this elaborate growth of the industry which led to risking the health of the population is the main argument in the fifth segment of the chapter. The last section signifies the various tactics adopted by tobacco giants to manipulate the tobacco control approaches through various counter strategies.

3.1. TOBACCO INDUSTRY IN INDIA

The tobacco industry's profits in India have been multiplying from the time tobacco crop has been introduced. Also, the trade in tobacco and setting up of the industry exposed the population to a lethal and addictive product. The following sections trace the history of tobacco introduction, its cultivation and refinement to industry in India during the Colonial and post independence times.

3.1.1. Tobacco in Colonial period

Tobacco was used as a crop of trade when introduced in India but the British exploited its profitable nature when they colonised India and increased its production. This increased production was responsible for setting up of tobacco industry in India. The following sub section describes the introduction of tobacco crop in India and tobacco industry's continuous growth in Colonial period.

3.1.1.1. Introduction of tobacco crop in India

As far as India is concerned, tobacco was first introduced in 1600 AD by the Portuguese who had a colony in Goa. The Persians traders carried tobacco along the silk route to distribute in the courts of Chinese, Persian and Mughal rulers. Initially the use of tobacco was limited to the elite class but within a century its use spread to men and women of all the classes. Its use was incorporated into the already prevalent

habit of chewing of areca nut. Tobacco was generally used to keep hunger away, to ward off toothaches and to work for longer working hours by the working class (Sanghvi as cited in Reddy & Gupta, 2004). As tobacco spread from the court of Adil Shah to the court of Akbar, concerns were raised by some courtesans on tobacco being a foreign plant and its safety as a consumable item (Bhonsle, Murti & Gupta, 1992).Amongst this confusion of side effects of tobacco consumption, the use of tobacco spread throughout Asia and in India tobacco chewing predominated its consumption pattern (Sudhershan &Mishra, 1999).

Chewing tobacco has been an important additive to *paan* in India from the times of its introduction. It is believed that it was introduced from South Sea Island, Sumatra and Java through south Pacific island (Gode, 1961).This habit has been prevalent in the Indian culture and in the South East Region for over 2000 years. In Hindu culture chewing of pan has been seen as one of the eight *Bhogas* of life. It was also a part of Mughal culture and the Mughal rulers employed specialists' skills to prepare paan on several occasions which increased its popularity and acceptance. The practise of chewing tobacco became widely prevalent by including it in preparations of *paan* suggesting that contemporary habits of tobacco use had begun in the seventeenth century. By the year of 1610, the use of smoking had also increased in India leading to both men and women in south India smoking *chutta* and *cheroots* on east coast of India. It was by 1711 that *bidi* smoking in India started getting prevalent (Bhonsle, Murti & Gupta, 1992).

3.1.1.2. Growth of Tobacco Industry in Colonial period

Initially, American tobacco was imported by British traders into India in order to finance the purchase of Indian commodities using it as barter. Combination of the European colonialism and the new consumerism made the plant of America to be most sought after commodities in the new world. In the seventeenth century the English colonies in America were one of the greatest producers of tobacco of the British Empire. The developments of capitalist agriculture in Britain led to an increased population that immigrated to the new world colonies including India (Jefrey &Rutchie, 2005). At the outset of 1605, tobacco was grown in the South and Central India and later spread to other parts (Akehurst, 1968). It was when the American colonies declared independence in 1776 that the East India Company

started growing tobacco as a cash crop in India. It used tobacco as an important cash crop for both domestic and foreign trade. The manufacturing industry was established much later in the early twentieth century as the British believed in exporting the tobacco leaf to Britain and re importing the cigarettes into India, with considerable value addition[16] in this process. As the consumption of cigarettes within India rose, the Imperial Tobacco Company in 1906 commenced production within India, retaining control on the produce (Annalakshmi, 2013, pp.1-2).

The benefits obtained from cultivation of tobacco, manufacture and marketing were great incentives for the farmers to cultivate tobacco and for the government to promote its growth and manufacture. Before the formation of Imperial Tobacco Company in India, British America Tobacco (BAT) was founded as a joint subsidiary of top tobacco corporations of United States (American Tobacco Company) and Great Britain (Imperial Tobacco Company). Prior to the expansion of the company in India, BAT expanded its market in China. Not being deterred by the initial political resistance and the boycott of its brands, the strategies adopted in China served as a blueprint for the company to expand its base to the countries of India, Latin America, South East Asia and Middle East before and after World War I. Although the initial focus of the company was in export trade, it expanded its reach into other countries through direct investments. During this initial phase of expansion the local cultivation of tobacco leaf in India was encouraged to be used for its cigarettes. This meant that the BAT operations became more independent as the local raw materials could be used for the production of cigarettes in its own factories (Cox, 2005 p.92).

An economic integration among nations in the late twentieth century led to the growth of tobacco industry. But the most important product which has played an important role in economic integration was machine made cigarette. This led to foreign investments in other countries which could be seen as early as 1890 when the American Tobacco Company's leading brands as Cameo, Pin head and Old Gold found markets in India, Britain, Germany, Japan, China and South Africa(Cox, 2005, p. 253). The tobacco industry even in the primitive forms had been engaged in trade with other nations. The companies used to tailor their entry into foreign markets and it varied from country to country. For example, British America set up its company and

[16] It is the difference between the price of the product or service and the cost of producing it. It increases the product's price or value.

distribution system in India as it had no domestic cigarette producers and subsequently employed local labour to work in the factories. It also encouraged the cultivation of Virginia Tobacco leaf in the local markets of India. In order to handle leaf procurement, it also formed Export Leaf Tobacco Company and provided expert advice to improve local cultivation in India. The company developed seedlings under varying climatic and soil conditions and also established leaf handling facilities and extension service which let the locals sell their produce of flue cured[17] bright tobacco leaf. For example, the Indian Leaf Tobacco Development (ITLD) Company, a British American subsidiary was encouraged for the growth of tobacco leaf and even provided favourable tariffs under the Imperial Preference Scheme[18] during the British Empire (Cox, 2005, p. 255).

BAT expanded its trade in India in 1901 and established the Imperial Tobacco Company i.e. the present Indian Tobacco Company (ITC) (Reddy & Gupta, 2004, p.21). The period under 1891-92 to 1921-22 in India saw three fold increase in the area under cultivation of tobacco. Evidence also tells that there has been an increase in the demand for tobacco particularly of cigarettes in India by 1920. Since there was no manufacturing of cigarettes in this period in India the imports for cigarettes increased. Table 3.1 enumerates the tobacco trade in India during the period of British showing the increased imports in India from 1880s to 1920s.

Table: 3.1. Tobacco Trade in British India (Rs in millions)

Year	Exports (Rupee in millions)	Imports (Rupee in millions)
1881-82	1.20	0.63
1912-13	3.84	6.94
1920-21	7.49	25.59
1921-1922	7.18	16.51

Source: Sanghvi, 1992 (as cited in Reddy & Gupta, 2004), p.21

[17] Tobacco leaves do not ripen as a whole; the bottom leaves ripen at first, then next to bottom and then the uppermost layer. The bottom leaves get over ripe and near worthless by the time the upper one is cured. In the process of flue curing the green leaves are dried with help of artificially created heat at controlled temperatures in barns specially constructed for this purpose. The curing process takes a week's time. Flue cured tobacco is known as bright cigarette tobacco.

[18] It was a system of reciprocally enacted tariffs or free trade agreements in which preferential rates (rates below general levels of tariff) were granted to one another by the constituent units of British Empire. It could also include other sort of preferences such as favourable allocation of the public contracts, indirect subsidies to shipping and preferential access to capital market.

The British officers of India Leaf Tobacco Development (ITLD) of ITC experimented on the black soils of Andhra Pradesh in 1920 for growing tobacco. After successfully cultivating Virginia tobacco in 1928 in Andhra Pradesh, commercial and large scale production of tobacco was started by ILTD on black soils of Guntur, Andhra Pradesh in 1929. It provided demonstrations to local farmers to grow tobacco and provided financial assistance for purchasing fuel, wood, fertilizers etc. Slowly cultivation of tobacco spread to all coastal districts of Andhra Pradesh (Reddy & Gupta, 2004, p.21). It was in the year 1933 that ILTD introduced Flue Cured Virginia (FCV) tobacco into international market. By the year 1938 India ranked second in the production of tobacco next to USA. This led to expansion of FCV cultivation in other parts of India including north Bihar, Uttar Pradesh and Gujarat (Kori, 1998).

By this time trade in tobacco had become an important part of the global tobacco industry. But World War II brought about drastic changes for the tobacco industry around the globe as the position of the British American was found to be in difficult phase because the British used to import tobacco for manufacturing but they had to give priority to food and war material. Due to weakening economic situation, the government had to limit the purchase of non essentials as cigarettes. Moreover, the communist revolution of 1949 in China ended any hopes of the revival of the company and saw the company experience reversal in India, Egypt and Indonesia (Cox, 2005, p.255). Consequently, the area under cultivation in the year 1945-46 decreased by 13.5% from 1939-40 and the production decreased by 2.2% in the same period in British India affecting the business of tobacco industry (Sanghvi as cited in Reddy & Gupta, 2004,p.20).

3.1.2. Tobacco industry in post independence period

Indian Central Tobacco Committee (ICTC) established the Central Tobacco Research Institute for systematic improvement of tobacco crop India in 1947. It led to seven research centres being set up in Chennai, Andhra Pradesh, Bihar, Mysore, Punjab and West Bengal. Although tobacco was grown in many parts of India during 1950s, the best of it was grown in West Bengal, Tamil Nadu, Bihar, Maharashtra, Karnataka, Punjab and Andhra Pradesh (Mujumdar, Pusalkar& Majumdar, 1965). However, the cultivation of FCV till 1960s was confined to the black soils in India. But its extension to Karnataka's light soils was seen due to increasing demand for light

bodied leaves and low content of nicotine and tar. Within 20 years of independence the area under tobacco cultivation increased in India (Tobacco Board as cited in Reddy & Gupta, 2004).

Table: 3.2. Tobacco economy in the post independence period

Year	Area (x1000 hectare)	Production (million kg)	Excise revenue (Rs in millions)	Export revenue (Rs in millions)	Tobacco consumption (million kg)
1950-51	360	260	258	150	245
1960-61	400	310	540	160	328
1970-71	450	360	2284	320	367
1980-81	450	480	7553	1400	360
1990-91	410	560	26957	2630	474
2000-01	290	490	81824	9034	470
2001-02	-	601	-	8885	-

Source: Tobacco Board 2002; Directorate of Tobacco Development, 1997(as cited in Reddy & Gupta, 2004, p.22)

Table 3.2 clearly represents that as the tobacco economy flourished in the post independence period generating revenue for India through excise and exports, the tobacco consumption also increased subsequently. From 1951 to 2001, there was "an increase in the production by 130%, in excise revenue by 31,614%, in export revenue by 5823% and in consumption by 92% along with an increase in the area under cultivation of various types of tobacco. There are various types of tobacco grown in India which is unmanufactured and is exported or consumed directly in the form of chewing tobacco. On the basis of end use and curing, the types of unmanufactured tobacco are FCV, Burley, oriental, sun cured, light air cured, dark air cured and dark fire cured. Of these, FCV forms the major part of the unmanufactured tobacco and is the primary ingredient in cigarettes. The production of FCV was 167.97 million kg in 2001-02 and it increased to 315.92 million kg in 2013-14 (Tobacco Institute of India, n.d.). Despite the increase in FCV cultivation, bulk of total tobacco production in India consists of non cigarette type making it the only country where the bulk

production consists of non cigarette types because the domestic demand of these products is higher than cigarette (Mujumdar, Pusalkar & Majumdar, 1965).

Today four of the international companies majorly control the tobacco market globally and have shares in Indian companies, namely British American Tobacco (BAT), Philip Morris International (PMI), Japan tobacco and Imperial Tobacco (Bialous & Peeters, 2012). The Indian Tobacco Company (ITC) is a subsidiary of BAT and controls around 76% of the cigarette market in India with most popular brands like Scissors, Bristol, Gold flake and Capstan. The second largest is Godfrey Philips India (GPI) Ltd affiliated to Philip Morris and produces brands like Cavenders, Red and White and Jaisalmer. The third largest player is the Vazir Sultan Tobacco which produces cigarette brands of Charminar, Vijay and Charms. The fourth one is Golden Tobacco Company (GTC) which is owned by Dalmia Group manufacturing Indian as well as foreign brands of cigarettes such as Rothman. The producers of smokeless tobacco earlier seen as unorganised are now turning into an organised corporate sector with two major players in India namely, Kothari Products and Dhariwal Industries (WHO, 2002). There is no national brand but two of the important *bidi* brands include 502 *pataka* and 501 *ganesh*. This *bidi* production is concentrated in the west and south India where each state has around 200 *bidi* manufacturers (Euromonitor as cited in Campaign for tobacco, 2010, p.3).

3.2. FACTORS FACILITATING TOBACCO GROWTH AND TRADE IN INDIA

As mentioned earlier, the tobacco industry is expanding in India despite tobacco control legislations growing stricter. There are various factors which facilitate the tobacco cultivation and its trade in India. These catalysts mentioned in succeeding subsections are important for the industry to stay in business.

3.2.1. Geographical conditions and tobacco cropping in India

The soil and the climatic conditions in India have been advantageous for the cultivation of tobacco crop. The various types of tobacco grown on diverse soils in India have benefited the tobacco growers. The following segment gives a detailed explanation on the soil quality required for the growth of tobacco and its comparison with other crops when grown alternately.

3.2.1.1. Soil conditions in India

The increased production of tobacco can be attributed to advantage offered in various parts of India for growing the crop in varied soil and climate conditions. Tobacco is considered to be a very sensitive plant and is grown in area where the soil is properly aerated and well drained. The required pH is 5 to 6 but in some parts it is best grown if the pH is 8 or more. In India the tobacco used for preparing cigar, *bidi*, *hookah* or chewing is grown on sandy loam to clay loam. This crop is raised in irrigated areas of Tamil Nadu or UP or semi irrigated areas of Bihar, Bengal and Mysore or as a dry crop in Andhra. But an exception to the general rule regarding soil requirements is found in case of cigarette tobacco. Heavy black soil which normally has poor drainage has been found apt for growing tobacco which is usually grown as dry crop on this soil. Despite soil conditions being unfavourable, it has been possible to raise cigarette tobacco fairly successfully. It offers advantage as the crop is grown as a dry crop and these soils do not get water clogged during the growing period. Moreover, the heavy clay content of the soil holds enough moisture to sustain the crop and the humidity during the curing period is high which makes the handling of the crop easy. Besides the soil, the climate also offers an advantage for tobacco growth. Rainfall, relative humidity, wind and sunlight are crucial for the growth of tobacco plant. Tobacco is tropical in origin but it can be grown under tropical, sub tropical and temperate climates. Moreover it can be grown in rotation with other crops which generates different yields and profits (Central Tobacco Research Institute, n.d.). Nonetheless, market conditions of high price and assured demand are more important determinants for farmers to grow tobacco than suitability of the land in the region (Panchmukhi et al., 2000).

3.2.1.2. Alternate cropping and tobacco cultivation

Tobacco developed as a cash crop due to its export value and domestic demand in India. Consequently, the tobacco farmers received better prices as compared to other famers despite the high cost of cultivation, curing and grading. A number of studies have been conducted in India on the comparative costs of cultivation between tobacco and other crops. These studies clearly indicate that the return per hectare for alternate crops as groundnut, jawar and cotton is more than for tobacco grown alone which also decreases the cost of cultivation. For example, eight alternative cropping systems

were investigated between 1992 and 1994 in Karnataka which found that single crops of chilli and cotton produced returns which were higher than that of tobacco. The returns were also higher in case of combination crops of soyabean and groundnut than tobacco mono crop (Nagarajan, Umamaheswara & Subba, 1995). However, given the existing level of technology, economic ground purely cannot be used as basis for an alternate cropping. It is also believed that FCV tobacco is more profitable than any other form of conventional farm activity if grown in traditionally cultivated areas. The only factor which would hamper the economics of this crop is over production (Rao, 1999).

The overall effects of alternate cropping will still be beneficial because it would save the government expenditure on health and medical care and considerably reduce the loss of productive workforce to tobacco related diseases (Panchamukhi et al., 2000). This is because lowered cultivation of tobacco will lower its manufacture; hence affect its sale and consumption, reducing the burden of tobacco related diseases. However, in order to weaken the beneficial effects of alternate cropping there have been questions around the loss of employment for the workers working in tobacco farms. Although it is recognised that tobacco is a labour intensive crop but shifting to other crops will not cause much dislocation in employment because only 5.6% of the total farm cultivators are engaged in tobacco farming in India. Since most of them who have already shifted to alternate cropping pattern have not been adversely affected, the debate on adverse unemployment around tobacco and alternate cropping is unduly exaggerated (Reddy & Gupta, p.278).

3.2.2. Institutions facilitating tobacco growth in India

Agriculture sector being a priority in India, the farmers are able to take loans from diverse sources as rural banks, cooperative banks, commercial banks, traders and moneylenders. These financial institutions advance crop loans for buying seeds, fertilisers, and insecticides etc. which are at a low interest of as much as 2 %. There is no special consideration from the bank for tobacco farmers as compared to other farmers. However, the banks do access the returns before giving loans and cash crops as tobacco get preferential treatment (Prasad, 2007, p.4).

The Government of India provides institutional support to a number of cash crops such as tobacco, tea, rubber and coffee. FCV tobacco receives various subsidies and

promotional activities while the direct subsidies for non-FCV tobacco in terms of cash discounts are negligible. FCV tobacco enjoys support of government in terms of its regulated production, technical research, dissemination of information, sales and export promotion. The Tobacco Board which was constituted in 1975 is a major promoter of FCV in the country and promotes sales overseas. Also it is the main body through which the government promotes cultivation of FCV tobacco. Subsidies for tobacco farmers are provided for purchase of coal, fertilisers, installing barns etc. because India is the third largest producer of FCV tobacco and more than half of FCV tobacco is exported generating revenue to the government (Tobacco Institute of India, 2017).In contrast to FCV tobacco, the promotional activities for *bidi* and chewing tobacco are constrained to new and improved varieties of nicotine, management of pesticides, and supply of quality seeds to the growers. Tobacco Board is under the Ministry of Commerce as tobacco is a source of foreign exchange to the country. Direct and indirect subsidies provided to the tobacco farmers under various programs from Tobacco Board are important factors in continuing tobacco cultivation by the growers (Panchamukhi et al; 2000).

This provisioning of subsidies is a direct violation of India's obligations to FCTC and domestic tobacco control laws (Rao, 2015) as alternate livelihood to tobacco farmers has been listed a supply reduction measure in the WHO FCTC. Article 17 of the FCTC guides the state to provide support for economically viable alternative activities for tobacco cultivators. However, supply reduction cannot be forced on famers but their wish to switch to alternate crops should be encouraged by the government. In recent times tobacco growing has been shifted from high income to low income and middle income countries. The major reason is the dependence of communities and families on tobacco, thinking that the gross income is higher for the plant and it is drought resistant in nature. Moreover, tobacco industry is also taking advantage that the tobacco control initiatives in India as COTPA and NTCP are demand side measures. Therefore, initiatives for supply side as providing viable alternate crop options such as "Barn Buyout Scheme" which provide a support of Rupees five lakhs per barn to tobacco farmers in India who are willing to shift from tobacco cultivation to other crops, have been limited to research settings (WHO, 2015, p.10).

Besides, the tobacco industry continues to maintain affiliations with various government agencies which help it to influence the Tobacco Control Policy. For

example, in India 6 out of the 10 shareholders in ITC are government owned insurance companies (India Tobacco Company [ITC], 2013). Also, the tobacco industry has a long history of using front groups and third party groups to lobby on its behalf and weaken the policies. International Tobacco Growers Association (ITGA)[19], of which India is a member, is funded and directed by tobacco companies. It is used by the industry to mobilise tobacco farmers despite their exploitation by major tobacco companies. Although the World Bank acknowledges that tobacco has been an attractive crop for the farmers due to stability in its global price as compared to other cash crops, it also argues that any reduced demand in tobacco due to decreased cultivation by switching tobacco farmers to other jobs, would have little long term effect on the countries' economies as this decline would be gradual. The spending on tobacco then could be reallocated to other goods and services. The only possibility is that the large producers of tobacco might be affected by this change and reduced demand of tobacco (World Bank, 1999). These large producers of tobacco have entered into various trade agreements in order to stay in business and also expand their base into the developing world. These trade agreements have not left India untouched playing an important role in the expansion of tobacco industry in India.

3.3. INDIA'S PLACE IN GLOBAL TRADE AGREEMENTS ON TOBACCO

Globalisation and trade liberalisation has been instrumental for the Transnational Tobacco Companies (TTCs) to gain access into new markets through exports and spreading tobacco beyond boundaries post 1990s.This processes of trade liberalisation changed the trade scenario which includes Structural Adjustment Program (SAP), unilateral liberalisation, multilateral system and bilateral and preferential trade agreements. SAP imposed on many countries by International Monetary Fund (IMF) and WHO in 1980s and 90s led to acceleration of trade liberalisation and global neoliberal development agenda. These programs required the countries to cut spending on health and other social sectors, privatisation of state owned enterprises, eliminate support for domestic markets and favour export oriented industries. This favoured the growth of tobacco companies in the emerging markets for expanding their production (Gore, 2000).

[19] It claims itself to be a nonprofit organisation founded in 1984 in order to present the cause of millions of tobacco farmers to the world. In fact it is a tobacco industry front group and is controlled by major cigarette manufacturers. It is dominated by large estate owners and does not represent the interest of small farmers or tobacco tenants.

The General Agreement on Tariffs and Trade[20] (GATT), as argued by the officials and other liberal circles in India, was said to enlarge the export of Indian products in the world market, especially in the developed countries. The export of commercial crops like tobacco along with cotton and jute under GATT was fully justified as they satisfied major conditions, meaning there was a genuine and growing surplus of these products after meeting the domestic demands. The ratio of exports to domestic prices was considered favourable and there was a growing demand for these products in international markets (Singh, 1995). Trade disputes during GATT era were significant in liberalisation of tobacco trade. Bilateral trade (non GATT) sanctions were used as an early mechanism. For example, the tobacco companies from developed countries used support of their government to threaten trade sanctions unless the developing countries including India opened their local markets to tobacco products. This came at the cost of health of the public and was detrimental to an extent of introducing smoke to the young population of these countries (Shaffer, Brenner &Houston, 2005).

In 1995, World Trade Organisation (WTO) subsumed GATT (Labonté, Mohindra & Lencucha, 2011). By and large the main principle of WTO is the removal of trade barriers which include tariff (financial measures as import taxes) and non tariff barriers (regulations designed to protect public health) to trade (Hawkes & Murphy, 2010). The elimination on non tariff barriers to trade was broadened in 1995 through Agreement on Technical Barriers to Trade (TBT)[21] to ensure that countries do not adopt technical barriers such as requirements for packaging, labelling and terminology which hampers cross border trade. It acknowledges the use of technical regulation for public health when these regulations are consistent with the international technical standards which mean if tobacco control measures become recognised as international measures (FCTC), they may enjoy presumption of being least restrictive under this agreement (Shaffer, Brenner & Houston, 2005). TBT also takes into account that the imported tobacco products are treated at par with the

[20] It was a legal agreement between various countries whose main purpose was to eliminate or reduce the trade barriers such as tariffs which helped to promote international trade. GATT was formed after World War II in order to boost economic recovery of the countries. India has been a member of GATT since 1948 and has been a WTO member since 1995. Simply put, GATT covers international trade in goods. WTO replaced GATT in 1995 but the agreement still exists in WTOs umbrella treaty for trade of goods.

[21] It is based on the principles of non discrimination, promoting access to the markets and technical assistance including special and differential treatment for developing countries. It also encourages the use of international standards and removal of unnecessary barriers to trade. The regulation also applies to safety and quality of the products such as tobacco.

domestic products but these imported products should not compromise human health. It also ensures that the technical regulations are not more trade restrictive than required to achieve the necessary objective of protection of health. Members are also required to notify to WTO the regulations which they wish to adopt and can have significant affect on trade but are not as per international standards (Lal, 2014).

The period of opening of markets and various trade agreements which made the export and import of tobacco products especially cigarettes relatively easy saw an increase in the export of cigarette from India. During 1990-91, 800 million pieces were exported but in the year 1998-1999 it had increased to 2543 million pieces of the cigarettes which was parallel to increase in the area under cultivation due to better prices being offered in the international markets (FAO, n.d.).WTO encouraged India to continue liberalising its trade and investment regimes to ensure strong economic growth when Indian economy slowed down post 1997 (World Trade Organisation, 1998). This slump in the growth saw increased export revenue on tobacco products to three times in 2000-01 as compared to period of 1990-91 (Table 3.2).

Similarly another agreement under WTO, the Trade Related Aspects on Intellectual Property Rights (TRIPS) 1995, aims to protect and enforce intellectual property rights in order to promote technological innovation and transfer of technology for shared advantage of producers and users. Under TRIPS, it is possible for a WTO agreement to refuse registration of a trademark which is misleading using the term light or mild suggesting that a particular product is less harmful than the other. Although the future of TRIPS and the tobacco labelling policy in Asia including India appears to be untouched and untested (World Trade Organisation[WTO], n.d.) yet in 2011 when the TBT and TRIPS council meeting discussed plain packaging in detail, India along with trade representatives from five countries voiced support in favour of Australia's plain packaging initiative. India's official comments in June 2011 TRIPs council meeting cited references supporting plain packaging. India's representation in WTO reflected India's longstanding commitment to flexibilities in terms of balancing property rights and need to protect and promote health (Drope & Lencucha, 2014).

The third stage of multilateral liberalisation has been through the WTOs Dispute settlement system. The mediation of WTO in trade disputes have opened up avenues for various countries to trade in risk commodities. Countries like India, Indonesia,

Thailand, and Philippines have used these rules to provide their domestic producers an access to the foreign markets. Tobacco appears to be under represented in WTO trade disputes because GATT era liberalisation and bilateral sanctions had already resulted in the market entry by TTCs (Mackenzie & Collin, 2012) in various developing countries including India. The damage has been irreversibly done in the era of neoliberal policies with little chance of its reversal in international communities. Recent evidences suggest that the tobacco industry is concentrating on multi lateral agreements in order to reduce the legislations on tobacco control (Collin, 2012).

One of the drawbacks of multi lateral agreements is that high income countries use it to their advantage to negotiate trade rules and gain advantages which they are unable to procure through WTO. Moreover the TTCs also hold power during these agreements which is more than the civil society groups due to lack of transparency in such negotiations (Kelsey, 2012). Empirical evidence has validated that openness to trade agreements leads to an increased consumption of tobacco products. It goes on to say that the effect of TTC marketing strategies on increasing consumption is more in poor and vulnerable countries compromising health of the population (Taylor et al;2000).

Despite the clarifications under international rules for tobacco control as FCTC of which India is a member, the tobacco industry continues to exploit the various investment agreements to influence the tobacco control measures best done through industry lobbying and chilling effect (Lal, 2014). These international agreements combined with vigorous lobbying by the tobacco industry compel the government to compromise the public health efforts made to control tobacco spread. This is known as "chilling effect" where due to threat of a dispute the government has to compromise on making a regulatory decision to pass the tobacco control measures. It is further enhanced in the developing countries like India where the capacity to access the international trade and investment law is limited. Thus the government feels restricted to break certain obligations under the international laws compromising on the control measures (WHO, 2012). A report by World Bank suggested that the price of accession is rising which gives rise to one sided power where the current WTO members wring out disadvantage out of the weaker economic partners. These concessions often involve tobacco or alcohol (Evenett & Primo Braga, 2005). In order

to curb this expansion of tobacco industry the Indian government has intervened in the tobacco market with tobacco taxation as the most effective means of controlling tobacco consumption. The taxation of various tobacco products and the associated revenue with shifts in the consumption to various types of tobacco has been described in detail in the next section.

3.4. TAXATION AND TOBACCO INDUSTRY IN INDIA

The taxation of various tobacco products presents a diverse picture in India; as diverse as the varieties of tobacco products being consumed. The tobacco products in India follow a complex process of tax regime with involvement of both central and the state government. Most smoked tobacco products are subjected to excise tax which is levied as rupee amounts per 1000 sticks. These taxes vary by the category of the product and tier and are specifically low for *bidi*s. In contrast the non smoking tobacco products are subject to ad valorem tax which is a percentage of the retail price (Reddy & Gupta, 2004).

3.4.1. Tobacco Taxes in India

The taxes on tobacco products are a big challenge for the government in order to prevent its misuse by the tobacco industry. The Indian government has not ensured that the taxes across the tobacco system are consistent and do away with substitution, meaning switching the use from one form of tobacco to another. Moreover, a robust system has not been set up to minimise the revenue leakage from the unorganised tobacco industry that processes tobacco products other than cigarettes which is described through different types of taxes levied on tobacco products.

Central government excise taxes

The Central government imposes excise taxes which are collected at the level of the manufacture of these products. The type of tax imposed depends upon the type of tobacco product. Two important aspects of these taxes are to be noticed, the categories under which these taxes are imposed and the form in which these taxes (specific and ad valorem) are imposed.

Specific and Ad valorem excises

The Central government taxes the cigarettes depending on the filter and length as it does to the *bidis*. Tobacco products other than *bidi* and cigarettes are taxed on ad valorem basis meaning they are taxed as a percentage of their retail price. Specific taxes are better than ad valorem taxes since they are easily administered and yield predictable revenue. In India specific taxes predominate the market but multiple tiers (varying length of cigarettes with presence or absence of filter) and very low taxes on *bidis* act as a barrier in its effective implementation. Another concern is that while the specific taxes and the ad valorem taxes have been raised from time to time there is no building up of inflation rates in the process. Without an annual inflation adjusted, increasing taxes on some or all tobacco products does not make a significant difference in prices of tobacco products (Reddy & Gupta, 2004, p.237).

After the 2008 ban on smoking and increased tax on unfiltered cigarette, chewing tobacco products sales increased by 6.5% as those consuming cheap cigarettes switched over to smokeless tobacco (Campaign for tobacco free kids, 2010, p. 5). Simultaneously during the period of 2008-2013, on 58% in the price of *khaini,* there was 51% decline in the consumption. Similarly, a 28% increase in the price of *zarda* lead to 24% decrease in its consumption. But the demand for tobacco products is inelastic[22] which means the increase in the prices should be very high in order to influence the consumption. For example, in order to reduce the consumption by half, the price increase should be more than half. But the change in the affordability or the higher price rise in case of smokeless tobacco may not influence the overall consumption due to low price of the products and tax evasion by the manufacturer. Thus, the laxity by the government and various tactics used by manufacturers compromises the effectiveness of tax in controlling the consumption of smokeless tobacco in India (Rout & Arora, 2014, p.11).

State Government Taxes

Previously as a part of tax rental agreement the states had transferred this power to tax tobacco to central government. The period between 1957 and 2005 saw the Central government collecting the additional excise duties on the sales tax levied by states and

[22] Inelastic demand for tobacco products means that demand would increase or decrease only slightly as compared to the change in the prices.

then transferring these revenues to states. In order to facilitate a more comprehensive tax base the additional excise duty in lieu of sales tax was abolished from March 1, 2006 and states were vested with the power to tax these commodities. Now the states levy ad valorem Value Added Tax (VAT) on cigarettes at the rate of 12.5%. As percentage of VAT imposed is different for every state in India, the chances of interstate cigarette smuggling increases diluting the purpose of controlling consumption thorough taxes (John et al., 2010, p.18).

Goods and Service Tax (GST) and tobacco

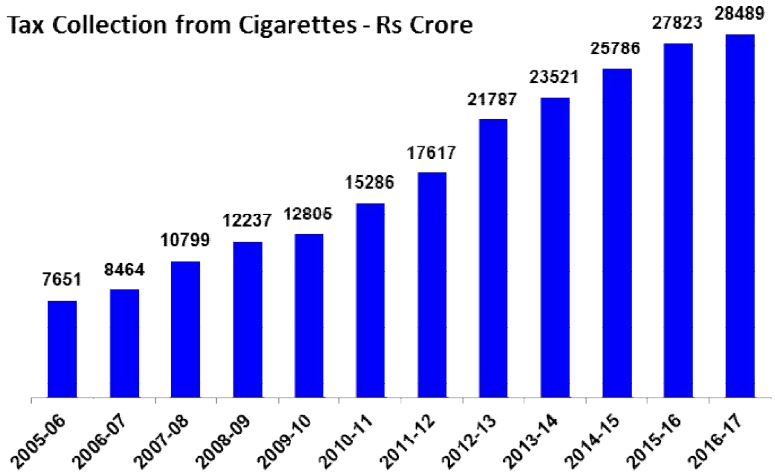
The impact of 28% GST which sounds high is on the base price or the pre tax price on tobacco products in India. This amounts to raising the cost of per stick of cigarette from rupees 4.30 to 5.50. An increase of Rupees 1.20 is way too small to make large difference. GST imposition could increase the revenue of the government but the industry may gradually increase cigarette prices which might not bring down consumption (Scroll, 2017). Meanwhile, post GST the price rise is different for cigarettes and other tobacco products. The average increase has been highest for the economy pack of cigarettes followed by the premium and mid prized pack. On the other hand, the price trends of smokeless tobacco and *paan masala* move in the opposite direction with respect to their pack sizes. In the case of smokeless tobacco the smallest pouch (Less than 2 grams) has seen the maximum price increase whereas an increase of 10 to 20 paisa per pouch has been seen in other pouch sizes. *Paan masala* has seen a decline in post GST price for smaller pouch and an increase for larger pouch. Additionally, the impact of GST has been negligible especially in the case of *bidis* (The Hindu, 2018), not making any substantial difference in the consumption pattern of tobacco products in the country.

Bidi taxes

The excise rate on *bidi* industry depends on whether the *bidis* are handmade or machine made. Moreover *bidi*s produced by manufacturer producing less than 2 million sticks per year and those which are homemade are exempt from the excise tax. *Bidi*s are under taxed when compared to cigarettes. *Bidi*s are taxed at Rupees 0.07 per gram as compared to Rupees 0.22 per gram for micro non filter cigarettes and Rupees 1.092 for regular filter cigarettes. Thus, per gram of tobacco in *bidi*s has one third of the excise rate of the non filter micro cigarette which in turn have one fifth of the tax

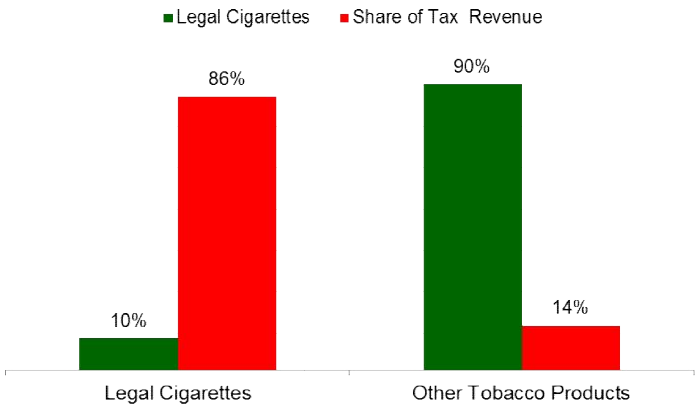
rate of regular filter cigarette. In order to establish the same per stick of the excise rate as the non filter micro cigarette, the tax rate would have to be increased from present Rupees 14 per 1000 sticks for *bidi*s to 168 per 1000 sticks (Sunley, 2008). It has been mentioned in the review of literature that *bidi* consumption is the most common form of smoking in India. Thus, the difference in the *bidi* and cigarette taxes makes it cheaper form of smoked tobacco in India. The unorganised market of *bidi* and lower taxes on it has little or no effect on those purchasing and consuming it.

Figure: 3.1. Tax collection from cigarettes in India



Source: Tobacco Institute of India[23]

Figure: 3.2. Share of cigarettes in tax revenues in India



Source: Tobacco Institute of India[23]

[23] https://www.tiionline.org/facts-sheets/revenue/

Figure 3.1 and 3.2 show the revenue which is earned by the sale of cigarettes in India. Although revenue on cigarettes has increased corresponding to increased taxes, the share of legal cigarettes is 10% of total tobacco products consumed in India while the revenue generated amounts to 86% of the total revenue collected. On the other hand, 90% of other tobacco products consumed generate revenue of only 14%. This is one of the prime reasons for the stricter laws on taxation of cigarettes and the step motherly treatment for other tobacco products especially the smokeless tobacco meaning the most commonly consumed tobacco products of *bidis* and *smokeless* tobacco are the least taxed in India.

3.4.2. Tobacco industry's defence to tax measures

The industries' counter claim to increased taxes in India and elsewhere is that it leads to illicit trade. Some also claim that this would divert the attention of the law keepers which should be focussed on many important issues (Gilmore, Radu-Loghin, & Zatushevski 2005). The other most frequent argument which the industry makes is that tobacco taxes are regressive meaning higher taxes cost more to the poor and the marginalised groups. The industry went far to the extent of arguing that this would lead to class warfare, pitting upper middle class people against the lower middle class (Koh, 1996). This helped the industry to garner support from other allies as labour unions and organisations representing minority groups (Balbach & Campbell, 2009).

Table: 3.3. Consumption of cigarettes in India

Year	Total domestic consumption including illegal cigarettes (Million Kgs)	Legal cigarette consumption (Million Kgs)	% of legal cigarettes in total tobacco consumption
1981/82	406	86	21%
2009/10	499	73	15%
2014/15	562	62	11%

Source: USDA and Industry Estimates in ITC Report, 2017, p.45

Tobacco industry continues to be severely affected due to the collective impact of growing taxes and intense regulatory pressure. While legal cigarette industry remains under threat, illegal cigarette sale continue to grow unabatedly (Table 3.3). The

industry maintains that high taxation and discriminatory regulation on cigarettes have only served to divert consumption of tobacco to lightly taxed or tax evaded tobacco products as smokeless tobacco, *bidi* and illegal cigarettes which are of inferior quality compromising the health objective of tobacco control. It also goes on to say that the per capita cigarette consumption in India is less than its global counterparts as China, Russia, USA and even the neighbouring countries like Pakistan and Bangladesh (ITC Report, 2017, p.71) pressing for less stricter tax regimens in India.

Moreover, the industry also puts forward the argument that the decline in the volume of legal cigarettes has lead to a reduction in the utilisation of Indian Flue Cured Virginia tobacco affecting the livelihood of 45 million tobacco farmers, farm workers as well as those associated with tobacco sector and in turn has affected the exports too. The industry uses the above mentioned arguments as a ground for reduction of taxes on cigarettes and continue to engage with the policy makers for the taxation policy which it thinks is cigarette centric (ITC Report, 2017, p.46).

The most important determinant driving demand for risk commodities as tobacco has been rise in the income level and rapid urbanisation (WHO,2012). Nevertheless, the increase in the price of the tobacco products is not enough to offset the increase in income in India. Affordability of tobacco products when compared to per capita national income in India increased from 2006 to 2011. This is to say that the affordability of these tobacco products has not been rising in comparison to national per capita income but they have also become affordable in the poorest of the households in India. The increase in the inflation of demerit goods like tobacco should be more than other tobacco products but disturbingly the case is reverse which leads to an increased consumption of tobacco products (MOHFW, 2014).

Table: 3.4. Tobacco consumption in India (million kgs / percentage)

Year	Legal cigarettes	Other tobacco products
1981-82	86 (21%)	320 (79%)
2016-17	52 (10%)	486 (90%)
Difference (%)	-34(-40%)	166(+52%)

Source: Tobacco Institute of India[24]

[24] https://www.tiionline.org/facts-sheets/tobacco-consumption/

Table 3.4 shows that the consumption of tobacco has increase in the past two decades. While the consumption of cigarettes has decreased owing to increased taxes, the consumption of other tobacco products has increased. This increased consumption of tobacco has been detrimental to the health of population in India. The combination of factors as reduced tariffs, liberalisation in FDI and minimal tobacco control measures in low and middle income countries including India leads to increased competition in the domestic markets. This causes a decrease in the price of tobacco products, and increase in promotional activities; all of which lead to an increased tobacco consumption. Although government tried to control this consumption through taxes but in the absence of any strong and committed public health protection the movements of tobacco products across countries came to seen as one of the determinants of NCDs (Labonte, Mohindra & Lencucha, 2011).

3.5. TOBACCO CONSUMPTION AND ASSOCIATED PUBLIC HEALTH DEBATES

Although systematic reduction in the cross border trade and investment which has been called trade liberalisation has improved Asia's economic condition and social progress including India, yet it has worked for or against health (Blouin, Chopra & van der Hoeven, 2009). An important instrument in these movements has been Trans National Risk Commodity Corporations[25] (TRCCs) which produce, promote and distribute such commodities on large scale. Trade liberalisation facilitates these TRCCs to quickly disseminate technology, investments, raw materials and final products across boundaries, thus driving risk commodity consumption transnationally (Hawkes, 2005). This growth of risk commodities has witnessed stagnation in high income countries but is on proliferation in low and middle income countries as TRCCs seek new opportunities from the growing middle class consumers in these countries (Stuckler et al; 2012). Foreign Direct Investment (FDI) is the most important strategy used by TRCCs to infiltrate new markets and grow transnationally making it directly related to consumption of risk commodity and prevalence of NCDs in low and middle income countries (Moodie et al., 2013).

[25] The commodities as tobacco, alcohol and ultra processed foods are called risk commodities. Trans National Risk Commodity Corporations (TRCCs) are those companies that manufacture, market and distribute such commodities on global scale.

Since 1980s, Asia has been a recipient of more FDI than any other region; nearly a quarter of the global total in 2011(World Investment Report, 2012). While the magnitude of growing NCDs in Asia including India has been elucidated, little is known about the trade liberalisation as 'cause of the causes' of NCDs in the region. The growth of Asian economy is largely related to its epidemiological transition. It is predicted that by 2025 four of the world's largest economies will be in Asian region and account for half of the world's global economic output, India being one of them. But the emerging epidemic of NCDs can slow this progress of which tobacco use is seen as the most significant preventable risk factor (Asian Development Bank, 2011), the details of which have already been mentioned in the review of literature.

But these demand side factors are less significant in countries with higher penetration of TRCCs meaning it increases the access and availability, lowered prices due to reduction in tariffs and taxes and increased promotion of advertisement of tobacco (Zeigler, 2006). Under GATT Articles 14 and 20, the protection of human health is considered primary allowing the countries to adopt restrictive measures when human health is compromised (Labonté, Mohindra & Lencucha,2011). The action is deemed necessary to protect human health and also to ensure that no other less restrictive trade measure is available. The being said, such measures cannot arbitrarily discriminate countries or be a covert restriction on international tobacco trade (Shaffer, Brenner &Houston, 2005).For instance, if a country wants restriction on tobacco imports it has to prove that the constraints are necessary for tobacco control and they are less restrictive on trade than alternate health measures as in the case of health warnings (Callard, Collishaw & Swenarchuk, 2001). The opening of markets and encouraging cross border trade has been instrumental in growth of tobacco industry especially cigarette industry in India. In late twentieth century when these trade movements were being conceived, debates on second hand smoke had gained momentum globally and in India, forcing government of India to take a tough stand on smoking in public which made tobacco industry defend the right of person to smoke.

3.5.1. Indian government's response to debates on second hand smoke

During the late twentieth century the consumption of cigarette in India was more as compared to later years. The worldwide trends were also high on cigarette smoking which gave rise to the debates on second hand smoke. Based on the results of the

research since 1970s the experts have established conclusive facts about the health effects of second hand smoke. Multiple problems ranging from breathing problems to diseases of cardio vascular system, second hand smoke has been considered as potentially deleterious to human health. It was not until 1970s that the environment consciousness was awakened and it was observed that cigarette smoke formed a type of pollution to which the population was unknowingly subjected. Thus, smokers were not only hurting themselves but were equally dangerous to those around them hence providing a rationale for smoking restrictions. Although tobacco companies started researching about second hand smoke in 1930s their research expanded in 1980s when there were lot of public discussions on the subject of smoking (Dunsby, 2005).

When debates were speeding up on effects of second hand smoking, they had a bearing on the tobacco related litigations in India. In the mid 1980s, health professionals at All India Institute of Medical Sciences (AIIMS) established the Health or Tobacco (HOT) Group. Although various other networks were formed during this period to fight for tobacco control but due to paucity of funds and lack of full time committed staff, these networks were not successful in coordinating the nationwide efforts for tobacco control. It was in year 1999 that High Court of Kerala issued a path breaking judgment in India for the first time, banning smoking in public places. This order was applicable throughout the state of Kerala banning smoking in theatres, bars, restaurants, shops, schools, trains, footpath and bus stands. Upholding this judgment and recognizing the delay in enacting a national law, the Supreme Court of India in November 2001 stepped in to ban smoking in public places throughout the country. It directed the Central and State governments to make sure that the ban is implemented (Reddy & Gupta, 2004, pp.180-181).

3.5.2. Industry's defence to second hand smoke

The industry challenged the evidence against second hand smoke by establishing its own research and by campaigns that portrayed the results as inconclusive and biased. By 1980s, it organized a team of research globally which said that other pollutants in the environment were more harmful than smoking and the buildings should have proper ventilation system in order to reduce the effects of such pollutants. The experts used by the tobacco industry were quick to point out the shortcomings in the studies on second hand smoke. They were of the view that nowhere was it mentioned

if the current non smoker was ever a smoker in his life. Moreover, they argued that numerous potential confounders in patients of lung cancer living in the household of a smoker could be lack of exercise, poor diet as well as hazardous occupation (Dunsby, 2005).

In response to the Supreme Court's ban on smoking in public places in India the industry responded by denying the harmful effects of smoking as well pleading that in any event the smoker voluntarily assumes the risk of smoking(Reddy & Gupta, 2004,p.183).These debates on second hand smoke initiated the discussions around individual's right to smoke.The argument on individual rights is concerned on whether it is the right of the individual to make choices or it is the protection of individual interests who do not smoke. In order to fight against the battle for tobacco control the term right has been used strongly as free choice which says that smokers have the liberty to consume the product, manufacturers have freedom to create the product, marketers have right to communicate it to public and the consumers have right to look into and analyse contending view points. Tobacco industry has always distorted the real depiction of rights. The disputation situated around environmental smoke says that the act of smoking is prohibited in the public space because non smoker also has a right not to breathe that air. But the opposing view always stresses that the act of smoking is not inhibited in a person's private space (Herbert, 2002).

The industry continues to maintain that the growing government intrusion into the life of adult smokers is a threat to the freedom of its citizens. These efforts of the industry have been making the smokers aware of the need to protect their rights and bringing into disrepute the tobacco control movement, which gives the smokers a justification for their behaviour. The tobacco industry has used the description "Health Nazi" which means that the efforts for tobacco control are not humanitarian but rights and life destroying monsters. The intention behind this term was said to be able to create something which could destroy tobacco control advocacy (Katz, 2005). Tobacco industry has been partially successful in creating an artificial world in which people's ordinary construction of realities is distorted which makes it difficult for the people to make informed choices about tobacco and health (Tyrell, 1999).

3.6. TACTICS ADOPTED BY TOBACCO INDUSTRY TO ATTRACT TOBACCO USERS

Naturally, trade liberalisation had effects which were just needed for the tobacco industries to expand its base globally. This caused an increase in competition in domestic markets and possible price reductions in tobacco products due to increased competition. Moreover, countries permitting such activities increased in advertising and promotion expenditure by international companies and by domestic producers. The lower prices and higher advertising expenditure led to increased demand and consumption of tobacco. This also facilitated penetration into tastes of women and children by entry of new firms into the market (Taylor, et al., 2000).

3.6.1. Tobacco advertisement, promotion and sponsorship

Strong market objectives have always been seen as the core of any successful business venture. The marketing strategies of the companies keep changing with time and are altered in order to target the audience tastes and preferences which change over time. It is the marketing strategies of these companies which change the tastes and preferences of the audience and allure them into new products every day (Goyat, 2011). The tobacco industry in India also promoted the use of tobacco through various means before the government of India raised serious concerns and legislation on tobacco grew stricter.

3.6.1.1. Tobacco Industry's promotional activities in India

The period of 1990s in India saw tobacco companies fighting for the rights of various sports and cultural events. Subsequently, the Indian cricket was sponsored by Wills, the flagship brand of ITC, until its withdrawal in March, 2001. The major tennis tournaments in the country were sponsored by the cigarette brand Gold Flake whereas boat racing was sponsored by boat racing brand. On the cultural front, Charms a cigarette brand exclusively marketed by VST for youth patronised the 'Spirit of Freedom' concert where biggest names in vocal and instrumental music participated (Reddy &Gupta, 2004, p.207). Moreover, in India women smokers are a minority; hence always been a target for the tobacco industry. In 1990s, GPI launched 'Ms' brand of cigarettes targeting the Indian women. The launch of this brand was met with hostility from women and various health groups. The industry defended itself by

saying that the brand was for emancipated women and all the models used for the same were in western attire. It also tried to associate famous film celebrities with this brand to increase the sale of tobacco products (WHO, 2003).

The tobacco giants of ITC and GPI in India introduced mini cigarettes which were non filter and less expensive than the regular cigarettes. GPI launched a 59 mm micro cigarette, Tipper in July, 2003. The industry officials explicitly explained that the industry does not make much revenue with these cigarettes but it sells these with hope that people will move up to a more expensive brand. In 1998, minis were the fastest growing product of ITC in India. The use of film stars to promote the mini cigarette of ITC brand was clearly visible during period of 1994-96(Reddy & Gupta, 2004, p.210).

3.6.1.2. Indian government's response to promotional activities of industry

In response, the civil society in India played a crucial role in creating a supportive environment for tobacco control. This was possible due to years of efforts of community mobilisation and advocacy with media and policy makers. In fact many legislative steps taken by the government were framed by the government on the basis of inputs from NGOs, medical institutes and anti tobacco groups. Nine national NGOs got together in 2001 to form an all India coalition called the Advocacy Forum for Tobacco Control (AFTC). This included experts from all fields ranging from public health, research scientists, health professionals and officers representing various Indian NGOs. AFTC actively engaged with Parliamentarians and Ministry of Health when India Tobacco Control Bill was being debated in Parliament in 2003. The Bill got cleared from both the houses of Parliament and became an Act with presidential assent on 18th May, 2003 (Reddy &Gupta, 2004. pp.188-189). Although India has a near comprehensive ban on direct as well as indirect advertisement of tobacco, it still allows for advertisement that is at the point of sale ,"in pack" or "on pack". The tobacco industry takes advantage of this and is still engaging in at the point of sale advertisements. It is interesting to note that these point of sale advertisements have increased post the Tobacco control law of 2004 in India (WHO, 2013), increasing the tobacco advertisement contribution from 3000 million in early 2004 to projected 3500 million within a year of passage of law in India (Reddy & Gupta,2004,p.205).

Indian government has used mass media to disseminate the negative effects of tobacco use which target the entire spectrum of tobacco products used in India namely cigarettes, *bidi* and smokeless tobacco. Anti tobacco advertisements have been aired on the televisions as well as radio. The Ministry of Health regularly releases anti tobacco advertisements on Prasar Bharti (independent Broadcast Corporation which replaced state radio and television services). The advertisements and infomercials aired during 2002 aimed extensively at popular youth channels on cable and satellite and on national channels to ensure wider reach of these health messages (Reddy & Gupta, 2004, p.222). The government introduced the COTPA Amendment Bill 2015 which proposes to bring changes in the existing act. This Bill has projected that brand name which was earlier being used for non-tobacco product promotion as a surrogate advertisement will be banned (COTPA Amendment Bill, 2015).

3.6.2. Packaging and labelling of tobacco products

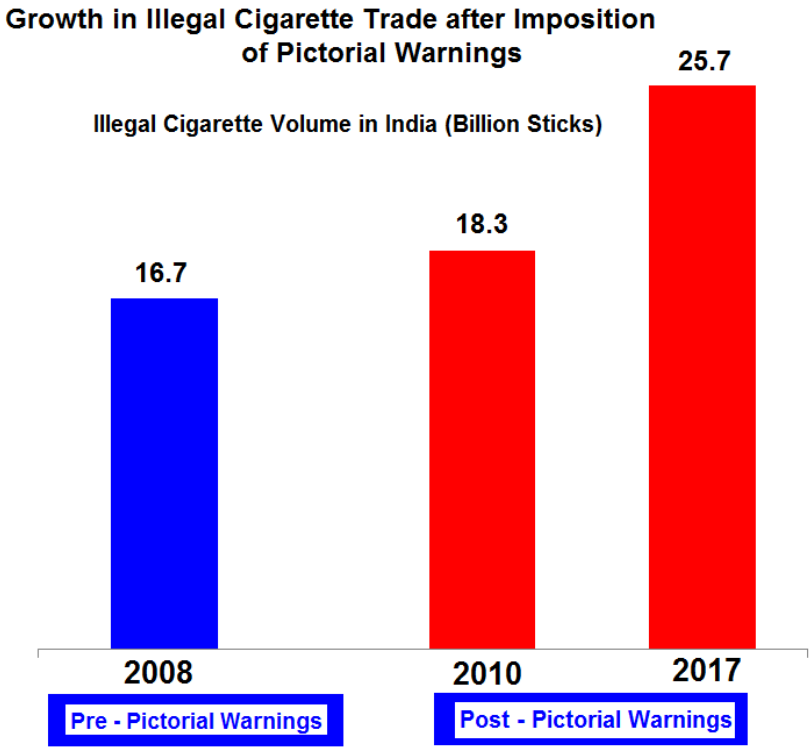
Tobacco companies have since long identified the segments with strong potential as customers. The companies have been very successful in investing in research which has produced tailored brand lines and communication messages using the approach of market segmentation. The major objectives of the segmentation are tailored to encourage smoking initiation, maintain brand loyalty, increase the consumption of tobacco and avert the smoking cessation efforts (U.S. Department of Health and Human Services, 1989). Expenditures devoted to promotion of low tar cigarettes have exceeded their market share which suggests that the companies tried to move the smokers to low tar cigarettes rather than quit the product (Federal Trade Commission, 1972).The companies have also researched on the important aspect of the new colour schemes which has been considered to be an important attribute to the overall brand identity. The colour and design of the packets have been seen by the tobacco industry as a means to meet the psychographic demands of the consumers. The cigarette packets are used by the tobacco industry to offer cognitive cues to the existing customers and attract the new ones (Lal & Jacob, 2014).

3.6.2.1. Industry's tactics for packaging and labelling of tobacco products in India

In order to restrict these signs which attract customers, the Indian government decided to increase the pictorial warnings from 50% of the area to 85% of the area on all

tobacco products. However, the Parliamentary committee on subordinate legislation in India had tabled that the increase of pictorial warnings from 50% to 85% on front and back sides of all tobacco products would be too harsh on the tobacco industry and increase the illicit cigarette business in India. It recommended that in case of *bidi* and smokeless tobacco the pictorial warnings should be restricted to 50% of the display area and only on one side of the packet saying that it would not leave a space for brand name and logo as there is a single round surface in case of *bidis*. It is to be noted that being a committee it is supposed to look if the legislation violates the constitutional principle and not supposed to frame the regulation strengthening the fact about the nexus between the government officials and tobacco industry (Prasad, 2016).

Figure: 3.3. Growth in illegal cigarettes after pictorial warnings



Source: Euromonitor International (2018)[26]

[26] https://www.tiionline.org/industry-issues/pictorial-health-warnings/

Table: 3.5. Comparison of warning signs on cigarette packets

Country	Annual cigarette consumption (billions) in 2016	Per capita adult cigarette consumption (Sticks)	Warning size
USA	262	1028	Text (only on side panel)
China	2351	1711	Text-30%(front and back)
Japan	174	1841	Text 30% (front and back)
India	88	96	Pictorial 85% (front and back)

Source: Tobacco Institute of India[27]

The tobacco industry also made desperate attempts to compare the pictorial warnings in India with countries of US, China and Japan which consumes more than 51% of the cigarettes globally and have text based warnings which inform the consumers (Table 3.5). In addition, the industry uses it age old rhetoric of increase in the sale of illegal cigarettes after the increased size of pictorial warnings in India (Figure 3.3).

3.6.2.2. Legislation on packaging and labelling in India

The government of India in response to industry's strategy made sure that the health warnings on tobacco products repelled users and helped them to make changes in their lifestyle and increased the warnings to 85% on tobacco products in 2016. But there is a reason why these images may fail to create the desired effects. Although the pictures were meant to be scarier than before, they were to highlight the same theme of oral cancer. The fatigue which sets in by watching the same theme may reduce the shock value of pictorial warnings with time. Moreover, there is less effort in depicting other negative fall outs of tobacco use except oral cancer which will help to educate people on multitude of conditions caused by use of tobacco. The current warnings are

[27] https://www.tiionline.org/industry-issues/pictorial-health-warnings/

in Hindi or English only and in many states the majority of people do not understand (Prasad, 2018).

Moreover, the legislation in India has been laying stress on the graphic warnings to be given on cigarette packets but 65% of the cigarette consumption occurs from single cigarettes being sold out at the *paan bidi* outlets and not in packets (Srivastava, 2000, p.14). While the Indian government has tried implementing the warnings what largely remain questionable is the sale of loose cigarettes and the non use of packets by the consumers. The reason for buying loose cigarette is non affordability of full packet by people of low socio economic background as well as the fear of being caught. There is also a perception that if they buy packet of cigarette they might end up consuming more than required. So even if the purchase of loose cigarettes may cut down the consumption, the packet remains with the vendor and the consumer misses on the pictorial warnings (Ramachandra & Ramachandra, 2015). Moreover, these anti tobacco health warnings on packets are not understood by all the population as it requires intense health education (Zahiruddiin et al., 2011).

CONCLUSION

The expansion of the tobacco industry from developed to developing world has been a matter of concern for the advocates of public health. The tobacco industry flourishing and sustaining despite stricter legislations in India is not only due to hard work done by the industry but also the fragmented opinion amongst the power corridors. The irony of tobacco control is that the government on one hand is more vigilant on checking the use of tobacco but on the other hand encourages the growth of tobacco crop for increased revenue and exports. Additionally, the industry tries to influence the various control measures by adopting tactics which are one step ahead of the government. When tobacco control laws become stringent, the industry adopts various plans to bypass these laws. The government of India although raised taxes on tobacco products but the maximum increase was seen in the case of cigarettes. This was instrumental in helping the tobacco users to switch from the use of cigarettes to other tobacco products diluting the purpose of the taxation as a measure to control tobacco use. Moreover, the use of trade agreements for expansion to developing countries like India is another way of expanding the global base of the industry. This expansion of industry and the changing disease profile has made proponents of public health more

vigilant. Subsequently, the government puts in innovative research capacity in tobacco control which can give a tough fight to industrial policies. That being said, the tobacco industry is still making profits which has not been contained by the government because the industry moves one step ahead of the state. The research base as well as advocacy built by the industry within the country has raised strong opposition against tobacco control laws assisting the industry in being profitable.

CHAPTER 4

CONTEXUALISING TOBACCO IN HISTORICAL DEVELOPMENT OF PUNJAB

INTRODUCTION

The objective of this chapter is to collate the events which played an important role in tobacco introduction and consumption in Punjab. The state of Punjab due to its historical importance, geographical location and religious minority has been an important example of diversity. In reality, the transitions in social, economic and developmental structure of Punjab have played a vital role in their bearing on health as well as health behaviour of the population. Eventually, these changes in the dynamics of the state have attracted attention from the community of research scholars. A retrospective review of the shaping of the present state of Punjab through various dimensions might place the subject of tobacco addiction within social, economic and political boundaries of the state.

Punjab is one of the states of northern India which is relatively small in terms of geographical boundaries and population but holds high importance in social, economic and political spheres of the country (Singh, 1999, p.3). Talking of Punjab's geography, it is a landlocked region in the northwest corner of the Indian subcontinent. Although it's political boundaries have oscillated throughout the history but its natural boundaries are clearly defined. The name Punjab (the land of five rivers) is derived from Jhelum, Ravi, Beas, Sutlej and Chenab. The contemporary state of Punjab and Punjab province in Pakistan has been the result of partition in 1947. The Indian state is now one fifth of what it used to be following further reorganisation and fragmentation in 1955 and 1966 (Tatla & Talbot, 1995).

The development of Sikh religion which was founded by Guru Nanak Dev in the fifteenth century gave Punjab a discrete ethnicity, religion and territorial distinctiveness. Additionally Punjab was transformed into agricultural canal colonies in the nineteenth century which gave it a distinct identity of an agriculturally predominant state. The Punjab today acquired its political identity in the year of 1966 when it was declared a Punjabi speaking state. It was between the period of 1966 and 1991 that Punjab attracted the attention of academic scholars and policy planners

mainly because of two reasons. Firstly, in the years of 1960s and 1970s the success of Green Revolution in Punjab increased the food output, which was a prominent success in Punjab. Secondly, in the years of 1980s the rise of militant confrontation in Punjab between the Sikh nationalists and the Indian government attracted global attention. The militancy rise in Punjab indicated some faulty lines in the federal political management of the Indian state (Singh, 2008).

The chapter is divided into four sections and corresponding subsections which contexualise the use of tobacco in the historical evolution of the state of Punjab. The sections are focused on the agricultural practices and transition from the pre-colonial times to post liberalisation era. Presenting an elaborate history in each section is beyond the scope of this thesis and the researcher has tried to place tobacco within the prominent changes in form of its cultivation, production and use in the state. Moreover, the use of tobacco has been discussed in these sections with segregation into various forms of its use wherever possible.

The first section is about pre-colonial Punjab during the Mughal period and the overtaking of Mughal Empire by the Sikh ruler Maharaja Ranjit Singh. It primarily talks about the agriculture under these rulers and the use of tobacco. The second section of the chapter is the period of Colonial Punjab which is primarily about making Punjab an agriculturally prosperous state and recruiting soldiers from Punjab in the British Army which introduced Punjabi culture to use of tobacco in a noticeable manner and escalated the concept of masculinity in Punjabi males.

The third section is on post independence Punjab which draws attention to the events responsible for placing tobacco in the debates of Green Revolution which was responsible for increased economy of Punjab, rise of Sikh radicalism and phenomenon of migration putting Punjab on world map. The fourth section talks about structural changes in Punjab post liberalisation which had an impact on the industry; of tobacco in particular, as well as changes in the social sector of health and education in Punjab which led to addiction among the local youth. These events changed the profile of Punjab from being an agriculturally prosperous state to a state struggling to stabilize its markets and economy.

4.1. INTRODUCTION OF TOBACCO IN PRE-COLONIAL PUNJAB

An important event in Punjab's history has been the foundation of Sikh religion by Guru Nanak Dev (1469-1539) who was born in the upper caste Hindu *Khatri*[28] family and from childhood had a dislike for religious orthodoxy, hypocrisy and Hindu caste hierarchy (Dhillon, 2006). He used the language of the masses, Punjabi, to preach his teachings. This was in sharp contrast to Hindu priests and Muslim clergy who used Sanskrit and Arabic languages respectively which were inaccessible to the local population. The priestly class had established an intellectual hegemony by using the old classical language which the masses could not understand; hence developing superiority of learning around them. By using Punjabi language, Guru Nanak attracted the followers from Hindu lower castes who came to be known as Sikhs, meaning a learner or a disciple (Singh, 1994).

4.1.1. Introduction of tobacco in Mughal Empire in Punjab (1556-1767)

When Sikh religion was in its newest form in Punjab, the battle of Panipat in 1556 paved the way for rule of Mughal Empire and Punjab was subsequently included in the provinces of Lahore, Multan and Delhi. Under Mughal rule, agriculture was the main source of wealth in Punjab which yielded so much that not only requirements of Punjab province were met but food grains were imported to other parts of the country. Although Punjab was superior in agriculture due to fertility of soil and natural rainfall, Mughal Emperors took responsibility in providing irrigation facilities and rainfall in the areas which were devoid of fertility and rainfall (Nijjar, 1968, pp.145-146). The technique of use of Persian wheel which drew water from the wells by means of a pot attached to a rope was responsible for the prosperity in agriculture of Punjab. It used artificial devices to draw water from the wells with the mechanism of pulley and lever system (Chutia, 2014).

In addition, the administrative structure which had been established under Akbar, made Punjab of Mughal period well organised and structured. Records say that Akbar made Lahore the capital of India (1585-1598) and during his stay in Punjab Akbar was visited by the Portuguese missionaries and few Englishmen (Nijjar, 1968, p.44).

[28] Khatri is a community which originated in Punjab and the word is derived from Kshatriya meaning the warrior and the ruling class. They played an important role in India's trans regional trade during Mughal period.

Although no direct accounts are mentioned on the introduction of tobacco in Punjab but as stated in the previous chapter tobacco reached court of Akbar when it was introduced to royalty by giving the nobles tobacco and pipes and subsequently spread to common masses. It was in the seventeenth century during the reign of Jahangir that tobacco crop was grown all over India, including northern India and tobacco was smoked through *hookah* (Gokhale, 1974). Lifestyle under the Mughal Empire was such that drinking alcohol and using tobacco was very much prevalent in those days. All Mughal rulers drank heavily and it was natural for their subjects to follow which led to people of Punjab using tobacco in form of *hookah* smoking (Nijjar,1968, p.140).

Punjab was most prosperous of the Mughal territories in the seventeenth century. Nonetheless the flourishing trade and agriculture in Punjab was dislocated due to the disturbed political conditions of the coming century. No single explanation can be found regarding the decline of Mughal Empire in the state. The decline in the administrative efficiency under Mughal rule and loss of local resources to the barons played an important role. Furthermore, during the seventeenth century, Guru Hargobind, the sixth guru of Sikhs, gave a call to his followers to procure arms and horses in order to build an army to wage war against the Mughal rulers (Singh, 1999, p.63). By this time the base of Sikh community had expanded. The geographical location of all the five gurus after Guru Nanak was the *Majha* area of Punjab around Amritsar which was considered the heartland of *Jat* peasant community who had a long standing history of social egalitarianism. The teachings of Sikh gurus attracted *Jats* into the fold of Sikhism (Habib, 1976, pp.95-98).This large scale conversion of Jat peasantry to Sikhism converted the character of Sikh community from a purely religious community to a community that was concerned with worldly and material affairs (McLeod, 1996, pp.9-13).

In continuation of the resistance to Mughal Empire Guru Gobind Singh, the tenth and the last living guru, called on his followers to become a community of Saint Soldiers to take up arms against oppressive rulers. On a historic day in Anandpur Sahib on 13 April 1699, Guru Gobind Singh made a significant announcement about the symbolic, physical, ideological and political transformation of the community, giving birth to *Khalsa* tradition which remains as the most defining moments of the Sikh history. The

resistance to Mughal Empire also meant denouncing the culture of tobacco consumption mainly in form of *hookah* which the Mughals introduced in Punjab. In response Khalsa provided a code of conduct for the Sikhs which later came to be known as Sikh Rehat Maryada Code under which it is considered objectionable for a Sikh to consume tobacco in any form. Use of tobacco is listed under Sikh Rheyat Maryayda (code of conduct) as one of the four transgressions (Uberoi,1980, pp.131-146). Fifty two *Hukams* or set of instructions in Sikhism which were set by Guru Gobind Singh sum up the principled way of life for *Khalsa*. In one of these set of instructions he says, *"Jagat Jooth tambakhu bihkia da tyaag karna"* which means abandon worldly ways, falsehood and poisonous tobacco (Annexure B).

Early European writers who came across the Sikhs in the late eighteenth century were baffled as to why tobacco was prohibited for the Sikhs as tobacco was being widely used by both the British and the Indians at that time. Of all the nations that the Europeans came into contact with, the Sikhs were the only one who had a religious rejection against tobacco[29]. To quote one of the European writers Col A.H.Polier,

> *"They abhor smoking of tobacco, for what reason I cannot find, but intoxicate themselves freely either with spirits or bang ; a cup of the last they seldom fail taking at night after a fatigue"(*Singh, 1962, p. 63).

In extract from another letter from Major Polier posted at Delhi to colonel Ironside at Belgram ,

> *"Each zemindar who from the Attock[30] to Hansey Issar[31], and to the gates of Delhi lets his beard grow, cries Wahgorow[32], eats pork, wears an iron bracelet, drinks bang, abominates the smoking of tobacco…."(*Singh ,1962, p. 65).

The resistance to use of tobacco in Punjab had started in the early eighteenth century after the formation of Khalsa. After the demise of Guru Gobind Singh, Banda Singh Bahadur proved to be his effective military and political successor. Although the successes of Banda Singh increased his popularity and hold in Punjab but the superior military of the Mughals prevailed and he was captured and killed in 1716. Banda Singh's rule was short lived but it shook the foundations of one of the most powerful empires in the world with such violence that it was never able to re establish its authority (Singh, 1999, pp.117-118).

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[29] http://www.sikhs.org/art9.htm
[30] It is the name of River Indus (sindh) in the north western frontier province of Pakistan.
[31] It is the name of present district of Hisar
[32] It means Waheguru meaning the Wonderful Lord.

4.1.2. Tobacco in the rule of Maharaja Ranjit Singh (1799-1849)

The growing weakness of the Mughal Empire and resisting foreign invasions after demise of Banda Singh Bahadur for three decades (1767-1798) enabled Sikhs to win power in Punjab by Maharaja Ranjit Singh (the first and only Sikh emperor of Punjab) in the late eighteenth century. With the help of a large Sikh army, he formed an extensive kingdom in the nineteenth century. In the treaty of 1809, he acknowledged Sutlej as the North West frontier of British authority in India. His power depended on the modernised army and on cooperation of Muslim chiefs of West Punjab (Tatla & Talbot, 1995, p.14).

The rule of Maharaja Ranjit Singh brought about a sense of peace and security and uniform administration which was needed for peaceful land cultivation. The entire population, barring a few was dependant on agriculture for its livelihood. After political upheavals under the previous rule, the cultivators got a sense of security and relief which improved the condition of agriculture under Maharaja Ranjit Singh's rule. Punjab in the times of Maharaja was divided into four divisions namely Peshawar, Multan, Kashmir and Lahore. Although the natural capabilities of agricultural production and produce were different in these areas due to climatic conditions and fertility of the soil yet the crops grown in these areas were pretty much the same (Singh,1939, p.142).

In the early nineteenth century these fertile conditions and well drained land was useful for cultivation of crops like tobacco along with major crops of wheat, maize, barley and sugarcane with some cotton, pulses, hemp and vegetables in these areas. Moreover, the Maharaja took various sound steps to increase the availability of resources to the peasants. Seasonal canal irrigation was provided in the south west region of Punjab where flourishing crop cultivation was doubtful and loans were offered to poor *Zamindars* to dig wells wherever possible for cultivation of land. The land revenue which was charged according to the condition of the crop was light and made sure there was no burden on the peasant class (Singh, 1939, pp.142-143). Tobacco produce could not be estimated accurately and was assessed on cash basis with other crops as sugarcane, pepper, cotton, false hemp, spring fodder and vegetables. These crops were to pay cash rates for under mixed system of land

revenue which was important method of tax collection under which standard crops were liable to be assessed on *kankut*[33] basis (Dhillon, 1939, p.126).

Following the death of Maharaja Ranjit Singh in 1839, the Sikh kingdom fell into pieces turning the things to the advantage of British. Following first Anglo Sikh war of 1846, the Trans Sutlej territories of Jalandhar and Hoshiarpur were annexed by the East India Company. The following years saw the collapse of the structure of Punjab which brought whole of Punjab under the rule of East India Company (Tatla & Talbot, 1995, pp.14-15).

4.2. PLACE OF TOBACCO IN PROMINENT CHANGES IN COLONIAL PUNJAB (1849-1947)

There were many changes in Punjab under the British rule which had a direct as well as indirect impact on tobacco cultivation, use and economy. The agricultural canal colonies made the state of Punjab more prosperous and concentrated tobacco growth in well irrigated areas of West Punjab. Also the cultural exchanges during British rule and the recruitment of Punjabi males into the British army was consequential in introducing the population to a culture of tobacco consumption in the form of cigarette smoking.

4.2.1. Agriculture and tobacco cultivation in Colonial Punjab

By the time Punjab was incorporated into the British Empire in year 1849, the British had already established itself from a trading monopoly to a territorial ruler in the Indian sub continent. Within few years Punjab was regarded as India's model agricultural province (Talbot, 2007, p.3). During these times Punjab was mainly a dry landmass and only few areas of the state received considerable rain. The west and the south east parts of Punjab were mostly dry. The farmers were dependant on wells for irrigation and ponds were used to store water in those areas. But the presence of several rivers in Punjab raised the possibility of development of irrigation through the network of canals(Singh ,2018).Within a few decades of consolidation of British Rule in Punjab, the colonial government started an ambitious program of canal irrigation network in Punjab which came to be popularly known as Canal Colonies Program as

[33] Under this system a representative field of every crop was taken and its yield was estimated. Out of the total yield a portion as paid to the state authorities as land revenue, meaning the revenue was paid in kind.

it involved the settlement of peasants from East Punjab (Post partition India Punjab) into areas of West Punjab (post partition Pakistan Punjab) where the network of canals had been developed (Ali,1999).

The canalisation of the region was done on such a massive stage that Punjab emerged as one of the largest irrigation systems in the world which proved profitable to the British. In addition the extension of transport facilities especially the railways acted as an impetus for progress of Punjab (Calvert, 1936). The closing decades of the nineteenth century saw the rural stability and order in Punjab threatened by the transformation arising from the commercialization of agriculture of the region. From the year of 1860 the prices of land and agricultural prices started rising in Punjab. This was the result of the vastly improved irrigation system. As a result, tobacco along with other cash crops as sugarcane and cotton was introduced (Talbot, 2007).

There were two main harvests, *Rabi* sown in October - November and reaped in the month of April-May and *Kharif* which was sown in June-August and reaped in early September to the end of December. The harvest of *Kharif* was followed by *Rabi,* while Rabi was followed by the extra crop which was known as *Zaid Rabi* which consisted of tobacco in the month of June (Latifi, 1911, pp.13-14). Of the total grown area, 43% was under *Kharif* crops and 57 % was under *Rabi* crops. The area under *Zaid Rabi* crop was not recorded separately (Roberts & Singh ,1947, p.12).

Although the predominant form of agriculture in Punjab was subsistence agriculture, during the second half of the nineteenth century when increased cultivation of cash crops like tobacco was introduced, the total area under all cultivatable crops increased (Siddiqi, 1986, p.43). That being said, tobacco along with indigo, opium and hemp were raised on less than 1% of the cropped area. Wheat occupied a major area forming one third of the cropped land between the period of 1874 and 1900. Millet gram, barley, jowar and other small grains as well as pulses occupied almost half of the total cropped area each year. Land under rice, cotton and oilseeds ranged from 3 to 4% of the total; that under sugarcane was less than 2%. Except tobacco, these crops enjoyed the patronage of the government and remained as significant export crops during the late nineteenth century in Punjab. By the early twentieth century the cultivation of tobacco in Punjab as compared to other cash crops declined (Siddiqi, 1986, p.44).

Table: 4.1. Distribution of Crops between period of 1874-75 and 1900 (Hectares in %)

Crops	1874-75	1878-81	1891-1900	Net change in 1891-1900 over 1874-75
Wheat	30.36	31.85	31.43	2.4
Rice	3.84	3.31	3.73	13.26
Other Food grains	56.55	55.06	47.25	-17.07
Oil seeds	3.00	2.35	4.18	38.12
Sugarcane	1.83	1.78	1.69	-8.91
Cotton	3.33	3.68	3.93	16.67
Tobacco	0.39	0.34	0.26	-35.64
Hemp	0.23	0.18	0.21	-11.17
Opium	0.05	0.05	0.04	-11.01
Indigo	0.06	0.36	0.43	-32.82

Source: Siddiqi, 1986, p.45

This gradual decrease in the area under cultivation of tobacco during the period (Table 4.1) could be attributed to the patronage and increased area under cultivation of cotton. Cotton textile industry which was the key manufacturing industry in Punjab got a further boost during the period of World War I due to increased military requirement of the government and shrinking imports from Lancashire (Singh &Singh, 2016).

The main tobacco grown in Punjab was *hookah* and snuff tobacco. But beginning of cultivation of cigarette tobacco in Punjab was also reported. From 1900 the cultivation of tobacco further decreased. For the quiquennium ending 1942-43 the total area under tobacco decreased to 0.23 percent of the total sown area amounting to 71,115 acres. Of this 98 percent area was irrigated and 2 percent was non-irrigated where tobacco was cultivated. The area under tobacco cultivation in 1943-44 further decreased to 32,745 acres of land. This huge reduction in the cultivation on tobacco was due to imposition of excise duty at the rate of one *anna* per pound form 1st April

1943 on *hookah* tobacco which was further increased to three *annas* per pound from March 1944 (Roberts & Singh, 1947, p.479).

The most important districts which grew tobacco in Punjab were Jullundur (present Jalandhar), Attock, Sialkot, Sheikhupura, Lyallpur, Gujaranwala, Gujat, Montogomery and Jhang, though it was grown on a small scale by Muslim and Hindu cultivators all over the province. During the period of 1943-44, there were only four important districts of Multan, Lyallpur, Attock and Jhang growing tobacco (Roberts & Singh, 1947, p.479-80). The yield of tobacco crop in Punjab varied from district to district. The highest yield was obtained in Attock while the lowest yield was in Muzzfargarh. The average yield of *hookah* tobacco in Punjab was taken to be about 12 *maunds* per acre though favourable conditions could push the yield to 30 *maunds* per acre. The cigarette tobacco out turn was about 15 *maund* per acre in Punjab (Roberts & Singh ,1947, p.484).

As far as the average total production of tobacco in Punjab province was concerned it was about 11 lakh *maunds.* Of this total production about 20 percent was retained by growers for home consumption and balance of the crop is sold in market. The total crop of the Punjab province was not enough to meet the needs of the province and about 2, 86, 000 *maunds* of tobacco were imported every year. About one third of the imports were from Delhi and North western frontier province and the remaining two thirds from other places. The imported manufactured tobacco consisted of 81% cigarettes, 12 % *bidis* , 4 % chewing tobacco, 2 % pipe and cut tobacco and 1% cigars. Of cigarettes manufactured locally about 50 % was exported mainly to UP and 50% was kept for local consumption. Similarly, 50 % of the snuff was exported mainly to Sind and a little to states of UP and Kashmir. Snuff was consumed mostly by the illiterate low class people in Punjab (Roberts & Singh, 1947, p.485-486).

As mentioned in the previous chapter, in 1944 Indian Central Tobacco Committee (ICTC) was formed to deal with the improvement of tobacco crop because the increase in the export of Virginia tobacco to United Kingdom from India had doubled in the year 1937-38 as compared to 1934-35. Thus, the research in Punjab prepared it to grow the varieties of Virginia tobacco in order to get a share of it exports (Roberts & Singh, 1947, p.488). Thus, the cultivation of tobacco and its trade under British in

Punjab was highly influential in introducing the local population to various varieties of tobacco use.

4.2.2. Militarization of colonial Punjab

Besides agriculture, the military history of Colonial Punjab also played a role in setting the use of tobacco in the Province. By the year 1875, the British Indian army drew a third of its recruits from Punjab. The proportion had risen to three fifths in 1914 although Punjab formed only one tenth of the British population (Talbot, 1988, p.47). This institutionalization of Punjabi heroism has been responsible for concept of masculinity which has been one of the reasons for the consumption of addictive substances like alcohol, tobacco and other drugs.

4.2.2.1. Military of Punjab during World Wars and use of tobacco

During First and Second World War Indian army's participation in British army was significant, of which Punjab army was an integral part. On the eve of First World War, the Punjabis accounted for sixty six percent of all the cavalrymen in the Indian army, eighty seven percent in artillery and forty five percent in the infantry (Yong, 2005, p.18). During the period of World War, not only there was an expansion of the tobacco industry but also increased use of tobacco among the soldiers. During World War I the use of cigarettes in the American and the British soldiers had increased (Goodman, 2005, p.94).

Tobacco formed an important part of rationing of the British army of which Punjabis formed a significant part. The Field Service Manual of 1914 during the First World War period listed out that in addition to all other supplies, a battalion of 1000 men would require 18 pounds of tobacco per day. It was issued as a regular ration but was sometimes in short supply as compared to other desirable food items. Weekly rations included twenty, sometimes thirty cigarettes per man for the British soldiers (Robertshaw, 2013).

The mention of tobacco in letters written by the soldiers from Punjab during their stay away from home for war signifies the importance of tobacco for consumption. A Punjabi Muslim soldier had written about the arrangements made by the government where he said that tobacco was supplied along with food and matches in trenches and he found the arrangements good (Omissi, 1999, p.106). Another Sikh soldier

however, in his letter mentioned that they were Sikhs and not consumers of tobacco and their duty was to show their prowess in the battlefield (Omissi, 1999, p.280), stressing the prohibitions of tobacco use in Sikh religion.

4.2.2.2. Militarization leading to rise in concept of masculinity

It would be erroneous to say that the concept of militarization of Punjab and its society was a result of the demands of the colonial rule. The region's pre colonial history as mentioned earlier had set the military theme in the state. The *Rehat Maryada Code* which enlisted dos and don'ts for the Sikhs, promoted a culture of martial bravery which stressed heroism, bravery, justice and fight against those attacking the Sikh Empire, produced a very distinct form of Sikh martial masculinity(Kohli,2106).

As far as colonial Punjab is concerned masculine power distributed itself through the network of institutions such as military, landed peasantry and religious identity (Talbot, 1991). This military modernity in the colonial period provided a possibility of "manhood enhancement" (Gupta, 2010). This over emphasis on masculinity of Sikhs particularly the Jat Sikhs subordinated the other Sikh and non Sikh groups. As a result, masculinity emerged from various social, political, religious and cultural factors (Kohli, 2106). This concept of masculinity is foregrounded in the colonial context and it impacted the Punjabi culture and society which changed the social structure as well as brought in a new culture of consumption.

4.2.3. Social Structure of Colonial Punjab and culture of tobacco consumption

The agricultural transformation in Punjab led to internal migration within population of Punjab from the crowded central and eastern parts to western wing. The western Punjab which was agriculturally most backward region became the most prosperous one. In 1941, the population of Punjab consisted majority of Muslims forming 53.2% ,Hindus 29.1 %, Sikhs 14.1 %, Christians 1.9 % of the total population and 1.3 % others formed rest of the population of Punjab (Krishan, 2004, p.83). The cultivation of tobacco as mentioned in the previous section was carried by the Hindu and Muslim cultivators in Punjab. The peasant social class also consisted of the soldiers who retired from military and were given land grants in canal colonies. These land grants

came to be seen as an economic reward for their service in the military to the British Empire (Bal, 1986).

As far as the land rights were concerned the British granted occupancy rights of the land in the canal colonies to the cultivating class of *Jats*. These rights were automatically converted into proprietary rights after ten years of cultivating the land. This created a profitable position against which the money lenders provided loans to the peasants causing a widespread indebtedness which led to the displacement of ancestral land holdings to money lenders on a large scale leading to political and economic crisis in the state. These events attracted the attention of the British and led to passing of Punjab Alienation of Land Act in 1901. Under this act the alienation of the land by those belonging to agriculture class were permitted but the sale to those belonging to non agricultural class was prohibited (Singh & Singh, 2016, p.258).

In response to the Punjab Alienation of Land Act, 1901, the non cultivating classes sought other alternatives in order to sue their surplus money (Latifi, 1911). This gave rise to the phenomenon of rural urban migration of Hindus particularly those in trading and commercial class. The high growth of urban population was found in western Punjab which was also agriculturally prosperous. Relatively rapid urban growth was found in western *Malwa* and southern *Majha* primarily due to rail modality, agricultural prosperity extension of rail lines, and development of grain markets and establishment of industry (Gill, 2016). In addition, the European presence in Punjab kicked modernisation at a faster pace and changed people's outlook. Moreover Punjabi soldiers were given massive share of military budget as salaries which transformed society and economy of Punjab. Many youngsters who were recruited in the British army were from the peasant background and during the World Wars had a chance to visit many countries as a part of their military assignment. Along with the positive mentalities on cleanliness and women empowerment, they brought with them the culture of smoking. The culture of prosperity social and economic, along with cultural exchanges with Europeans brought the culture of consumption of tobacco in form of cigarettes (Singh, 2018) in addition to the use of *hookah* and snuff already popular in Punjab.

This increased education of women, availability of nonfarm jobs and changes in legislations of rural property which affected Punjabi families. The income from

traditional family sources such as agriculture and family trade was now combined with a wage and salary income. Urbanisation and industrialisation created new opportunities for employment and the most important change in the aspect was that the earning opportunities for women were available. With the improvement in the status of women their economic activity increased considerably. While the change in the status of women varied region wise but a large number of younger women from urban area and some rural areas, began working outside their home and contributing their wage income to the household. There were a number of factors which moderated the change in the role of women namely the desire for improved living standard, need for cash and prominence of material values (Safilios-Rothschild, 1990 as cited in Gill & Matthews,1995). Thus, using tobacco as a cash crop for the export value, introduction of growth of cigarette tobacco, creation of economic prosperity through development of canal colonies, benefits of military service and cultural exchanges with the Europeans increased the grip of the culture of tobacco in colonial Punjab. Also a new culture of cash, material values and consumerism proved to be a pushing force in increased tobacco consumption in colonial Punjab.

4.3. TOBACCO IN POST INDEPENDENCE PUNJAB

Though Punjab continued to remain a dominantly agricultural region even after partition in 1947 but this over dependence on agriculture was responsible for the non development of industrial sector. Unfortunately, Punjab post independence was economically not prosperous. It had the character of economic backwardness namely traditional agriculture, lack of organised industrial sector and inadequate transport and communication facilities. British had wanted Punjab to remain an agricultural state and to supply agricultural products; hence did little for the industrial development of Punjab. The period before and after Green Revolution played an important part, in addition to the colonial footprints left behind, in making of contemporary Punjab which now is known more for its various forms of substance abuse including tobacco, than its prosperity or history.

4.3.1. Place of tobacco before Green Revolution in Punjab (1947-1966).

Before independence Punjab was well balanced in terms of economic resources such that every sub region was vital for the prosperity of other regions. That being said, the area of West Punjab was relatively better irrigated than East Punjab. Moreover, there

were some marked disparities industrially, where East Punjab got little attention and there was high concentration of industry in West Punjab (Anwar, 1953). With the end of British rule, Punjab was bifurcated; the Pakistani side being the West Punjab and the Indian side being East Punjab. This disturbance during the partition upset the industrial economy of the state as raw material sources and markets also got divided. East Punjab incurred more loses as it was dependant on West Punjab not only for the supply of raw materials like tobacco, wheat, cotton, salt, wool etc. but also for its markets. Accordingly, the wealth and development sources which came in the share of East Punjab were relatively small (Rai, 1965).

As already mentioned, most of the tobacco cultivated in the Punjab province was in West Punjab and during partition these areas went to Pakistan side of Punjab. Tobacco factories were among most of the factories is Punjab which produced raw tobacco for other parts of the country and was mainly agro based. Out of total 397 factories in the border districts only two were tobacco factories pre independence. After partition only 287 factories remained out of which only one tobacco factory survived (Chowdhary, 2000, p.59). This fear and panic of partition discouraged investment and capital availability became a big problem. Moreover, the geographical disadvantage of the state sharing the border with a hostile country could not attract capital from other states. The State government with the help of Central government lost no time in providing assistance to displaced persons and started training centres to offer short term vocational courses with intensive training in small scale industries. This led to the revival of manufacturing sector in the state. Although the First Five Year plan laid stress on agriculture, Punjab government was equally focused on industrial development of the state (Singh& Singh, 2016, p.263).

Just as the industrial economy had started to recover, the agitations of Hindus and Sikhs in Punjab to assert their demand for a separate state in 1965 and reorganise Punjab on basis on language, gave a shock to the industry. In 1966, three states of Haryana, Himachal and Punjab were formed, the result of which was that all registered paper and glass factories had gone to Haryana. The developing industrial complex around Delhi had also gone to Haryana while the forest and mineral resources were either transferred to Haryana or Himachal. Thus, at the time of Green Revolution, Punjab became a less important state in terms of its industrial development (Bhalla, 1995).

4.3.2. Green Revolution in Punjab (1966-1990)

Historically, Punjab was the most suitable choice for Green Revolution Strategy in 1966 because it was relatively better irrigated state and the forcibly migrated peasantry from canal colonies after the partition of 1947 had accumulated rich experiences of managing irrigated agriculture[34] (Singh, 2016). There is no clear evidence that the policy makers in India took into account the sociological and religious characteristics of the *Jat* peasantry in arriving at any decision on introducing Green Revolution strategy in Punjab. However, some of the policy planners were aware of the historical background of Punjab peasantry and would have taken it into consideration in addition to the material conditions prevailing in Punjab agriculture (Randhawa, 1974).

4.3.2.1. Effect of Green Revolution in Punjab on tobacco cultivation and industry

Since historic times the cropping patters have changed in various regions due to different reasons. For example, rice cultivation was introduced in Punjab which is now on the threshold of change of another cropping pattern due to low profitability and ecological conditions. Similarly, the Green Revolution in Punjab also eliminated tobacco cultivation from the state. Inspite of all the impetus received for tobacco cultivation, the cultivation of crop decreased due to calculated decision making and more due to family tradition and custom. Meanwhile the cost of labour excluded the family labour where women and children were involved in the labour. In Punjab about 1,000 hectare was under tobacco growth until 1964. Later, the Government Tobacco Research Centre was closed down. The remaining area was phased out and later prospered as cotton belt after American cotton was introduced and cultivation of rice had also begun in some areas (Kaur, 2002, pp.18-20).

As the agriculture sector became more productive it had an impact on the entire economy of Punjab. As far as the industrial sector is concerned, the increasing use of new agricultural technology stimulated demand for inputs as fertilisers, diesel, power etc. and other consumption goods. Increasing per capita income of the rural

[34] One of the most significant changes which took place during Green Revolution was the increase in the quality irrigation amounting to an increase in irrigation coverage. Green Revolution gave Punjab a lead in the terms of economic growth and transformation, putting it as India's most prosperous states. Over three decades Punjab remained number one in the terms of per capita income ranking in India during the years of 1970s, 80s and 90s. Green Revolution was needed for food security leading to modern agricultural practices which was supported by extensive research and assured market system.

population provided push to all sorts of consumption good industries and food production industries like breweries, beverages, edible oil manufacturing and grain mills. Moreover, there was a growth in the urban population by 25% in the year 1971-1980 as compared to previous decade. However, there was an overall deceleration in the industrial output by the year 1980-81 and 1990-91.Having said that the major record in the output was in the industries of beverages , tobacco and tobacco products, paper products, petroleum, rubber ,plastic and coal products (Singh & Singh,2016,pp.265-266).

This increased output of tobacco and tobacco products further enhanced the religious identity of Sikhs of Punjab who were determined to root out the vices of use of tobacco, alcohol and other drugs from Punjab. It also affected the ideas of identity and self in people of Punjab with three sets of conflicts emerging in Punjab crisis due to Green Revolution. The first set of conflicts emerged out of very nature of Green Revolution such as class conflicts, pauperisation of lower peasantry, labour displacing mechanisation leading to the farmers' protests. The second forms of conflicts were seen in the form of religious and cultural factors which revolved around Sikh identity. These were deeply embedded in the cultural erosion brought about by Green Revolution which commercialised all relations and led to the creation of an ethical vacuum where everything had a price and nothing was sacred, leading to the religious revivalism, which emerged to rectify the social and moral crisis, by looking for a separate Sikh identity. The third conflict was the sharing of power; economic and political between the centre and the state (Shiva, 1991, p.174).

The profitable effects of Green Revolution in terms of increased agricultural production were short lived and seemed to be emulating the canal colony strategy in British period leading to structural imbalances in the economy, with a developed agrarian sector and a backward non agrarian sector. The absence of autonomy for Punjab to chart its own economic priorities and development in correspondence with its own stage of economic evolution was due to the Indian political leadership controlling power at the centre. This initiated a strategy of development which suited the ambition of government at the centre for achieving self sufficiency in food to deal with domestic and foreign policy requirements. This brought about unrest in the social and political dimensions of Punjab after Green Revolution (Singh, 2016, p. 377).

4.3.2.2. Tobacco use in social and political changes due to Green Revolution

The short term affluence and profitability generated by Green Revolution created conflicts between traditional values and the culture of conspicuous consumption. Two decades of transformation in society, economy and culture in Punjab had generated a moral and ethical crisis. Basically, the culture of cash and profitability deranged the old social order and disintegrated the moral norms that governed the Punjabi society. This circulation of new cash led to epidemics of social diseases like alcoholism, smoking, drug addiction, spread of pornographic films and literature and violence against women. Green Revolution not only caused economic and political disturbance but also lead to communal disruption because of the contingent overlapping of the farming community in Punjab with a *Jat* Sikh identity. Concurrently, it was possible to represent the conflicts related to Green Revolution as communal conflicts and treat them as only having a religious base remotely related to politics of technological changes and its socio economic impact. Although Green Revolution failed to bring long lasting peace and prosperity in Punjab, there were of course cultural reasons which facilitated the communalising of Punjab crisis. Green Revolution apart from being a technological and political plan was certainly a cultural strategy which substituted the traditional peasant values of cooperation with competition, of prudent living with obvious consumption and of soil and crop husbandry with figures of subsidies and profits (Shiva, 1991).

It was in the 1980s that the hopefulness associated with Green Revolution began to fade away. This Green Revolution strategy which was earlier a strategy for crating cheap food surplus for growing industrial and urban area, created an artificial economic package for the more prosperous farmers in the state which created an economic surplus for them. However, small land holdings in the period of 1970s and 80s disappeared because of the inability of small peasants to maintain their land due to increased input cost caused by Green Revolution. In other words, the distribution of the operated land shifted in the favour of big farmers which lead to unrest in the state (Singh, 1984).

4.3.2.3. Rise of Sikh radicalism and tobacco use in Punjab

When the degenerative form of modernisation was expressed in menacing the spread of alcoholism, smoking, drug addiction and lewd music (Singh, 2008) with increased

economic prosperity of Punjab, religion came as a rescue to this cultural degeneration and was also a solace to the victims of new forms of consumption. Sant Jarnail Singh Bhindrawale, who later came to be associated with religious fundamentalism and separatism, gained its popularity with Punjab peasantry by launching an ideological crusade against the cultural corruption of Punjab. The worst hit by this violence of cultural corruption were women and children who became ardent followers of Bhindrawale in his first phase of rising in the State. His second phase of popularity saw men joining his movement replacing vulgar movies with visits to *Gurudwaras* and reading the teachings of Sikh gurus instead of pornographic literature (Shiva, 1991).

The popularity of the Sant grew as he revived the fundamental values of purity, dedication and hard work teachings of Sikh religion. During his early phase of rising, Bhindrawale made no anti Hindu or anti government statement but focused on the positive values of the Sikh religion. This movement of Sikh revivalism took a negative turn with interference of party politics especially Congress. Sant was used against the Akalis[35] for party politics and when he himself was killed in Blue Star operation, Punjab politics and Sikh religion had been totally communalised. Following the assassination of Indira Gandhi, the danger to Sikh identity became a grave concern for Punjab. The earlier and regenerative and ethical form of Sikh revivalism was replaced by the communal form. Although it never became a large scale communal conflict between Hindu and Sikhs within Punjab but it continued to be in conflict with the communal Hindu centre and Sikh people in a Sikh state (Tully & Jacob, 1988).

This larger movement of the Sikh assertiveness which was going on in Punjab also led to a ban on smoking in some areas. In early May of 1981, All India Sikh Student Federation resolved not to allow the sale of cigarettes and other tobacco products in the city of Amritsar and issued an ultimatum to all tobacco sellers located in the city. The tobacco sellers were given a choice to either switch to some other jobs or leave the city by 15th May 1981. Although a procession was planned on 31st May, zealous Sikh students started turning up every evening to threaten tobacco sellers to close their shops. As this harassment continued the scared shop keepers stopped displaying

[35] Akalis are the members of Shiromani AKali Dal which is a political party in Punjab

the cigarette packets. Some shops started selling cigarettes secretly far away from the Golden Temple, some shops were closed and others were forced to sell cold drinks. Provoked with closing of *paan* shops near temples too, the Arya Samajh supporters took out procession on May 29 marching with swords and carrying lightened cigarettes on the sticks. This proved to be an insufferable insult to the Sikhs. In response to this pro tobacco procession, Sant Jarnail Singh Bhindrawale brought his rural followers for anti smoking procession on May 31st. From then onwards militancy in Punjab entered its most violent phase (India Today, 1981). Due to the communal tensions in Punjab, the Prime minister passed a law prohibiting the sale of tobacco, meat and alcohol around the areas around Golden Temple and Hindu Durgiana temple in Amritsar on February 27, 1983 (Kaur & Gill, 2004).

By 1980s, Punjab farmers started organising themselves on the grounds of being treated like a colony of the centre to feed rest of India[36] .The farmers protests started to take a communal colour when Harcharan Singh Longowal on 23rd May 1984 announced the farmers' agitation would include attempts to stop the supply of food grains to Food Corporation of India. Since Punjab provided the bulk of reserve of grains used to sustain the government distribution system, a successful grain blockade implied a serious national crisis and would have given Punjab a bargaining tool for its demands for a grater state autonomy. On 3rd June 1984, Indira Gandhi called out the army in Punjab and Golden Temple was attacked in operation Bluestar; a direct blow to the Sikh faith and dignity. This shifted the identity of the Sikhs from a farming community to a religious community in the national consciousness[37]. Accordingly, the movement in Punjab was not to protect the interests of the farmers but had been submerged by a movement to protect the Sikh identity (Shiva, 1991, p.184).

4.3.2.4. Tobacco use and phenomenon of migration in Punjab

Another unique phenomenon linked with Green Revolution which came to be associated with habits of drinking and smoking in Sikh men has been emigration of Punjabi youth to countries of England, Australia, Canada and USA. The Sikh community was not only known to be adventurous for travel and migration and

[36] This statement was made by a representative of the Punjab farms organisation, Christian Science Monitor, 30th may, 1984.

[37] This increased the drugs smuggled in Punjab which were used by the Sikh militant groups to finance their operations.

exposure to modern ideas abroad but also got impacted by the Western culture. Quite a few Sikh men got addicted to habits of smoking and drinking. It is considered that a Sikh who is without turban and smokes remains no longer a Sikh. The Sikhs in the rural areas started looking up to these westernized Sikh youth and initiated habits of smoking, cutting their hair and trimming their beards. This phenomenon was noticeable in some rural areas especially in Patiala region of Punjab (Singh, 1984).

With the increasing number of Sikhs migrating abroad, the Green Revolution period also witnessed the phenomenon of in migration in the state (Mehra & Singh, 2014). The subsistence peasant economy was transformed to commercial agriculture and this transition was not smooth and affected the social, economic and cultural life of rural people on one hand and their organic dependence on other hand. The multiple cropping patterns were suddenly replaced by few commercial crops which were grown for profit making. As a result the commercial crops of wheat, cotton and rice squeezed the labour demand to few peak periods which the local labourers failed to meet. The inflow of migrant labourers popularized the paddy crop in Punjab as they were trained traditionally in paddy transplantation but the local labourers lacked this skill as paddy has never been the staple food of Punjab. With time the small trickle of migrant labourers from Bihar, eastern Uttar Pradesh, Jharkhand, MP and other states had swollen into a full-fledged stream visiting Punjab during labour demands (Singh, 2012a).

This movement of migrants had both socio economic as well as cultural impacts on both places of migration and emigration (Kaur, 2003). The migrants moved from a less developed area to more developed area (Haan, 2007) and were poor unskilled and landless labours belonging to lower socio economic class group (Roy, 2011). In migration just like migration overseas had deep effect on Punjab's polity and society and there had been discussions on nature of effects and long term consequences. In the recent years of economic decline in Punjab the discourse has been framed in negative terms. The increased intake of *gutka, paan masala* etc. have been attributed to the presence of migrant labourers in the state. Moreover, they are blamed for the rise in crime, for polluting Punjabi culture, for changing the balance in Hindu Sikh identities and for changing the voter balance in certain constituencies (Kaur et al., 2011).

Also, the *Zamindaari* culture had been quiet popular in Punjab and use of labourers from other states as mentioned earlier had a profound impact on the cultural exchanges between two communities in Punjab. Although there are few writings on the socio cultural exchange process of the Punjabi community with the migrant labourers yet few accounts hold the migrants responsible for increase in tobacco use in Punjab. The characteristic of tobacco use which defines the inclusionary aspect can be clearly seen through the exclusionary one where the term *'hookah paani band'* has been used in order to outcaste an individual from the community where sharing the pipe or water with him, seen as relevant to social ties, is prohibited in rural areas of Punjab. Thus the cohesion among not only the members of the same caste but the village as a whole is denied to him (Hasan, 1975).

It is to be noted that the cultivation and use of tobacco before Green Revolution had been in the form of *hookah* tobacco or snuff tobacco. Though there are accounts of cigarettes being introduced in the colonial period, the use of other forms of smokeless tobacco as *gutka* and *paan masala* became more prominent with the increase in the migrant labourers in Punjab. Also the culture of cash and consumption generated through Green Revolution polluted the Punjabi society and vices of alcohol and tobacco addiction apart from other drugs set in. The Sikh religion of Punjab also could not save it from falling prey to tobacco use which became more pronounced in the post liberalisation Punjab.

4.4. EFFECTS OF LIBERALISATION ON TOBACCO INDUSTRY AND ITS USE (FROM 1990 ONWARDS)

Punjab did not get its worthwhile in introduction of the New Economic Policy (NEP) in 1991. Facing a severe crunch post this period due to spending on militancy the state government sought new ways to trim expenditure on many important sectors of the economy such as health, education and other sectors which had a bearing on tobacco industry as well as the consumption of tobacco and diseases associated with it (Gill, Singh & Brar, 2007).

4.4.1. Tobacco industry in Punjab post liberalisation

During 1990s new economic initiatives were being taken by the Indian government relaxing internal and external constraints which allowed expansion of the industrial

sector and boosted the Indian economy. Punjab on the other hand was suffering from extreme social and political turmoil which disrupted the functioning of the state and the avenues provided by the national economic policy reform. The turmoil prevented the state from engaging in any developmental activities which lead to derailment of the institutions collecting revenue and providing health and education to the population. The government in turn started borrowing from the centre in order to cover the shortfalls which increased the debt on the state government dramatically. When the Indian government initiated the liberalization and globalization of economy in the 1991, Punjab was in a state of complete institutional disruption and extreme fragility. Between 1991 and 1993 strong police action dismantled the terrorist organisations responsible for the insurgency in Punjab resulting in increase in casualties among the terrorists, security personnel and civilians, before the violence came to an end in 1993(SATP,2012).

In response to agricultural marketing cum trading activities which were strengthened during the period of Green Revolution, rapid urbanisation and agricultural prosperity led to clustering of large scale and small scale industries in large cities. During the period post militancy, the state of Punjab witnessed insecurity of lives as well livelihoods, leading to deceleration of the industry specially cotton industry. However the major growth in the output was recorded in beverages, tobacco and tobacco products, paper and paper products, rubber, petroleum and coal products (Jain, 2016, p.265). During the period of 1990-91 to 2000-01, the overall industry grew except for beverages, tobacco and tobacco products. The period post 2000-01 recorded a negative output growth in almost all the industries which is responsible for the dismal performance of the manufacturing sector in the recent times. As a result, most of the manufacturing units in Punjab resemble the characteristics of informal enterprises with hardly any up gradation of technology in these units. In order to survive this, firms use intensive and extensive usage of labour adding to the vulnerability of the working class (Jain, 2008).

With the passage of time the agro based and food, beverage and tobacco industry shifted from urban to rural areas of Punjab(Table 4.2). The concentration of these industries more in the rural areas was due to easy availability of raw materials and labour as well as government's efforts in establishing these industries in the rural areas for reducing regional disparities (Ravita, 2011).

Table: 4.2. Percentage of food, beverage and tobacco based industries in Punjab

Year	Percentage in urban and rural areas of Punjab	
	Urban (%)	Rural (%)
1990-91	50.5	49.50
1995-96	48.47	51.53
2000-01	46.97	53.03
2004-05	46.19	53.81
2005-06	46.09	53.91

Source: Computed from Ravita, 2011, p.120

The boom in the beverages, tobacco and tobacco manufacturing industry as mentioned earlier in the post liberalisation period was responsible for the increased production. The Industrial Policy of Punjab in 1987 and 1989 were accountable for providing incentives for all the manufacturing industries in Punjab. The incentives in the industrial policy of 1989 were designed afresh in order to attract fresh investments in agro based industries. The main aim was to provide incentives to fresh investors in the state. Furthermore, the industrial policy of 1992 was designed to emphasize growth of border districts by providing more incentives and job opportunities to the youth (Kaur, 2014, p.100).

Table: 4.3.Production and employment in beverages, tobacco and tobacco manufacturing industry in Punjab

Year	Production in lakh rupees	Number of workers employed in numbers
1980-81	2881.63	3329
1990-91	1718390	5618
2000-01	79445	7875
2008-09	8372	289708
2009-10	8000	162000
2010-11	19	117
2013-14	20	100
2014-15	2204	108

Source: Computed from Statistical Abstract of Punjab 2012, p.318; 2016 p.324

During the decade of 1985-86 to 1995-96, the number of food, beverage and tobacco industry in border districts of Gurdaspur and Amritsar also doubled (Ravita, 2011,

p.120). However, post 2000-01, there was a decline in the production as well as employment in the beverage, tobacco and tobacco manufacturing industry in Punjab. As already stated the manufacturing sector of Punjab recorded a negative output growth post 2000s which equally affected the beverage, tobacco and tobacco manufacturing industry (Table 4.3). Moreover, the Industrial Policies of Punjab had stopped supporting the industries related to *gutka* and tobacco and then finally stopped giving them any incentives for their growth (Government of Punjab, 2003).Simultaneously, the Centre influenced the policy framework giving special incentives to Congress ruled states of Himachal and Uttarakhand, much to the disadvantage of Punjab, leading to shifting of industrial units in these states (Sharma, 2014).

However, to revive the slump in the manufacturing sector, Industrial Policy of 2013 aimed at encouraging new investments in Punjab by providing liberal package of fiscal incentive[38] to promote industries (Government of Punjab, 2013). This led to a boost in the beverage, tobacco and tobacco manufacturing industry in Punjab in 2014-15 (Table 4.3). Moreover, it was reported in 2013-14 that one of the tobacco honcho in the state shared the dais with Badals (the then ruling family of Punjab) in Punjab Investors Summit and had promised to make investments in the state. Badals belong to Shrimoni Akali Dal (SAD), the party which claims to be upholder of Sikh ideology and knows that Sikh religion strictly prohibits the use of tobacco. The news report also mentioned that for few years the Akali Dal did not even shy away from taking donations from a leading tobacco company product (Sarin, 2014), highlighting the politics of tobacco control in the state.

4.4.2. Changes in the social sector of Punjab and its effect on tobacco use

The changes in the industry of tobacco manufacturing in Punjab as well as the associated politics definitely had an influence on the tobacco consumption in the state which had a bearing on the health of the population. Moreover, the employment patterns of the state and compromised education sector pushed youth of Punjab towards substance abuse, tobacco being one of them. In the wake of severe resource crunch in post liberalisation period, the state looked for ways and means to reduce the

[38] The instruments such as tax reduction, incentives, grants and subsidies applied by government to support various organisations and individuals.

public spending on crucial sectors of economy as agriculture, health, education and other social sectors. This has lead to a fast corrosion of services in Punjab, especially health and education (Gill, Singh & Brar, 2010).

4.4.2.1. Tobacco use and lifestyle diseases in Punjab

By and large the true essence of NEP calls out for growing interdependence of the nations/states through cross border transactions of various goods, free movement of capital and people, ideas, knowledge and diffusion of technology at an astonished speed (Gill, Singh & Brar, 2010), affecting people's health and health delivery both in a positive and negative manner directly or indirectly. Admittedly, the positive impacts can be seen in the form of better living conditions, access to health care, increased life expectancy etc. Conversely, the negatives in the form of rising treatment costs, high incidence of manmade diseases, elite oriented health policies etc. cannot be ignored. The high consumption of tobacco, alcohol, packed food and aerated beverages has also affected people's health (Mohan, Reddy & Prabhakaran, 2011).

Table: 4.4. Comparison of GATS 1 and 2 Punjab

	GATS 1(in percentage)	GATS 2 (in percentage)
Total tobacco users	11.7	13.4
Current users of smoking	6.9.	7.3
Males	12.7	13.6
Females	0.4	0.4
Current users of smokeless	6.5	8.0
Males	12.2	15
Females	0.2	0.3

Source: Computed from GATS 1& GATS 2, India

Tobacco which is a risk factor to most NCDs is on increased use in Punjab (Table 4.4).. The use of tobacco in any form in Punjab in GATS 1 report was 11.7% in adults and 21.6% of males and 0.5% of females use tobacco in any form. Tobacco smoking was 6.9% in adults; 12.7% males and 0.4% females smoked. Current users of smokeless tobacco were 6.5% of adults; 12.2% males and 0.2% females in Punjab consumed smokeless tobacco (GATS India 2009-10, p.31). The GATS India 2016-17 has rung alarming bells for Punjab as the use of tobacco has increased to 13.4% adults using tobacco in any form. Tobacco smoking has increased to 7.3% increasing further

in males and use of smokeless tobacco is 8% for the adults increasing to 15 % in males and 0.3 percent in females (GATS India, 2016-17,pp.30-31).

The state of Punjab as expected has experienced an epidemiological transition Unrestricted use of agro chemicals, increased dietary fats, and physical inactivity and behaviour patterns (of tobacco , alcohol and other drugs[39]) have not only raised the burden of new diseases in the state but has already attracted non communicable diseases like diabetes, cancers, stroke etc. The chronic non communicable man made diseases have begun to dominate compared to earlier dominance of malnutrition and infectious diseases. It is a matter of serious concern that the agriculture growth in the state has disturbed the environment and ecology which has in turn influenced the health and disease pattern in the state (NFHS 3, 2005-06; NFHS 4,2015-16).

Despite the changing disease pattern in Punjab, the public health expenditure as a proportion of Net State Domestic Product (NSDP) in Punjab has never reached to 1% for most of the normative years against the normative ratios of 3% of the national income. This lowered expenditure makes it clear that the post reform period saw the decrease in the public health expenditure over time which weakened the state run hospitals, CHCs, PHCs and dispensaries (Singh & Singh, 2016, p.322). Moreover, the public health infrastructure is unimpressive and people do not prefer visiting public health institutes due to non presence of health staff or non friendly environment or non availability of medicine (Singh, 2011). Also the health programs suffer due to non presence of staff, non availability of health machinery and equipments, buildings and residential accommodations, specifically located in the rural areas. Therefore the whole burden of health care falls on the CHC/PHC which are not adequately equipped and suffered from rampant absenteeism of health staff (Chaudhury et al., 2006).

Another area where the state differs as compared to other states at the national level is underplaying the role of NGOs. One of the reasons for the weak presence of the NGOs in the state is the fact that NGOs are viewed as a symbol of poverty and largely signal the failure of the government. Another reason is the strong presence of *Gurudawaras* in the state which make great contributions to various range of social service in the state. Although their approach may be different than the NGOs but their

[39] Opium, heroin and poppy husk are most commonly consumed drugs in Punjab. The consumption of tobacco does not inhibit the daily activities of the person as is the case with these drugs.

presence in the state is difficult to miss (Singh, 2011, p.128). The NGOs can complement the state machinery and help in spreading more awareness on use of tobacco in the state.

4.4.2.2. Role of education and unemployment in tobacco use in Punjab

As far as the literacy process of the state is concerned, it moves with the national scenario of literacy build up. In both the cases, the literacy rates grew with each passing Census but at a slow pace and it took some considerable time before reaching some worthwhile levels. However, the lower levels of education in the farming households have become a great constraint in the transformation of rural economy. As compared to the nation, the state of Punjab has been spending less on education of per student (Brar, 2008). In brief, the period after liberalisation has not been conducive to the education sector in terms of infrastructure and resources in the state (Gill, Singh & Brar, 2007).

Moreover, the local youth who are getting education are no longer interested in tilling the land like their fathers. But the poor quality of education in Punjab makes the graduates incapable of making the cut to get few high skill jobs which are available (Manish, 2012). In addition, those who are unemployed want jobs within Punjab but those seeking nonfarm jobs are left with very few available jobs due to the process of deindustrialisation happening in Punjab (Singh, 2000). Unemployment in the educated rural youth of Punjab has left them little to do and they indulge in various forms of addictions in order to while away time. While unemployed youth in other states can be seen engaging in politics or extortion, in Punjab addiction is a reaction to unemployment of those who enjoy both cultural and financial prosperity (Jeffry & Young, 2012). In addition, the Macho culture of Punjab is very prone to consumerism (Chopra, 2010) which has been seen in the rich middle class in rural areas (Goyal & Kaur, 2009) giving rise to problem of addiction[40] out of the aspirations of wealthy and aspiring rural population with slowing agricultural economy (Advani, 2013).

[40] According to Punjab Opiod Dependence Survey, 2015 carried in the age group of 18-35 years showed that 56 % of the opium users in Punjab belong to rural areas. Most commonly used opium drug is heroin(53%) followed by opium/dodda/phukki (33%). Rests 14% use the pharmaceutical opiods. This study estimated that around 2.3 lakh people in Punjab are opium dependant which forms around 1%.. But the drug economy of Punjab not only provides high profits but is also used for political gains. Punjab being a border area, the neighbouring countries use it to spread Narcoterrorism and fund terrorist activities.

Thus, post reform period the economy of Punjab decelerated and regressed as compared to the national economy. Instead of attending to the structural problems faced by Punjab economy, the political leadership engaged in populist fiscal profligacy through subsidies which further increased state government's indebtedness. Consequently the sectors of health and education considered central to the human development suffered due to lack of investible public resources. The self interested behaviour of the political parties has lead to drying up of investment opportunities in the state and consequently intensified its economic crisis (Singh & Singh, 2016, p.340), hence unemployment and substance abuse including tobacco in the youth of the state.

CONCLUSION

The changing dynamics of Punjabi culture and society have played a crucial role in development of Punjab; social, economical as well as political. The story of Punjab's prosperity which eventually led to stagnation in the growth of its economy can be attributed to number of factors. This temporal account of Punjab is important to place the use of tobacco within the changes the state went through. As the region has been invaded and ruled by various invaders, it boundaries have been expanding and contracting during these periods. The transformation of Punjab from agrarian to industrial society affected its overall political fortune but compromised the social sector development in Punjab. Moreover, in post reform period the economy of Punjab decelerated and regressed as compared to the national economy. Consequently, the sectors of health and education considered central to the human development suffered due to lack of investible public resources. The institutional arrangements for delivering development have become even more dysfunctional even after a succession of the democratically elected government. The self interested behaviour of the political parties has lead to drying up of investment opportunities in the state and consequently intensified its economic crisis. This led to unemployment status of Punjabi youth which in turn has been responsible for various forms of addictions (alcohol, tobacco and opium derivatives) in the state.

CHAPTER 5

TOBACCO CONTROL POLICIES AND LAW: TRANSLATION IN DISTRICT JALANDHAR, PUNJAB

INTRODUCTION

The objective of this chapter is to study the translation of Tobacco Control Policies and law in district Jalandhar, Punjab. It also focuses on the barriers in implementing tobacco control measures in the district and the role of various stakeholders in executing these measures. That being said, the chapter does not draw attention to the evolution of tobacco control legislation but highlights various laws under which the tobacco control measures are being taken in district Jalandhar. The legislations of Punjab government under which it controls tobacco use are not solely concentrated to Punjab and are followed throughout the country. However, the control of the states over these legislations and how seriously they are pursued or tailored according to demographics of the states is different for every state, including Punjab. It is worth mentioning that throughout the chapter the use of word tobacco includes all the forms of tobacco being used unless specified. Although health department in the district finds primary mention in the chapter, it involves various other departments as stakeholders in the implementation of various tobacco laws which get translated into Tobacco Control Program in the district. These control measures are compromised by tobacco industry which exploits the loopholes in implementing tobacco legislation in the district.

The chapter is divided into five sections and subsections which bring together various findings from field on tobacco control in the district. The first section details various Acts which control tobacco use and its sale in the state. These Acts are translated into tobacco control measures and program in Punjab which is the main focus of the second section. This section also expands on the structure of the State Tobacco Control Cell (STCC) in Punjab.

The third section of the chapter locates district Jalandhar in debates on tobacco control. This section lays out the organisational structure of the District Tobacco Control Cell (DTCC) of Jalandhar and details the implementation of Tobacco Control

Program in the district. The fourth section is based on the barriers faced in implementing Tobacco Control Program in Jalandhar which in turn compromise tobacco control efforts and leaves loopholes in its functioning. The fifth section of the chapter is based on the tactics adopted by tobacco industry to influence tobacco control measures in district Jalandhar. It starts with profiling of industry in district and ends at various strategies devised by companies to keep the sales and profits of the industry high.

5.1. TOBACCO CONTROL LEGISLATION/ACTS IN PUNJAB

The challenges produced by tobacco use in Punjab have been reported in the previous chapter. These challenges have been tackled by Punjab government with the help of various legislative steps. The commitment of Punjab government to contain the use of tobacco in Punjab has been lauded by various agencies in the past. It is important to mention that COTPA, 2003 is the only legislation which focuses solely on tobacco control. Although named Cigarette and Other Tobacco Products Act, it is majorly concentrated on smoking tobacco (*bidi* and cigarette use) prohibiting the advertisement and trade of all forms of tobacco. The various Acts for tobacco control in Punjab have been described in the following sub sections.

5.1.1. Cigarettes and Other Tobacco Products Act (COTPA), (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) 2003

The various sections of this Act prohibit advertisement of tobacco products and also provide for the regulation of trade and commerce as well as production, supply and distribution of cigarettes and other tobacco products in all states of India, including Punjab. The various sections under this Act and penalties associated with offence under these sections are enumerated in Table 5.1. It is interesting to note that there is no fine or punishment for the consumption of smokeless tobacco products under this Act.

Table: 5.1. Penalties for violation under COTPA, 2003

Sections of COTPA	Penalties(Fine or Imprisonment or both)
Section 4: Prohibition on smoking in Public place	a)To the individual offender: Upto Rs 200/-b) To owner ,manager or authorised office: Fine equivalent to number of offences in public places
Section 5: Prohibition on advertisements on cigarettes and other tobacco products	a) 1st offence: 2 years/Rs 1000/- b) 2nd offence: 5 years/Rs 5000/-
Section 6: Prohibition on the sale to minors and around educational institutes	Up to Rs200/-
Sections 7,8 and 9: Prohibition on the sale of cigarette and other tobacco products without specified health warning	a) Manufacturer: 1st offence : 2years/Rs 5000/- 2nd offence : 5 years/rs10,000/- b) Selling/Retailing 1st offence: 1 year/Rs1000/- 2nd offence: 2 years/Rs 3000/-

Source: STCC, Punjab,n.d.[41]

5.1.2. Poison Act, 1919 & Punjab Poisons Possession and Sales Rules, 2014

Section 2 of the Poisons Act, 1919 specifies that it is the power of the state which "may by rule regulate within whole or any part of the territories under its administration the possession for sale and the sale, whether wholesale or retail, of any specified poison." Also under Punjab Poisons Possessions and Sales Rule 2014, no person should store or sell any poison specified in the schedule, unless he possesses a

[41] http://pbhealth.gov.in/Status%20of%20Tobacco%20Control%20IN%20PUnjab.pdf

license in form A granted or permitted under these rules. Entry 69 in the Schedule of the Rule specifies that nicotine is a poison. In Punjab running a *hookah* bar also invite penal provisions under this Act. Besides, a Bill introduced by the health department to permanently ban the *hookah* bars in the state of Punjab has been passed by the Legislative Assembly and approved the President of India (STCC, Punjab, n.d.).

5.1.3. Food Safety and Standards Act (FSA), 2006

According to the provisions contained in Regulation 2.3.4 under prohibition and restriction on sale of products, Food Safety and Standards (Prohibition and Restriction in sale) Regulation (FSSR) 2011, issued under FSA 2006, lays that manufacture, storage distribution or sale of any articles of food having tobacco and nicotine as ingredient is prohibited. Under the Act, Food Safety Officers (FSOs) are required to collect samples of the flavoured/scented tobacco products which are tested for any trace of nicotine or tobacco (Government of Punjab, n.d.).

5.1.4. Drugs and Cosmetics Act, 1940

The tobacco companies look for alternatives for promoting its products as well as the use of tobacco. The tobacco companies have launched E-cigarettes in order to lure youngsters into smoking tobacco. Punjab is the first state to unapprove E-cigarettes as it is considered as an unapproved drug for which a circular was taken under which Punjab State Drug Controller declaring E cigarettes illegal. The Punjab government issued notices to ecommerce portals for banning the advertising and sale of E-cigarettes in Punjab under Drugs and Cosmetics Act, 1940 (The Economic Times, 2016).

5.1.5. Juvenile Justice (Care and Protection of Children) Act, 2015

Under Section 77 of the Act “whoever gives, or causes to be given, to any child intoxicating liquor or any narcotic drug or tobacco products or psychotropic substance, except on the order of duly qualified medical practitioner shall be punishable with rigorous imprisonment for a term which may extend to seven years and shall be liable to a fine which may extend up to one lakh rupee”. Under section 2(12) of the Act “child” means a person who has not completed eighteen years of age. Under this act the sale of tobacco to minors in prohibited (STCC, Punjab n.d.). These legislative steps taken by the government get translated in the field through various

control measures which act as important instruments to prevent tobacco use and sale under Tobacco Control Program.

5.2. TOBACCO CONTROL PROGRAM IN PUNJAB

The National Tobacco Control Program (NTCP) was conceived by Ministry of Health and Family Welfare in 2007-08 and was launched in 21 states and covered 42 districts during 11th Five Year Plan in the first phase of the program. It was during the 12th Five Year Plan (2012-2017) that Punjab was included in the program. The objectives of the program were to bring greater awareness about the harmful effects of tobacco use, the laws controlling its use and to facilitate implementation of tobacco control laws (MOHFW, 2013).

The following sub sections are based on the steps being taken by Punjab government for tobacco control in the state. These steps are local to the state of Punjab and lay emphasis on how Punjab government has tailored its approach to tobacco control. These approaches are accountable for control measures in Punjab in a precise yet comprehensive manner requiring coordination amongst different departments of Health, Education, Police and Excise and Taxation in the state.

5.2.1. State Tobacco Control Cell (STCC), Punjab

At the state level, State Tobacco Control Cell (STCC) in Department of Health, Punjab carries out the duties listed in the NTCP. It is responsible for the training of stakeholders, spreading awareness and IEC at state level and monitoring and implementation of tobacco control laws and their subsequent reporting. It is also accountable for tailored trainings for academicians, health professionals, students, police, food and drug safety officers etc. The integration of tobacco with other health programs like Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS), Revised National Tuberculosis Control Program (RNTCP) and National Mental Health Program (NMHP) is deemed essential and helpful to diversify the approach to tobacco control. The team members of these programs work in collaboration with those working for other programs in order to sync the findings with each other. The role and responsibilities of STCC Punjab are the implementation of the various activities of tobacco control as per the established format, appointment of staff at state/ district tobacco control cell, establishing the tobacco cessation clinics in health care facilities, organizing training and sensitization programs on tobacco

control, sharing as well as disseminating all government orders and best practices to the district, adapting the IEC material developed by National Tobacco Control Cell (NTCC) and disseminating it to the districts and working with civil society, other departments and professional bodies in order to spread awareness on tobacco control (Department of Health & Family Welfare, n.d.)

5.2.2. Implementation of various Tobacco Control Measures in Punjab

Punjab government has taken various measures for controlling the menace of tobacco in the state. Some of these steps made Punjab state a pioneer in Tobacco Control Program in India and set examples for various states to follow in the initial years of conception of program. There have been various reports which have been sceptical of commitment of Punjab government on tobacco control and have blamed it of losing grip on crusade against tobacco. The subsequent sub sections highlight the present status of tobacco control in the state. These measures so listed are not specific to Punjab and details of these measures have been mentioned under the previous chapters. However, the sub sections elaborate these measures with respect to their specificity to Punjab and how the state has tailored them to curb the use of tobacco.

5.2.2.1. Tobacco taxation in Punjab

The elaborate system of tax on tobacco products has been mentioned in chapter three of the thesis. The states have been vested with the power to tax tobacco products under Value Added Tax (VAT). The Punjab Government in 2013-14 seemed determined to attack the cigarette industry when it increased the VAT on cigarettes from 20.5 % to 50%. The additional money so collected amounting to Rupees 100 crores were to go to Punjab Cancer Fund. But this decision was reversed in less than 10 months and VAT was reverted back to 20.5%. This you turn of the Badal government raised political tempers in Punjab. The Badal government defended its decision saying that cigarette smuggling from neighbouring state where the tax was 20% had increased in past ten months and tax reduction was meant to control smuggling. Badals went against the Sikh ideology upheld by their party SAD and reduced taxes on tobacco products (Sarin, 2014).

Due to strong political opposition, VAT rate on the sale of cigarettes in Punjab at present is 33% while that on smokeless tobacco products and *bidis* is 14.5% (The Tribune, 2015). Although various activists have written for increase in VAT, the taxes

remained the same till the time of data collection. Punjab is already fighting with the problem of drug abuse and availability of such substances of abuse as tobacco might aggravate the problem. But levying of VAT and changing it finally from 50 % to 33 % did not deter the trade of illegal cigarettes in Punjab. As many as 54 outlets in Ludhiana, 25 in Jalandhar and 17 in Amritsar were named in the list of those selling contraband cigarettes. These cigarettes carry international brand names and are cheaper due to tax evasion as they are smuggled into the state. The money so collected is used to promote criminal and terrorist activities which pose a huge threat to the national security as well as that of Punjab (Verma, 2017a). Ludhiana is seen to be emerging as the biggest selling point of the illegal cigarettes in India. These illegal cigarettes in Punjab are being procured from countries like South Korea and Malaysia (PTI, 2017a) questioning the vigilance of the government to control the tobacco use in the state.

5.2.2.2 Protection from exposure to second hand smoke in Punjab

The fines and punishments to help curb people smoking in public and protecting the rights of non smokers have helped control smoking in public places in the state. The tables below present the number of fines been imposed on the offenders. These tables are not divided into the fines imposed under various sections of COTPA,2003 and are a total of the fines imposed on all the offenders.

Table: 5.2. Total number of *challans* from October 2008 to March 2017 in Punjab

S.No	Year	No. of *challans*
1.	October 2008 to Dec 2010	1848
2.	Year 2011	1831
3.	Year 2012	13090
4.	Jan 2013-Dec 2013	23968
5.	Jan 2014-Dec 2014	22834
6.	Jan 2015-Dec 2015	23609
7.	Jan-2016 to Dec 2016	25766
8.	Jan –March 2017	6083
	Grand Total	1,16,506

Source: STCC, Punjab, n.d.[42]

[42] http://pbhealth.gov.in/2(a).pdf

These *challans* are a collective of all the departments issuing fines under COTPA. The collection of fines in table 5.2 shows that the period from 2008 to 2011 saw a slow start in tobacco control in state and after Punjab was formally included in Tobacco Control Program in 2012, the vigilance of Punjab government also increased. That being said, increase in fines can also be analysed as the failure of the government to change the health behaviour of the population and make them complaint with the government regulations. Although data so provided presents a positive picture but segment of the people who were *challaned* is not mentioned. Simply put, how many manufacturers or retailers, kiosks holders or those smoking in public were charged for flouting rules has been not displayed in detail.

5.2.2.3. Education and Communication on tobacco use in Punjab

Under the campaign of making Punjab tobacco smoke free, all districts of Punjab were declared smoke free in 2015. Hoshiarpur city was declared the First COTPA complaint city of Punjab. Moreover, it was notified that "Punjab State No Tobacco Day" (PSNTD) will be celebrated each year from 1st November with a different theme all over Punjab. The state has conducted a three month long campaign in the year 2018 with theme of "Youth against Tobacco". Extensive anti tobacco awareness activities were done in major cities and villages of all districts of Punjab. In addition a yellow line campaign has been launched in the state according to which a yellow line indicating tobacco free zone will be drawn at hundred yards from the school. Focus has also been drawn to population in the slum area in all districts of the state in month of April in 2018. A total of 415 awareness activities during the three month long campaign have been done in the slums through street plays, exhibitions and IEC material distribution[42].

5.2.2.4. Packaging and labelling of tobacco products in Punjab

The Department of Health and Family Welfare in Punjab issued notices to the Department of Food Supplies in 2015 to not approve the packaging of cigarettes in packets of one or two. These packets due to low costs were attracting the adolescents and the habit of tobacco use at young age was a matter of concern for the government. Moreover, the government issued warnings on sale of loose cigarettes because its sale dilutes the purpose of packaging with pictorial warnings. The Legal Metrology Wing under department of Food Supplies has been instructed not to allow tobacco

companies to pack less than ten cigarettes in a packet. The department was asked to issue strict instructions to tobacco companies to abide by the rules (STCC, Punjab,n.d.).

With the purpose to evade the ban on gutka sale, the manufacturers were selling separate packets of *paan masala* without tobacco and separate pouches of flavoured tobacco which can be mixed and consumed with *paan masala*. In order to check the manufacturers who were escaping the ban, Department of Health and Family Welfare extended the ban on manufacture, storage, sale or distribution of *gutka, paan masala* and any other food products containing nicotine or tobacco as their ingredients for another one year (Majeed, 2018).

5.3. TOBACCO CONTROL PROGRAM IN DISTRICT JALANDHAR

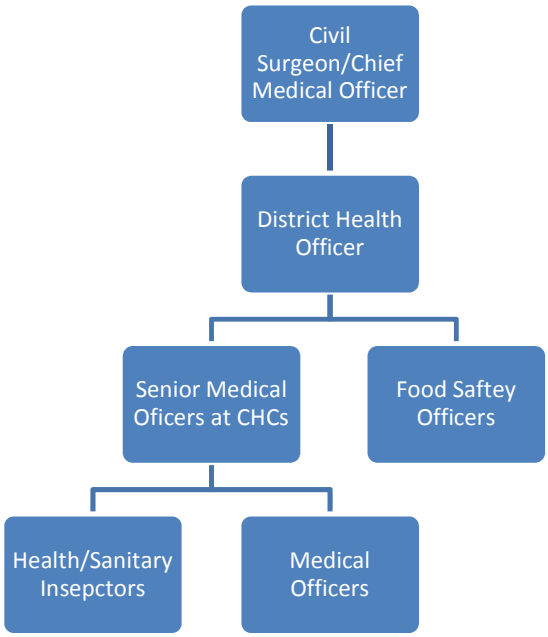
The Tobacco Control Program in the district is run by the District Health Department and other departments act as auxiliaries for effective implementation of the program. There is a District Level Coordination Committee (DLCC) which is chaired by the Deputy Commissioner of Jalandhar and includes representatives from Department of Health, Department of Police, Education Department, Legal Metrology Department, Department of Excise and Taxation and Department of Municipal Corporation. All these departments are required to work in synergy with one another to effectively execute Tobacco Control Program at the district level. Although the responsibility of the program is given to Health department, the other departments are required to supplement the efforts of Health department and work in their capacity to control tobacco use as well as sale in the district. The researcher found that the seriousness possessed by Health Department in the district was lacking in other departments. The information was primarily collected from the health department and the departments whom the health officials referred the researcher to. The next sub sections are divided into organisational structure of DTCC in Jalandhar and the implementation of the tobacco control measures in Jalandhar.

5.3.1. District Tobacco Control Cell (DTCC), Jalandhar

District Jalandhar has a District Tobacco Control Cell (DTCC) in District Hospital which establishes coordination between different departments for tobacco control. The role of DTCC is crucial as most of the activities envisaged under NTCP are to be

implemented at the district and sub district level. The DTCC is headed by the Chief Medical Officer (CMO) or Civil Surgeon who appoints the District Health Officer as the Nodal officer for Tobacco Control Program at district level in Jalandhar. The Nodal officer functions through Senior Medical Officers (SMOs), Medical Officers and Health Inspectors in various blocks as well as Food Safety Officers in the district. There is no NGO in Jalandhar working for the subject tobacco control. An organisation named Generation Saviour from Chandigarh had once visited the district to collect data on compliance under COTPA of various districts of Punjab.

Figure: 5.1. DTCC Jalandhar



In district Jalandhar, the DTCC functions with coordination from departments of Health, Education, Municipal Corporation and Police. They are collectively responsible for carrying out various activities enlisted under the NTCP which are concerned with raising awareness, collecting fines from offenders, offering help to those who want to quit tobacco use, checking the kiosks as well as educating the kiosk holders and establishing inter department coordination. The major activities of the DTCC include training of the relevant stakeholders through special modules which include doctors, nurses, teachers, officials from municipal and food authorities etc. It is also responsible for conducting regular raids at public places, government buildings, health facilities, educational institutes etc. The DTCC Jalandhar is

accountable for school awareness program in schools in order to prevent youngsters from falling prey to tobacco use at early stage of life.

5.3.2. Implementation of Tobacco Control Program in district Jalandhar

The implementation of various control measures has been established through interviews of officials working in the Health department, Education department, Police department and Department of Municipal Corporation. Interviews with the kiosk holders also highlighted the influence of tobacco industry on manipulating these measures in the district. The various themes and sub themes listed under provide details on how the various tobacco control measures have been used in Jalandhar.

5.3.2.1. Implementation of tobacco taxation as control measure in district Jalandhar

Taxes play an important role and are seen as the most successful measure in controlling the sale of tobacco. The tax rates on various products in state of Punjab have been mentioned earlier. The government officials were of the view that taxes on the products should be increased from the present, especially on *bidi* and smokeless tobacco products in order to curb its use and prevent the young generation from getting addicted to it. The tax rates of *bidi* and smokeless tobacco which is cheap as compared to cigarettes, made it easily accessible to the school going children in the district. In the words of SMO Noormahal,

> *..... Reduction in the sales has been due to increased taxes on the tobacco products. (Female, 55 years)*

Even the kiosk holders were of the view that increased taxes in the past had led to a decreased sale of tobacco products. In words of a kiosk holder from UP,

> *The previous increase in the taxes did affect our sales. Now we have heard that GST is being implemented. It will further cause a reduction in our sales and we will be left with nothing. (Male, 24 years,)*

The researcher observed that the sale of cigarettes was less than the sale of other products as *bidi* and smokeless tobacco in the district. This could be due to increased tax on cigarettes which was more than on other tobacco products. In addition, those buying a packet of smokeless tobacco use it multiple times in a day and can extend

use of one packet for two days making it a cheaper alternative to other tobacco products.

5.3.2.2. Protection from exposure to second hand smoke in district Jalandhar

All the concerned departments in Jalandhar were vigorously involved in collecting fine from offenders as listed under various sections of COTPA. These numbers are a false interpretation of the reality because it provides a false picture of the problem being solved or the District Administration being more vigilant.

Table: 5.3. *Challans* under Health Department

Months (Year 2016)	*No.of Challans*	Amount collected (In Rupees)
January	43	580
February	62	8760
March	164	11596
April	64	7130
May	294	27350
June	223	13280
July	354	26460
August	182	10870
September	171	8090
October	168	7900
November	180	6580
Total	1905	128596

Source: Office of the Civil Surgeon, District Hospital, Jalandhar[43]

[43] As given by Health Inspector,District Hospital,Jalandhar

Table: 5.4.*Challans* under Police department

(From: 1st January, 2016 to 31st December 2016)

Police station	No of challans	Amount collected(In Rupees)
Div no 1	07	400
Div no 2	87	6560
Div no 3	-	-
Div no 4	15	2800
Div no 5	22	1100
Div no 6	22	3700
Div no 7	29	4800
Div no 8	51	3270
Sadar	20	400
Cantt	43	4300
New Baradari	-	-
Rama mandi	03	75
Bhargo Camp	10	440
Basti bawa khel	03	150
Total	312	27995

Source: Police headquarters, DSP Urban, Jalandhar city [44]

[44] As given by office of DSP Urban ,Jalandhar city

Table: 5.5. *Challans* under Municipal Corporation

Month	No. of *challans*	Amount collected(In Rupees)
July 15	31	7400
Nov 15	9	1200
Jan 16	2	200
Feb 16	4	500
May 16	3	260
Total	49	9560

Source: Office of Municipal Corporation, Jalandhar city[45]

The kiosk holders were selling loose cigarette and provided lighters which were hanging from kiosks to smokers who wanted to smoke near the kiosks in public (Figure 5.2).

Figure: 5.2. Lighter hanging at the kiosk in urban area of field

[45] As given by Health Officer, Municipal Corporation, Jalandhar city

But the District Administration relies on the fines collected for measuring the success of the program and these calculations give faulty assumptions of the program managers doing their work efficiently. The above tables based on the fines collected by various departments do not provide homogeneous data on the control drive being carried out by various departments. There is no breakdown on the data on how many people were fined for public smoking or how much fine has been collected from the kiosk holders for flouting the rules. The data does not provide a clear indicator on how to follow a target based approach for tobacco control and tailoring of program as per the statistics of the district.

5.3.2.4. Tobacco advertisement, promotion and sponsorship in district Jalandhar

The advertisements of tobacco products although not done openly, was being done through promoting the use of other products such as mouth freshener cool lip whose samples had been reported to contain traces of nicotine. Moreover, some *hookah* bars is the district were functioning which promote the use of tobacco in the youngsters. In addition the point of sale advertisements with the brand name of tobacco companies was found at few kiosks in the district. In words of DSP Urban, Jalandhar,

> *The government of Punjab should concentrate on the profiling of those consuming tobacco products and in what forms are these products consumed. Even if there are fines and punishments people pay and are let off. There are no efforts to monitor the stocking and licensing of the tobacco products. Monitoring should not be confined to a mere formality. The use of tobacco is increasing in consumption as tobacco industry is using hookah bars to allure youngsters. Although hookah bars should not be functioning, there are some which are thriving in the district. Tobacco is being promoted in various ways in the district through mouth fresheners and hookah bars. (Male, 50 years)*

5.3.2.5. Packaging and labelling of tobacco products in district Jalandhar

Separate pouches of tobacco were being provided by the kiosk holders as presence of tobacco in products as mouth freshener, *paan masala* etc. is prohibited. This leaves the program managers helpless since the loopholes in the act leave enough space for the industry to manipulate it to suit their needs. The FSOs collect the samples of mouth freshener (cool lip) to check for any traces of nicotine (Table 5.6) but the presence of separate pouches of tobacco weakens the rationale of the law.

Table: 5.6. Tobacco adulterations in food samples collected

Months (Year 2016)	Total food samples	Samples adulterated with tobacco
January	75	0
February	79	2
March	74	0
April	95	1
May	97	4
June	87	2
July	88	1
August	75	0
September	73	0
October	94	4
November	57	0
December	72	1
Total	966	15

Source: Office of the Civil Surgeon, District Hospital, Jalandhar city[46]

Flavoured tobacco was being circulated in various forms of adulterated *paan masala* and mouth fresheners in the district. It was very easy for the school children to procure mouth freshener which later becomes addictive if adulterated with nicotine. Moreover, cigarettes were being sold in packets of two to five cigarettes per pack in order to attract young costumers with less paying capacity.

In words of FSO in District Hospital,

> *Cool lip and Paan Masala are sampled for every brand in the market and if they have nicotine or tobacco in them they are sent to the laboratory for checking their contents. Flavoured tobacco in any form is not allowed. Separate tobacco pouches are being sold. Tobacco molasses are mostly used in hookah bars labelling it as flavoured hookahs. (Female 40 years)*

5.3.2.6 Education and Communication on tobacco use in district Jalandhar

The huge task which District Administration confronted was changing the health behaviour of tobacco users and preventing adolescents from falling prey to tobacco use. The passage and implementation of laws and engaging the population to comply

[46] As given by Food Clerk, District Hospital, Jalandhar

with the laws in the district required constant reminders on ill effects of consuming tobacco. The lack of Behaviour Change Communication (BCC) activities and the callous attitude of the population in adhering to tobacco control laws pose a great challenge to the District Administration. The officials from different departments opined that various information channels such ad media, television, health warnings and advertisements play a crucial role in tobacco control. The use of multifaceted strategies along with other community education programs was considered important to bring change in the trajectory of tobacco use. In Jalandhar for education and communication the use of FM radio for campaigning against the use of tobacco was being done. In addition rallies and competitions in government schools were carried out but these were limited to World No Tobacco Day celebrated on 31st May each year. In the words of Health Officer at the Municipal Corporation,

> *The program should involve more of BCC and IEC activities because only penalising people is not sufficient. The doctors should be more involved in the BCC activities and there should be more of inter departmental coordination to spread awareness on tobacco. (Male, 55 years)*

The Medical Officer at Shankar seconded,

> *Health workers should be trained in a better way to provide BCC activities in the public and also there is no sufficient workforce for tobacco control in Jalandhar. Our CHC has no sanitary inspector or health workers. BCC activities are compromised because of this. (Male, 32 years)*

In addition, there were no sensitization drives or group discussions carried out by the health department to spread awareness among kiosk holders. They were fined for flouting rules on tobacco sales but were never counselled on laws related to tobacco and the associated health risks. All the kiosk holders interviewed were aware that tobacco use causes cancer but had no information on other health effects of tobacco use. The departments had no count on the number of kiosk holders in the district and had no measures to intensify the efforts at the department levels to include kiosk holders as a stakeholder in tobacco control. The FSO in District Hospital said,

> *Cases can be made against those selling tobacco products flouting rules but small sellers do not even know that what they are doing is prohibited under law because they are not sensitised. (Female, 40 years).*

5.3.3. Tobacco Control Program's integration with other health programs in district Jalandhar

Integrating tobacco control with other health programs has proved to be a valuable tool in checking tobacco use and preventing its initiation in early stages of life. It helps in sharing the responsibility of tobacco control with various health programs. However, these health programs which program managers in district implement are of different design and size which compromises the integration of various programs with Tobacco Control Program.

5.3.3.1. Place of tobacco control in School Health Program

There a total of 422 high, middle and senior secondary schools and 900 primary schools in district of Jalandhar. The high, middle and senior secondary schools are covered under Tobacco Control Program which targets the students from age group 12 to 18 years of age. The topic of tobacco use is not discussed separately but forms a part of broader health discussions and is confined to the celebrations of World No Tobacco Day on 31st May every year. The IEC is done by the teachers or the health teams visiting these schools that inform and educate the students on preventive health aspects of the diseases and on the need for a healthy body. When asked about the kind of counselling provided to children using tobacco the DEO (secondary) replied,

> *Teachers act as counsellors to the students and counsel them regarding their career and various issues which students bring up. One teacher in each school acts as a counsellor to them for any kind of personal or professional support but no counselling for tobacco is being done on regular basis. (Male, 55 years)*

Tobacco control as far as schools are concerned is restricted to the presence or absence of kiosks selling tobacco within 100 yards of educational institutes. It is to be noted that in the rural areas of the district tobacco products are sold in shops along with regular household items of use. So absence of a kiosk in rural area does not mean that there is no sale of tobacco products. The researcher observed that tobacco products were being sold in the shops adjacent to a high school in *Lambra* village. These shopkeepers had never been raided by health department to check the sale of tobacco products.

5.3.3.2. Oral Health Program and tobacco control

It has already been mentioned in the review of literature that consumption of tobacco especially in smokeless form is damaging for oral health of an individual. The oral health and tobacco use in Tobacco Control Program although deemed very crucial, is not taken seriously by Health department in district Jalandhar. There is no direct involvement of the dentists in the program although the dentists counsel the patients in their own capacity when they visit dental clinics in CHCs. The role of Oral Health Specialists in tobacco control is considered to be of extreme importance but their role in the district is limited to detecting the cases of oral cancer and referring them for treatment. There was no screening for oral cancer being done under the Health department till the time of data collection.

However, during an informal visit to a Medical College in Jalandhar, the Oral Surgeon in the department of Oral and Maxillofacial Surgery had started a drive against oral cancer under which they were screening patients regularly and had established collaboration with the Psychiatric and ENT department of the college. The intra department coordination in District Hospital on the other hand was confined to recognition of oral cancer cases and their referral to empanelled hospitals under District Hospital, Jalandhar. In words of SMO Noormahal,

> *During the dental fortnight awareness is generated regarding oral cancer and its relation with the use of tobacco. The dentist counsels the patients during their check up and no separate screening is done (Female, 55 years)*

The concentration of the Health department as far as the oral effects of tobacco use are concerned is limited to oral cancer. Various other oral health issues of halitosis (bad breath), periodontitis (gum diseases), tooth mobility and other cosmetic problems due to use of tobacco were not discussed by various stakeholders involved in controlling tobacco use in the district.

5.3.3.3. Integration with other health programs

The integration of tobacco control program with other health programs such as Revised National Tuberculosis Control Program (RNTCP), Reproductive and Child Health (RCH) and Adolescent Health is nowhere to be seen in the district. The health officers when asked about the integration seemed clueless and were not able to provide satisfactory answers. The integration with other programs which concentrate

on NCDs is an important element of Tobacco Control Program in order to target various age groups and genders using tobacco. The actual capacity and implementation of these programs is largely dependent on the resources made available to the health department in the district. The most startling observation of the researcher was that the health officials had to be guided into talking about the program integration as they drew a blank on the topic of integration with other health programs being run in the district.

5.4. BARRIERS IN IMPLEMENTATION OF TOBACCO CONTROL MEASURES IN DISTRICT JALANDHAR

The above mentioned tobacco control measures draw attention to the gaps in tobacco control in the district. The control measures are not implemented in full letter and spirit and are a band aid solution to the problem of tobacco use in the district. On ground these measures are far from what they are in the policy plan. The reasons for this hiatus in tobacco control measures were identified by the researcher and have been documented in detail in the following subsections.

5.4.1. Interdepartmental politics in the district

The lack of coordination among various departments is a significant barrier in the implementation of program in the district. The various departments are not able to function properly due to political interference and the departments put the onus of tobacco control on each other leading to a compromised tobacco control in the district.

5.4.1.1. Political will of the District Administration in tobacco control

The subject of tobacco control lacks a political will and is not on the priority list of the District Administration. The policy makers are responsible for framing the policies but they fail to take into account the ground realities of implementation. The translation of the policy is limited to collecting fines from offenders in the district. The political will is not concentrated on the Tobacco Control Program but is directed more on other health programs. In addition, the complete and comprehensive translation and tailoring of the program according to demography of the district is absent This generalization of the program with no target based approach to various age groups in the district is a drawback in the manner the program is being implemented in the district.

5.4.1.2. Lack of involvement of policy makers in tobacco control

The policy makers play a vital role in framing of the policy but overlook the practical feasibilities for its implementation and monitoring. These policies are not well rehearsed and their implementation is far different from what is laid down in these policies. The officials in the district were of the view that the higher authorities should make surprise visits to the fields frequently and be very strict in their actions against the offenders. Not only those selling and buying tobacco should be punished but any laxity on part of the departments responsible for the same should be strictly dealt with. The officers interviewed from various departments were very vocal in saying that policy makers should cut out a role model for the population and should not be involved in the politics played by tobacco industry. They were of the view that the policies are tailored keeping in mind the vested interests of the industry and the policy makers should be more concerned for the population's long term interest rather than being controlled by tobacco industry.

The kiosk holders were convinced of the nexus of the government officials and the tobacco industry. They said that it was ironical on part of government talking of tobacco control when it has stakes in the industry and will never turn strict or hostile for it. They were of the view that lack of a strict response on these issues has encouraged the industry to flout rules and flourish in business. Moreover, there were no alternate employment opportunities being provided to them by the policy makers and they were made scapegoats for the wrong doings of the industry. In the words of a kiosk holder from UP,

> *The government is working for the interests of the tobacco industry because it earns through revenues but the question is that why do policy makers target poor people like us when they cannot control the industry? The government does not provide us with alternate employment so that we do not sell tobacco in these kiosks. The policy makers will never do anything which will hampers the business of tobacco giants. (Male, 38 years)*

5.4.1.3. Lack of interdepartmental coordination in tobacco control

There is a lack of coordination among various departments responsible for running Tobacco Control Program in the district. The officials in Health Department thought that they were crunching under the burden of tobacco control and other departments should share the responsibility and take the program more seriously. They also

elaborated that that other departments conveniently transferred the responsibility to implement and monitor Tobacco Control Program to Health Department. The other departments fail to understand that along with the health implications of tobacco use there are social, economic and political implications of the same. This inter departmental coordination is limited to raids on persons smoking in public or on those selling tobacco products. The offenders take advantage of this situation and strongly convey to raid teams that departments should attack those manufacturing tobacco products and not target small sellers or consumers. In the words of FSO in District Hospital,

> *.....there is a lack of coordination with different departments because they think that it is the responsibility of the Health Department to implement Tobacco Control Program and do not take any initiative unless the health department is involved. (Female, 40 years)*

Moreover the DSP urban said,

> *……there is a complete lack of coordination between various departments responsible for tobacco control. The various department need to be together on working for tobacco control which is not absent in the district. (Male, 50 years)*

The department of Municipal Corporation works separately from other departments and any kind of regular departmental feedback on tobacco control is missing. In words of the Health officer at Municipal Corporation,

> *The coordination, when it comes to tobacco control, is less among the departments working for the same goal. I think more inter department coordination is required to help each other to work on tobacco control. (Male, 50 years)*

To add to the woes, there is no licensing of the kiosks holders in the district for selling tobacco products. The Health department says that it is the responsibility of the Excise department to provide licenses to the kiosk holders. However, Punjab Tobacco Vend Act 1958 under which licensing of the tobacco sellers should be done was under dispute between Health department and Department of Excise and Taxation till the time of data collection. The lack of any registration makes it difficult for follow up of kiosk holders and to make a detailed data base of the sale of various tobacco products in the district. No one from any department had visited the kiosk holders for providing information on licensing or registration. When the kiosk holders get any information on raids being conducted in the district, they find it very easy to escape. They resume their business again, once the departmental aggression is over. Most of these kiosk

holders are known to each other and they carry out their business as a part of the larger network.

In view of the Sanitary Inspector in District Hospital,

> *There is no licensing of kiosks selling tobacco and proper care should be taken for registration by Excise department. This will help in controlling the menace of tobacco and people will have fear of fine in their minds. Most of the unemployed people especially the migrants open kiosks and no record is maintained. Care should be taken to get proper numbers for better implementation of the program. This is possible when the ongoing dispute between Health and Excise department is solved (Male, 48 years).*

This lack of inter department harmonization has led to blame game among various departments involved in tobacco control in Jalandhar. The workforce in a single department was not sufficient for tobacco control and to achieve a cumulative effect all the concerned departments were not distributing the tasks among themselves.

5.4.2. Problems faced by officials in implementation of Tobacco Control Program in district Jalandhar

Since the major responsibility of Tobacco Control Program is under Health Department, health officials involved in Tobacco Control Program face hurdles in implementing the program. These personal and organisational barriers limit the success of Tobacco Control Program in Jalandhar.

5.4.2.1. Expectations about their job performance

The Nodal officers along with Health/Sanitary Inspectors are accountable for implementing Tobacco Control Program in their respective blocks. Their job is restricted to collection of fines and counselling the offenders on the spot. Although these officials were supportive of their role in tobacco control but no special training was given to them. They said that the workforce in the district was exhausted due to the burden of other health programs on them. Moreover, they had limited control over their job and job expectations were ambiguous in nature, meaning they were confused whether to collect fine, counsel the offenders or handle other health programs. They were left them with a lot of paperwork and workload and they could not concentrate on a single health program.

5.4.2.2. Availability of resources

The health officials were divided on their opinion on availability of workforce to deal with issues pertaining to tobacco use. In addition, there was no clear demarcation of the budgetary allocation for the district as well as the respective departments for tobacco control. These health institutions were working in their limited capacity and using the already work loaded workforce to address the issues relating to tobacco. The District Administration was trying to project that the workforce was capable of multi tasking and handling different issues and problems of diverse programs together. This was a shallow claim by the government, required the kind of activities and full time dedication demanded by Tobacco Control Program. Moreover the government was not disseminating funds to various departments for tobacco control; diluting the whole meaning of the program.

Another reason for the lack of resources is that Tobacco Control Program is not treated at par with other health programs. The burden of other diseases is seen to be much higher and tobacco as a risk factor to these diseases is overlooked. As stated earlier, the Health Inspectors were entrusted with lot of responsibility and paper work to complete which left them with little time for field counselling of the population. They were not able to engage fully with the community and had not been provided adequate training for tobacco control in the district. This lack of training had left them with superficial knowledge regarding Tobacco Control Program.

5.4.2.3. Threat and challenge to their authority

When department teams raided kiosks selling tobacco for any kind of sale discrepancies, they faced confrontation because kiosk holders advised them to fine those producing tobacco in various forms. The officers said that they collected fine and tried to be rational with those fined but sometimes violence took place and police had to intervene. In order to provide protection to the officers, two constables from police force accompanied the health teams. In the words of Sanitary Inspector in District Hospital,

> *Practically in field we encounter problems as people and kiosk holders protest when we challan them. The constant question which is always asked is that if the production of these tobacco products is not banned, there is no point in challaning them. (Male, 48 years)*

The kiosk holders on the other hand felt frustrated when they were projected as culprits and those up in the hierarchy were spared; hence they ended up arguing with teams raiding them. The health officials felt that the government needed to tighten their noose around tobacco industry which might bring a change in the way kiosk holders react when raids are conducted.

5.5. TOBACCO INDUSTRY'S INFLUENCE ON TOBACCO CONTROL MEASURES IN DISTRICT JALANDHAR

Tobacco industry in the district had employed various tactics to dilute tobacco control. Although it was projected that the District Administration was taking stringent action against the tactics adopted by the industry, the authenticity of these claims was shockingly different. The next subsections provide details about the profile of the industry in district and how it influenced the Tobacco Control Program.

5.5.1. Profile of tobacco industry in Jalandhar

As mentioned in chapter four, Green Revolution saw the influx of migrant population in Punjab to work as farm and industrial labourers. This migrant population brought with itself a culture of tobacco use in varied forms and have also been actively involved in selling tobacco products in the district. Most kiosk holders belonged to *Churasia* community of UP which is entrusted with the family occupation of preparing *paan* and were handling tobacco kiosks in the district since decades. There is no written information on the profile of tobacco industry in the study district and it is through the interviews with the kiosk holders that the researcher could draw a sketch of the industry

Table: 5.7. Tobacco brands being sold in Jalandhar district

Brand name	Products sold
ITC	Wills navy cut
	Gold flake India
	Gold Flake premium
	Classic
GPI	Red and White
	Four square
	Cavenders
Shikhar group	Shikhar Gutka
Sudershan tobacco	Pattachhap Khaini
Bidi	Kisan *bidi*

Source: Data collected from field

When contacted the kiosk holders said that sale of both smokeless and smoking tobacco is equally prevalent in the district. The major brands sold for cigarettes from GPI were Read and White, Four square and Cavenders and those being sold from ITC were Wills Navy cut, Gold flake India, Gold flake premium and Classic. The *bidi* named Kisan *bidi* and smokeless tobacco product Shikhar *gutka* was being sold in the district in urban as well as rural areas. The *gutka* belongs to Trimurti fragrances private limited known as Shikhar group[47].The *khaini* being sold was *Pattachhap* which is manufactured by Sudershan tobacco private limited in Haryana[48]. The website of GPI says that Red and White cigarette which was marketed as real men cigarette at its launch caught the imagination of North Indian male. Ever since Red and White brand has been associated with a brand which symbolises the macho spirit of Indian men especially in the regions of Delhi, Punjab and Haryana. The brands tagline "*hum red and white peene walo ki baat hi kuchh aur hai*" is part of the informal glossary of the smokers' life[49]. This was applicable to field study because the maximum numbers of cigarettes being sold were from Red and White Brand.

5.5.2. Tobacco industry's tactics to weaken tobacco control

The various strategies of tobacco industry in the district to bypass control measures were a hindrance in functioning of Tobacco Control Program. Not only did it weaken the measures being taken but also added new customers to its market base by offering new brands and products. The District Administration had turned a blind eye to the legislations being flouted openly which proved advantageous to the industry to expand and strengthen its market base in the district. The researcher was shocked to observe that the kiosks near District Hospital, Jalandhar were fearlessly working against the tobacco control laws due to support being provided by the industry for sale of tobacco products.

5.5.2.1. Profits offered by tobacco industry in the district

The kiosk holders came to Punjab to find jobs which were not available at their native places and for them business of selling tobacco products was like selling any other commodity for consumption. The profit in tobacco sale was good and some of them

[47] http://shikhargroup.in/company/about-us
[48] https://www.zaubacorp.com/trademark/PATTA%20CHHAP%20TEJ%20TOBACCO/970622
[49] https://www.godfreyphillips.com/cigarettes

considered it as a better job as compared to other labour jobs. Moreover they never ran out of business and got 5 % to 10% profit margin on all tobacco products. Although some kiosk holders were reluctant to talk about the profit margins, some were very honest in sharing that they found the sale of tobacco profitable.

Small kiosk holders did not find the job profitable enough but kiosk holders running big businesses in the prime areas of the district were satisfied with their jobs and were earning good. The sale of premium brands of cigarettes with greater profit margin fetched them better money as the clients in prime areas demanded premium tobacco products. A kiosk holder from Bihar, selling cigarettes in the prime location of Jalandhar had an interesting story to offer. In his words,

> *I am helping my father run this kiosk. I am a graduate from Lovely Professional University and I did job in computer and garment sector but I was not getting paid enough. This job is paying me the best. First I was reluctant to do this job but seeing the profit it made for me, I though it is better to sit here in the kiosk. (Male, 24 years).*

Another kiosk holder from Gorakhpur said,

> *The selling of loose cigarette is more profitable than the packet itself and it provides more margin than the packed cigarette. I know selling loose cigarettes is not allowed but most of the customers come and ask for loose cigarette.(Male , 45 years).*

The above excerpt by the kiosk holder signifies that if buying loose cigarette is advantageous to population in the district as tobacco use is considered a taboo in society of Punjab, it is equally profitable for the sellers to sell loose cigarettes. Most of the cigarette being sold was loose and the researcher came across only one tobacco user at the kiosks asking for a full packet of cigarette.

5.5.2.2. Varied approaches for sale of tobacco products

The tobacco industry in district provided mild cigarettes for sale to the customers by promoting it to be relatively safe than the regular cigarettes. Slim cigarettes and mild cigarettes were being sold in the urban areas of the district. The kiosk holders in the urban areas were approached by sales person who sold them latest brands and informed about any new schemes for sale of tobacco products being launched. Also the kiosks were selling toffees and cold drinks which attracted children in buying them and they were exposed to varied tobacco products (Figure 5.3).

Figure: 5.3. Toffees being sold to children at tobacco kiosks in urban area of field

In words of a kiosk holder from Bihar,

> *Sometimes people come and ask for thandi (mild) cigarette. These cigarettes do not harm the health as does the regular cigarette...not everyone but few customers ask for it. (Male 57 year)*

On the other hand, the industry penetrated in rural areas of Jalandhar through sale of tobacco products at the village shops which sold items of daily use because the open sale of tobacco products at kiosks in villages is a cultural taboo. Due to this taboo the village youngsters as told by the shop owners consumed smokeless tobacco more than other forms of tobacco. Although these shops in the villages were not solely dependent on the sale of tobacco products for their earnings, the demand for these products made them procure and sell it. The tobacco industry took advantage of the callous attitude of the District Administration and promoted various products for sale.

5.5.2.3. Incentives offered by industry in the district

The tobacco industry employs numerous tactics not only to attract customers but also the sellers of tobacco products. The kiosk holders in the district were offered money for putting up posters which bore the brand name of a particular tobacco company. These posters informed that cigarette smoking is injurious to health and left the choice in the hands of the customers to smoke or not. The kiosk holders got an amount of Rupees 400 to 500 per month in order to display such posters (Figure 5.4). Moreover the larger packets containing sachets of *gutka* offered free sachets in order to allure the sellers into buying more (Figure 5.5). The companies also offered some free gifts when the kiosk holder bought the tobacco products in large quantities. These incentives were a source of additional income for kiosk holders who were from economically and socially weaker background.

Figure: 5.4.Point of sale advertisements at kiosks in the field

Figure: 5.5.Incentives given in form of free pouches in the field

Although it was tough getting information on the kinds of incentives being given by the industry, some tobacco sellers were vocal about the marketing strategies of tobacco industry. A Punjabi shopkeeper in rural area said,

> *The tobacco companies offer gifts like free tobacco packets on buying 30 packets of smokeless tobacco. These gifts are either free smokeless tobacco packets or some gift item like a show piece or something. (Male, 25 years)*

Another kiosk holder from UP said,

> *We get Rupees 400 to 500 per month for display for the posters of a tobacco company. Although it is not so prevalent now due to stricter rules but tobacco companies still provide lucrative offers which cannot be resisted or missed. (Male, 32 years)*

In contrast, most of the kiosk holders denied getting incentives in any form from the tobacco industry and blamed stricter legislation for the loss of lucrative sales offers.

5.5.2.4. Using debates of free will and tobacco use in the district

These debates of free will and choice as mentioned earlier have been used by industry to make the government look like a criminal who curbs the personal choice of tobacco consumption. Although kiosk holders acknowledged the ill effects associated with its consumption but left the choice of consuming tobacco to the individuals. The kiosk holders had knowledge regarding the legislative steps being taken by the government to prevent the spread of tobacco use. Those who were well informed had either been in tobacco business since years or had been fined for breaking rules. The kiosk holders were of the collective view that they could not stop anyone from buying and consuming tobacco because it was a matter of individual choice. They elaborated by saying that the warnings on tobacco packets clearly warned that tobacco causes cancer but that did not deter the users from buying tobacco products (Figure 5.6). However, the researcher observed that these warnings did not hold any meaning because most of the users bought loose cigarettes. The kiosk holders unequivocally said that if tobacco products at the level of production were being manufactured then why users were being fined for consuming tobacco.

Figure: 5.6. Free will and choice of customers showed by this poster in the field

A Punjabi kiosk holder in the urban area had been running his family business of selling tobacco in the kiosk which his father established in 1974. In his words,

> *If we take food in more than the required quantity it is also harmful. I believe anything taken in moderate amount does no harm and those using tobacco should consume it in limits. But if it starts consuming you then it is harmful.* (*Male, 47 years)*

Moreover, when asked if he consumed tobacco, he denied it elaborating that nobody in his family consumed tobacco in any form. When probed further, he said it is their choice not to consume tobacco.

CONCLUSION

The chapter captures the organisational set up as well as insight of various officials and kiosk holders on Tobacco Control Program in the district. Tobacco control was seen as low on priority as compared to other health programs and lacked inter department coordination in the district. The organisational and personal constraints of work force with no special training for tobacco control limited the successful implementation of the program. The officials in the district tried to present a perfect control program through fines imposed on offenders. However, they failed to understand the role of behaviour change and providing IEC material tailored according to demography of the district in restricting the use of tobacco. This lack of organised approach to tobacco control in the district proved advantageous for kiosk holders who overtly defied legislation and sold banned tobacco products. Moreover, these migrant kiosk holders in the district were an important stakeholder in tobacco control but were not sensitised and excluded from the process of tobacco control. Having said that, the tobacco industry had a strong hold on its market and in spite of strict legislations was making profits in the district. Its influence in diluting the tobacco control laws made Tobacco Control Program in the district struggle for its betterment. To summarise, the Tobacco Control Program lacked a holistic approach to contain the menace of tobacco in district Jalandhar.

CHAPTER 6

TOBACCO USERS IN DISTRICT JALANDHAR: ORAL CANCER AND ITS SOCIAL CORRELATES

INTRODUCTION

The objective of this chapter is to study the health implications of tobacco use in form of oral cancer and the social correlates of tobacco use in Jalandhar. There are various social factors which determine the behaviour as well as disease in an individual. Simply put, those who live in poor socio economic conditions since childhood attain lower levels of education and occupation which may influence the health behaviour in a negative way leading to occurrence of diseases. Similarly, the use of oral cancer is socially patterned and its prevalence is more in the disadvantaged groups and in those from low socio economic background (Kruger & Tennant 2016). This consumption of various forms of tobacco products especially smokeless tobacco, driven by different determinants translates into oral cancer. As far as Punjab is concerned, the increase in oral cancer has been blamed on the lifestyle changes of which tobacco use forms an important part. In addition the migrants in Punjab from other states especially UP and Bihar have been blamed for increasing the use of tobacco in culture of Punjab.

In this chapter, the researcher explores several dimensions of tobacco use to establish a strong understanding of its consumption as a social practice as well as its translation into disease. The chapter is divided into six sections of which the first section bursts the myth of cancer in Punjab and introduces two groups of tobacco users one being the patients of oral cancer and second being the local and migrant labourers in district Jalandhar.

The second section of the chapter is based on the social correlates of tobacco use in the study groups. Within this broader term, the variables under socio demographic profile as well as socio economic profiles are analysed for their similarities and difference across and within the groups. The third section elaborates the type of tobacco consumed and the effect it had on tobacco users. It lays stress on the varied form of tobacco use, the quantity of tobacco use and if its consumption led to compromising the basic needs of family of tobacco users. The fourth section details the role of social support in changing the behaviour of tobacco users. It outlines the

social support in the form of family, peer group as well as the individual's will power of quitting the use of tobacco.

The fifth section of the chapter informs about the impact oral cancer had on the lives of the patients. This section is exclusive for the patients as it becomes very important to understand the emotional as well as the financial pain which this disease brings of which tobacco use is a risk factor. The last and final section touches on the importance of the role of the government to check the use of tobacco in the district. This section represents the views of the respondents who find government an equal culprit for not restraining the use of tobacco.

6.1. RELATION OF CANCER AND MIGRATION PHENOMENON IN PUNJAB WITH TOBACCO USE

There are various historical episodes which gave Punjab a distinct identity before and after independence as indicated in chapter four. Of this entire phenomenon the prevalence of cancer in the state has received attention in the last two decades. The associated health behaviour due to changes in the lifestyle has been seen as the major factor in the spread of cancer in the state. As stated earlier smokeless tobacco is a risk factor for oral cancer and its consumption has increased in the last six years. In addition, the presence of a large number of migrant labourers in Punjab in agricultural as well as industrial sector has been considered responsible for the cultural pollution of Punjab. The next sub section analyses the myth of cancer in Punjab and what role has the government played in exaggerating these claims. This fragment is of utmost importance because it brings forward the critical issues associated with the data on cancer in Punjab as well as the exaggerated response of government to it.

6.1.1. Myth of cancer in Punjab

Before reaching to field data, it is very important to look at the cancer alert in Punjab in order to relate the experiences from the field with government's claims. Literature on cancer in Punjab emphasises that the state is affected with cancer specially the Malwa belt, which saw an increase in the cancer incidence due to use of pesticides and fertilisers. However, experts from the Tata Memorial Hospital Mumbai, which is the country's top cancer treatment, have recently debunked the myth of Punjab especially the Malwa region, being cancer belt of India. The number of cases being

reported in Punjab for every 100,000 incidents is almost equal to the national average. In addition, the various types of cancer present in the area are found to be similar to other parts of the country. The most common cancer prevalent in Punjab is of oesophagus followed by breast and cervical cancer. These are directly related to faulty lifestyle and are caused by smoking, consumption of alcohol and late marriages. Moreover, it will be wrong to label Malwa belt as cancer prone on the basis of presence of uranium in groundwater or over use of pesticides and fertilisers. A high dose of pesticides and fertilisers causes Lymphoma which affects the immune system and uranium causes Leukemia or blood cancer. The reason for this infamous tag of cancer has been Punjab's poor maintenance of cancer registry. The past studies which blamed uranium and pesticides for high rates of cancer in Punjab were cross sectional surveys which gave information on the incident and prevalent cases and hence the number observed was always more. Moreover, the Cancer Atlas which is based on the histopathological[50] records is not the right way to access the burden of Punjab (Verma, 2017).

This lack of maintenance of data has generated a perception that the state has a disproportionately high incidence of cancer. However the cancer mortality per 1, 00,000 people in Punjab is 80.6 which is below the national average of 97.6 and far below the north east which is 237.4. Yet so popular is the perception that the state government spends excessively on the diseases. In the year 2013, for example, the government set aside 500 crores of rupees annually to organise medical camps to eradicate cancer and another 450 crores for treating cancer. That being said the state's entire health budget was 3443 crores. As a result of this limited fund, health care in Punjab is suffering in several ways. NSSO data's 2015 numbers reveal that households in Punjab have highest out of pocket expenditure on the health care in the country which is Rs 28,539 against the national average of rupees 18,628. There is a lack of specialists in the public sector in Punjab which forces people to seek care in private (Rajshekhar, 2016).

Punjab government in 2017 started cancer screening in 22 districts in order to detect breast, cervix and mouth cancer. It also initiated free annual preventive health check up program to diagnose diseases such as hypertension, cancer and diabetes. The

[50] It is the examination of the tissues under microscope in order to study the manifestations of the disease.

Health and Family Welfare Minister blamed the previous government of not taking serious action to initiate screening and awareness program on cancer despite the fact that this disease had extremely impacted all the districts of the state (PTI, 2017b). During the time of data collection the screening for oral cancer was not being done in the field and any suspected patients of oral cancer were referred to District Hospital in Jalandhar. The District Hospital further referred the patients to various hospitals empanelled under Punjab government for cancer treatment.

Further, oral cancer is on increase in Punjab due to tobacco use and promotion of tobacco and *paan masala* use in the advertisements and films and improper implementation of ban on the sale of tobacco use within 100 yards of educational institutes (Rana, 2018). As already mentioned in the previous chapter, the shopkeepers in the villages were selling tobacco products along with the items of daily use and the higher secondary school in village *Lambra* had few shops in its immediate vicinity selling tobacco products. This problem was more pronounced in the rural areas as there were no regular raids on tobacco selling shops as compared to urban area in the district.

To add to the confusion, the Punjab government is also clueless on the total number of patients being affected with this deadly disease. A RTI query filed to National Program of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), Punjab and Health Department had asked two important questions. The first was the total number of cancer cases in Punjab and second was the type of cancer with maximum prevalence in men and women. Information was also asked for the number of deaths in state related to cancer for years 2012-17. The State government mentioned that the consolidated information on the number of deaths due to cancer was not available. The only reply given was the number of patients registered under Mukh Mantri Punjab Cancer Rahat Kosh Scheme (MMPCRKS). Health department officials also said that a registry of cancer patients was started in 2011 in Government Medical College Patiala. It is the same year when MMPCRKS was launched and the department also collects data from this scheme. Under MMPCRKS, patients who apply for government help for treatment in the hospitals are given rupees one and a half lakh a year by the government. Till year 2012-17 44,991 patients had availed the benefits of the scheme. Of 22 districts only three districts, Moga, Bathinda and

Fazilka have kept a record of the number of deaths. To elaborate in Moga of 1908 patients 1327 have died, Bathinda has seen 500 deaths of 1673 patients and in Fazilka 596 deaths out of 1256 patients. In districts of Moga, Bathinda, Fazilka, Pathankot, Muktsar and Fathegarh Sahib, women primarily reported with breast cancer while men reported with cancer of oesophagus, mouth, lungs, prostrate and brain. It is startling to note that there is no data of total patients and no record on deaths due to cancer in the state (Singh, 2018).

As far as district Jalandhar is concerned there is a record of number of cancer cases availing benefits under MMPCRKS. It is to be noted that government employees, ESI employees and their dependants or patients who have taken any form of health insurance are not included in this scheme.

Table: 6.1. Status Report under MMPCRKS of district Jalandhar

Year	No of cases of cancer in Jalandhar	No of cases in Punjab
2013	243	5565
2014	543	8121
2015	493	8150
2016	601	8925
2017	505	8799

Source: Department of Health and Family Welfare Punjab[51] (n.d)

The number of patients taking treatment under MMPCRKS in Jalandhar district has no consistent pattern. The data does not show the break up according to the type of cancer the patient suffers from. The lack of data is a very big drawback in accessing and analysing the change in the pattern of cancer. Put simply it is not clear which cancer dominated Punjab earlier and if there has been a shift how NPCDCS and Tobacco Control Program has addressed that shift and tailored its approach accordingly. Moreover, the data of those who were not availing the scheme but were

[51] http://pbhealth.gov.in/cancercontrol/District%20Wise%20Status%20Report.pdf

cancer cases was not available on the website of Department of Health and Family Welfare, Punjab.

6.1.2. Groups under study in the district

The groups under study are similar as tobacco users form part of these groups but the main difference in these groups is that one group is affected by the deadly disease of oral cancer and the other group is cancer free(Annexure C). The responses so obtained have been analysed keeping the focus on tobacco use.

Group I: Punjabi oral cancer patients

Although tobacco use, especially in smokeless form, causes various oral health diseases but fatality and seriousness associated with oral cancer and the propaganda of the Punjab government associated with cancer was one of the reasons for selecting this research group. In addition, the training of researcher as an oral health professional and findings from the previous study reinforced the selection of patients of oral cancer in the district. That being said, the researcher's main aim was not to strengthen that the use of smokeless tobacco causes oral cancer but to trace the social factors responsible for tobacco use.

The semi structured interview schedule focused on the socio demographic profile of the cancer patients, types of tobacco used and impact of oral cancer in their lives. All ten patients of oral cancer were males aged 30-55 (35 being the lowest and 54 being the highest). The researcher did not exclude any females in the group intentionally but those interviewed at the time of data collection in the hospital were males. This corroborates with the fact stated in the review of literature that oral cancer is more prevalent in males than in females. The patients were permanent residents of Punjab though necessarily not from Jalandhar. All of them were Hindus except one who was a baptised Sikh. It is not through the lens of progress of the disease but through the process of its initiation and the factors which prevented the individual from choosing a healthy life for himself, that the researcher analysed the data. The themes derived from the interview of oral cancer patients also highlighted the chronological order of the disease initiation and its treatment.

Group II: Migrants and Local labourers

The migrants in Punjab have moved from less developed area to a highly developed area (Haan, 2007 as cited in Gill, Sharma & Sharma, 2017). Most of these migrants are landless, poor and belong to lower class groups. Also the in migration of males is more than the females in Punjab. In addition, the wages being provided are more in the manufacturing sector than the agricultural sector; thus the migrating labourers are moving towards big cities for better employment in Punjab (Gill, Sharma & Sharma, 2017).Out of the total 70 percent of the people coming to the cities are outside the state and only 30 % percent belong to rural Punjab. Moreover, 47% of the migrants enter Punjab due to poverty and 42% shift due to lack of remunerative opportunities in their respective places. In case of illness they approach cheap private medical facilities or quacks as they cannot spend time waiting in the government hospitals (Nibber, 2018). This and many other features of the migrants in their way of life, sets them apart from the local population.

During the process of in depth interviews with the oral cancer patients a decision was taken to conduct Focus Groups Discussions (FGDs) amongst migrant and local labourers in the district to probe the use of tobacco across diverse groups. These groups were further sub divided into agricultural labourers (migrant as well as local) in rural area of Khambra and migrants working in unorganised sector in the urban area(Urban Estate phase 2, of Jalandhar city) and a group of Punjabi labourers working in the unorganised sector in rural area of Pholriwala. These groups were all males since Punjab has negligible percentage of female tobacco users and those using it are not open about it. For the ease of analysis this group is further renamed into three separate groups.

Group IIAgriMix: One group of Agricultural labourers in rural area (migrant as well as local) in Khambra

Group IIMigrant: Two groups of migrant labourers working in the unorganised sector in the city

Group IILocal: One group of Punjabi labourers working in unorganised sector in rural area in Pholriwala

Migrant labourers in Jalandhar

The migrant labourers in rural as well as urban area of the district were from UP and Bihar and were aged 18 and above. The agricultural migrant labourers were seasonal labourers and were to return to their native places after the harvesting season. On the other hand, the migrant labourers working in unorganised sector in the urban area were staying there for more than ten years and used to go back to their native places for vacation only. Those working in the unorganised sector worked in varied occupations as masons, security guard and rickshaw pullers.

The farm labourers said that they migrated seasonally to Punjab because of the better wages being offered during the season of sowing and harvesting. Those working as unorganised labourer said that the opportunities in Punjab are more than their states of UP and Bihar. They also said that the living conditions in the state of Punjab were better than their native states. A migrant from UP in Group IIMigrant said,

> *We have come to Punjab because it offers better employment and work to us. It is not poor as states of UP and Bihar. Some of the migrants who migrated long back have better standard of living than their contemporaries in home states.* (*Male, 40 year old)*

Local Labourers in Jalandhar

Jalandhar is not an agricultural district though 47.06% of the population in Jalandhar is residing in the rural areas yet the main workforce which is engaged in agriculture is only 39.5% in the agricultural sectors (District Census Handbook-A, 2011, p.12). Among the total workers in the district, 11.06% are cultivators, 8.61% are agricultural labourers, 3.84% are household industry workers and 76.48% are other workers (District Census Handbook-A, 2011, p.76) The local labourers working in the agricultural sector as well as unorganised sector, aged 18 and above, belonged to rural areas of Khambra and Pholriwala respectively and had been residing there since birth. The locals though worked with migrants yet had their distinct identity of being Punjabis and referred to migrants as "*bhaiyaas"*.

6.2. SOCIAL CORRELATES OF TOBACCO USE IN DISTRICT

The various factors which affect the use of tobacco in different groups have been enumerated in the section on social correlates of tobacco use. Under this section the socio demographic factors as well as socio economic factors within and across the

groups have been analysed for their impact on choices of the individuals primarily related to tobacco use.

6.2.1. Socio demographic factors and tobacco use

The various socio demographic factors as mentioned in the sub sections played a vital role in informing the individuals about choices they made in life, tobacco use in this case. These factors namely age, gender, religion and place of residence determined the use of tobacco in both the groups and subgroups and its translation into oral cancer.

6.2.1.1. Age

Age played an important role in addiction to tobacco use in all the groups. The respondents across all groups were aged above 18 years and were using tobacco from the start of their adolescence. The groups said that the curiosity in the age of adolescence to experiment with something new especially the risky behaviour, introduced them to the use of tobacco. Punjabis across the groups including oral cancer patients as well as labourers said that they initiated tobacco use when they were around 12 to 13 years of age. The migrant labourers on the other hand started using tobacco in smokeless form by the age of 9 or 10 years. The adolescents are the most susceptible population group to initiate the use of tobacco. The earlier the start of tobacco use more is the nicotine dependence and more difficult it gets to quit or reduce its use in later lives. Thus, the habit of tobacco use which started in adolescence became an addiction in adulthood. In addition the prolonged use of tobacco from a very young age also increased the risk of getting oral cancer.

6.2.1.2. Gender

All the respondents and participants across the groups were males. But they had varied view points on the use of tobacco among females in Punjab and those from migrant community. Oral cancer patients as well as the group of Punjabi labourers (in Group IIAgriMix and IILocal) were of the view that the use of tobacco among women in district Jalandhar is negligible as compared to those from the states of UP and Bihar. They said that they had not seen Punjabi women use tobacco and it was the migrant women staying in Punjab who used tobacco.

However, the migrant labourers (in Group IIAgriMix and IIMigrant) said that Punjabi women drank *hookah* and consumed tobacco though not openly. They said that migrant women on the other hand used tobacco in the form of smokeless tobacco or *paan*. They elaborated that fewer migrant women who had been staying in Punjab used tobacco and were getting adapted to the culture of Punjab. A migrant labourer (Group IIAgriMix) from Bihar said,

> *Women in Bihar used to smoke bidi but now the culture has changed. Punjabi people might be denying this but women here also consume alcohol and cigarette. (Male, 45 years)*

In words of another migrant labourer (Group IIMigrant),

> *The ladies consume tobacco before marriage in Bihar and UP but they quit once they are married. They only consume smokeless tobacco. We have ourselves seen women in Jalandhar drinking hookah when we used to work in rural areas. But now the atmosphere is changing and the ladies do not use tobacco. (Male, 28 years)*

The role of gender in Jalandhar and in the native places of the migrants highlights the social as well as cultural context and the gender inequality in the use of tobacco across groups. The use of tobacco for females in Punjab is a cultural taboo but is normalized in the culture of UP and Bihar. Moreover, the discussion revealed that form of tobacco consumed is also different across women; the migrant women use tobacco in *paan* and in smokeless form while those from the district used *hookah* over smokeless tobacco. Moreover, the lesser use of smokeless tobacco as compared to males in Jalandhar decreased the risk of getting oral cancer; hence no females in Group I of oral cancer patients.

6.2.1.3. Religion

It has been explained in detail in chapter four the prohibitions on use of tobacco in Sikhism. The respondents of the study in all the groups followed Hindu and Sikh religion. But there were inter and intra group variations as far as use of tobacco is concerned. The oral cancer patients (Group I) were all Hindus except one who was an *Amritdhari* Sikh. The 38 year old Sikh patient was a non-tobacco user and non-alcoholic. He was a strong believer in Sikhism and its teachings. His father said,

> *Nobody in our family takes tobacco or alcohol in any form. We are strong believers of teachings of Sikhism. Even we are surprised how he got cancer when he had clean habits which we as a family also follow. It is very disheartening for us because we thought only tobacco users get oral cancer. (Male,65years)*

This excerpt from the interview of patient's father strengthens the fact about use of tobacco being prohibited in Sikhism. Moreover, apart from alcohol and tobacco use, excessive sun exposure and Human Papillomavirus (HPV) have also been considered as risk factors for oral cancer (Verma et al; 2018) which the patient and his family were not aware of.

Similarly, few Punjabis in IIAgriMix and IILocal were *Mazhabi* Sikhs. In FGD, on the agricultural farm, one of the local Sikh farm labourer said that that tobacco is prohibited in Sikh culture but Sikhs do consume tobacco in various forms. In his words,

> *I belong to Sikh family. But I take tobacco in smokeless form. My wife is Amritdhari. But when we interact with migrant labourer we end up consuming tobacco. I still take it and have not made any attempt to quit it. My wife tells me not to use it but now I am addicted to it. (Male, 50 years)*

But the migrant labourers in Group IIMigrant were of the view that they have seen Punjabi Sikhs using tobacco in every form but they refrain from consuming tobacco openly due to cultural restrains. A migrant from UP said,

> *In Punjab Sikh people eat khaini but they are not open about it. They are secretive in nature as the use of tobacco is not as open as alcohol in Punjab. I think any form of addiction is more in Punjab than UP. So it is not only Hindus or migrants who use tobacco in Punjab. (Male, 22 years)*

The prohibitions on use of tobacco in Sikh religion in very pronounced. This is the main reason that the researcher did not encounter Sikhs buying, selling tobacco or consuming it openly during the field work.

6.2.1.4. Place of residence

The place of residence of the study groups determined the availability of tobacco to the users in all the groups; oral cancer patients as well as the labourers. The groups were of the view that tobacco in various forms was easily available at the kiosks in Jalandhar. In the urban areas the kiosks were situated at a distance of every 100 metres whereas in rural areas the kiosks were found on the periphery. Within the villages the shops selling products of daily use sold tobacco products. A Punjabi labourer from Group IIAgriMix said,

> *People from UP and Bihar sell tobacco at these kiosks more than Punjabis because they are migrants and do not have any alternate employment. This makes the tobacco products easily available to locals as well as migrants. (Male,55 years)*

The migrants from the same group however denied theses allegations saying that even Punjabis sell tobacco in the rural areas and it can be easily procured from village shops. This substantiates the findings of the researcher from the field where rural areas has no presence of kiosks and sale of tobacco was confined to village shops selling items of daily use. Another migrant from Group IIMigrant said,

> *The various forms of tobacco are available in the kiosks in the urban areas and it is not difficult to procure tobacco in Jalandhar whether you stay in urban or rural area. (Male, 30 years)*

The oral cancer patients (Group I) had also echoed that tobacco can be procured easily in all the areas of Punjab including Jalandhar. In words of wife of one of the patients

> *It is very easy to procure tobacco in Punjab. There are kiosks at every step and you do not need to go far to purchase it. Its easy availability in rural as well as urban area is a major factor in increasing tobacco addiction in Punjab. (Female, 45 years)*

Therefore, the easy availability of the use of tobacco in the neighbourhood is also considered one of the important factors for initiating as well as continuing its use. Moreover, those in adolescence get influenced by the easy availability of the tobacco in neighbourhood and initiating the use of tobacco becomes relatively easy continuing the cycle of early initiation and nicotine dependence by the time adulthood is reached.

6.2.2. Socio economic factors and tobacco use

The various socio economic conditions affect the use of tobacco; meaning the lack of opportunities and knowledge through low socio economic background compromises the decision making powers of people in these groups in determining what healthy behaviour is. Put simply, the lower level of education translates into lower occupational securities and low buying capacity. Hence these groups are prone to using smokeless tobacco and *bidi* more than any other form of tobacco as it is cheap. In addition buying tobacco might further aggravate the poverty as the money to be spent on essentials gets diverted to buying tobacco.

6.2.2.1. Education

The education levels of the oral cancer patients were low and they had not studied beyond class ten. They started working at an early age in order to support their families and had no resources to complete their education. On the other hand, the migrant as well as non migrant labourers (from Group II) were either uneducated or

were not educated beyond primary (class five). One of the respondents from Khambra in Group IIAgriMix from Bihar said,

> *People who are educated know about the harmful effects of tobacco use like the kinds of diseases it causes. But people like us had no knowledge about it when we started and now we are addicted to it. (Male, 45 years)*

In the words of another migrant in Group IIMigrant from UP,

> *I am a graduate and I know about the tobacco ill effects when I was young and used to read and see it on TV that tobacco should not be used. It causes various diseases especially cancer. My education and my will power helped me to stay away from tobacco. (Male, 22 years)*

This statement highlights that health behaviour (tobacco use in this case) and the associated health outcomes in both the groups were extremely influenced by education levels which do not fall directly within the immediate realm of health care. The lower levels of education left them with little knowledge about the choices to be made in life and it in turn affected their health behaviour. The previous chapter had elaborated on the lack of BCC activities on tobacco use in the district. The anti tobacco campaigns in schools were also limited to the celebration of World No Tobacco Day in the district. Thus, a robust anti tobacco campaign in media and in schools helps adolescents to make informed choices in life.

6.2.2.2. Income

The patients of oral cancer (in Group I) were working in the unorganised sector or on contractual basis. The monthly income of the patients was less than Rupees ten thousand and they belonged to lower middle class families. The family was dependant on them for earnings and after diagnosis of cancer they had stopped working.

In words of a Group I patient,

> *I used to work in electricity department on daily wages and used to earn Rupees 4500 per month. Now with this disease there is a lot of burden on my family for my treatment expenses. (Male, 44 years)*

Another patient from Group I said,

> *I used to work as security guard with monthly earning of Rupees 6000 in private sector. There is no other source of income to us. I feel guilty of putting this pressure on my family. (Male, 44 years)*

The labourers working in unorganised sector in Group IIMigrant and IILocal were being paid on daily basis and their earnings were also less than ten thousand per

month. Those working in the agricultural sector (Group IIAgriMix) earned less than those working in urban areas in the unorganised sectors. The discussion on income was a sensitive topic in all the groups and the researcher did not force them to give an account of their earnings unless they specified themselves. In words of a migrant labourer in Group IIAgriMix from Bihar,

> *We earn only to make both ends meet. How much a farm labourer earn you know that. Our income leaves us with only money to buy essential items. We collect our money and go back home when the season is over. (Male, 55 years)*

Due to lesser earnings, the use of smokeless tobacco, which is a cheap alternative to *bidi* and cigarette, was more pronounced in the groups. Moreover, this occupational life of the respondents involved human relations and networks which influenced their choice of health behaviour.

6.2.3. Collective social practise of tobacco use

This section draws attention to how the use of tobacco maintains social identity of the users within their groups. It also emphasises that the act of tobacco use is a social activity which determines the initiation as well as continuation of its use in the social environment of the group of participants.

6.2.3.1. Peer pressure

Both the groups said that they started consuming tobacco in adolescence due to peer pressure to fit in their circle. Punjabis across the groups including oral cancer patients as well as labourers said that they consumed tobacco for first time under influence of their friends when they started working or hanging out with those using it. The migrant labourers on the other hand said that the consumption of tobacco was prevalent at their native places and they started using tobacco in smokeless form. Both the groups used to hang out with peers with same family background and the same income level. The decision to use tobacco was toughened by the desire to be accepted and establish an identity in their social group. They consumed tobacco and made friends with those who enjoyed the same habits making them realise that using tobacco was normal. In the subsequent years of life they got addicted to use of tobacco and continued its use. A patient in Group I said,

> *I was very young, around 12 years when I started consuming tobacco and continued doing so even after I got married. My wife and my children asked me to quit but I*

lacked will power to do so and now I have landed my whole family in trouble. (*Male, 44 years*)

Another patient said,

I was employed as a security guard and I have retired from army. I started using chewable tobacco when I was in army under peer pressure. My family discouraged me from taking tobacco and alcohol but I did not listen to them. (Male, 52 years)

A migrant labourer from Group IIMigrant said,

I was around ten when I first used tobacco in smokeless form with my friends and after that there was no looking back. I have been using tobacco since 20 years now... (Male, 30 years)

6.2.3.2. Influence of parents and tobacco use in migrant labourers

The labourers across different groups in the discussion mentioned that the influence of elders in the family who used to consume tobacco was also influential in determining their habit of tobacco use. A migrant labourer from UP in Group IIMigrant said,

Everyone in our family consumes tobacco and it is not considered a taboo. When we entered adolescence we also started consuming smokeless tobacco with our friends. Even in our family the elders used to consume smokeless tobacco or smoke bidi. For us it was a natural way of life. We did not know about its effects on health when we started its use.(Male, 28 years)

In the words of another migrant from Bihar in Group IIAgriMix,

If parents are consuming tobacco in any form, their children will consume tobacco. Parents should set an example of not taking tobacco so that next generation is not addicted.(Male , 55 years)

The patients of oral cancer and the Punjabis from the labour class did not talk about the role of their family members consuming tobacco in any form. It is interesting to note, as mentioned earlier, that in Punjab the use of tobacco is a taboo and openly using tobacco has not been a part of Punjabi culture. In the migrant labourers on the other hand, it was an intergenerational transmit of habit of tobacco intake. In their early adolescence they saw their family members using tobacco and which conditioned their young minds to initiate use of tobacco at an early age.

6.2.3.3. Role of culture

The Punjabi labourers held a view that the use of tobacco is not as prevalent in Punjab as is in the native states of UP and Bihar of the migrant labourers. Punjabis said that the culture of tobacco use percolated from the migrants who started working in the farms as well as industries in the state. When they worked together they consumed

tobacco in groups in order to take a break from the hectic routine. The Punjabis in Group IIC from Pholriwala were also of the view that the migrants have moved into their place of residence and established a number of kiosks on the periphery of the villages selling tobacco in varied forms. A Punjabi labourer from Group IILocal said,

> *Till the migrants are here the use of tobacco will increase. According to a government survey you say that the use of tobacco has increased in Punjab. Did the government make a data base on how many migrant labourers in Punjab consume tobacco? It is their culture. Punjabis take alcohol but not tobacco.(Male, 20 years old)*

The group in Pholriwala constantly denied Punjabis consuming tobacco in any form and felt non acceptance for the migrants in their area. They believed that migrants have tainted the culture of Punjab. Although some of them had their teeth stained with tobacco use (observed by the researcher), when confronted they said it is an occasional use and were not ready to elaborate on it. The migrant group on the other hand denied that their movement into the state polluted the Punjabi culture. A migrant labourer in Group IIMigrant said,

> *From the time we have met Punjabi labourer they have been eating tobacco even before they met us. Then how are we to be blamed for tobacco culture in Punjab? It is just that they are not open about its use but they also consume in same quantities as we do. (Male, 28 years)*

Another migrant from same group said,

> *Punjabi people smoke near the kiosks and go home. They do not keep packets of cigarettes with them. We are more open to tobacco use in our culture. (Male, 50 years)*

6.3. TOBACCO CONSUMPTION AND ITS EFFECTS

Tobacco consumption not only causes detrimental influence on health but also puts economic burden on tobacco users and compromises the basic health needs of the family. Moreover the use of tobacco in varied forms (smoking as well as smokeless) is considered as risk factor for different disease profiles. For instance, the use of smokeless tobacco is associated more with the diseases of the oral cavity and smoking tobacco is considered to be risk factor for various lung diseases. The following sub sections elaborate on the various types of tobacco consumed in the groups and affect it had on the users.

6. 3.1.Type of tobacco consumed

The various types of tobacco use within and across the groups, the differences as well as its similarities speak to the previous sections on the social and the cultural context of tobacco use. Nonetheless, it is also important to study how different forms of tobacco use alone or in synergy with other products of substance abuse were being used by different groups of respondents.

6.3.1.1. Use of tobacco and alcohol in oral cancer patients

The patients of oral cancer used tobacco in smokeless form and consumed one to two pouches of smokeless tobacco daily. Seven out of ten respondents admitted to using alcohol along with tobacco which gives a synergetic effect and is seen as the biggest risk factor for oral cancer. However, they were not aware of the effects of tobacco use on oral cavity.

A patient from Group I said,

> *One of my relatives has been working in an alcohol factory for many years. He stays close to my house and we used to meet in the evenings for a drink and the use of smokeless tobacco was otherwise also a daily routine. Now the doctor told me that prolonged use of alcohol and smokeless tobacco were the major factors, in fact the only factor, for pushing me towards this deadly disease. (Male, 44 years)*

The hesitation to smoke tobacco in the group was more than use it in smokeless form (*gutka*). The reason for using smokeless tobacco was that unlike smoking its use was not prominent and they did not have to worry about acceptability in society of Punjab. In addition, the use of alcohol in Punjab is widely prevalent and the society has not been as repulsive to use of alcohol as it has been to tobacco.

6.3.1.2. Dual use of tobacco in migrant labourers

The use of tobacco in the migrant labourers in all groups was in the form of smokeless tobacco product *(gutka*) or *bidi* smoking or both. A few migrant labourers also consumed *paan* with tobacco which is not widely used in Punjabis. The kiosks in the district being run by the migrants provided *paan*, the sale of which was nowhere to be seen in the shops providing tobacco in rural area. The migrant labourers were also sceptical about the quality of tobacco being sold in the state. A migrant labourer in Group IIAgriMix from Bihar said,

The tobacco being sold in Punjab is synthetic in nature and not in its purest form. In our place in Bihar we grind it ourselves and prepare it in the purest form. The synthetic tobacco is not good for health and it cuts through the oral mucosa of those consuming it.(Male,50 years)

In words of another migrant in Group IIMigrant from UP,

I started the use of tobacco at a young age in smokeless form. I now smoke bidi when the pouch of smokeless tobacco is finished. (Male, 28 years)

Another youngster from UP in the same group said,

I do not consume tobacco in any form. These days' people are getting aware about the harmful effects of tobacco use. But some people around me consume tobacco in smokeless form and smoke bidi too. New generation uses cheap cigarettes to fulfil tobacco craving. (Male, 22 years)

6.3.1.3. Quantity of tobacco used daily

The respondents from both the groups used to consume smokeless tobacco ten to fifteen times in a day. After the dissolution of tobacco in the oral mucosa, they would again put the smokeless tobacco in the same place in the vestibule (the space between the cheek and alveolar mucosa) of mouth. Some of them also smoked *bidi* as well as used smokeless tobacco.

In the words of a migrant labourer in group IIMigrant from Bihar,

I consume gutka as well as smoke bidi whenever I feel like. The use of smokeless tobacco is more as compared to bidi smoking. Once my smokeless tobacco dissolves, I resort to bidi smoking. Both these options are cheap as compared to cigarette and I cannot afford packets of cigarette daily. (Male, 28 years)

In words of oral cancer patient,

I kept tobacco in my oral cavity throughout the day for ten times I think. The moment it dissolved I used to put it again as one packet can be used for two days which depends on how many times you use it.(Male, 40 years)

The above excerpt validates the fact that more frequently the smokeless tobacco is used more are the odds of getting oral cancer. However, there are very few studies in literature in India which provide information about the relation between the frequency of use of smokeless tobacco and oral cancer.

6.3.1.4. Use of tobacco for medicinal purpose

Tobacco for medicinal purpose was exclusively used by migrant labourers from Group IIAgriMix and IIMigrant. Migrants brought out an interesting revelation that some of their friends back home started using tobacco when they experienced tooth

ache and people suggested to put tobacco in the vestibule to relieve pain. Of the entire research and field visit conducted, two respondents from both groups said that they used tobacco for medicinal purposes in the initial years of life for easing toothache and pain in gums. In words of a migrant labourer from Bihar in Group IIAgriMix,

> *I got addicted to tobacco when I first used it to relieve my toothache when I was young. Thereafter, I started consuming tobacco and still consume it.(Male,50 years)*

Another respondent from UP in Group IIMigrant said,

> *Once, a compounder at a clinic asked me to use tobacco to relieve bleeding in my gums. Moreover people from UP who eat paan use tobacco in it. Some people also think that paan helps in digestion of food. (Male, 25 years)*

6.3.2. Effects of tobacco use

Apart from the harmful health effects of tobacco use, there are other effects of tobacco use which affect the efficiency of the person consuming it daily. These effects can be ability to concentrate better after consuming tobacco or compromising the basic needs of the family by spending money on tobacco. That being said, the respondents were not aware of these effects in early years of life which addicted them to tobacco use.

6.3.2.1. Effects of tobacco use in everyday life

Due to addictive nature of tobacco, its use became a routine in both the groups which helped them concentrate better on their daily activities and non use made them crave for more. When asked about their knowledge on the deleterious effects of tobacco on health, they said television was seen as an important medium for communicating the messages regarding the use of tobacco. Despite being aware of the ill effects of tobacco use the respondents were not successful in quitting the use of tobacco.

The Punjabis in both the groups had differences with their families over indiscriminate use of tobacco but they did not stop using it. The oral cancer patients got to know about the effects of tobacco use when they were detected with the disease. Their resentment on prolonged use of tobacco was not sympathised by their family members who thought that quitting in time could have saved them and their family from unnecessary discomfort. The patients acted as counsellors to those visiting them, telling everyone not to indulge in the use of tobacco at any stage of life.

A patient (Group I) elaborated,

> *I knew that tobacco use is not good for health but I was never given any professional counselling even when I used to visit doctor for any minor ailments. Though my family tried to convince me to quit using tobacco I did not listen to them and argued with them. The government started this campaign in media on that tobacco use causes cancer. Although I noticed the advertisements I thought that I cannot get this disease as I do not consume too much tobacco .I never knew that not only the dose of tobacco but its prolonged use can also cause cancer. I was under the misconception that if I did not get any diseases since so many years it cannot happen to me in this life. There are other friends of mine who consume gutka but they are healthy and fine. (Male, 40 year)*

Another patient from Group I said,

> *When I started using tobacco there was no TV at our place and we had no information about what happens if one uses tobacco for long. So we continued to use it. Now the media is very informative and everyone knows that use of tobacco causes cancer. I had quarrels with my family over this habit of tobacco use. (Male, 52 years)*

Another Sikh labourer from Group IIAgriMix said,

> *My wife tells me not to use tobacco as it is not allowed in Sikhism. She is baptised and prohibits me from using tobacco but I never listened to her. (Male, 50 years)*

The migrant labourers on the other hand did not talk of any differences with family due to tobacco use because its use was a part of their culture. Most of the people consume tobacco in varied forms in that culture which is not seen with so much contempt as in Punjabi families.

6.3.2.2. Economic effects of tobacco use

Both the groups were users of smokeless tobacco (*bidi* too in case of migrants) and had been using it for long time. They were from low socio economic status and worked as workers on daily wage. At the age of initiation, the cost of smokeless tobacco was as low as two rupees per pouch which was not a burden for the users. As the cost of tobacco increased in the subsequent years so did their earning and spending rupees five to ten on daily use of tobacco did not compromise the basic needs of the family.

A patient from Group I mentioned,

> *Smokeless tobacco does not cost much and sometimes one sachet of tobacco can be used for two days. It depends upon how many times the person is consuming tobacco. Otherwise the cost daily varies from ten to fifteen Rupees which is affordable and I did not have to compromise on the daily expenditures of the household. (Male, 45 years)*

Another Group I patient said,

> *The sachet of smokeless tobacco used to cost Rupees two when I started it and now it has increased to Rupees ten. It is still affordable as the sachet runs for two days. So it does not cost much to us. (Male,52 years)*

In words of another patient,

> *Despite being from a low socio economic background, the use of tobacco never compromised the basic necessities of my family due to its cheap selling price. Although you could say that I could buy more food for the same money spending around 20 Rupees per day amounts to Rupees 600 per month which made no difference to my family budget. Sometimes one sachet of tobacco was extended to the following day making the expenses lesser. (Male, 54 years)*

The group of labourers also echoed the same thought that cost of tobacco did not deter them from using it and they also shared it within their groups making it cheaper to use. A migrant labourer from Bihar in Group IIMigrant said,

> *The smokeless tobacco is cheap and does not cost more than ten Rupees. The packet can be used for two days also and we also share tobacco within the group if the packet finishes. (Male, 28 years)*

The lesser price of smokeless products as mentioned in the previous chapters due to lesser taxes and less stringent rules as compared to smoking tobacco make its procurement as well as its use easy and cheap. Also the use of smokeless tobacco does not need any paraphernalia as matches or lighters which further reduces the cost of its consumption.

6.4. SOCIAL SUPPORT AND BEHAVIOUR CHANGE

The change in the health behaviour, tobacco use in this case, is determined by supportive social environment which includes the support of family, friends as well as the decisive power of the individual to choose for himself and make decisions on quitting tobacco use. This support helps to positively influence the health behaviour and can be extremely beneficial for someone wanting to quit tobacco. This holds true for respondents across the groups, few of whom quit, few tried and most of them expect oral cancer patients were unsuccessful in quitting.

6.4.1. Support of family and peers to quit tobacco use

Although this subsection details the quitting of tobacco use there are major differences in why the two groups quit or continued the use of tobacco. The patients of oral cancer (Group I) quit the use of tobacco only after contracting the disease. Any

previous efforts at quitting failed because of lack of will power as well as motivation. The dialogues with the family as well as friends (who were not tobacco users) were seen with contempt and interference in one's life. Any thoughts on quitting were warded off in the company of peers who consumed tobacco and alcohol. While some patients blamed the addictive nature of tobacco as major reason for not being able to quit, some were resentful that they did not listen to advice of their families. In words of patient in Group I,

> *I tried to quit when my children starting telling me how bad it was for my health to consume tobacco in any form. Although I succeeded for few days, I could not hold back the use since I had been addicted to it and used it for stress relieving for almost twenty years which I regret now.(Male,40 years)*

Wife of one of the patients said,

> *He used to quit for few months and then again used to start consuming it. Now when he has been detected with oral cancer he has quit the use. We used to quarrel with him; even our children used to tell him to stop using it. (Female, 45 years)*

A patient said in remorse,

> *My kids asked me to quit and I had stopped using it few years ago. But the use of smokeless tobacco had done its damage and I am suffering from this disease now. (Male 54 years)*

The labourers (migrants as well as Punjabis) on the other hand were disease free and going back to tobacco use was not difficult for them. Some said that they quit the use of tobacco but the group they used to hang out with influenced them to using tobacco again. The group believed that a strong will power is required to quit the use of tobacco and they have become habitual to its use. Once they start using it, they cannot live without it and need its regular supply.

In words of migrant working in Group IIMigrant from UP who worked as a security guard in an insurance company,

> *I take bidi at times but when I am at my workplace I cannot smoke or consume tobacco in any form. It is strictly prohibited in the company area. I have not quit totally but I have reduced the use of tobacco because of my work place culture. (Male, 30 years)*

Another migrant from same group said,

> *I tried quitting tobacco and did not consume it for sometime but at work my friends used to force me to share smokeless tobacco with them. Firstly, I tried saying no to them but they knew that I had been consuming tobacco for long. I finally gave in and started using tobacco again. I have not been able to quit and I think one needs strong will to stop using it. (Male, 28 years)*

The role of social support in the informal settings of home or workplace plays an important role in motivating the users to quit tobacco use. Tobacco was seen as an effective coping mechanism by the users to deal with stresses of everyday lives, as mentioned by one of the respondents. On the other hand, having friends using tobacco in social circle impedes the process of tobacco cessation. Both the groups were from low socio economic backgrounds which precipitates work place stress as well as family responsibilities with limited income. Apart from the social support the individual's own personality to handle withdrawal of tobacco and associated anxiety which increased the risk for relapse and re-use, plays an equally important role.

6.4.2. Individual factors and Unrealistic optimism about tobacco use

The lack of the will power to quit the use of tobacco despite getting the social support was one of the major factors for no change in the tobacco use behaviour by most of the users in both groups. However, a Punjabi from Group IIAgriMix said,

> *I consumed tobacco for fifteen years but now I have quit its use. But people around me still consume it and do not quit. You need strong will for quitting tobacco and support of those around you. (Male, 40 years)*

Moreover, oral cancer patients said that earlier they lacked the determination to quit the use of tobacco. They knew that it causes oral cancer because the pouches of tobacco have warning symbols on them. However, they were positive that they would not get the disease but later blamed their non change in health behaviour as the major factor for fatal disease. A patient in Group I said,

> *I never noticed any kind of warning on the tobacco products because I have been using it for years. I have never tried to interpret or look into these warnings. I got to know about them when I was detected with oral cancer. The picture on the product which I did not pay attention to was actually a warning. (Male, 50 years)*

Another oral cancer patient said,

> *I know there is pictorial warning on tobacco products that it causes cancer. I have seen it but I was so addicted that I never thought that I can get cancer. I thought I do not use it so much that it will cause cancer. (Male, 40 years)*

This unrealistic optimism among patients of oral cancer referred to the underestimation of likelihood of experiencing negative emotions, disease in this case. It was not surprising that tobacco users individually exhibited such optimism. Thus, the continued use of tobacco before contracting oral cancer showed that the patients not only viewed tobacco as risk factor inaccurately but also were less interested in the

risk information. Thus, they did not change their risk perception in response to information that was being provided through warning labels on tobacco products.

6.5. IMPACT OF ORAL CANCER ON PATIENTS

The pain and suffering associated with oral cancer ranges from physical pain due to the disease, mental and emotional pain due to the changes associated with relationships and financial pain due to the cost of the treatment. This section on impact of oral cancer speaks to previous section on indiscriminate use of smokeless tobacco and living in risk denial. Although Group II spoke about cancer as detrimental effect of using tobacco, this section includes experiences of oral cancer patients as part of discussion.

6.5.1. Detection of oral cancer and associated grief

The patients experienced pain due to ulceration in the oral cavity in the initial stages of the disease. The symptoms were ignored for few days as ulceration in the mouth was considered normal but continuous pain in the oral cavity made the suffering associated with it intolerable for which they consulted a general practitioner. The patients were given normal medication in form of topical ointments and other anti-inflammatory drugs. Most of these patients were from the rural areas of Punjab where general practitioners or Registered Medical Practitioner (RMPs) were easily available as compared to a dentist. They visited dentist on subsequent increase in size of ulceration, who then referred them to an oncologist. An oral cancer patient said,

> *I noticed ulceration in my mouth during the initial stages which I thought would heal with time. But it grew more painful, increased in size and did not heal. I went to a general practitioner who then referred me to a dentist. (Male, 54 years)*

In words of another patient,

> *I went for tooth extraction for the swelling in the lower molar area of oral cavity. The swelling did not subside after extraction; so biopsy was done which confirmed my case of oral cancer. (Male, 40 years)*

They could not believe that they had been detected with oral cancer and this drove them into agony, restlessness and self guilt. It had become difficult for them to accept the reality. In initial days of detection they did not feel like interacting with anyone from outside or within the family. Some of them were not able to face their children who had stopped them for consuming tobacco and even warned them of the health consequences of tobacco use, cancer being one of them.

6.5.2. Cancer related emotional distress after treatment

The patients suffering from oral cancer experienced feelings of regret and remorse for putting themselves and their family in trouble. The questions which arose in their minds were about the hardships of their disease and its affect on their families. However, later they felt that instead of repenting it would be better to counsel and spread awareness amongst those around them on tobacco use. In words of wife of a patient,

> *It is emotionally and mentally draining for him as well as the family. Our children are young. Since he had a surgery of his tongue he cannot communicate properly. His inability to communicate properly makes him mentally unwell and sad. Our children have been affected by this disease process. (Female 42 years)*

An oral cancer patient said,

> *The family was devastated with the news of oral cancer and we are still coping with it as much as we can. I ask people to not use tobacco in any form. (Male, 54 years)*

Another 38 year old patient's father said,

> *There are emotional costs of cancer...his shop is looked after by his wife. The kids cannot concentrate well on their studies. (Male, 65 years)*

Moreover, the oral cancer patients interviewed were male members and were the sole bread earners of the family. Their disease prevented them from working or spending time with friends at workplace which exaggerated their insecurities and emotional turmoil. The disease put a great financial burden on their families which either the spouses were sharing by working or they were being helped by the relatives with the finances.

6.5.3. Cost of treatment in private hospital

The cost of the treatment for the patients from Punjab under Below Poverty Line (BPL) is covered under MMPCRKS. As stated earlier, patients of cancer are given an amount of Rupees one and a half lakh by Punjab government. But the cost of treatment not only involves the money spent on medicines and surgery but also includes cost of travelling and the cost of missing a day's work for the working family members who accompany the patients. The economic burden of oral cancer was huge for the patients and their families and they sought financial support from their relatives. Despite the assistance from government, the private hospital had high costs

of treatment, enough to push the patient into debt and helplessness. In words of an oral cancer patient,

> *The family has borrowed money from relatives for my treatment as we cannot afford such hefty amount in the private sector. The government sector has lot of waiting time and they do not provide a personalised care as seen in the private hospital. Apart from the treatment costs, there are miscellaneous costs as the cost of travel and loss of wages for those who accompany me to hospital for my treatment. (Male, 40 years)*

Although all the patients were referred to tertiary sector public hospitals, they had low level of trust in the government settings due to vulnerabilities and disempowerment of their socio economic status. They reported that they were not treated properly nor were their queries were answered in the government hospitals. Moreover, the treatment for cancer is considered to be riskier medical procedure for which the patients were not ready to take a chance in the government settings. They also complained of rush and increased waiting time in the government hospitals.

6.6. VOICES OF LABOURERS ON ROLE OF THE GOVERNMENT IN PROMOTING TOBACCO USE

While closing the discussion Group II was vocal in highlighting the role of government in promoting tobacco use. As mentioned in the previous chapters, there are various loopholes in the way the District Administration checked the use of tobacco. The voices of the group emphasised that use of tobacco cannot be seen only as an individual choice but the sale and the easy availability of tobacco in the district and the administration turning a blind eye to it, is a major factor in continued use of tobacco by the population.

6.6.1. Tobacco sale to the minors

The sale of tobacco to minors has been a subject of debate with the kiosk holders during the process of data collection. The kiosk holders had denied selling any form of tobacco to minors. But in FGDs, the labourers talked about their observation on kiosk holders selling tobacco products to the minors too. In words of a migrant in Group IIAgriMix from Bihar,

> *The sale of tobacco to children is banned but we have seen kiosk holders selling tobacco products to minors. The kiosks also display sweets and other items which attract children and have tobacco products being displayed at the same place. This makes the children curious. Sometimes children come asking for tobacco for their*

parents. The kiosk holders do not enquire about it and give them tobacco. (Male, 55 years)

The groups said that the District Administration was a failure in curtailing the sale as well as use of tobacco. Everything was on paper and in field every banned tobacco product was being sold to minors. Sale of these products to children in young age addicts them to tobacco use and longer the addiction, lesser are the chances to quit.

6.6.2. Liaison with the tobacco producers

The respondents in the group of labourers were of the view that government collects taxes from the sale of tobacco on one hand and runs program for controlling the use of tobacco. The group was vocal in saying that the government did not want to stop youngsters getting addicted to tobacco use so that the youth gets hooked to these vices and not ask for employment opportunities. The local labourers wanted the district administration to work in the communities on ground level to strictly contain the use of tobacco. In words of migrant labourer in Group IIAgriMix from Bihar,

Government is equally responsible for this addiction to tobacco. It is earning revenue and the companies are making money out of it. The government is corrupt. Only it is to be blamed, no one else. There are kiosks selling tobacco everywhere. If the supply is checked then no one will sell it. The use of alcohol has decreased in Bihar because the government banned it. Why not do it with tobacco? (Male, 55 years)

Another migrant labourer form UP in Group IIMigrant said,

The government is confused. It has increased the taxes because it knows people will not stop consuming it. Hence it will increase the earning of the government. (Male, 28 years)

6.6.3. Lack of BCC activities

The labourers agreed that when they started using tobacco they had no access to information. They did not know about the harmful health effects of using tobacco and they could not seek help if they wanted to quit. They were of the opinion that the government should provide information in detail to the youngsters to prevent them from falling prey to use of tobacco. The Punjabi labourers residing in the villages said that there were no health talks on the use of tobacco in their village and there was a lack of timely dissemination of information to youngsters, highlighting the failure of the government in engaging the communities in tobacco control. In the words a Punjabi labourer in Group IILocal,

I remember there have been health check up camps in the village but there has been no health talk on the use of tobacco. No special teams have visited the village to provide knowldege on tobacco use. (Male, 24 years)

Although all the respondents are from low educational level and low socio economic background yet they were aware that government plays an equally important role in modifying the health behaviour of the population. Given the age of the population, Tobacco Control Program is a recent program and was started in Punjab in the year 2012 which could be another reason for the lack of information. Nonetheless, the BCC activities at present were not as regular as they should have been in the district.

CONCLUSION

The case of Punjab is peculiar because of the socio demographic as well as health profile of the region which has changed since Green Revolution. The perception created around the number of cancers cases, has seen the draining of state health budget into cancer control. Provisioning of funds to those who cannot afford cancer care is a band aid solution to the subject of cancer in the state. Moreover, lack of a uniform data base is a big drawback for the government to initiate action and control on cancer. In addition, the health system in the public hospitals is not conducive to the needs of the patients suffering from life threatening diseases as cancer. Having said that, use of tobacco is a social phenomenon and it becomes important to place tobacco in a social context. Moreover the variations and similarities of tobacco use within the groups based on socio demographic and socio economic profile of the respondents determine the type of tobacco used and its predisposition to disease. In addition, the role of social support in changing the health behaviour of the population is equally important as the individual level efforts to quit use of tobacco. That being said the role of the government to intervene in the early stages of tobacco use and take into account the social context of tobacco use in controlling its spread is of prime significance.

CHAPTER 7

DISCUSSION AND CONCLUSION

INTRODUCTION

This final chapter is a reflection as well as critique of the Tobacco Policy, its translation and the role of various stake holders involved in tobacco control in the district. It tries to interlink all the major themes with each other and emphasize that nothing related to tobacco control can be seen in separate compartments. The discussion is not only related to the established literature and its relation to the present study undertaken by the researcher but is also a critical analysis as well as expression of the researcher's reading of the data. There are certain domains in tobacco use and control which the researcher found have not been addressed adequately in the study district. The findings from the study field, relating them to existing concepts for the broader themes of the study and critically analysing the same, form an important skeleton for this chapter. Although in the previous chapters some comments as well as analysis of the themes have been explicitly written about, this chapter is focused on the main findings from the study. These main findings are not confined to their boundaries and keep speaking to each other throughout the writing. In addition, the use of word tobacco is a blanket term for all the kinds of tobacco used unless specified. Also the use of the term district refers to district Jalandhar where the study has been carried out.

The chapter is divided into six sections to present studies in India as well as globally which relate or establish contrast to the present study. These various sections accommodate intra and inter country experiences on the subject of tobacco control as well as its use. The gaps which the researcher has stirred out of her present understanding of the subject and experiences from field can direct the future course of research on tobacco. The first section deals with the politics of inter departmental coordination for tobacco control in the district. This section specifies the importance of inter department synchronisation and how it effects the tobacco control as well as its use. The findings from the field and its relation with various studies help to detail the section with clarity. The second section deals with integration of Tobacco Control

Program with other health programs which are of help in curbing the use of tobacco across different ages and genders relating it with the experiences from the field.

The third section details the response of the Health Department to various measures of tobacco control as tobacco control is primarily considered the duty of the Health Department. The fourth section is based on the influence of tobacco industry on tobacco control measures in the district. The manipulation by the industry and failure of the administration to deal with it while looking across experiences from Indian and other countries form an important part of this section. The fifth section builds on oral cancer and the social correlates of tobacco use in the district. This segment charts out the differences in tobacco use across groups in the district as well as the impact of oral cancer on the patients. The last section lays out policy implications for future research on the topic of tobacco use and its control specifically targeted at the state of Punjab.

7.1. POLITICS OF INTER DEPARTMENTAL COORDINATION FOR TOBACCO CONTROL

The Tobacco Control Program in the district was not on the priority list of the government as told by officials from different departments. This corroborates with the fact that the decisions made by the policy makers are usually dependant on limited information and ambiguity which in turn is based on the fact that the ways to understand the policy problem and the competition among the actors to address the same can be different (Zahariadis, 2007, p.66). They do so by holding on to the information they are provided by their trusted sources and adapting the information to their already held beliefs about the subject. They reveal their biases towards certain sources of evidence which may be more important than the nature of evidence itself (Cairney, 2016, p.6). This biased attitude for Tobacco Control Program in the district was responsible for the lack of comprehensive approach to the subject of tobacco control.

The Health officials, Health Officer in Municipal Corporation and DSP in Police department mentioned strongly about the lack of political will and inter department coordination in the district. In an environment that is already political in nature, the evidence is rarely conclusive and persuasion and arguments are the tools used by the policy participants in order to resolve a problem (Sanderson, 2009, p.712) which was not the case with the departments in the district. The officials collectively were of the

view that despite the program in place; it was not the top priority of the Punjab government. This helps to identify issues which hold the top priority in the agenda of the policy makers. It is not only about the evidence but how problems are framed by the advocates and how they are comprehended by those responsible for delivering solutions to the same. Elaborating further, it is about the power to selectively pay attention to certain studies, to link the evidence of the policy problem to convenient solution and ensure that the policy makers have the required motive to turn the solution into policy (Béland, 2005). In case of Punjab there was a dearth of literature on holistic approach of the Tobacco Control Program at the district level which was another reason for the policy makers not paying attention to the comprehensiveness of the program.

Also, the lack of coordination across departments in the district was responsible for policy not being tailored or implemented taking into account the varied demographics of it use. This elaborates the fact that the process of policy making is not as linear as it seems. There are various problems with the agenda of policy namely the evidence based policy making, the cognitive capacity of the policy makers and the unpredictable policy environment. It becomes customary to identify the series of policy stages which are linear in nature starting from agenda setting, policy formulation, legitimating, implementation, evaluation and policy maintenance, succession or termination (Cairney, 2012, p.33). However in reality, these processes are made in a cyclic form, therefore the assumed linearity gives a misleadingly simple impression on how policies are made and hence implemented (Lomas & Brown, 2009, p.914).

The district had an active Tobacco Control Program but the inclusive nature of the program remained questionable. Although officials involved in tobacco control were working with the given resources to improve the scenario, the state government had not tailored it according to the type of tobacco being used and the demographics of the population in the district. The targeted interventions for migrant and local population were completely missing in the district. A study done in Poland indicated that due to extensive measures of tobacco control taken by the government of Poland , the diseases associated with use of tobacco reduced as well as the health of the population improved. Although the government was still working on improving the

Tobacco Control Program but through a dedicated program it was able to bring initial changes in the health profile of the patient (Zotanski, Zatonski & Prezwosniak, 2013). A strong will like this leads to drop in the consumption of tobacco and those using tobacco; who then get more active in the community which might lead to increased economic activity and growth (Yach, 2001). Although there is a global treaty and the subject of tobacco control has come a long way, yet India has not been able to bring tobacco control from the backburner of political precedence to the forefront of global agenda and form it as a part of sustainable development (Reddy et al., 2012). The officials also complained of lack of political will and no involvement of policy makers in Tobacco Control Program in the district. As a result, departments other than health adopted a callous attitude towards the program. A strong political commitment as well as inter department coordination needed is still missing for tobacco control process (Malhi et al., 2015).

The hiatus in the policy context is observable in the district where various departments were involved in their respective duties of tobacco control but due to inter department politics there was a loss of coordination in the field. Despite National Tobacco Control Program in existence, it was the Health Department in the district which was actively involved in the efforts of tobacco control. The lack of coordination and cooperation between various departments acted as a deterrent for tobacco control at district level. Inter department coordination is vital for implementation of various measures. For example, taxation of tobacco products is an effective tobacco control measure which requires coordination between the finance and commerce ministries. Similarly education ministry should recognize the importance of teaching role of tobacco as a harmful substance to youngsters. It is also important that the tobacco control policies tailored by the states are in accordance with the national priorities for tobacco control. In addition, the district of Jalandhar had no active NGO participating for tobacco control. A wider social movement as well as the role of NGOs along with other department is also considered necessary for the tobacco control on a comprehensive level (Reddy et al., 2012).

Similarly, the efforts of the government in controlling the menace of tobacco hold no importance if it does not think of providing alternate employment for those involved in sale of tobacco products. Kiosk holders in the district were of the view that

government should try and provide alternate employments to those selling tobacco instead of fining them. Being a signatory to the WHO FCTC, India's Agricultural Ministry can look for economically viable crop diversification options for tobacco growers in India. Studies in various states have shown that in order to create an alternative to tobacco crop, basic infrastructural facilities of irrigation, transportation, fertilizers , markets and roads etc. and technical support needs to be created for the farming community by the Ministry of Agriculture along with the agriculture universities in the country. In addition, extensive support by the government in order to provide safe options for the farmers can help them to switch over to the other forms of cropping (WHO, 2015). However, literature on providing any kind of alternate employment to those selling tobacco in kiosks in Punjab or India could not be found.

Moreover, problems faced by the officials involved in Tobacco Control Program in the district were not addressed by the state government or the policy makers. The various problems being faced by the officials were the expectations about their job performances, availability of the resources and threat to their authority when they visit the field to check working of tobacco control measures. The health workforce was already crunching under the workload of other health programs and was not adequately trained for their duties enlisted in the Tobacco Control Program. In addition, the officials had to face confrontation by the offenders in the field who were not ready to pay fines for breaking rules under COTPA, 2003.

Michael Lipsky, a political scientist coined the term Street Level Bureaucrats (SLBs) for such "public service workers who interact directly with the citizens in their course of job and have substantial discretion in the execution of their works" (Lipsky,1969). In the district Health/Sanitary Inspectors and Nodal Officers who went out in the field for tobacco control can be classified as SLBs. Lipsky also says that not only they have considerable influence in the lives of the people with whom they socialize to meet the expectations of the government services but also watch over the treatment citizens receive in government programs. In short, they are mediators of the legitimate relationship of the citizens to the state. The problems which these SLBs face arise from the lack of personal and organizational sources, physical and psychological threats and conflicting role expectations. Lipsky also notes that some of the SLBs are untrained and inexperienced (Lipsky, 1980) as was the case in district where there was no special training provided to officials working in the field for tobacco control.

Therefore, the ambiguity of goals and under training and nature of the job make it difficult for the SLBs to perform their job efficiently. They are in a dilemma on how to represent policy at their required level of job (Sanyanga, 2005). The burden of other health programs for those working in health department was another reason for their confusions on how to handle all programs efficiently. The district administration consisting of various departments working for tobacco control was more concerned in collection of fines than making it a holistic and well informed program. That being said, Tobacco Control Policy is seen as a regulatory policy in which the regulation is a prescription by the government which must be complied with intended targets and failure to do so involves penalty (Howlett & Ramesh, 1995), substantiating the technical approach to fine collection for curtailing tobacco use in the district.

7.2. TOBACCO CONTROL PROGRAM'S INTEGRATION WITH OTHER PROGRAMS

The School Health Program and Tobacco Control in district Jalandhar were confined to occasional lectures on adverse effects of tobacco use during health lectures in school in the age group of 12 to 18 years. The school students participated in sensitisation drives on World No Tobacco day but there was no addressal or professional counselling at the school level for students using tobacco. The teachers acted as counsellors and educated the children on various health issues in the district. Moreover, in district across the local and migrant groups the age of initiation of tobacco varied from 9 to 13 years. In order to curb early use of tobacco, school tobacco control policies can be effective in preventing the use of tobacco among students, need for tobacco cessation among teachers and teaching about tobacco prevention in the classrooms (Goldstein et al., 2003) because adolescence is the age when tobacco experimentation is frequently reported (U.S. Department of Health and Human Services, 1994).

The research established in the developed countries provides evidence of curbing the use of tobacco in schools by enforcing tobacco free policies in the schools (Pentz, Sussman &Newman, 1997). The School authorities in the district were concerned only for noting the presence of any kiosks within 100 yards of the school premises as sale of tobacco within this distance is prohibited. However, in the rural areas of the district tobacco products were being sold in the shops selling items of daily use. In the

rural area of Lambra, tobacco products in these shops were being sold in the vicinity of a school and the health authorities had never raided these shops for checking the sale of tobacco products. In India, evidence has shown that schools in the state of Bihar with Tobacco Control Policies have reduced the use of tobacco while those without this policy have higher use of tobacco both by the students as well as the school personnel (Sinha, Gupta & Pedneker, 2004).

Another need for the control of tobacco use in adolescence especially in the low and middle income countries is that the children in these countries will be largest to make transition into adolescence and adulthood. It can help prevent the use of tobacco in productive years of their lives (Khubchandani, Clark & Kumar, 2014). Moreover, both the reports of GATS (GATS 2009-10; GATS 2016-17) say that the women in India use tobacco in smokeless form which is culturally and socially acceptable at some places in India. These women initiate the use of tobacco in smokeless form from their adolescent age and it is continued in the adulthood which can not only cause oral cancer but also affects the reproductive health of the women. The School Tobacco Control Program can act as a stimulant in preventing the young girls from initiating the use of tobacco in young age (Begum et al., 2015). It has also been found that school policies on tobacco use and curriculum responsible for preventing tobacco use has been responsible for checking use of tobacco and promoting activism against tobacco (Reddy & Gupta, 2004).

Integrated within the School Health Program is the Oral Health Program under which the team of medical officers checks the overall health and oral health of the students in the district. The role of dentists in tobacco cessation in district is limited to dental fortnight camps during which they counsel patients on ill effects of tobacco. Despite this, the direct involvement of the dentists in the Tobacco Control Program is absent in the district. There is enough research evidence which says that integration of oral health in Tobacco Control Program is a vital step. The contribution of oral health professionals for Tobacco Control Program is vital and unavoidable. Their engagement with the community and providing cessation counselling forms an important part of tobacco control (Mehta & Kaur, 2012).

TCC or any activities were not present in the public health facilities of the district till the time of data collection. Also, in the district the oral screening for detection of oral

cancer was nowhere to be seen. As mentioned in previous chapter, the Health and Family Minister in 2017 blamed the previous government of not taking adequate action on oral screening in the state. This reassures that the political will of the Punjab government was inadequate in controlling tobacco menace and the resulting health implications of the same. The oral cancer patients in the district did not visit a dentist on noticing the symptoms of oral cancer. Instead they relied on local practitioners for treatment which delayed the diagnosis of cancer.

In dentists in developed countries have regular contacts with a large percentage of the population and can detect the adverse effects of tobacco on oral cavity which can be easily controlled. The tobacco cessation activities are as natural as the measures used for oral hygiene in the dental offices. But in developing countries especially in India dentists are fewer in number and national political commitment is required to achieve considerable gains. The WHO Global Oral Health Program contains several activities for controlling the diseases related to tobacco as well as emphasizes the need for community interventions in low and middle income countries. This helps in not only detecting the oral effects of tobacco use but also early screening for oral cancer (Kabasi et al., 2014).

Moreover, there is a complete lack of integration of Tobacco Control Program with other health programs in study district. The Senior Medical Officers at the CHCs admitted that there was no integration with other programs and stressed on the need for connecting the programs with each other. It is well established fact that tobacco is a risk factor for multiple diseases (Critchley & Unal, 2004), the integration of Tobacco Control Program with other national health programs is instrumental in providing for the judicious use of resources as well as prospects for intervention at primary and secondary level of care. This helps in reducing the illness addiction and death caused by the use of tobacco (Gritz, Sarna & Dresler, 2007). Though several countries have functional tobacco control program at national levels, they are frequently isolated from other health programs. The tobacco cessation services when integrated with the primary health services have a greater reach into the community. When a patient attends the clinic for Tuberculosis, RCH, NCD or any dental ailment, an enquiry about the active or passive use of tobacco by the doctor can help to increase the rate of tobacco cessation (MOHFW, 2005).

Tobacco cessation being a part of the Maternal and Child Health services as use of tobacco is associated with delay in conception, complications in pregnancy and outcomes as sudden death, pre term delivery and low birth weight (Centre for Disease Control and Prevention, 2011). Ante natal clinics can incorporate proper screening and counselling of pregnant mothers to avoid tobacco use and assist them in quitting (Kumar & Gautam, 2006). The officials interviewed believed that the women in the district do not consume tobacco in any form; hence tobacco cessation was not integrated with RCH. Also most of the officials blanked out when asked about the importance of integrating Tobacco Control Program with other health programs.

Moreover, under "National Framework for Joint TB-Tobacco Collaborative Activities" developed by Union Ministry of Health and Family Welfare, the Punjab government had started a pilot in December 2018 (The Pioneer, 2018) to link tobacco control with TB Program in the state, which was missing at the time of data collection in the district. Tobacco is considered as an important risk factor while designing and delivering the tuberculosis program (WHO, 2007). Half the deaths among tuberculosis male patients can be attributed to tobacco smoking in India, which has the highest burden of tuberculosis globally (Gajalakshmi, et al., 2003). The WHO Tobacco Free Initiative and WHO Stop TB program along with International Union Against Tuberculosis and Lung Disease integrated tobacco control into TB control program in Nepal which showed improvement in detection and management of TB cases with respiratory systems along with the recording of their smoking status and providing the cessation services (WHO, 2009).

7.3. HEALTH DEPARTMENT'S RESPONSIVENESS TO TOBACCO CONTROL

The Health Department concentrated solely on collection of fines under COTPA for smoking in public places and used the data to signify the success of the program. It is said that if the tobacco control interventions are not integrated into the health system, the cancers related to tobacco will impose a huge health burden (World Health Organization, 2010).The DTCC in Jalandhar conducted scattered activities regarding tobacco awareness on World No Tobacco Day. A similar study done in six districts of Andhra Pradesh resulted in the discussion about non utilization of work force in the health system for tobacco control activities (Panda et al., 2012). The present study in

Jalandhar and that in Andhra Pradesh as mentioned confirm that there has been no budgetary allocation for these activities of tobacco control. Due to this lack of funding, Non Governmental Organizations (NGO) in the district did not take initiative towards the subject of tobacco control.

Moreover, winning confidence of those using tobacco and raising awareness amongst them was being done at a very slow and random pace in the district. The officials admitted that the BCC activities for community's understanding of effects of tobacco use were carried out randomly in the district. The administration focused on the imposition of fines but made relatively less efforts to educate people and change their attitudes towards tobacco use. The counselling was provided during fining the offenders and little efforts were made to engage the community in BCC activities. This change in the behaviour along with stricter legislation can act as a stimulus for controlling the menace of tobacco. Counselling is regarded as one of the best practices in the process of tobacco control (CDC, 2007). Also, population level communication campaigns have been found to have significant public health impact and have found to be cost effective and feasible to implement in already resource crunched environment in low and middle income countries

(Turk, et al., 2015) and individually focused interventions for tobacco control have limited effect on influencing the tobacco use among populations (Klausner, 1997).

These community wide tobacco interventions have little to do with providing direct services to individual tobacco users but focus attention on employers, health providers, community leaders and politicians who have the position and power to implement policies that target the social norms about tobacco use in the population (National Cancer Institute, 1991). The local population as well as the migrants in the district used tobacco but there were no interventions which targeted these communities separately marking their social norms which controlled use of tobacco in these groups. It is acceptable that national and state level interventions have a role to play in tobacco control but local community intervention is the heart of the Tobacco Control Program. These community interventions tailored according to the needs of the community help to change the social norms that govern tobacco use (Cummings, 1997).

In the study, district authorities admitted that there was not only lack of resources in terms of manpower and funds for tobacco control but also the present human power was ill equipped to deal with the subject. This reinforces the fact mentioned earlier that Tobacco Control Program in the district is not prioritized as much as other programs. The respondents in a similar study however say that Tobacco Control Program should not be integrated with other programs as the purpose of the study gets diluted while some blame it on the government which they think was unsuccessful in integrating tobacco control with other programs (Persai, Panda & Gupta, 2016). In addition, the health programs which the program mangers handle in the district are of different design and size. Tobacco being low on priority is a concern not only for India but also for other developing as well as developed countries (Panda et al., 2012). The impact of the Tobacco Policy in Australia was considered insignificant due to improper translation of tobacco policy into practice as it was considered a low priority issue (Robertson et al., 2012). Studies from developed (Ayres & Griffith, 2007) and developing countries (Thankappan, Pradeepkumar & Nichter, 2009) suggest similar barriers of scarcity of human resources and IEC material hamper the effective implementation of Tobacco Control Program. In similarity with district Jalandhar, barriers of finances and costs have also been highlighted in the studies conducted in India and different parts of the world (Thompson et al., 2009).

However, the researcher observed people smoking near the kiosks openly and when enquired about this from kiosk holders they told that people smoked there because it is was safer to smoke near the kiosk than other place because in Punjab use of tobacco is considered to be a taboo. Although the legislation which penalizes smokers for smoking in public places is in place yet the Health Officials in the district complained that people do not have a healthy attitude towards the legislation and do not make an effort to help the government to implement the legislation seriously. A study done in a town in Andhra Pradesh showed that the higher the socio economic status of the population the better the understanding of the tobacco laws (Persai, Panda & Gupta, 2016).

This makes it more necessary for the government to stress on communication strategies for tobacco control especially among the lower and middle quintiles of the population in terms of income as well as education. Those from low income and low

education groups in the district had restricted knowledge on the harmful effects of tobacco use. This knowledge and perception about the use of tobacco including its social acceptance can influence the tobacco consumption in various socio demographic groups (vanZyl et al., 2013). But in contrast , a cross country comparison for 14 low and middle income countries done where GATS was carried out revealed that despite a high awareness regarding the harmful effects of smoking people continue to smoke developing a tolerant attitude towards it (Gupta & Kumar,2014). This is similar to the results from the study district where the tobacco users knew that the use of tobacco causes cancer through awareness created in media yet kept consuming it.

Another major culprit to the new tobacco users entering the existing group is the sale of loose cigarettes. The district officials said that the sale of loose cigarettes was banned but kiosk holders were selling loose cigarettes. It clearly reflected the inefficiency of the department to contain the sale of loose cigarettes. Moreover, the presence of lighters hanging in the kiosks in the district encouraged smokers to buy loose cigarettes and smoke near the kiosks. A report from Euromonitor International India has reported that 70% of the cigarettes consumed in India are in the loose form. The report also indicated a trend of increasing sale of loose cigarettes in India (Euromonitor International, 2012). This is in contrast to a population based study in Mexico which reports that the prevalence of buying single cigarettes at last purchase was only 10%. Also the population buying loose cigarettes used it as a method to cut consumption and quit smoking. But some of the participants did report that the sale of loose cigarettes acted as a stimulant for them to smoke even if they wanted to quit smoking (Thrasher, et al., 2009). The sale of loose cigarette was also due to cultural bias associated with tobacco use in Punjabi society and higher costs of cigarette than other tobacco products.

Another study from United States reported the prevalence of 77% in buying loose cigarettes among a convenience sample of young adults in disadvantaged areas (Stillman, et al, 2007). Moreover, non daily smoking of cigarettes have been associated more with the buying of loose cigarettes (Sacks et al., 2012). The findings from GATS 2009-10 supported that average number of cigarettes smoked daily were less than five as compared to those who smoked daily and bought cigarettes in packs (GATS India, 2009-10). A similar study from Latin America suggested that social

deprivation was strongly associated with purchase of loose cigarette (Linetzsky et al., 2012). However, due to stricter legislation on sale of loose cigarettes, greater effort required finding the single cigarette for sale may lower the level of consumption and provide a harm reduction strategy for the smokers (Royal College of Physicians, 2007).

When asked about strategies to curb tobacco use, the health officials as well as the kiosk holders were of the view that most effective of all was an increase in the tobacco taxes which led to increased prices of tobacco products. The kiosk holders' business in the district had been affected with the increase in the prices of the tobacco products. During the process of data collection some of them were worried for the impact of GST on tobacco products which meant their sales might be affected in the near future. It is well established that tobacco taxation has been recognized one of the most effective population based strategies for tobacco control and reducing the use of cigarettes (WHO, 2008). In high income countries, a 10% price increase for a packet of cigarettes reduces the demand for cigarettes by 4% in adult population (Jha, & Chaloupka, 1999).The increase in taxes is an effective policy tool in reducing smoking participation as well as use in young adults and those from low socio economic status. But the question which remains unaddressed is that the poor in India consume more of *bidis* and smokeless tobacco products (GATS India, 2016-17) and the taxes on these products are not high enough to check their use as mentioned in chapter four.

In addition, the legislation on tobacco which was translated in the district Jalandhar focused more on viewing tobacco control in context of cigarette smoking giving smokeless tobacco a step motherly treatment. Though the literature in India is increasingly concentrating on the smokeless tobacco consumption, its place in the legislation is yet to be ascertained. The most frequently consumed smokeless tobacco type in the district is *gutka*, while in the national average *khaini* is the most frequently consumed smokeless tobacco product (GATS India, 2016-17). The tobacco users in the district were using smokeless tobacco since years and were of the view that easy availability and affordability of the same addicted them to its indiscriminate use. While the prevalence of cigarette smoking is reduced in the developed world, the use of smokeless tobacco is on increase (Siegel et al., 1992).

Also migrants in the district said that smokeless tobacco was being sold to minors in both urban and rural areas of Jalandhar. It has been suggested that smokers switch over to smokeless tobacco due to its perceived less detrimental health effects while other say its use can be seen as an entry point for tobacco use in youngsters (Asplund, 2001). The government is trying to address these issues by focusing on the health warnings on the tobacco packages but the interpretation of these warnings on smokeless as well as smoking tobacco products by those using it remains a matter of concern (Begum, Schensul & Nair, 2017). The respondents in the district continued using tobacco though they saw the warnings on the tobacco products but had no knowledge how to interpret it due to lack of BCC activities. Moreover the sale of loose cigarettes also weakens the purpose associated with these health warnings on the packets.

In order to be more vigilant for tobacco use, monitoring plays an essential role in checking the timely status of health programs. In the study district a monthly meeting and scattered field visits in the district do not translate to what the monitoring of the program should be all about. The health officers' suggested that policy makers should be equal participants in the monitoring of the program as well as bring policy changes as per present requirements of tobacco use and sale. The burden of monitoring was confined to the Health Department and the policy makers did not pay attention to the inter department coordination in the district which was a major requisite for program success. These results are similar to the study done in six districts of Andhra Pradesh where the monitoring of the program was confined to health department only. The monitoring of tobacco use and prevention polices has been the focus of the WHO report on Global tobacco epidemic. To maximize the impact of tobacco control policies, the monitoring of tobacco use and exposure to second hand smoke is thought to be comprehensive and extensive in nature. Trends in tobacco use changes over time and a good monitoring is seen as a long term commitment, to be taken seriously. The impact of interventions for tobacco control and their improvement cannot be done without an effective monitoring system in place. Monitoring of demographic trends, tobacco control policies, health impact, compliance and social and economic impact of tobacco use is to be seen in the priority list of the countries which is not done in a comprehensive manner in India (Persai, Panda & Gupta, 2016) as well as the study district.

Apart from all the criticism, the officials across departments of Health, Education, Municipal Corporation and Police were of the view that Tobacco Control Program had improved since its inception. They elaborated on population being more aware of the ill effects of tobacco use due to the awareness being spread through the program. The officers said that there were no kiosks in the vicinity of educational institutes and people did not smoke in public places but the researcher found it otherwise as mentioned earlier. However, the past decade has seen a paradigm shift in the tobacco related policies which have seen a significant reduction in the tobacco use in various countries (Shimkhada & Peabody, 2003). The Government of India has also enacted various legislations and tobacco control measures (Reddy & Gupta, 2004). Till date there has been considerable improvement in the tobacco control but few measures which target the tobacco economy have not been seriously addressed. There is also a dire need for mobilization of the stakeholders involving the general community to educate and spread awareness to those around them for controlling the menace of tobacco (Chowdhry, 2016) which was the researcher's prime concern in the district.

7.4. TOBACCO INDUSTRY'S INFLUENCE ON TOBACCO CONTROL MEASURES

There was only one case in the village Lambra of Jalandhar where the shopkeeper said that he voluntarily stopped selling any kind of tobacco products because he felt that tobacco was detrimental to one's health and he did not want to contribute in selling poison to population. When asked if he missed on the profits made, he made it clear that he chose people over profits. A similar study done in California explored the reasons why some grocery store holders stopped selling tobacco. They cited health reasons as well as decreasing tobacco sales as the reasons for ending tobacco sales in their shops (McDaniel & Malone, 2014).

Also, in the district due to lack of licensing of these outlets, the officials had no data on number of kiosks selling tobacco in different areas of the district. It is a well established fact that tobacco outlet density increases the likelihood of smoking among minors as well as adults (Novak et al., 2006) and living in close proximity to tobacco outlets makes quitting more difficult (Reitzel et al., 2011). The tobacco users in the district said that tobacco in varied forms was readily available and accessible in the rural as well as urban areas of the district. This ready accessibility of tobacco is said

to dilute the anti tobacco messages and tobacco use control efforts (Chapman & Freeman, 2009).

A study in New York (McDaniel & Malone, 2011) provided the same results where kiosk holders quit sales of tobacco but the taxes in New York were higher than the neighbouring states which could be another reason for declining tobacco sales. This corroborates with the fact that the raise in tobacco taxes not only checks the prevalence of tobacco use directly but also indirectly by limiting the number of tobacco outlets (Chaloupka, Yurekli & Fong, 2012). Reducing the number of outlets not only reduces the prevalence of smoking (Novak et al., 2006) but also enhances smoking cessation (Reitzel et al., 2011).

As mentioned previously the tobacco industry has been very active in expanding the markets and entering new markets through newer tactics. In district Jalandhar tobacco industry offered incentives and gifts to sellers by giving free packets of smokeless tobacco and *bidi* on purchase of large quantity of tobacco products. These incentives by the tobacco industry acted as a stimulus for the sellers to sell these products. Moreover, the salesmen visited the kiosks for noting the requirement of any kind of tobacco products which saved the time of kiosk holders in procuring the tobacco products. A study replicates the same results where the tobacco companies provided incentives for the prime placement of their products, covering a larger display areas and offer reduced prices on buying a particular quantity of the tobacco products. The study showed that tobacco companies spend 81% of their marketing amount on retailer incentives and price their brands competitively as well as their prime placement (Feighery et al., 2003).

The tobacco companies in the district advertised their products within the kiosks through display boards bearing name of the company and provided sellers with monthly incentives ranging from Rupees 400 to 500. In India the display of advertisements inside the shops is being done on a regular payment basis (Chaudhry,Chaudhry & Chaudhry,2007). Another small study of the tobacco retailers in California found that the tobacco retailers were more likely to offer payments for display slots to sellers and the retailers themselves received payments from tobacco companies for increasing the sales (Feighery et al., 1999). A similar study done on the tobacco sellers showed that a very common strategy adopted by tobacco companies

was to give some cents off the total purchase. In return to this the retailer was expected to use specific displays provided by the tobacco industry. In order to attain the prime placement of their product the tobacco companies compete with each other in order to get more visibility in the kiosks. They want the customers to see their products and then letting them choose from those available is the strategy of the industry (Feighery, et al., 2003). A study in Mumbai demonstrated that the Point of Sale advertisements remained highly visible and prominent as COTPA ,2003 prohibits tobacco advertising with an exception to on pack and Point of Sale (POS) advertisements (Khariwala et al;2016).

In the study district especially in the rural areas the shops selling products of daily routine also sold tobacco products and displayed the advertisements in their area of shop. A similar study done in four different cities in India showed that such advertisements were also seen at the shops who were not selling tobacco at all. These advertisements catch the attention of the customer and are responsible for the young population to take up tobacco use. It is not a new phenomenon in India to observe the products name on the boards of kiosks or shops selling tobacco. As mentioned earlier, the display of these advertisements inside the shops is done on a regular payment basis. Similar strategies which incentivize the display of tobacco advertisements in shops have been seen in US (Lavack & Toth, 2006) and UK (Pollay, 2007). New Zealand has acted on phasing out these advertisements due to their negative impact on population (Fraser, 1998).

The tobacco kiosks in the urban area in the district were situated in the market places and shops selling tobacco products in rural areas were situated within the villages. Historical considerations indicate that the advertisements for tobacco products were not common in India before the 2003 legislation on tobacco control. The shops or kiosks selling these tobacco products are located in the busy market places and the boards on the shops are definitely the places for promotion of their products. On the other hand the advertisements for smokeless tobacco products are virtually nonexistent at the point of sale because *paan masala* advertisements in media are being used as surrogate for these advertisements (Chaudhry, Chaudhry & Chaudhry, 2007). As observed in the district the display boards carrying advertisements were

from the cigarette companies and displayed names of popular cigarette brands inside the kiosks.

The profits on the sales of tobacco products as reported by most of the kiosk holders or shop owners varied from 5 to 10%. In a study done in disadvantaged areas of England the retailers reported a profit of 4 to 6% on regular tobacco products but around 7-10% on premium cigarette brands. These findings reflect that the tobacco industry makes higher profits on premium brands of cigarette because it shifts the higher taxes to premium cigarette brands keeping the price of cheaper cigarette brand low and affordable to their customers (Hyland et al.,2003). Moreover the sellers in the disadvantaged areas tend to carry cigarettes with lower average price (Rodriguez et al., 2013). Similarly in the study district most of the cigarette brands being sold by the kiosk holders were cheap and affordable although those located in prime localities kept cigarettes of premium quality.

In the rural areas of the district, children come to shops which sell tobacco products along with the items of daily use. Similarly, the kiosks in the urban areas also kept some items as toffees and cold drinks for children. Whenever children visited kiosks or shops they were exposed to tobacco products in display which might have tickled their curiosity and they might end up consuming tobacco in near future making the program efforts meaningless and obstructed. A study done in Norway showed that the Point Of Sale (POS) advertising Ban was required to protect children and youth form the advertising effect of seeing packages in the stores (Scheffels & Lavik, 2013). Research also shows that familiarity with a brand through exposure and the preference for it increases the probability of smoking initiation (Biener & Siegel, 2000).

The Indian legislation on tobacco is a demand side provision which has no provisions for supply side of tobacco. As put forward by all the interviewees in the district be it officials, kiosk holders or tobacco users, the government was not tightening the noose around tobacco industry as it should have been. As mentioned earlier in chapter four, the previous ruling party in Punjab SAD, was taking donations from one of the tobacco honchos in the state. In line with what the interviewees said, there is a misalignment between the public health goals set up by the government and business mandate of the tobacco industry which continues to push industry's effort to dilute the tobacco control measures (Young & Borland, 2012).Even when the tobacco

companies are owned by or effectively controlled by the government as in China and Japan the choice has been to direct these companies to monetary benefits rather than fulfilling the health objectives. These steps are completely incoherent with the health policy and the public health benefits of tobacco control. Moreover the kind of consensus reached on the demand side provisions in FCTC has certainly not been seen in the supply side policies (Malone, 2010).

It is also seen that policy context shifts with time and may create new windows of opportunities. The orientation of the government and views of bureaucrats, politicians and those in the system influence tobacco control decisions but are mutable (SKlair, 2002). Relatively less research has been done on how to change the course of the industry and little pressure on controlling its spread in the district. Despite the opposition to the tobacco industry control measures on the supply side, a number of tobacco control measures as regulating profits (Gilmore, Branston & Sweanor, 2010), banning some tobacco products (Hall & West, 2008) as ban on sale of loose cigarettes and manufacture of smokeless tobacco products in district, imposing targeted reductions on supply (Enzi,2007) and resisting the privatization of the state owned companies(Gilmore, Fooks & McKee,2011).None of these have been adopted in the policy except in Bhutan(Ugen,2003). A New Zealand committee proposed annually reducing the amount of imported tobacco, the number and quantity of tobacco product for sale at each outlet and number of retail outlets (Maori Affairs Committee of New Zealand Parliament,2010)but the official responses show whether this might be accomplished or not. Moreover, exploratory research into resistance to supply side measures to tobacco control suggests that the present mindsets in the governments may hamper the adoption of these measures (Edwards et al., 2011).

7.5. ORAL CANCER AND ITS SOCIAL CORRELATES OF TOBACCO USE

The kiosk holders selling tobacco products in the district are migrants from UP and Bihar. The kiosk holders out of their experience said that most of the migrant population prefers smokeless tobacco or *bidi* for smoking. The district administration verbally talks of the influence of use of tobacco by migrant population on the local population but has no data to prove its validity. A major proportion of these workers come to Punjab because of better employment opportunities, higher wages, and lower socio economic exploitation in addition to near absence of caste oppression. Although

there has been no direct study linking the use of tobacco among migrant workers in Punjab but there are studies which say that the level of education for the migrant labourers is very low(Sethi, Ghuman & Ukpere, 2010).

The migrant and the local labourers in the district as well as oral cancer patients from low socio economic background consumed smokeless tobacco or *bidi*. These findings are consistent with GATS survey which says that the use of *bidi* and smokeless products is more common in people in lower quintile of wealth (GATS India, 2009-10).The labourers in the district were either uneducated or received primary education and the oral cancer patients were also not educated beyond matric. There are studies where overall use of tobacco has been associated with those who are less educated but the use of cigarettes have increased with increasing education (Gupta, 1996). In India *bidi* is consumed more by those from low socio economic status due to their low cost and cigarettes are consumed by those with greater financial resources (Narayan et al., 1996). A similar socio economic gradient has been observed for those using smokeless tobacco including chewing tobacco, *paan* and tobacco powder (Rani, et al., 2003).

The age of initiation of tobacco use of the respondents was their early period of adolescence. This use of tobacco started with peer pressure and the need for experimentation in early stages of life. A study done in Atlanta reported the adults initiated smoking in the age group of 12 to 16 years and continued it throughout their lives and that they received their first cigarette from a friend. The respondents perceived tobacco use as cool and wanted to spend time with their friends (Klein, Sterk & Elifson, 2013).Since most of the tobacco users in the district were primarily smokeless tobacco users, the determinants for the smokeless tobacco use are influence of friends and siblings as well as favourable attitude for tobacco use (Kimberly et al., 2000). There are numerous other studies available which point to the fact that tobacco initiation in early years of life is seen as an influence of those around the user. It is one of the important factors for better integration of Tobacco Control Program with the School Health Program in the district. Moreover, effective enforcement of underage sale laws regulating tobacco being sold has significant impact on the youth smoking (DiFranza, Savageau & Fletcher, 2009). However, the boards displaying no

sale to minors were not present in the kiosks as well as shops selling tobacco products in urban and rural areas of the district respectively.

In addition, it is very crucial to record the number of times smokeless tobacco is consumed daily in order to establish a relation between the frequency of consumption and chances of being affecting with oral cancer. The respondents who were suffering from oral cancer used to consume smokeless tobacco ten to fifteen times daily. Each time tobacco got absorbed in oral mucosa, the respondents again put the smokeless tobacco in the vestibule to get the kick. Although there is available literature which links the number of cigarettes consumed to increased risk of health issues, the literature on frequency of consumption of smokeless tobacco is limited in its scope. A study reported that even smoking one to four cigarettes per day can increase the risk of Ischemic Heart Disease (IHD) in both the sexes (Bjartveit & Tverdal, 2005). In a study carried out in India to find the content of nicotine in popular Indian smoking and smokeless brands it was found that the content of nicotine in smoking forms is more than the smokeless form but it was largely compensated by the greater intake of chewing tobacco (Reddy & Shayak Haider Ali, 2008).

According to Centre for Disease Control, using chewing tobacco seven to eight times in a day equals to smoking 30 to 40 cigarettes per day. An increased risk of carcinomas of the oral cavity and pharynx has been reported in patients who use chewing tobacco (Fant et al., 1999). This risk increases with the frequency and duration of the habit of consuming smokeless tobacco (Sawyer & Wood, 1992). The odds for oral cancer is estimated 7.3 in smokers, 1.3 in alcohol users and 11.4 in those consuming smokeless tobacco habitually (Prabhakaran & Mani, 2002) which upholds the results in our study which found out that the patients of oral cancer were consuming smokeless tobacco from the time of adolescence.

In the district, patients of oral cancer used smokeless tobacco and alcohol in synergy which caused the deadly disease of oral cancer. Use of tobacco is also associated with increased alcohol consumption (Windle & Windle, 1999). Over the past decade the use of smokeless tobacco has been seen as an alternative to smoking (Critchley &Unal, 2003) which is apt in case of findings in Punjab which has seen an increase in the use of smokeless tobacco from past six years (GATS India, 2016-17).The oral manifestations of using smokeless tobacco are not addressed adequately in public

hospital settings in the district which manifests into oral cancer at last stage. As mentioned earlier the use of smokeless tobacco causes gingival recession, tooth wear, loss of tooth and leads to oral cancer (Agbor et al., 2013). Alcohol acting independently and in synergy with tobacco has been implicated as oral carcinogen. Case control studies have concluded that the use of alcohol and tobacco for long period increases the relative risk of oral cancer (Chi, 2009). The alcohol and tobacco consumption is not only associated with the disease but also with its progress and poor prognosis (Bundgaard, Bentzen & Wildt, 1994).

The diagnosis of early lesions and counselling in use of smokeless tobacco can ultimately prevent the onset of the disease or check its progress and dentists can play a vital role in it. The tobacco interventions are mostly restricted and not adopted fully by the dentists. A study reported that incorporation of oral examination in the dental office or in community setting as a part of the behavioural intervention for tobacco cessation conducted by oral health professionals may increase tobacco abstinence rate among smokers and smokeless tobacco (Carr & Ebbert, 2012).Moreover the efficacy and feasibility of oral cancer screening and counselling by dental professionals have been intensely evaluated (Johnson, 2004).Consistently reported studies from, US, UK, Netherlands, Australia, Japan, Pakistan , India ,Canada, New Zealand, Saudi Arabia and Norway showed that barrier to dentists being involved in Tobacco Control Program was lack of training (Hanioka et al.,2012) which was the case in the study district.

The respondents in Jalandhar were not aware of the health effects of tobacco use, oral cancer being one of them. They did not receive any counselling from health department nor did they notice any BCC activities in the community. They were constantly asked by the family to quit, citing health reasons but lacked will power to quit the use of tobacco. There are few studies which discuss the fact that the one of the main reasons for late diagnosis of oral cancer is the general lack of knowledge in public about the signs and symptoms of oral cancer and its risk factors (Hertrampf et al., 2012). It is very relevant because the stage at which oral cancer is diagnosed is very crucial in determining the morbidity and mortality following the treatment (Oluwatunmise, Scott& Tim, 2012). Results similar to our study were reported in the study done in a hospital in Bangalore where tobacco users were generally unaware of

the ill effects of tobacco use on general health, oral health as well as oral cancer (Pai, Arora & Dyasanoor, 2014).

The patients did not notice any symptoms of cancer in their oral cavity unless they suffered from tooth ache or swelling in the oral cavity. Some complained of a minor ulcer which did not heal despite taking medication from a local practitioner. The patients did not visit dentists for the detection of their problem and instead relied on the local doctors for pain relief. The referral to dentists took place either from the local doctors or when the symptoms in the mouth exaggerated so much so that the pain became intolerable. Most of the cases of cancer are diagnosed at advanced stages and early detection of these cases reduces the mortality rates. Hence early detection of these cases through screening by dental professional can help a great deal in reducing the burden of oral cancer (Tax et al., 2017). Oral health professionals are required to perform routine extra oral and intra oral examination on their patients for purpose of detecting abnormalities and as a means to screen oral cancer (Clovis, Horowitz & Poel, 2002).

There is evidence to suggest that regular dental examination is associated with earlier stage at diagnosis for oral cancer, hence efforts should be made to screen for cancer during recall visits (Rock, Takach, & Laronde, 2014). A study done in Canada showed that the dental hygienists conduct only partial examination while screening for such conditions. There are other studies which second that the dental hygienists needed to be more vigilant while performing intra oral and extra oral examination which include tactile and visual components (Cotter et al., 2011). The study district has dentists performing all the procedures themselves with no dental assistant or hygienists to assist them and do not find time for basic procedures (Menon, 2016). While increased age has been associated with increased risk for oral cancer, there seems to be an increase in the patients of oral cancer below 40 years (LaRonde et al., 2008), as one oral cancer patient among those interviewed in the study district was aged 35 years. The oral cancer patients said that in recent times the detrimental effects of use of tobacco are being corresponded in media which identifies media channels as the best in communicating the knowledge about cancer and its screening (Cobban et al., 2009).

In addition, daily expenditure by tobacco users on smokeless products in the district was affordable to them. The expenditure on these products did not compromise the basic needs of their family; hence they did not get discouraged to use these products. Most of the studies are based on the expenditure related to smoking and its effects on basic household needs. The studies on the smokeless tobacco related expenditure find little or no mention. The oral cancer patients quit the use of tobacco citing health concerns as the major factors. There are studies in India and China where the health concerns due to smoking lead tobacco users to quit smoking (Hyland et al., 2004).

In India family norms play an important role as family values are considered to be part of one's identity. The people who quit owing to family pressure understand the social implications of being a non-tobacco user. This is opposite to what is experienced in groups where smoking is considered to be a norm and they experience less social pressure to quit it (Meijer, 2015) as was the case with the migrant labourers in the district. The use of tobacco was considered a norm in their social groups whereas Punjabi tobacco users felt more pressure from the families to stop use of tobacco. These tobacco users in Jalandhar belonged to people from low socio economic status and were not educated enough to understand the ill effects of tobacco use when they started it. Moreover, their working conditions, absence of any recreational activity and peer pressure forces them to indulge in various social abuse activities (Amrutha, Karinagannanavar & Ahmed, 2016). The efforts to quit were not always successful in the tobacco users and they started using tobacco again. In GATS India 2009-10, the intention to quit tobacco was figured to be 40% of the total tobacco users (Rafful et al., 2013). This certainly points to the fact that skilled support in the form of counselling or pharmacotherapy is necessary for the tobacco users to help them quit which was not available in the district till the time of data collection.

As far as suffering from oral cancer is concerned, the patients not only suffered from the physical pain of the treatment but also experienced emotional pain of misery due to their disease. The guilt of not being able to quit the use of tobacco despite being warned by the family deepened their pain and the depression associated with it. There are many studies in Japan mentioning the suffering of cancer patients where they suffered pain by thinking negatively about their problem (Kaneko & Majima, 2006). Moreover the families of the cancer patients turn into an insensitive state where they deny and do not believe reality (McGrath,Paton & Huff, 2004). The families'

suffering involved uncertainty in the future combined with fear of isolation (Hinds, 1992). The families of oral cancer patients suffered from the economic insecurities, after effects of treatment and recurrence of disease in future. A systematic analysis done on suffering in cancer patients shows that the stress of suffering in cancer patients may be more in young patients where cultural expectations for caring of parents in the family by young patients is more as in Asian families (Best et al.,2015).

Whether a given situation is experienced as suffering depends upon interpretation by and its importance to the patients (Yang, Staps & Hijmans, 2010). This suffering has been portrayed as objective physical and social isolation and a sense of loneliness (Chapman & Gavrin, 1993). Patients may lose sense of community and connectedness due to hospitalization (Kuuppelomaki & Lauri, 1998) and withdraw from the society due to the fear of stigmatization and distortion of their body image by disease (Llyod et al., 2008). These feelings could be seen in the patients undergoing treatment for oral cancer in the district. The disease took a great toll on their physical, mental and emotional health as well as drained them of their economic freedom.

The patients of oral cancer were from low socio economic background and had taken loans from relatives for their treatment. As mentioned earlier under Mukh Mantri Punjab Cancer Rahat Kosh Scheme (MMPCRKS) the Punjab government provides a financial assistance of Rupees one and a half lakhs for the treatment of cancer patients. Given the cost of treatment this amount is not sufficient for covering the total treatment cost of the disease. The patients had returned to private care after being disappointed by the treatment provided to them at the public hospitals. The economic burden of cancer in India is significant because of low public sector allocation to health which is around 1.2% of the GDP (Reddy et al., 2011). The expenditure not only included the treatment of cancer but also the transport cost, the cost of living at the place of treatment and other miscellaneous charges. The poorly run public sector puts the out of pocket expenditure on the households which is catastrophic in nature (Mahal, 2010). Moreover the households decrease other expenditures of their daily routine in order to deal with cancer related expenditure. They also deal with the cost of cancer by increasing the financial burden on the unaffected members (Roberts, 1992) as was the case with patients in the district. The patients or oral cancer were dependant on their families as well as their relatives for the cost of cancer treatment as well for their routine expenditures.

As mentioned earlier the patients interviewed were working in unorganised sectors. Apart from the economic burden of cancer, the treatment meant loss of wages for those accompanying them. Moreover the loss of income not only by those affected but also by those accompanying them, as most of them are employed in the informal sector which provide limited security benefits (Mahal et al.,2013), meaning working in the informal sector the oral cancer patients in the district could not claim any financial help or health security from their employers.

The local agricultural labourers in the district accused the migrants of introducing them to tobacco culture when they used to work together on agricultural farms in the district. While both local and migrants consumed smokeless tobacco, use of *bidi* and *paan* was more pronounced in migrant labourers. Similarly use of tobacco and alcohol as in oral cancer patients was more in Punjabi population. Researchers argue that understanding the socio cultural context of tobacco use is of supreme importance in order to appreciate the prevalence rates and the unique cultural situation governing the use of tobacco among different populations (Nichter,2009). The migrants also said that the use of tobacco could cure tooth aches and use of areca nut in *paan* provided health benefits such as proper digestion. A similar study in the Cambodian American Community found that tobacco is seen as an agent for maintaining dental hygiene and aids in healing. These are the factors which enable and reinforce the use of tobacco in the community (Friis et al., 2006). Despite these considerations there is a paucity of research regarding the influence of identity on culturally specific use of tobacco in Punjab. In a study done in US, the respondents from South Asian Community admitted that the culturally specific tobacco behaviour is used to maintain the traditional as well as customary aspects of ethnicity. The use of tobacco products was normative and organic behaviour whenever they met in their culturally specific groups (Mukherjea, et al; 2012).

7.6. IMPLICATIONS OF THE STUDY FOR POLICY AND FUTURE DIRECTION OF RESEARCH

Although Indian laws on tobacco have seen amendments and improvements with time, the lack of political coherence and will of the government has played a major role in spreading tobacco epidemic in the state of Punjab. The political lobby working for the interest of the tobacco industry and the ways in which industry controls the

legislation is an open secret. This political incoherence leads to a lack in inter departmental coordination. Health has always been the responsibility health department but in order to achieve health goals inputs, resources as well as distribution of duties in other departments in also required. The connections of departments in tobacco control are a lateral movement across the boundaries which call for a better synchronization in the near future in the district.

In order to link tobacco and other health programs, a proper data base should be maintained in every health program in Punjab where patient should be asked mandatory questions about tobacco usage. This will not only help to sync Tobacco Control Program better with other health programs but also help to ensure that a data base is created which gives the government direct data related to tobacco usage and its disease causation. The demographics so established, kind of tobacco consumed the socio economic status of the patient and the diseases associated with it can be quantified. The involvement of the dentists in public hospitals should be of prime importance in screening the patients for effects of tobacco on oral health in the district. But in the public set up due to the rush of the patients, the dentists are not able to engage with the patients. The lack of dental auxiliary makes the matters worse. The filling up of these posts and training them to counsel against use of tobacco can help the government fight tobacco use.

In addition the tobacco policies are never formulated at the local level and the research conducted informs the process of decision making. The social, economic and political aspect of the tobacco policy is not well researched in the state of Punjab. Tobacco control is as much a social problem as is the health issue. The social aspect of the problem is extremely important to target tobacco users and understand their psychology and sociology. The social issues related to tobacco use need to be highlighted by research based evidence and communicated to the policy makers to help them look beyond the visible. This will help to tailor the program using a target based approach and the users can be counselled and approached using the demographic variables in Punjab. Moreover the BCC activities will be of extreme help in designing an approach depending upon the usage as well as the demographics of the target population in the district. The warnings which are shown in media also need to be rotated to make them more interesting. The health communication

department should be strengthened and proposals from young scholars can help the government plan BCC activities in a better manner.

The research base on tobacco industry is not as strong as in developed countries. The literature falls short of the topic on political economy of tobacco control in India. A collection of all the industry documents should be arranged in a repository which should be freely available for the scholars to access. The writings on tobacco industry should be encouraged and widely published in media and academia. A database should be constructed on the available on the industry's reach in different states of India and the kind of new tobacco products being launched in the market in these states.

The control program on tobacco is not specific and does not speak well with all the age groups in the district. The customized messages in the language the target group understands are missing in the government set up in the district. The program on tobacco should be tailored according to the demographics of the state. The one size fits all approach should be abandoned and new challenges accepted to deal with the menace in a personalized way. The differences in tobacco consumption in the local and migrant population should be enumerated with the help of a strong database in Punjab. The state governments should carry out state specific surveys and list out the prevalence of tobacco use in migrant population in Punjab and target these populations accordingly. More attempts should be made at improving the training of the health workers and increasing their engagement with the population. Their training should train them in providing necessary counselling and need for support, in case of users who want to quit tobacco. Moreover the messages disseminated through them on non-use of tobacco should be more local and population specific.

Although in district Jalandhar every department was engaged in the fining the offenders, there was no substantial evidence to suggest what did it contribute to the program. This sole reliance on numbers has set a trend where the tobacco use and its control are largely being computed. The neglect on the social and psychological aspect, except for the addiction and its neurophysiologic effects, is evident in the research on tobacco in Punjab. An approach is needed to link legislation, industry and state together within the realm of social correlates of tobacco use. All these factors affecting tobacco consumption cannot be seen separate from each other. The

government frames legislations but is not able to change the attitude of population as it fails to address these dimensions which can bring a revolt in the already laid control measures.

The historical context in which tobacco use started and continues till date, the changes in the consumption pattern if any and reasons for the same, is a subject matter of reflection and scrutiny in Punjab. The engagement with researchers from diverse backgrounds and exploiting their potential should be a priority of the policy makers. The research on the other hand should be directed to policy makers to help them understand trends and then provide suggestions which are pragmatic and consequential to the underlying policy for tobacco. The amicable working of researchers and policy makers can bring a change for the much awaited amendments in tobacco control policy.

Not only the buyers but the sellers of tobacco products, the kiosk holders to be precise, need to be included as major stakeholders for tobacco control. Licensing the kiosk holders in Punjab and educating them on various tobacco laws should be an indispensable part of Tobacco Control Program. The government should make efforts to hold meetings with few representatives of the kiosk holders in every state including Punjab. The information on tobacco laws should be disseminated in a friendly manner and the kiosk holders should not be made culprits for selling the products government endorses.

The lack of commitment from government's side to make the policy more inclusive is a reason of its weak implementation in the field. The tobacco control essentially considered a health subject is covered under various Ministries which makes it difficult to implement certain laws in totality. Moreover the bureaucratic responsibilities and the inter ministry politics in tobacco control leave it with loopholes which are exploited by tobacco industry. The government should try to accommodate tobacco control under a single umbrella so that the functioning can be handled better with fewer hindrances throughout the country.

As mentioned earlier that health is a state subject and the individual states need to focus on the health services in the state. The percentage of GDP being spent on health in Punjab is less than 1% which is below the national average. Not only does it affect the way in which the Tobacco Control Program is being managed but also fails to

provide adequate support to the patients of oral cancer. There are many hidden costs in the treatment namely the cost of travel, accommodation as well as loss of wages, not to forget the emotional support required for rehabilitation of the patients. The government of Punjab should make effort to increase its public spending on health so that it can curtail the disease before it starts and focus on the screening process of cancer.

In conclusion we can state that the use of tobacco is dependent on the triad of history, structure and individualism all of which are related to each other. This goes on to say that tobacco use has been present since centuries in Punjab and as science and technology evolved so did its use. But the problem with the policy makers in Punjab is that they find it difficult to address the complex scenario of tobacco control. Instead of being the part of this policy process, the policy makers use heuristics to gather information and seek good enough solutions which deranges institutional response on use of tobacco. Reducing this use to individualism and ignoring the weak institutional support or structural issues in addressing the use of tobacco has been a major drawback the way tobacco use is being addressed in the district. Moreover, tailoring the approaches to methods which target the cultural variations of tobacco use in migrant and local population in the district can make a difference. Also, relating the number of those using tobacco to the questions of why, how, when and where through different approaches adopted by different disciplines will be able to make the subject of tobacco more elaborate and rich. Conveying these findings through practical approaches to the policy makers in the state can add another dimension to policy of tobacco control. In a nutshell, involvement of various stakeholders through varied approaches and looking at tobacco use through lens of migrant and local population is of extreme importance. Nonetheless, the effort to highlight the increasing use of tobacco in Punjab due to a misguided approach by the government is of help in setting the foundation for future studies.

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ANNEXURES

ANNEXURE A.1. LIST OF DOCUMENTS

Global Adult Tobacco Survey 2009-10, India Report.

Global Adult Tobacco Survey 2016-17, India Report

Report on Tobacco Control in India, 2004.

WHO Framework Convention on Tobacco Control, 2003

Imperial Gazetteer of India provincial series Punjab volume I and II 1908

European Accounts of the Sikhs 1962,

Maharaja Ranjit Singh 1939,

Punjab under the Great Mughals, 1968

Textbook of Punjab Agriculture, 1947

Operational guidelines National Tobacco Control Program, 2012

ANNEXURE A.2. CHECKLIST FOR KIOSKS

- Presence of no sale to minor posters
- Point of sale advertisements
- Presence of hanging lighters
- People smoking near the kiosks
- Sale of loose cigarettes
- Sale to minors
- Products being sold
- Items of daily use or toffees and cold drinks for children

ANNEXURE A.3.SEMI STRUCTURED INTERVIEW SCHEDULE FOR OFFICIALS INVOLVED IN TOBACCO CONTROL

HEALTH OFFICIALS

Name

Age

Sex

Designation

Years of experience

Program oriented

When was the tobacco control program started in Punjab?

What is the workforce involved under NTCP?

Is the present workforce sufficient to deal with tobacco control program?

If not, how does it affect the program implementation?

What is the number of raids has been conducted in past one year?

What has been the experience of the team on raids?

What is the money spent on advertisements for tobacco control and what is the frequency of such advertisements?

Are there any NGOs involved under the tobacco control program?

How effective is the tobacco control program in the current form for controlling the problem?

What improvements have been made in the tobacco control program since its inception?

How is it being managed at the grass root level?

What are additional resources required for implementation of the program?

What do you have to say about the vertical integration with other programs on a long term basis?

How is the constant monitoring of the program in the field being done?

Is there any involvement of the Panchayati Raj Institutions for the program?

Any suggestions you would like to give to the government for the improvement of the program?

Patient oriented

Are the patients being provided any pharmacological help at district level?

What is being followed of the following levels of prevention?

Primordial level

Community and clinic

Health education at school level

Check up and monitoring

Enforcing the policies

Primary level

Tobacco cessation for users without diseases

Secondary level

Early diagnosis and treatment of the diseases related to tobacco use

Tertiary level

Treatment facilities in special clinics and hospitals

Treatment for heavy users and victims of tobacco related diseases

Pharmacotherapy

Tobacco cessation centres at the District hospitals

Presence of a counsellor

ਐਨ ਟੀ ਸੀ ਪੀ ਅਧਿਕਾਰੀ

ਸਿਹਤ ਅਧਿਕਾਰੀ

ਨਾਂ

ਉਮਰ

ਲਿੰਗ

ਅਹੁਦਾ

ਤਜਰਬਾ (ਸਾਲਾਂ ਵਿਚ)

ਪ੍ਰੋਗਰਾਮ ਸੰਬੰਧਤ ਜਾਨਕਾਰੀ

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਪੰਜਾਬ ਵਿਚ ਕਦੋਂ ਸ਼ੁਰੂ ਹੋਇਆ

ਐਨ ਟੀ ਸੀ ਪੀ ਵਿਚ ਕਿਨੇਂ ਅਧਿਕਾਰੀ ਕੰਮ ਕਰਦੇ ਹਨ?

ਕੀ ਇੰਨੇ ਲੋਕ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਲਈ ਵਾਜਿਬ ਹਨ?

ਜੇ ਨਹੀਂ, ਤਾਂ ਪ੍ਰੋਗਰਾਮ ਦੀ ਕਾਮਯਾਬੀ ਤੇ ਇਸਦਾ ਕੀ ਅਸਰ ਹੈ?

ਪਿਛਲੇ ਇਕ ਸਾਲ ਵਿੱਚ ਤੰਬਾਕੂ ਪ੍ਰੋਗਰਾਮ ਅਧੀਨ ਕਿੰਨੇ ਛਾਪੇ ਮਾਰੇ ਗਏ ਹਨ?

ਇੰਨਾ ਛਾਪਿਆ ਤੇ ਟੀਮ ਦਾ ਕੀ ਤਜਰਬਾ ਰਿਹਾ ਹੈ?

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਦੇ ਇਸ਼ਤਿਹਾਰਾਂ ਤੇ ਕਿੰਨਾ ਖਰਚ ਕੀਤਾ ਜਾਂਦਾ ਹੈ ਅਤੇ ਇਹ ਇਸ਼ਤਿਹਾਰ ਕਿੰਨੇ ਸਮੇਂ ਬਾਅਦ ਦਿੱਤੇ ਜਾਂਦੇ ਹਨ?

ਕੀ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਸਮਾਜ ਸੇਵੀ ਸੰਸਥਾਵਾ ਵੀ ਸ਼ਾਮਲ ਹਨ?

ਵਰਤਮਾਨ ਰੂਪ ਵਿਚ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਸਮਸਿਆ ਦੇ ਹਲ ਲਈ ਕਿੰਨਾ ਪ੍ਰਭਾਵੀ ਹੈ?

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਦੇ ਸ਼ੁਰੂ ਹੋਣ ਤੋਂ ਲੈ ਕੇ ਹੁਣ ਤਕ ਇਸ ਵਿੱਚ ਕੀ ਸੁਧਾਰ ਕੀਤੇ ਗਏ ਹਨ?

ਹੇਠਲੇ ਪੱਧਰ ਤੇ ਇਹ ਪ੍ਰੋਗਰਾਮ ਕਿਵੇਂ ਚਲਾਇਆ ਜਾ ਰਿਹਾ ਹੈ?

ਪ੍ਰੋਗਰਾਮ ਨੂੰ ਕਾਮਯਾਬ ਕਰਨ ਵਾਸਤੇ ਹੋਰ ਕੀ ਸਾਧਨ ਲੋੜੀਂਦੇ ਹਨ?

ਕੀ ਇਸ ਪ੍ਰੋਗਰਾਮ ਨੂੰ ਲੰਬੇ ਪੱਧਰ ਤੇ ਕਿਸੇ ਹੋਰ ਪ੍ਰੋਗਰਾਮ ਨਾਲ ਜੋੜਨਾ ਚਾਹੀਦਾ ਹੈ?

ਫੀਲਡ ਵਿਚ ਇਸ ਪ੍ਰੋਗਰਾਮ ਨੂੰ ਲਗਾਤਾਰ ਕਿਵੇਂ ਮਾਨੀਟਰ ਕੀਤਾ ਜਾ ਰਿਹਾ ਹੈ?

ਕੀ ਇਸ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਪੰਚਾਇਤੀ ਰਾਜ ਵਿਭਾਗ ਦੀ ਕੋਈ ਭੂਮਿਕਾ ਹੈ ?

ਪ੍ਰੋਗਰਾਮ ਦੇ ਸੁਧਾਰ ਲਈ ਸਰਕਾਰ ਨੂੰ ਤੁਹਾਡਾ ਕੀ ਸੁਝਾਅ ਹੈ?

ਮਰੀਜ ਸੰਬੰਧਤ

ਕੀ ਜਿਲ੍ਹਾ ਪੱਧਰ ਤੇ ਮਰੀਜ ਨੂੰ ਔਸ਼ਧ ਸਹਿਯੋਗ ਦਿੱਤਾ ਜਾ ਰਿਹਾ ਹੈ?

ਰੋਕਥਾਮ ਦੇ ਹੇਠਲੇ ਪੱਧਰਾਂ ਤੇ ਕੀ ਕੰਮ ਕੀਤਾ ਜਾ ਰਿਹਾ ਹੈਂ

ਪ੍ਰਾਇਮੇਰਡੀਅਲ ਪੱਧਰ

ਕਮਿਊਨਿਟੀ ਤੇ ਕਲੀਨਿਕ

ਸਕੂਲ ਪੱਧਰ ਤੇ ਸਵਾਸਥ ਸਿਖਿਆ

ਚੈੱਕ ਅੱਪ ਤੇ ਮਾਨੀਟਰਿੰਗ

ਨੀਤਿਆਂ ਨੂੰ ਲਾਗੂ ਕਰਵਾਉਣਾ

ਪ੍ਰਾਇਮਰੀ ਪੱਧਰ

ਤੰਬਾਕੂ ਦੀ ਵਰਤੋਂ ਕਰਣ ਵਾਲਿਆ ਲਈ ਬਿਨਾ ਬੀਮਾਰੀ ਤੰਬਾਕੂ ਦੀ ਰੋਕਥਾਮ

ਸੈਕੰਡਰੀ ਪੱਧਰ

ਤੰਬਾਕੂ ਸੰਬੰਧਤ ਬੀਮਾਰਿਆਂ ਦੀ ਛੇਤੀ ਪਛਾਣ ਅਤੇ ਇਲਾਜ

ਤੀਜਾ ਪੱਧਰ

ਖਾਸ ਕਲੀਨਿਕਾ ਅਤੇ ਹਸਪਤਾਲਾ ਵਿਚ ਇਲਾਜ ਦੀਆ ਸਹੂਲਤਾ

ਤੰਬਾਕੂ ਸੰਬੋਧਿਤ ਬੀਮਾਰਿਆਂ ਤੋਂ ਪੀੜ੍ਹਤ ਅਤੇਇਸ ਦੀ ਅੱਤ ਵਰਤੋਂ ਕਰਨ ਵਾਲਿਆਂ ਦਾ ਇਲਾਜ

ਫਾਰਮਾਕੋਥਿਰਾਪੀ

ਜਿਲਾ ਪੱਧਰ ਤੇ ਹਸਪਤਾਲਾ ਵਿਚ ਤੰਬਾਕੂ ਮੁਕਤੀ ਕੇਂ ਦਰ

ਕੋਂਸਲਰਾਂ ਦੀ ਮੌਜੂਦਗੀ

DISTRICT EDUCATION OFFICER

How many schools in the District are covered under Tobacco Control Program?

What is the age group of students targeted for the program?

What are the funds provided for school program?

What is the kind of training is provided to school teachers?

What is the frequency of discussions on tobacco in schools?

What is the kind of IEC involved for school children?

Is there any provision for counselling of children using tobacco?

Were any kiosks found near schools? If yes was any action taken by the officials involved under the program?

Are there any targets given by the government to be covered in the schools under the program?

Did the NTCP officials ever visit the school? If yes what is the frequency of such visits?

ਜਿਲਾ ਸਿਖਿਆ ਅਧਿਕਾਰੀ

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਜਿਲੇ ਦੇ ਕਿੰਨੇ ਸਕੂਲ ਸ਼ਾਮਲ ਹਨ?

ਇਸ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਟਾਰਗੇਟ ਕੀਤੇ ਗਏ ਵਿਦਿਆਰਥੀ ਕਿਸ ਉਮਰ ਸਮੂਹ ਦੇ ਹਨ?

ਸਕੂਲ ਪ੍ਰੋਗਰਾਮਾ ਵਾਸਤੇ ਕਿੰਨੇ ਫੰਡ ਦਿਤੇ ਗਏ ਹਨ?

ਸਕੂਲ ਦੇ ਅਧਿਆਪਕਾ ਨੂੰ ਕਿਸ ਤਰਾਂ ਦੀ ਟ੍ਰੇਨਿੰਗ ਦਿੱਤੀ ਗਈ ਹੈ?

ਸਕੂਲਾ ਵਿਚ ਤੰਬਾਕੂ ਤੇ ਵਿਚਾਰ ਵਟਾਂਦਰਾ ਕਿੰਨੇ ਚਿਰ ਬਾਅਦ ਕੀਤਾ ਜਾਂਦਾ ਹੈ?

ਸਕੂਲ ਦੇ ਬੱਚਿਆ ਨੂ ਤੰਬਾਕੂ ਨਾ ਵਰਤਨ ਲਈ ਕਿਸ ਤਰਾਂ ਜਾਗਰੁਕ ਕੀਤਾ ਜਾ ਰਿਹਾ ਹੈ?

ਕੀ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਵਾਲੇ ਬੱਚਿਆ ਦੀ ਕੋਂਸਲਿਗ ਦਾ ਕੋਈ ਬੰਦੋਬਸਤ ਹੈ?

ਕੀ ਸਕੂਲ ਦੇ ਨੇੜੇ ਤੰਬਾਕੂ ਵੇਚਣ ਦੇ ਅੱਡੇ ਹਨ?

ਜੇ ਹਾਂ, ਤਾਂ ਸੰਬੰਧਤ ਅਧਿਕਾਰਿਆ ਨੇ ਕੀ ਕਾਰਵਾਈ ਕੀਤੀ?

ਕੀ ਸਰਕਾਰ ਨੇ ਇਸ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਸ਼ਾਮਲ ਸਕੂਲਾ ਨੂੰ ਕਿਸੇ ਤਰਾਂ ਦੇ ਟੀਚੇ ਦਿੱਤੇ ਹਨ?

ਕੀ ਐਨ ਟੀ ਸੀ ਪੀ ਅਧਿਕਾਰਿਆ ਨੇ ਕਦੇ ਸਕੂਲਾਂ ਦਾ ਦੋਰਾ ਕੀਤਾ? ਜੇ ਹਾਂ ਤਾਂ ਕਿੰਨੇ ਕਿੰਨੇ ਸਮੇਂ ਬਾਅਦ?

DEPUTY SUPERINTENDENT OF POLICE

How many members from the police department form a part of the tobacco control team for raids?

What is the frequency of registration of criminal cases for illegal sale of tobacco products?

Who are these people against whom cases have been registered?

What kind of demands do you face for letting off the offenders?

Has your team face any confrontation from these offenders?

How many raids have been conducted in the past one year?

Are there any casualties faced by the police department?

What is your source of information for illegal sale of tobacco products?

Do you get any tip offs from other states or other districts?

Is there any inter district or interstate smuggling of illegal tobacco products?

If yes, how much cooperation do you get from other state machinery?

Any suggestions on behalf of police department for the government on tobacco control program?

ਡਿਪਟੀ ਸੁਪਰਿਨਟੇਨਡੈਂਟ ਆਫ ਪੁਲਿਸ

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਦੇ ਛਾਪਿਆਂ ਲਈ ਬਨਾਈ ਗਈ ਟੀਮ ਵਿਚ ਕਿਨੇਂ ਪੁਲਸ ਵਾਲੇ ਹੁੰਦੇ ਨੇ?

ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾ ਦੀ ਗੈਰ ਕਾਨੂੰਨੀ ਬਿਕਰੀ ਕਰਣ ਵਾਲਿਆ ਖਿਲਾਫ ਕੀ ਕੋਈ ਕ੍ਰਿਮਿਨਲ ਕੇਸ ਵੀ ਦਰਜ ਕੀਤਾ ਜਾਦਾਂ ਹੈ?

ਜੇ ਹਾਂ, ਤਾਂ ਕਿੰਨੇ ਸਮੇ ਵਿਚ ਕਿੰਨੇ ਕੇਸ ਦਰਜ ਹੋ ਜਾਂਦੇ ਹਨ?

ਇਹ ਕਿਹੜੇ ਲੋਕ ਹਨ ਜਿਹਨਾਂ ਖਿਲਾਫ ਮਾਮਲੇ ਦਰਜ ਹੋਏ ਹਨ?

ਅਜਿਹੇ ਲੋਕਾ ਨੂੰ ਛੱਡਣ ਵਾਸਤੇ ਕੀ ਤੁਹਾਡੇ ਕੋਲ ਕਿਸੇ ਤਰ੍ਹਾ ਦੀ ਮੰਗ ਆਉਂਦੀ ਹੈ?

ਕੀ ਤੁਹਾਡੇ ਸਟਾਫ ਨੂੰ ਅਜਿਹੇ ਲੋਕਾ ਖਿਲਾਫ ਕਾਰਵਾਈ ਕਰਦੇ ਸਮੇ ਕਿਸੇ ਵਿਰੋਧ ਦਾ ਸਾਹਮਣਾ ਕਰਨਾ ਪਿਆ ਹੈ?

ਪਿਛਲੇ ਇੱਕ ਸਾਲ ਦੋਰਾਨ ਜਲਧਰ ਵਿਚ ਕਿੰਨੇ ਛਾਪੇ ਮਾਰੇ ਗਏ ਹਨ ?

ਕੀ ਇੰਨਾ ਛਾਪਿਆ ਦੋਰਾਨ ਤੁਹਾਡੇ ਸਟਾਫ ਦਾ ਕੋਈ ਨੁਕਸਾਨ ਹੋਇਆ ਹੈ?

ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਦੀ ਗੈਰ ਕਾਨੂੰਨੀ ਬਿਕਰੀ ਬਾਰੇ ਜਾਣਕਾਰੀ ਕੋਣ ਦਿੰਦਾ ਹੈ?

ਕੀ ਤੁਹਾਨੂੰ ਅਜਿਹੀ ਜਾਣਕਾਰੀ ਹੋਰ ਸਟੇਟਾਂ ਅਤੇ ਜਿਲ੍ਹੇਆਂ ਤੋਂ ਭੀ ਮਿਲਦੀ ਹੈ?

ਕੀ ਜਿਲ੍ਹੇਆਂ / ਸਟੇਟਾਂ ਵਿਚਾਲੇ ਤੰਬਾਕੂ ਦੇ ਗੈਰ ਕਾਨੂੰਨੀ ਉਤਪਾਦਾਂ ਦੀ ਤਸਕਰੀ ਭੀ ਹੁੰਦੀ ਹੈ?

ਜੇ ਹਾਂ, ਤਾਂ ਤੁਹਾਨੂੰ ਦੂਜੇ ਰਾਜਾਂ / ਸਟੇਟਾਂ ਤੋਂ ਕਿੰਨਾ ਸਹਿਯੋਗ ਮਿਲਦਾ ਹੈ?

ਕੀ ਤੁਸੀ ਪੁਲ਼ੀਸ ਵਿਭਾਗ ਵਲੋ ਸਰਕਾਰ ਨੂੰ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਬਾਰੇ ਕੋਈ ਸੁਝਾਅ ਦੇਣਾ ਚਾਹੋਗ਼ੇ ?

HEALTH INSPECTORS

Name

Age

Sex

Designation

Were you given any training under tobacco control program?

If yes, what was the duration and who provided the training?

What are the effects causes by tobacco use?

How do you make people aware of harmful effects of tobacco?

Are you provided any incentives through the program?

Do you pay any visits in community?

If yes, what is your frequency of your visits?

How do you maintain the record of your activities?

Do you face any hindrances in the field? If yes, please elaborate.

Where do you refer the people using tobacco?

How much do the people in community cooperate?

Do you come across children who use tobacco?

Which age group uses tobacco in any form?

Did you find any women in the field who use tobacco?

If yes, what is the socio economic profile of such women?

How do you spread awareness about the effects of tobacco?

How do you support those who are willing to quit tobacco?

ਸਿਹਤ ਇੰਸਪੈਕਟਰ

ਨਾਂ

ਉਮਰ

ਲਿੰਗ

ਪਦਵੀ

ਕੀ ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਬਾਰੇ ਕੋਈ ਟ੍ਰੇਨਿੰਗ ਦਿੱਤੀ ਗਈ ਹੈ

ਜੇ ਹਾਂ, ਤਾਂ ਕਿੰਨੇ ਸਮੇ ਦੀ ਅਤੇ ਕਿਸ ਨੇ ਦਿੱਤੀ?

ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਦੇ ਕੀ ਪ੍ਰਭਾਵ ਹਨ?

ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਦੇ ਨੁਕਸਾਨ ਬਾਰੇ ਤੁਸੀ ਲੋਕਾ ਨੂੰ ਕਿਵੇ ਜਾਗਰੂਕ ਕਰਾਉਂਦੇ ਹੋ?

ਕੀ ਇਸ ਪ੍ਰੋਗਰਾਮ ਰਾਹੀ ਤੁਹਾਨੂੰ ਕੁਝ ਇਨਸੈਟਿਂਵ ਦਿੱਤੇ ਗਏ ਹਨ?

ਕੀ ਤੁਸੀ ਸਮਾਜ/ ਲੋਕਾ ਕੋਲ ਜਾਂਦੇ ਹੋ?

ਜੇ ਹਾ, ਤਾ ਕਿੰਨੇ ਸਮੇ ਬਾਅਦ?

ਤੁਸੀ ਅਪਨੇ ਕੀਤੇ ਕੰਮ ਦਾ ਕਿਵੇ ਰਿਕਾਰਡ ਰਖਦੇ ਹੋ?

ਕੀ ਤੁਹਾਨੂੰ ਅਪਨੀ ਜਿੰਮੇਵਾਰੀ ਨਿਭਾਉਣ ਵਿਚ ਕੋਈ ਦਿੱਕਤ ਆਉਂਦੀ ਹੈ? ਜੇ ਹਾਂ, ਤਾਂ ਕਿਸ ਤਰਾਂ ਦੀ?

ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਕਰਨ ਵਾਲੇ ਲੋਕਾ ਨੂੰ ਤੁਸੀ ਕਿਸ ਕੋਲ਼ ਭੇਜਦੇ ਹੋ?

ਸਮਾਜ ਦੇ ਲੋਕ ਤੁਹਾਨੂੰ ਕਿੰਨਾ ਸਹਿਯੋਗ ਕਰਦੇ ਹਨ?

ਕੀ ਕਦੇ ਤੁਹਾਡਾ ਵਾਸਤਾ ਕਦੇ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਕਰਣ ਵਾਲੇ ਬੱਚਿਆ ਨਾਲ ਪਇਆ ਹੈ?

ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਕਿਸੇ ਵੀ ਰੂਪ ਵਿਚ ਕਿਹੜੇ ਉਮਰ ਸਮੂਹ ਦੇ ਲੋਕ ਜਿਆਦਾ ਕਰਦੇ ਹਨ ?

ਕੀ ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਕਰਨ ਵਾਲੀ ਕੋਈ ਔਰਤ ਭੀ ਕਦੇ ਮਿਲੀ ਹੈ?

ਜੇ ਹਾਂ, ਤਾਂ ਅਜਿਹੀ ਔਰਤ ਦੀ ਸਮਾਜਿਕ ਅਤੇ ਆਰਥਿਕ ਸਥਿਤੀ ਕੀ ਸੀ?

ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਦੇ ਪ੍ਰਭਾਵ ਬਾਰੇ ਤੁਸੀ ਲੋਕਾ ਨੂੰ ਕਿਵੇ ਜਾਗਰੂਕ ਕਰਦੇ ਹੋ?

ਤੁਸੀ ਉਹਨਾ ਲੋਕਾ ਦੀ ਮਦਦ ਕਿਵੇ ਕਰਦੇ ਹੋ ਜਿਹੜੇ ਤੰਬਾਕੂ ਨੂੰ ਛੱਡਣਾ ਚਾਹੁੰਦੇ ਹਨ?

ANNEXURE A.4. SEMI STRUCTURED INTERVIEW SCHEDULE FOR PATIENTS OF ORAL CANCER

Demographic information

Name

Age

Sex

Religion

Migrant

If yes, from which place and since how many years have you been staying in Punjab?

Employment status

Education

Individual income

Family income

Tobacco use habits

At what age did you start the use of tobacco?

How did the use of tobacco start?

Use of tobacco at home

Peer pressure

Advertisements

Stress

Movies

Any other reasons

Type of tobacco use

Chewable

Non chewable

Both

Alcohol use, if any

What is the quantity of tobacco used daily?

Do you know about the effects of tobacco?

How did you come to know about the above said effects of tobacco?

Radio

Television

Posters /Banners

Internet

Friends

Doctors

Newspapers

Books

What is /was the daily expenditure on tobacco related products?

Did it affect the basic needs of your body and household? If yes how?

Efforts at quitting

Did you try quitting? If yes, at what age?

Did anyone else ask you to quit tobacco?

What were the symptoms when you quit tobacco use?

If you did not quit, what made you consume tobacco for such duration?

Did you ever see the warning on tobacco? If yes,

Was it in text or pictorial?

How did you interpret it?

When was your oral cancer first detected and by whom?

Did you notice the symptoms in your mouth?

What was the problem you faced when cancer was detected?

How did your family react to detection of oral cancer?

Did you get any help from government for treatment?

What was the total cost of treatment for your case?

Are you suffering from any other medical condition?

How do you educate people around you not to use tobacco?

ਮੂੰਹ ਦੇ ਕੈਂਸਰ ਦੇ ਮਰੀਜ

ਜਨਗਨਨਕ ਸੂਚਨਾ

ਨਾਂ

ਉਮਰ

ਲਿੰਗ

ਧਰਮ
ਪਰਵਾਸੀ

ਜੇ ਹਾਂ, ਤਾਂ ਦਸੋ ਕਿਹੜੀ ਥਾਂ ਤੋਂ ਆਏ ਹੋ ਅਤੇ ਪੰਜਾਬ ਵਿਚ ਕਿੰਨੇ ਸਮੇਂ ਤੋਂ ਰਹਿ ਰਹੇ ਹੋਂ?

ਰੋਜਗਾਰ

ਸਿਖਿਆ

ਨੀਜੀ ਆਮਦਨ

ਪਰਿਵਾਰਕ ਆਮਦਨ

ਤੰਬਾਕੂ ਸੰਬਧੀ ਆਦਤ

ਤੁਸੀ ਕਿੰਨੀ ਉਮਰ ਵਿਚ ਤੰਬਾਕੂ ਖਾਣਾ ਸ਼ੁਰੂ ਕੀਤਾ?

ਤੂਹਾਂਨੂ ਤੰਬਾਕੂ ਖਾਣ ਦੀ ਆਦਤ ਕਿਵੇਂ ਪਈ?

ਘਰ ਵਿਚ ਤੰਬਾਕੂ ਦਾ ਖਾਇਆ ਜਾਨਾ

ਦੋਸਤਾ ਦਾ ਦਬਾਅ

ਵਿਗਆਪਨ

ਤਨਾਅ ਕਰਕੇ

ਫਿਲਮਾ ਕਰਕੇ

ਕੋਈ ਹੋਰ ਕਾਰਨ

ਤੰਬਾਕੂ ਖਾਣ ਦੇ ਪ੍ਰਕਾਰ

ਚੱਬਨ ਵਾਲਾ

ਸਿਗਰਟ

ਦੋਨੋਂ

ਸ਼ਰਾਬ ਦਾ ਪ੍ਰਯੋਗ

ਤੁੰਸੀ ਤੰਬਾਕੂ ਕਿੰਨੀ ਮਾਤਰਾ ਵਿਚ ਰੋਜ ਖਾਂਦੇ ਹੋ?

ਕੀ ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਦੇ ਪ੍ਭਾਵ ਬਾਰੇ ਪਤਾ ਹੈ?

ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਦੇ ਉੱਤੇ ਦੱਸੇ ਪ੍ਰਬਾਵ ਬਾਰੇ ਕਿਵੇਂ ਪਤਾ ਲੱਗਿਆ?

ਰੇਡਿਓ

ਟੀ ਵੀ

ਪੋਸਟਰ / ਬੈਨਰ

ਇੰਟਰਨੈੱਟ

ਦੋਸਤਾ ਕੋਲੋ

ਡਾਕਟਰ ਕੋਲੋ

ਅਖਬਾਰ

ਕਿਤਾਬਾਂ

ਤਹਾਡਾਤੰਬਾਕੂ ਦਾ ਰੋਜ਼ਾਨਾ ਖਰਚ ਕਿੰਨਾ ਹੈ/ ਸੀ?

ਕੀ ਤੰਬਾਕੂ ਦੇ ਪ੍ਰਯੋਗ ਅਤੇ ਖਰਚ ਨੇ ਤੁਹਾਡੇ ਸ਼ਰੀਰ ਅਤੇ ਘਰ ਤੇ ਅਸਰ ਪਾਇਆ?

ਜੇ ਹਾਂ, ਤਾਂ ਕਿਵੇਂ?

ਤੰਬਾਕੂ ਛੱਡਣ ਦੀ ਕੋਸ਼ਿਸ਼

ਕੀ ਤੁਸੀ ਕਦੇ ਤੰਬਾਕੂ ਛੱਡਨ ਦੀ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ? ਜੇ ਹਾਂ, ਤਾਂ ਕਿੰਨੀ ਉਮਰ ਵਿਚ?

ਕੀ ਤੁਹਾਨੂੰ ਕਿਸੇ ਹੋਰ ਨੇ ਵੀ ਤੰਬਾਕੂ ਛੱਡਣ ਬਾਰੇ ਕਿਹਾ?

ਤੰਬਾਕੂ ਛੱਡਣ ਕਰਕੇ ਤੁਹਾਡੇ ਸਰੀਰਕ ਲੱਛਣ ਕੀ ਸੀ?

ਜੇ ਤੁਸੀ ਤੰਬਾਕੂ ਖਾਣਾ ਨਹੀ ਛੱਡਿਆ ਤਾਂ ਉਸਦੀ ਕੀ ਵਜ੍ਹਾ ਸੀ?

ਕੀ ਤਸੀ ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾਂ ਤੇ ਲਿਖੀ ਚਿਤਾਵਨੀ ਦੇਖੀ ਹੈ?

ਜੇ ਹਾਂ, ਤਾਂ ਕੀ ਇਹ ਲਿਖਤ ਵਿਚ ਜਾਂ ਚਿੱਤਰ ਰਾਹੀਂ ਸੀ?

ਤੁਸੀ ਇਸ ਚਿਤਾਵਨੀ ਤੋ ਕੀ ਸਮਝਿਆ?

ਤੁਹਾਨੂੰ ਮੂੰਹ ਦੇ ਕੈਸੰਰ ਬਾਰੇ ਪਹਿਲਾ ਪਤਾ ਕਿਸ ਤੋਂ ਲਗਿਆ ਅਤੇ ਕਦੋਂ?

ਕੀ ਤੁਸੀ ਇਸ ਦੇ ਲੱਛਣਾ ਨੂੰ ਅਪਨੇ ਮੂੰਹ ਵਿਚ ਮਹਿਸੂਸ ਕੀਤਾ?

ਕੈਸੰਰ ਦੇ ਪਤਾ ਲੱਗਣ ਤੋਂ ਬਾਅਦ ਤੁਹਾਨੂੰ ਕਿਹੜੀ ਸਮਸਿਆਵਾਂ ਦਾ ਸਾਹਮਣਾ ਕਰਨਾ ਪਿਆ?

ਮੂੰਹ ਦੇ ਕੈਸੰਰ ਦੇ ਪਤਾ ਲੱਗਣ ਤੇ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਦਾ ਕੀ ਰੁੱਖ ਸੀ?

ਕੀ ਤੁਹਾਨੂੰ ਇਲਾਜ ਵਾਸਤੇ ਕੋਈ ਸਰਕਾਰੀ ਮਦਦ ਮਿਲੀ?

ਤੁਹਾਡੇ ਇਲਾਜ ਦਾ ਕੁੱਲ ਖਰਚਾ ਕਿੰਨਾ ਸੀ?

ਕੀ ਤੁਹਾਨੂੰ ਕੋਈ ਹੋਰ ਬੀਮਾਰੀ ਵੀ ਹੈ?

ਤੰਬਾਕੂ ਨਾ ਵਰਤਣ ਲਈ ਤੁਸੀਂ ਆਪਣੇ ਨੇੜਲੇ ਲੋਕਾਂ ਨੂੰ ਕੀ ਸਿਖਿਆ ਦਿੰਦੇ ਹੋ?

ANNEXURE A.5.SEMI STRUCTURED INTERVIEW SCHEDULE FOR KIOSK HOLDERS

Name

Age

Sex

Education

Migrant

Since how many years are you selling any form of tobacco products?

What are the main tobacco products you sell?

How many packets of tobacco products do you sell daily?

Smoking form

Smokeless form

What is the age group which asks for tobacco products?

Which is the most sought after tobacco product?

Which are the major brands sold for smoking as well as smokeless tobacco?

What do these tobacco products cost you?

Did you receive any warning for the legal issues involved in the sale of tobacco products?

Do you sell your products to children? If yes, what is the age group of these children demanding tobacco products?

In what form is the tobacco product sold to them?

Do you get any incentives for sale of your products?

Do you sell loose cigarettes?

If yes, how many on a daily average?

Which age group asks for smokeless tobacco products?

Who are the retailers from where you procure your tobacco products?

How much is the scope of profit in sale of tobacco products?

Do you have an alternate business? If yes, what is the nature of that business?

Is there anyone else in the family who is involved in the sale of tobacco products?

Do you about the harmful effects of tobacco? Please elaborate on the same.

Do you wish to continue the same business in near future?

ਤੰਬਾਕੂ ਵੇਚਨ ਵਾਲ਼ੇ ਖੋਖਾ ਮਾਲਕ

ਨਾਂ

ਉਮਰ

ਲਿੰਗ

ਸਿਖਿਆ

ਪਰਵਾਸੀ

ਤੁਸੀ ਕਦੋਂ ਤੋਂ ਕਿਸੇ ਵੀ ਤਰਾਂ ਦੇ ਤੰਬਾਕੂ ਉਤਪਾਦ ਬੇਚ ਰਹੇ ਹੋ?

ਤੁਸੀ ਮੁੱਖ ਤੋਰ ਤੇ ਤੰਬਾਕੂ ਦੇ ਕਿਹੜੇ ਉਤਪਾਦ ਵੇਚਦੇ ਹੋ?

ਤੁਸੀ ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾਂ ਦੇ ਕਿੰਨੇ ਪੈਕੇਟ ਰੋਜ ਵੇਚ ਲੇਂਦੇ ਹੋ?

ਸਿਗ਼ਰਟ ਵਾਲੇ

ਚਬਣ ਵਾਲੇ

ਤੰਬਾਕੂ ਉਤਪਾਦ ਖਰੀਦਣ ਵਾਲੇ ਕਿਹੜੇ ਉਮਰ ਸਮੂਹ ਦੇ ਹੁੰਦੇ ਹਨ?

ਤੰਬਾਕੂ ਦਾ ਕਿਹੜਾ ਉਤਪਾਦ ਸਭ ਤੋਂ ਜਿਆਦਾ ਵਿਕਦਾ ਹੈ?

ਤੰਬਾਕੂ ਦੇ ਸਿਗ਼ਰਟ ਅਤੇ ਚਬਣ ਵਾਲੇ ਉਤਪਾਦਾਂ ਦੇ ਕਿਹੜੇ ਮੁੱਖ ਬ੍ਰਾਂਡ ਬਿਕਦੇ ਹਨ?

ਤੰਬਾਕੂ ਦੇ ਇਹਨਾ ਉਤਪਾਦਾ ਦੀ ਤੁਹਾਡੀ ਕੀ ਲਾਗਤ ਆਉਂਦੀ ਹੈ?

ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾ ਨੂੰ ਵੇਚਣ ਸੰਬੰਧਤ ਕਨੂੰਨੀ ਮੁਦਿਆਂ ਬਾਰੇ ਕੀ ਤੁਹਾਨੂੰ ਕਦੇ ਕੋਈ ਚਿਤਾਵਨੀ ਦਿੱਤੀ ਗਈ ਹੈ?

ਕੀ ਤੁਸੀ ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦ ਬੱਚਿਆ ਨੂੰ ਵੀ ਬੇਚਦੇ ਹੋ?

ਜੇ ਹਾਂ , ਤਾਂ ਕਿਹੜੀ ਉਮਰ ਦੇ ਬੱਚੇ ਇਹਨਾ ਉਤਪਾਦਾ ਦੀ ਮੰਗ ਕਰਦੇ ਹਨ?

ਕਿਹੜੇ ਰੂਪ ਵਿਚ ਤੰਬਾਕੂ ਤੁਸੀ ਇਹਨਾ ਬੱਚਿਆ ਨੂੰ ਵੇਚਦੇ ਹੋ?

ਕੀ ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾ ਨੂੰ ਵੇਚਣ ਤੇ ਕੋਈ ਪ੍ਰੋਤਸਾਹਨ ਵੀ ਮਿਲਦਾ ਹੈ?

ਕੀ ਤੁਸੀ ਖੁੱਲ੍ਹੀ ਸਿਗਰਟ ਵੀ ਬੇਚਦੇ ਹੋ?

ਜੇ ਹਾਂ ,ਤਾਂ ਇਕ ਦਿਨ ਵਿਚ ਔਸਤਨ ਕਿੰਨਿਆ ਸਿਗਰਟਾਂ ਵੇਚ ਦਿੰਦੇ ਹੋ

ਤੰਬਾਕੂ ਦਾ ਚਬਣ ਵਾਲ਼ੇ ਉਤਪਾਦ ਤੁਹਾਡੇ ਕੋਲੋਂ ਕਿਹੜੇ ਉਮਰ ਸਮੂਹ ਦੇ ਲੋਕ ਮੰਗਦੇ ਹਨ?

ਕਿਹੜੇ ਖੁਦਰਾ ਵਪਾਰਿਆਂ ਤੋਂ ਤੁਹਾਨੂੰ ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦ ਮਿਲਦੇ ਹਨ?

ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾ ਦੀ ਬਿਕਰੀ ਵਿਚ ਕਿੰਨਾ ਮੁਨਾਫਾ ਹੋ ਜਾਂਦਾ ਹੈ?

ਇਸ ਤੋ ਇਲਾਵਾ ਤੁਹਾਡਾ ਕੋਈ ਹੋਰ ਰੋਜ਼ਗਾਰ ਦਾ ਸਾਧਨ ਹੈ ? ਜੇ ਹਾ ਤਾ ਕੀ ਰੁਜ਼ਗਾਰ ਹੈ ?

ਕੀ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਵਿਚ ਕੋਈ ਹੋਰ ਵੀ ਤੰਬਾਕੂ ਦੇ ਉਤਪਾਦਾ ਦੀ ਵਿਕਰੀ ਕਰਦਾ ਹੈ ?

ਕੀ ਤੁਹਾਨੁ ਤੰਬਾਕੂ ਵਰਤਨ ਦੇ ਪਰਭਾਵ ਬਾਰੇ ਪਤਾ ਹੈ? ਉਹਦੇ ਤੇ ਚਾਨਣਾ ਪਾਓ.

ਕੀ ਤੁਸੀ ਭਵਿਖ ਵਿਚ ਵੀ ਏਹੋ ਕੰਮ ਕਰਨਾ ਚਾਹੋਗੇ?

ANNEXURE A.6. IERB APPROVAL

INSTITUTIONAL ETHICS REVIEW BOARD
Jawaharlal Nehru University
New Delhi-110067

Name of the Ethics Committee: IERB-JNU IERB Ref. No.2016/Student/107

Title of the Project Proposal: **"Policy context and social correlates of Tobacco use: A case study of District Jalandhar, Punjab"**

Principal Investigator: Ms. Shaveta Menon (Ph. D Student) C/o Supervisor: Dr. Ramila Bisht, CSM&CH/SSS/JNU

Telephone: 8800103748 **Email: shaveta_003@yahoo.com**

Collaborators' Name:

FOR OFFICIAL USE

The proposal was reviewed in a meeting held on 8th December, 2016 at 4:00 PM. The following members were present:

1. Professor Shiv K. Sarin, Chairperson
2. Prof. S.C. Malik, Member
3. Prof. Ravinder Gargesh, Member
4. Prof. Vijay Kumar
5. Prof. Ramesh C. Juyal, Member
6. Dr. Tripti Khanna, Member
7. Advocate Rukhsana Chaoudhary , Member
8. Advocate Omika Dubey, Member
9. Dr. Sushil Kumar Jha, Member
10. Dr. Paul Raj , Member
11. Prof. Amita Singh, Member Secretary

The committee resolved to

[✓] Approve - indicating that the proposal is approved as submitted;
[ ] Approve – after clarifications – indicating that the proposal is approved if the clarifications Requested are provided to the satisfaction of designated committee members;
[ ] Approve after amendment/s – indicating that the proposal is approved subject to the incorporation of the specified amendments verified by designated committee members;
[ ] Defer – indicating that the proposal is not approved as submitted but it can be reassessed after revision to address the specified reason/s for deferment;
[ ] Disapprove – indicating that the proposal is not approved for the reason specified.

Comments:

RECOMMENDED

Member Secretary,
IERB, Ethics Committee

Prof. Amita Singh
Member-Secretary
Institutional Ethics Review Boa
Jawaharlal Nehru University
New Delhi - 110067

Date of Approval: 04.02.2017 (after acceptance of revisions)

*(1st part to be filled in by PI and presented at the time of Review (Periodic, Continuing, Interim)).

ANNEXURE A.7. INFORMED CONSENT FORM FOR OFFICIALS INVOLVED IN TOBACCO CONTROL

HEALTH OFFICIALS

(To be filled by PI at the time Review periodic, continuing, interim)

Department:

Designation in Tobacco Control Program:

Title of the project: Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab

Investigators: Shaveta Menon

Centre/School: Centre for Social Medicine & Community Health

School Of Social Sciences

Brief description of the study

In my research, I want to focus on the state of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Government of India has been trying to address the use of tobacco and related diseases in Indian population, the approach to socio demographic factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The status of tobacco control and factors responsible for the same will be studied in context of the state of Punjab, streamlining the research area to district Jalandhar.

The role of the officials in the Tobacco Control Program at the district level will be to familiarize the researcher with the Tobacco Control Program running in Jalandhar district and its implementation on the field. The officials will not hide or manipulate any kind of information which can be relevant to the research.

CONSENT FORM (for the participant /subject)

The advantages and disadvantages of the research in which I am expected to participate have been explained to me. I will be involved in giving the information desired of me to help in the research by answering the questions put to me.

I willingly, under no pressure from the researcher-

(i) Agree to take part in this research, and agree to participate in all investigations which will help acquire knowledge for the benefit of the mankind,

(ii) Agree to respond in the interview to best of my ability.

I give my consent to researcher for obtaining government data on tobacco control from the concerned officials of my department. I have been informed that JNU and

the researcher (Shaveta Menon) will take my prior consent before they draw benefits from the research in which I have participated.

Signatures

Subject Principle Investigator:

DATE:

CONTACT DETAIL

Details of Researcher

Address

Mobile No.

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਦਿਕਾਰੀ ਲਈ ਸਹਿਮਤੀ ਫਾਰਮ

ਸਿਹਤ ਅਧਿਕਾਰੀ

ਪ੍ਰੋਜੈਕਟ ਦਾ ਸਿਰਲੇਖ: ਨੀਤੀ ਪ੍ਰਸੰਗ ਅਤੇ ਤੰਬਾਕੂ ਵਰਤਣ ਦੇ ਸਮਾਜਿਕ ਸਬੰਧ: ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ, ਪੰਜਾਬ ਦਾ ਇਕ ਕੇਸ ਅਧਿਐਨ

ਵਿਭਾਗ:

ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਵਿੱਚ ਅਹੁਦਾ:

ਖੋਜਕਾਰ ਦਾ ਨਾਮ

ਸ਼ਵੇਤਾ ਮੈਨਨ

ਸੈਂਟਰ : ਸੋਸ਼ਲ ਮੈਡੀਸਨ ਅਤੇ ਕਮਿਊਨਿਟੀ ਹੈਲਥ

ਸੋਸ਼ਲ ਸਾਇੰਸਜ਼ ਸਕੂਲ

ਜਵਾਹਰ ਲਾਲ ਨਹਿਰੂ ਯੂਨੀਵਰਸਿਟੀ, ਦਿੱਲੀ.

ਅਧਿਐਨ ਦਾ ਸੰਖੇਪ ਵੇਰਵਾ:

ਮੇਰੀ ਖੋਝ ਵਿਚ ਮੈ ਪੰਜਾਬ ਦੇ ਜਿਲਾ ਜਲੰਧਰ ਵਿਚ ਹੋ ਰਹੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸ ਦੇ ਨੀਤੀ ਪ੍ਰਸੰਗ ਦਾ ਅਧਿਐਨ ਕਰਨਾ ਚਾਹੁੰਦੀ ਹਾ. ਭਾਰਤ ਸਰਕਾਰ ਵੱਲੋ ਅਬਾਦੀ ਵਿਚ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਅਤੇ ਇਸ ਨਾਲ ਸਬੰਧਤ ਰੋਗਾ ਨਾਲ ਨੱਜੀਠਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ ਗਈ ਹੈ ਪਰ ਸਮਾਜਿਕ ਰੂਪ ਤੇ ਜਿੰਮੇਦਾਰ ਤਤਾ ਨੂੰ ਧਿਆਨ ਵਿਚ ਨਹੀ ਰਖਿਆ ਗਿਆ. ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸੇ ਲਈ ਜ਼ਿੰਮੇਵਾਰ ਹਾਲਤ ਨੂੰ ਪੰਜਾਬ ਰਾਜ ਦੇ ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ ਦੇ ਪ੍ਰਸੰਗ ਵਿਚ ਅਧਿਐਨ ਕੀਤਾ ਜਾਵੇਗਾ. ਇਸ ਵਿਚ ਖਾਸ ਤੌਰ 'ਤੇ ਮੂੰਹ ਦੇ ਕੈਂਸਰ ਦੇ ਸਮਾਜਿਕ ਕਾਰਨਾ ਨੂ ਅਤੇ ਉਸ ਦੇ ਪ੍ਰਭਾਵ ਨੂ ਦੇਖਆ ਜਾਏਗਾ.

ਜ਼ਿਲ੍ਹਾ ਪੱਧਰ 'ਤੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਅਧਿਕਾਰੀ ਦੀ ਭੂਮਿਕਾ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਜਲੰਧਰ ਜ਼ਿਲ੍ਹੇ ਅਤੇ ਖੇਤਰ' ਤੇ ਇਸ ਦੇ ਲਾਗੂ ਕਰਨ ਵਿੱਚ ਚੱਲ ਨਾਲ ਖੋਜਕਾਰ ਜਾਣੂ ਕਰਨ ਲਈ ਹੋ ਜਾਵੇਗਾ. ਅਧਿਕਾਰੀ ਕਿਸੇ ਵੀ ਕਿਸਮ ਦੀ ਉਸ ਜਾਣਕਾਰੀ ਨੂੰ ਓਹਲੇ ਨਹੀ ਕਰੇਗਾ ਜੋ ਕਿ ਖੋਜ ਕਰਨ ਲਈ ਸੰਬੰਧਤ ਹੋ ਸਕਦੀ ਹੈ.**ਸਹਿਮਤੀ ਫਾਰਮ (ਭਾਗੀਦਾਰ / ਵਿਸ਼ੇ ਲਈ)**

ਇਹ ਖੋਜ ,ਜਿਸ ਵਿਚ ਮੇਰੇ ਹਿੱਸਾ ਲੈਣ ਦੀ ਸੰਭਾਵਨਾ ਹੈ, ਉਸ ਦੇ ਫਾਇਦੇ ਅਤੇ ਨੁਕਸਾਨ ਮੈਨੂੰ ਸਮਝਾਏ ਗਏ ਹਨ .ਖੋਜ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਮੈ ਜਾਣਕਾਰੀ ਮੁਤਾਬਿਕ ਸਵਾਲਾ ਦੇ ਜਵਾਬ ਦੇ ਕੇ ਆਪਨਾ

ਯੋਗਦਾਨ ਦੇਨਾ ਚਾਹੁੰਦਾ ਹਾ.

ਮੈਨੂੰ ਖ਼ੁਸ਼ੀ-ਖ਼ੁਸ਼ੀ ਬਿਨਾ ਕਿਸੇ ਦੇ ਦਬਾਅ ਹੇਠ

(I) ਇਸ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ, ਅਤੇ ਸਾਰੇ ਪੜਤਾਲ, ਜੋ ਮਨੁੱਖਜਾਤੀ ਦੇ ਭਲੇ ਲਈ ਗਿਆਨ ਹਾਸਲ

ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰੇਗਾ, ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾ.

(Ii) ਆਪਣੀ ਯੋਗਤਾ ਮੁਤਾਬਿਕ ਇੰਟਰਵਿਊ ਵਿਚ ਜਵਾਬ ਦੇਣ ਲਈ ਸਹਿਮਤ ਹਾ.

ਮੇਰੀ ਸਹਿਮਤੀ ਸਪਸ਼ਟ ਕੋਈ ਵੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ ਨਹੀ ਹੈ. ਮੈਨੂੰ ਅਤੇ ਮੇਰੇ

ਨਾਲ ਸਬੰਧਤ ਪੜਤਾਲ ਕਰਕੇ ਪ੍ਰਾਪਤ ਕੋਈ ਵੀ ਅਜਿਹੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ,

ਖ਼ੋਜਕਾਰ ਨੂੰ ਮੇਰੇ ਕੋਲੋ ਦੋਬਾਰਾ ਸਹਿਮਤੀ ਪ੍ਰਾਪਤ ਕਰਨੀ ਪਏਗੀ.

ਮੈ , ਮੇਰੇ ਵਿਭਾਗ ਦੇ ਸਬੰਧਤ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਤੇ ਸਰਕਾਰ ਡਾਟਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਖੋਜਕਾਰ ਦੀ ਮਦਦ ਕਰਨ ਲਈ ਸੇਹਮਤ ਹਾ . ਮੈਨੂੰ ਸੂਚਿਤ ਕਰ ਦਿੱਤਾ ਗਿਆ ਹੈ ਕਿ ਜਵਾਹਰ ਲਾਲ ਨੇਹਰੂ ਉਨਿਵਰਸੀਟੀ ਅਤੇ ਖੋਜਕਾਰ (ਸ਼ਵੇਤਾ ਮੈਨਨ) ਇਸ ਖੋਜ ਤੋ ਲਾਭ ਖਿੱਚਣ ਤੋ ਪਿਹਲਾ ਮੇਰੇ ਕੋਲੋ ਸਹਿਮਤੀ ਲੈਣ ਲਈ ਵੱਚਨਬਦ ਹਨ.

ਦਸਤਖਤ

ਵਿਸ਼ਾ ਅਸੂਲ ਇਨਵੈਸਟੀਗੇਟਰ

ਮਿਤੀ :

ਸੰਪਰਕ ਵੇਰਵਾ

ਖੋਜਕਰਤਾ ਦਾ ਵੇਰਵਾ

ਪਤਾ ਮੋਬਾਈਲ ਨੰ

INFORMED CONSENT FORM FOR DISTRICT EDUCATION OFFICER

(To be filled by PI at the time Review periodic, continuing, interim)

Title of the project: Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab

Investigators: Shaveta Menon

Centre/School: Centre for Social Medicine & Community Health

School Of Social Sciences

Brief description of the study

In my research, I want to focus on the state of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Government of India has been trying to address the use of tobacco and related diseases in Indian population, the approach to socio demographic factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The role of the education department is to take necessary steps in preventing the adolescents from using tobacco in any form.

CONSENT FORM (for the participant /subject)

The advantages and disadvantages of the research in which I am expected to participate have been explained to me. I will be involved in giving the information desired of me to help in the research by answering the questions put to me.

I willingly, under no pressure from the researcher-

(i) Agree to take part in this research, and agree to participate in all investigations which will help acquire knowledge for the benefit of the mankind,

(ii) Agree to respond in the interview to best of my ability.

I give my consent to researcher for obtaining the education department's data and role in the Tobacco Control Program .I have been informed that JNU and the researcher (Shaveta Menon) will take my prior consent before they draw benefits from the research in which I have participated.

Signatures

Subject Principle Investigator:

DATE:

CONTACT DETAIL

Details of Researcher

Address

Mobile No.

ਜ਼ਿਲ੍ਹਾ ਸਿੱਖਿਆ ਅਫਸਰ ਲਈ ਸਹਿਮਤੀ ਫਾਰਮ

ਪ੍ਰੋਜੈਕਟ ਦਾ ਸਿਰਲੇਖ: ਨੀਤੀ ਪ੍ਰਸੰਗ ਅਤੇ ਤੰਬਾਕੂ ਵਰਤਣ ਦੇ ਸਮਾਜਿਕ ਸਬੰਧ: ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ, ਪੰਜਾਬ ਦਾ ਇਕ ਕੇਸ ਅਧਿਐਨ

ਖੋਜਕਾਰ ਦਾ ਨਾਮ

ਸ਼ਵੇਤਾ ਮੈਨਨ

ਸੈਂਟਰ : ਸੋਸ਼ਲ ਮੈਡੀਸਨ ਅਤੇ ਕਮਿਊਨਿਟੀ ਹੈਲਥ

ਸੋਸ਼ਲ ਸਾਇੰਸਜ਼ ਸਕੂਲ

ਜਵਾਹਰ ਲਾਲ ਨਹਿਰੂ ਯੂਨੀਵਰਸਿਟੀ, ਦਿੱਲੀ.

ਅਧਿਐਨ ਦਾ ਸੰਖੇਪ ਵੇਰਵਾ:

ਮੇਰੀ ਖੋਜ਼ ਵਿਚ ਮੈ ਪੰਜਾਬ ਦੇ ਜਿਲਾ ਜਲੰਧਰ ਵਿਚ ਹੋ ਰਹੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸ ਦੇ ਨੀਤੀ ਪ੍ਰਸੰਗ ਦਾ ਅਧਿਐਨ ਕਰਨਾ ਚਾਹੁੰਦੀ ਹਾ. ਭਾਰਤ ਸਰਕਾਰ ਵੱਲੋ ਅਬਾਦੀ ਵਿਚ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਅਤੇ ਇਸ ਨਾਲ ਸਬੰਧਤ ਰੋਗਾ ਨਾਲ ਨੱਜੀਠਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ ਗਈ ਹੈ ਪਰ ਸਮਾਜਿਕ ਰੂਪ ਤੇ ਜਿੰਮੇਦਾਰ ਤਤਾ ਨੂੰ ਧਿਆਨ ਵਿਚ ਨਹੀ ਰਖਿਆ ਗਿਆ. ਸਿੱਖਿਆ ਵਿਭਾਗ ਦੀ ਭੂਮਿਕਾ ਕਿਸੇ ਵੀ ਰੂਪ ਵਿਚ ਤੰਬਾਕੂ ਦਾ ਇਸਤੇਮਾਲ ਲਈ ਅੱਲੜ ਨੂੰ ਰੋਕਣ ਲਈ ਜ਼ਰੂਰੀ ਕਦਮ ਲੈਣ ਲਈ ਹੁੰਦਾ ਹੈ.

ਸਹਿਮਤੀ ਫਾਰਮ (ਭਾਗੀਦਾਰ / ਵਿਸ਼ੇ ਲਈ)

ਇਹ ਖੋਜ ,ਜਿਸ ਵਿਚ ਮੇਰੇ ਹਿੱਸਾ ਲੈਣ ਦੀ ਸੰਭਾਵਨਾ ਹੈ, ਉਸ ਦੇ ਫਾਇਦੇ ਅਤੇ ਨੁਕਸਾਨ ਮੈਨੂੰ ਸਮਝਾਏ ਗਏ ਹਨ .ਖੋਜ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਮੈ ਜਾਣਕਾਰੀ ਮੁਤਾਬਿਕ ਸਵਾਲਾ ਦੇ ਜਵਾਬ ਦੇ ਕੇ ਆਪਨਾ ਯੋਗਦਾਨ ਦੇਨਾ ਚਾਹੁੰਦਾ ਹਾ.

ਮੈਨੂੰ ਖ਼ੁਸ਼ੀ-ਖ਼ੁਸ਼ੀ ਬਿਨਾ ਕਿਸੇ ਦੇ ਦਬਾਅ ਹੇਠ

(I) ਇਸ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ, ਅਤੇ ਸਾਰੇ ਪੜਤਾਲ, ਜੋ ਮਨੁੱਖਜਾਤੀ ਦੇ ਭਲੇ ਲਈ ਗਿਆਨ ਹਾਸਲ ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰੇਗਾ, ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾ.

(Ii) ਆਪਣੀ ਯੋਗਤਾ ਮੁਤਾਬਿਕ ਇੰਟਰਵਿਊ ਵਿਚ ਜਵਾਬ ਦੇਣ ਲਈ ਸਹਿਮਤ ਹਾ.

ਮੇਰੀ ਸਹਿਮਤੀ ਸਪਸ਼ਟ ਕੋਈ ਵੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ ਨਹੀ ਹੈ. ਮੈਨੂੰ ਅਤੇ ਮੇਰੇ ਨਾਲ ਸਬੰਧਤ ਪੜਤਾਲ ਕਰਕੇ ਪ੍ਰਾਪਤ ਕੋਈ ਵੀ ਅਜਿਹੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ, ਖ਼ੋਜਕਾਰ ਨੂੰ ਮੇਰੇ ਕੋਲੋ ਦੋਬਾਰਾ ਸਹਿਮਤੀ ਪ੍ਰਾਪਤ ਕਰਨੀ ਪਏਗੀ.

ਮੈਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਵਿੱਚ ਸਿੱਖਿਆ ਵਿਭਾਗ ਦੇ ਡਾਟਾ ਅਤੇ ਭੂਮਿਕਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਖੋਜਕਾਰ ਦੀ ਮਦਦ ਕਰਨ ਲਈ ਸੇਹਮਤ ਹਾ . ਮੈਨੂੰ ਸੂਚਿਤ ਕਰ ਦਿੱਤਾ ਗਿਆ ਹੈ ਕਿ ਜਵਾਹਰ ਲਾਲ ਨੇਹਰੂ ਉਨਿਵਰਸੀਟੀ ਅਤੇ ਖੋਜਕਾਰ (ਸ਼ਵੇਤਾ ਮੈਨਨ) ਇਸ ਖੋਜ ਤੋ ਲਾਭ ਖਿੱਚਣ ਤੋ ਪਿਹਲਾ ਮੇਰੇ ਕੋਲੋ ਸਹਿਮਤੀ ਲੈਣ ਲਈ ਵੱਚਨਬਦ ਹਨ.

ਦਸਤਖਤ

ਵਿਸ਼ਾ ਅਸੂਲ ਇਨਵੈਸਟੀਗੇਟਰ

ਮਿਤੀ :

ਸੰਪਰਕ ਵੇਰਵਾ

ਖੋਜਕਰਤਾ ਦਾ ਵੇਰਵਾ

ਪਤਾ

ਮੋਬਾਈਲ ਨੰ

INFORMED CONSENT FORM FOR DEPUTY SUPERINTENDANT OF POLICE

(To be filled by PI at the time Review periodic, continuing, interim)

Title of the project: Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab

Investigators: Shaveta Menon

Centre/School: Centre for Social Medicine & Community Health

School Of Social Sciences

Brief description of the study

In my research, I want to focus on the state of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Government of India has been trying to address the use of tobacco and related diseases in Indian population, the approach to socio demographic factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The police department plays an important role in collaboration with the health authorities in nabbing the offenders and providing protection to the officials on raid in the field. The department and its activities are important for the researcher to strengthen the subject of tobacco control.

CONSENT FORM (for the participant /subject)

The advantages and disadvantages of the research in which I am expected to participate have been explained to me. I will be involved in giving the information desired of me to help in the research by answering the questions put to me.

I willingly, under no pressure from the researcher-

(I) Agree to take part in this research, and agree to participate in all investigations which will help acquire knowledge for the benefit of the mankind,

(ii) Agree to respond in the interview to best of my ability.

I give my consent for researching the responsibilities of the police department in tobacco control program and will share the data regarding the tobacco control activities by the department with her .I have been informed that JNU and the researcher (Shaveta Menon) will take my prior consent before they draw benefits from the research in which I have participated.

Signatures

Subject Principle Investigator:

DATE:

CONTACT DETAIL

Details of Researcher

Address

Mobile No.

ਡਿਪਟੀ ਸੁਪਰਿਨਟੇਨਡੈਂਟ ਆਫ ਪੁਲਿਸ ਲਈ ਸਹਿਮਤੀ ਫਾਰਮ

ਪ੍ਰੋਜੈਕਟ ਦਾ ਸਿਰਲੇਖ: ਨੀਤੀ ਪ੍ਰਸੰਗ ਅਤੇ ਤੰਬਾਕੂ ਵਰਤਣ ਦੇ ਸਮਾਜਿਕ ਸਬੰਧ: ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ, ਪੰਜਾਬ ਦਾ ਇਕ ਕੇਸ ਅਧਿਐਨ

ਖੋਜਕਾਰ ਦਾ ਨਾਮ

ਸ਼ਵੇਤਾ ਮੈਨਨ

ਸੈਂਟਰ : ਸੋਸ਼ਲ ਮੈਡੀਸਨ ਅਤੇ ਕਮਿਊਨਿਟੀ ਹੈਲਥ

ਸੋਸ਼ਲ ਸਾਇੰਸਜ਼ ਸਕੂਲ

ਜਵਾਹਰ ਲਾਲ ਨਹਿਰੂ ਯੂਨੀਵਰਸਿਟੀ, ਦਿੱਲੀ.

ਅਧਿਐਨ ਦਾ ਸੰਖੇਪ ਵੇਰਵਾ:

ਮੇਰੀ ਖੋਜ ਵਿਚ ਮੈ ਪੰਜਾਬ ਦੇ ਜਿਲਾ ਜਲੰਧਰ ਵਿਚ ਹੋ ਰਹੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸ ਦੇ ਨੀਤੀ ਪ੍ਰਸੰਗ ਦਾ ਅਧਿਐਨ ਕਰਨਾ ਚਾਹੁੰਦੀ ਹਾ. ਭਾਰਤ ਸਰਕਾਰ ਵੱਲੋ ਅਬਾਦੀ ਵਿਚ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਅਤੇ ਇਸ ਨਾਲ ਸਬੰਧਤ ਰੋਗਾ ਨਾਲ ਨੱਜੀਠਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ ਗਈ ਹੈ ਪਰ ਸਮਾਜਿਕ ਰੂਪ ਤੇ ਜਿੰਮੇਦਾਰ ਤਤਾ ਨੂੰ ਧਿਆਨ ਵਿਚ ਨਹੀ ਰਖਿਆ ਗਿਆ. ਪੁਲਿਸ ਵਿਭਾਗ ਸੇਹਤ ਵਿਭਾਗ ਦੇ ਸਹਿਯੋਗ ਨਾਲ ਇਕ ਮਹੱਤਵਪੂਰਨ ਅਪਰਾਧੀ ਨੂੰ ਫੜਨ ਅਤੇ ਖੇਤਰ ਵਿਚ ਛਾਪਾ ਮਾਰਨ ' ਤੇ ਅਧਿਕਾਰੀ ਨੂੰ ਸੁਰੱਖਿਆ ਪ੍ਰਦਾਨ ਕਰਨ ਵਿੱਚ ਅਹਿਮ ਭੁਮਿਕਾ ਅਦਾ ਕਰਦਾ ਹੈ. ਵਿਭਾਗ ਦੇ ਇਸ ਕੰਮ ਦੀ ਜਾਨਕਾਰੀ ਖੋਜਕਾਰ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਦੇ ਵਿਸ਼ੇ ਨੂੰ ਮਜ਼ਬੂਤ ਕਰਨ ਲਈ ਜ਼ਰੂਰੀ ਹੈ.

ਸਹਿਮਤੀ ਫਾਰਮ (ਭਾਗੀਦਾਰ / ਵਿਸ਼ੇ ਲਈ)

ਇਹ ਖੋਜ ,ਜਿਸ ਵਿਚ ਮੇਰੇ ਹਿੱਸਾ ਲੈਣ ਦੀ ਸੰਭਾਵਨਾ ਹੈ, ਉਸ ਦੇ ਫਾਇਦੇ ਅਤੇ ਨੁਕਸਾਨ ਮੈਨੂੰ ਸਮਝਾਏ ਗਏ ਹਨ .ਖੋਜ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਮੈ ਜਾਣਕਾਰੀ ਮੁਤਾਬਿਕ ਸਵਾਲਾ ਦੇ ਜਵਾਬ ਦੇ ਕੇ ਆਪਨਾ ਯੋਗਦਾਨ ਦੇਨਾ ਚਾਹੁੰਦਾ ਹਾ.

ਮੈਨੂੰ ਖ਼ੁਸ਼ੀ-ਖ਼ੁਸ਼ੀ ਬਿਨਾ ਕਿਸੇ ਦੇ ਦਬਾਅ ਹੇਠ

(I) ਇਸ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ, ਅਤੇ ਸਾਰੇ ਪੜਤਾਲ, ਜੋ ਮਨੁੱਖਜਾਤੀ ਦੇ ਭਲੇ ਲਈ ਗਿਆਨ ਹਾਸਲ ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰੇਗਾ, ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾ.

(Ii) ਆਪਣੀ ਯੋਗਤਾ ਮੁਤਾਬਿਕ ਇੰਟਰਵਿਊ ਵਿਚ ਜਵਾਬ ਦੇਣ ਲਈ ਸਹਿਮਤ ਹਾ.

ਮੇਰੀ ਸਹਿਮਤੀ ਸਪਸ਼ਟ ਕੋਈ ਵੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ ਨਹੀ ਹੈ. ਮੈਨੂੰ ਅਤੇ ਮੇਰੇ ਨਾਲ ਸਬੰਧਤ ਪੜਤਾਲ ਕਰਕੇ ਪ੍ਰਾਪਤ ਕੋਈ ਵੀ ਅਜਿਹੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ, ਖ਼ੋਜਕਾਰ ਨੂੰ ਮੇਰੇ ਕੋਲੋ ਦੋਬਾਰਾ ਸਹਿਮਤੀ ਪ੍ਰਾਪਤ ਕਰਨੀ ਪਏਗੀ.

ਮੈਨੂੰ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਪ੍ਰੋਗਰਾਮ ਵਿਚ ਪੁਲਿਸ ਵਿਭਾਗ ਦੀ ਜ਼ਿੰਮੇਵਾਰੀ ਲਈ ਮੇਰੇ ਸਹਿਮਤੀ ਦੇਣ ਅਤੇ ਉਸ ਦੇ ਨਾਲ ਵਿਭਾਗ ਨੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਦੇ ਕੰਮ ਦੇ ਸੰਬੰਧ ਡਾਟਾ ਪ੍ਰਾਪਤ ਕਰਵਾਉਨ ਲਈ ਸਿਹਮਤ ਹਾ. .

ਮੈਨੂੰ ਸੂਚਿਤ ਕਰ ਦਿੱਤਾ ਗਿਆ ਹੈ ਕਿ ਜਵਾਹਰ ਲਾਲ ਨੇਹਰੂ ਉਨਿਵਰਸੀਟੀ ਅਤੇ ਖੋਜਕਾਰ (ਸ਼ਵੇਤਾ ਮੈਨਨ) ਇਸ ਖੋਜ ਤੋ ਲਾਭ ਖਿੱਚਣ ਤੋ ਪਿਹਲਾ ਮੇਰੇ ਕੋਲੋ ਸਹਿਮਤੀ ਲੈਣ ਲਈ ਵੱਚਨਬਦ ਹਨ.

ਦਸਤਖਤ

ਵਿਸ਼ਾ ਅਸੂਲ ਇਨਵੈਸਟੀਗੇਟਰ

ਮਿਤੀ :

ਸੰਪਰਕ ਵੇਰਵਾ

ਖੋਜਕਰਤਾ ਦਾ ਵੇਰਵਾ

ਪਤਾ

ਮੋਬਾਈਲ ਨੰ

INFORMED CONSENT FORM FOR HEALTH INSPECTORS

(To be filled by PI at the time Review periodic, continuing, interim)

Title of the project: Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab

Investigators: Shaveta Menon

Centre/School: Centre for Social Medicine & Community Health

School Of Social Sciences

Brief description of the study

In my research, I want to focus on the state of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Government of India has been trying to address the use of tobacco and related diseases in Indian population, the approach to socio demographic factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The health inspectors play an important role in educating community against the use of tobacco and problems related to its use. They can establish a more relevant contact with the community and can reach places where higher officials cannot.

CONSENT FORM (for the participant /subject)

The advantages and disadvantages of the research in which I am expected to participate have been explained to me. I will be involved in giving the information desired of me to help in the research by answering the questions put to me.

I willingly, under no pressure from the researcher-

(I) Agree to take part in this research, and agree to participate in all investigations which will help acquire knowledge for the benefit of the mankind,

(ii) Agree to respond in the interview to best of my ability.

I give my consent to researcher for obtaining any information on the tobacco use in the community and my role in its prevention. I have been informed that JNU and the researcher (Shaveta Menon) will take my prior consent before they draw benefits from the research in which I have participated.

Signatures

Subject Principle Investigator:

DATE:

CONTACT DETAIL

Details of Researcher

Address

Mobile No.

ਸਿਹਤ ਇੰਸਪੈਕਟਰ ਲਈ ਸਹਿਮਤੀ ਫਾਰਮ

ਪ੍ਰੋਜੈਕਟ ਦਾ ਸਿਰਲੇਖ: ਨੀਤੀ ਪ੍ਰਸੰਗ ਅਤੇ ਤੰਬਾਕੂ ਵਰਤਣ ਦੇ ਸਮਾਜਿਕ ਸਬੰਧ: ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ, ਪੰਜਾਬ ਦਾ ਇਕ ਕੇਸ ਅਧਿਐਨ

ਖੋਜਕਾਰ ਦਾ ਨਾਮ

ਸ਼ਵੇਤਾ ਮੈਨਨ

ਸੈਂਟਰ : ਸੋਸ਼ਲ ਮੈਡੀਸਨ ਅਤੇ ਕਮਿਊਨਿਟੀ ਹੈਲਥ

ਸੋਸ਼ਲ ਸਾਇੰਸਜ਼ ਸਕੂਲ

ਜਵਾਹਰ ਲਾਲ ਨਹਿਰੂ ਯੂਨੀਵਰਸਿਟੀ, ਦਿੱਲੀ.

ਅਧਿਐਨ ਦਾ ਸੰਖੇਪ ਵੇਰਵਾ:

ਮੇਰੀ ਖੋਜ਼ ਵਿਚ ਮੈ ਪੰਜਾਬ ਦੇ ਜਿਲਾ ਜਲੰਧਰ ਵਿਚ ਹੋ ਰਹੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸ ਦੇ ਨੀਤੀ ਪ੍ਰਸੰਗ ਦਾ ਅਧਿਐਨ ਕਰਨਾ ਚਾਹੁੰਦੀ ਹਾ. ਭਾਰਤ ਸਰਕਾਰ ਵੱਲੋ ਅਬਾਦੀ ਵਿਚ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਅਤੇ ਇਸ ਨਾਲ ਸਬੰਧਤ ਰੋਗਾ ਨਾਲ ਨੱਜੀਠਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ ਗਈ ਹੈ ਪਰ ਸਮਾਜਿਕ ਰੂਪ ਤੇ ਜਿੰਮੇਦਾਰ ਤਤਾ ਨੂੰ ਧਿਆਨ ਵਿਚ ਨਹੀ ਰਖਿਆ ਗਿਆ. ਆਊਟਰੀਚ ਵਰਕਰ ਤੰਬਾਕੂ ਅਤੇ ਇਸ ਦੇ ਵਰਤਣ ਨਾਲ ਸਬੰਧਤ ਸਮੱਸਿਆ ਦੀ ਵਰਤੋ ਦੇ ਖਿਲਾਫ ਭਾਈਚਾਰੇ ਨੂੰ ਸਿੱਖਿਆ ਵਿੱਚ ਇੱਕ ਅਹਿਮ ਭੂਮਿਕਾ ਅਦਾ ਕਰਦੇ ਹਨ. ਜਿੱਥੇ ਉੱਚ ਅਧਿਕਾਰੀ ਨਹੀ ਪਹੁੰਚ ਸਕਦੇ, ਉਹ ਭਾਈਚਾਰੇ ਦੇ ਨਾਲ ਇੱਕ ਸੰਪਰਕ ਸਥਾਪਤ ਕਰ ਸਕਦੇ ਹਨ.

ਸਹਿਮਤੀ ਫਾਰਮ (ਭਾਗੀਦਾਰ / ਵਿਸ਼ੇ ਲਈ)

ਇਹ ਖੋਜ ,ਜਿਸ ਵਿਚ ਮੇਰੇ ਹਿੱਸਾ ਲੈਣ ਦੀ ਸੰਭਾਵਨਾ ਹੈ, ਉਸ ਦੇ ਫਾਇਦੇ ਅਤੇ ਨੁਕਸਾਨ ਮੈਨੂੰ ਸਮਝਾਏ ਗਏ ਹਨ .ਖੋਜ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਮੈ ਜਾਣਕਾਰੀ ਮੁਤਾਬਿਕ ਸਵਾਲਾ ਦੇ ਜਵਾਬ ਦੇ ਕੇ ਆਪਨਾ ਯੋਗਦਾਨ ਦੇਨਾ ਚਾਹੁੰਦਾ ਹਾ.

ਮੈਨੂੰ ਖ਼ੁਸ਼ੀ-ਖ਼ੁਸ਼ੀ ਬਿਨਾ ਕਿਸੇ ਦੇ ਦਬਾਅ ਹੇਠ

(I) ਇਸ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ, ਅਤੇ ਸਾਰੇ ਪੜਤਾਲ, ਜੋ ਮਨੁੱਖਜਾਤੀ ਦੇ ਭਲੇ ਲਈ ਗਿਆਨ ਹਾਸਲ ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰੇਗਾ, ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾ.

(Ii) ਆਪਣੀ ਯੋਗਤਾ ਮੁਤਾਬਿਕ ਇੰਟਰਵਿਊ ਵਿਚ ਜਵਾਬ ਦੇਣ ਲਈ ਸਹਿਮਤ ਹਾ.

ਮੇਰੀ ਸਹਿਮਤੀ ਸਪਸ਼ਟ ਕੋਈ ਵੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ ਨਹੀ ਹੈ. ਮੈਨੂੰ ਅਤੇ ਮੇਰੇ ਨਾਲ ਸਬੰਧਤ ਪੜਤਾਲ ਕਰਕੇ ਪ੍ਰਾਪਤ ਕੋਈ ਵੀ ਅਜਿਹੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ, ਖ਼ੋਜਕਾਰ ਨੂੰ ਮੇਰੇ ਕੋਲੋ ਦੋਬਾਰਾ ਸਹਿਮਤੀ ਪ੍ਰਾਪਤ ਕਰਨੀ ਪਏਗੀ.

ਮੈ ਕਮਿਊਨਿਟੀ ਵਿੱਚ ਤੰਬਾਕੂ ਵਰਤਣ ਦੀ ਜਾਣਕਾਰੀ ਅਤੇ ਇਸ ਦੇ ਰੋਕਥਾਮ ਵਿੱਚ ਮੇਰੇ ਭੂਮਿਕਾ ਪ੍ਰਾਪਤ ਕਰਨ ਦੀ ਖੋਜਕਾਰ ਨੂ ਮੇਰੇ ਸਹਿਮਤੀ ਦੇਂਦਾ ਹਾ . ਮੈਨੂੰ ਸੂਚਿਤ ਕਰ ਦਿੱਤਾ ਗਿਆ ਹੈ ਕਿ ਜਵਾਹਰ ਲਾਲ ਨੇਹਰੂ ਉਨਿਵਰਸੀਟੀ ਅਤੇ ਖੋਜਕਾਰ (ਸ਼ਵੇਤਾ ਮੈਨਨ) ਇਸ ਖੋਜ ਤੋ ਲਾਭ ਖਿੱਚਣ ਤੋ ਪਿਹਲਾ ਮੇਰੇ ਕੋਲੋ ਸਹਿਮਤੀ ਲੈਣ ਲਈ ਵੱਚਨਬਦ ਹਨ.

ਦਸਤਖਤ

ਵਿਸ਼ਾ ਅਸੂਲ ਇਨਵੈਸਟੀਗੇਟਰ

ਮਿਤੀ :

ਸੰਪਰਕ ਵੇਰਵਾ

ਖੋਜਕਰਤਾ ਦਾ ਵੇਰਵਾ

ਪਤਾ

ਮੋਬਾਈਲ ਨੰ

ANNEXURE A.8. INFORMED CONSENT FORM FOR ORAL CANCER PATIENTS

(To be filled by PI at the time Review periodic, continuing, interim)

Title of the project: Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab

Investigators: Shaveta Menon

Centre/School: Centre for Social Medicine & Community Health

School Of Social Sciences

Brief description of the study

In my research, I want to focus on the state of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Government of India has been trying to address the use of tobacco and related diseases in Indian population, the approach to socio demographic factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The status of tobacco control (especially the smokeless from) and factors responsible for the same will be studied in context of the state of Punjab, streamlining the research area to district Jalandhar. It will also talk about the health implications of tobacco use and socio demographic factors responsible for tobacco use especially in case of oral cancer patients.

CONSENT FORM (for the participant /subject)

The advantages and disadvantages of the research in which I am expected to participate have been explained to me. I will be involved in giving the information desired of me to help in the research by answering the questions put to me.

I willingly, under no pressure from the researcher-

(i) Agree to take part in this research, and agree to participate in all investigations which will help acquire knowledge for the benefit of the mankind,

(ii) Agree to respond in the interview to best of my ability.

My consent is explicitly not for disclosing any personal information. For disclosing any such personal information obtained from the investigations conducted on me and those related to me, further consent should be obtained.

I have been informed that JNU and the researcher (Shaveta Menon) will take my prior consent before they draw benefits from the research in which I have participated.

Signatures

Subject/Patient Witness Principle Investigator:

DATE:

Research participant /Parent/Guardian consent

Name of the Participant Sign.

Name of the Parent/Guardian Sign.

Relationship to the Participant Sign.

Name of the Investigator/ Researcher Sign.

Name of the Witness Sign.

CONTACT DETAIL

Details of Researcher

Address

Mobile No.

ਮੂੰਹ ਦੇ ਕੈਂਸਰ ਦੇ ਮਰੀਜ਼ ਲਈ ਸਹਿਮਤੀ ਫਾਰਮ (ਵਿਸ਼ੇ / ਮਰੀਜ਼ ਲਈ)

ਪ੍ਰੋਜੈਕਟ ਦਾ ਸਿਰਲੇਖ: ਨੀਤੀ ਪ੍ਰਸੰਗ ਅਤੇ ਤੰਬਾਕੂ ਵਰਤਣ ਦੇ ਸਮਾਜਿਕ ਸਬੰਧ: ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ, ਪੰਜਾਬ ਦਾ ਇਕ ਕੇਸ ਅਧਿਐਨ

ਖੋਜਕਾਰ ਦਾ ਨਾਮ

ਸ਼ਵੇਤਾ ਮੈਨਨ

ਸੈਂਟਰ : ਸੋਸ਼ਲ ਮੈਡੀਸਨ ਅਤੇ ਕਮਿਊਨਿਟੀ ਹੈਲਥ

ਸੋਸ਼ਲ ਸਾਇੰਸਜ਼ ਸਕੂਲ

ਜਵਾਹਰ ਲਾਲ ਨਹਿਰੂ ਯੂਨੀਵਰਸਿਟੀ, ਦਿੱਲੀ.

ਅਧਿਐਨ ਦਾ ਸੰਖੇਪ ਵੇਰਵਾ:

ਮੇਰੀ ਖੋਜ ਵਿਚ ਮੈ ਪੰਜਾਬ ਦੇ ਜਿਲਾ ਜਲੰਧਰ ਵਿਚ ਹੋ ਰਹੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸ ਦੇ ਨੀਤੀ ਪ੍ਰਸੰਗ ਦਾ ਅਧਿਐਨ ਕਰਨਾ ਚਾਹੁੰਦੀ ਹਾ. ਭਾਰਤ ਸਰਕਾਰ ਵੱਲੋ ਅਬਾਦੀ ਵਿਚ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਅਤੇ ਇਸ ਨਾਲ ਸਬੰਧਤ ਰੋਗਾ ਨਾਲ ਨੱਜੀਠਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ ਗਈ ਹੈ ਪਰ ਸਮਾਜਿਕ ਰੂਪ ਤੇ ਜਿੰਮੇਦਾਰ ਤਤਾ ਨੂੰ ਧਿਆਨ ਵਿਚ ਨਹੀ ਰਖਿਆ ਗਿਆ. ਤੰਬਾਕੂ ਕੰਟਰੋਲ (ਤੱਕ ਖਾਸ ਕਰਕੇ ਚੱਬਨ ਵਾਲਾ ਤੰਬਾਕੂ)ਅਤੇ ਉਸੇ ਲਈ ਜ਼ਿੰਮੇਵਾਰ ਹਾਲਤ ਨੂੰ ਪੰਜਾਬ ਰਾਜ ਦੇ ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ ਦੇ ਪ੍ਰਸੰਗ ਵਿਚ ਅਧਿਐਨ ਕੀਤਾ ਜਾਵੇਗਾ. ਇਸ ਵਿਚ ਖਾਸ ਤੌਰ 'ਤੇ ਮੂੰਹ ਦੇ ਕੈਂਸਰ ਦੇ ਸਮਾਜਿਕ ਕਾਰਨਾ ਨੂ ਅਤੇ ਉਸ ਦੇ ਪ੍ਰਭਾਵ ਨੂ ਦੇਖਆ ਜਾਏਗਾ.

ਸਹਿਮਤੀ ਫਾਰਮ (ਭਾਗੀਦਾਰ / ਵਿਸ਼ੇ ਲਈ)

ਇਹ ਖੋਜ ,ਜਿਸ ਵਿਚ ਮੇਰੇ ਹਿੱਸਾ ਲੈਣ ਦੀ ਸੰਭਾਵਨਾ ਹੈ, ਉਸ ਦੇ ਫਾਇਦੇ ਅਤੇ ਨੁਕਸਾਨ ਮੈਨੂੰ ਸਮਝਾਏ ਗਏ ਹਨ .ਖੋਜ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਮੈ ਜਾਣਕਾਰੀ ਮੁਤਾਬਿਕ ਸਵਾਲਾ ਦੇ ਜਵਾਬ ਦੇ ਕੇ ਆਪਨਾ ਯੋਗਦਾਨ ਦੇਨਾ ਚਾਹੁੰਦਾ ਹਾ.

ਮੈਨੂੰ ਖ਼ੁਸ਼ੀ-ਖ਼ੁਸ਼ੀ ਬਿਨਾ ਕਿਸੇ ਦੇ ਦਬਾਅ ਹੇਠ

(I) ਇਸ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ, ਅਤੇ ਸਾਰੇ ਪੜਤਾਲ, ਜੋ ਮਨੁੱਖਜਾਤੀ ਦੇ ਭਲੇ ਲਈ ਗਿਆਨ ਹਾਸਲ ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰੇਗਾ, ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾ.

(Ii) ਆਪਣੀ ਯੋਗਤਾ ਮੁਤਾਬਿਕ ਇੰਟਰਵਿਊ ਵਿਚ ਜਵਾਬ ਦੇਣ ਲਈ ਸਹਿਮਤ ਹਾ.

ਮੇਰੀ ਸਹਿਮਤੀ ਸਪਸ਼ਟ ਕੋਈ ਵੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ ਨਹੀ ਹੈ. ਮੈਨੂੰ ਅਤੇ ਮੇਰੇ ਨਾਲ ਸਬੰਧਤ ਪੜਤਾਲ ਕਰਕੇ ਪ੍ਰਾਪਤ ਕੋਈ ਵੀ ਅਜਿਹੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ, ਖ਼ੋਜਕਾਰ ਨੂੰ ਮੇਰੇ ਕੋਲੋ ਦੋਬਾਰਾ ਸਹਿਮਤੀ ਪ੍ਰਾਪਤ ਕਰਨੀ ਪਏਗੀ.

ਮੈਨੂੰ ਸੂਚਿਤ ਕਰ ਦਿੱਤਾ ਗਿਆ ਹੈ ਕਿ ਜਵਾਹਰ ਲਾਲ ਨੇਹਰੂ ਉਨਿਵਰਸੀਟੀ ਅਤੇ ਖੋਜਕਾਰ (ਸ਼ਵੇਤਾ ਮੈਨਨ) ਇਸ ਖੋਜ ਤੋ ਲਾਭ ਖਿੱਚਣ ਤੋ ਪਿਹਲਾ ਮੇਰੇ ਕੋਲੋ ਸਹਿਮਤੀ ਲੈਣ ਲਈ ਵੱਚਨਬਦ ਹਨ.

ਦਸਤਖਤ

ਵਿਸ਼ਾ / ਰੋਗੀ: ਗਵਾਹ: ਅਸੂਲ ਇਨਵੈਸਟੀਗੇਟਰ:

ਮਿਤੀ :

ਖੋਜ ਭਾਗੀਦਾਰ / ਸਰਪ੍ਰਸਤ ਦੀ ਸਹਿਮਤੀ

ਭਾਗੀਦਾਰ ਦੀ ਨਾਮ ਦਸਤਖਤ

ਮਾਤਾ ਪਿਤਾ / ਸਰਪ੍ਰਸਤ ਦਾ ਨਾਮ ਦਸਤਖਤ

ਭਾਗੀਦਾਰ ਦਾ ਰਿਸ਼ਤਾ ਦਸਤਖਤ

ਇਨਵੈਸਟੀਗੇਟਰ / ਖੋਜਕਰਤਾ ਦੇ ਨਾਮ ਦਸਤਖਤ

ਗਵਾਹ ਦਾ ਨਾਮ ਦਸਤਖਤ

ਸੰਪਰਕ ਵੇਰਵਾ

ਖੋਜਕਰਤਾ ਦਾ ਵੇਰਵਾ

ਪਤਾ

ਮੋਬਾਈਲ ਨੰ

ANNEXURE A.9. INFORMED CONSENT FORM FOR KIOSK HOLDERS
(To be filled by PI at the time Review periodic, continuing, interim)

Title of the project: Policy Context and Social Correlates of Tobacco use: A Case study of District Jalandhar, Punjab

Investigators: Shaveta Menon

Centre/School: Centre for Social Medicine & Community Health

School Of Social Sciences

Brief description of the study

In my research, I want to focus on the state of tobacco control in Punjab, Jalandhar district in particular, through a detailed study of the policies and plans laid down for the same. Although Government of India has been trying to address the use of tobacco and related diseases in Indian population, the approach to socio demographic factors responsible for tobacco use and the diseases it cause, have not received appropriate attention. The sale of tobacco has been on rampant bases and many small kiosk holders play an important role in the sale of tobacco to the public. Through this study the researcher wants to know the experience your experience as a kiosk holder with the tobacco sales and the kind of customers you cater to.

CONSENT FORM (for the participant /subject)

The advantages and disadvantages of the research in which I am expected to participate have been explained to me. I will be involved in giving the information desired of me to help in the research by answering the questions put to me.

I willingly, under no pressure from the researcher-

(I) Agree to take part in this research, and agree to participate in all investigations which will help acquire knowledge for the benefit of the mankind,

(ii) Agree to respond in the interview to best of my ability.

I give my consent to researcher for investigating me regarding the tobacco products I sell and my knowledge of the same. I have been informed that JNU and the researcher (Shaveta Menon) will take my prior consent before they draw benefits from the research in which I have participated.

Signatures

Subject Principle Investigator:

DATE:

CONTACT DETAIL

Details of Researcher

Address

Mobile No.

ਖੋਖੇ ਵਾਲਿਆ ਲਈ ਸਹਿਮਤੀ ਫਾਰਮ

ਪ੍ਰੋਜੈਕਟ ਦਾ ਸਿਰਲੇਖ: ਨੀਤੀ ਪ੍ਰਸੰਗ ਅਤੇ ਤੰਬਾਕੂ ਵਰਤਣ ਦੇ ਸਮਾਜਿਕ ਸਬੰਧ: ਜ਼ਿਲ੍ਹਾ ਜਲੰਧਰ, ਪੰਜਾਬ ਦਾ ਇਕ ਕੇਸ ਅਧਿਐਨ

ਖੋਜਕਾਰ ਦਾ ਨਾਮ

ਸ਼ਵੇਤਾ ਮੈਨਨ

ਸੈਂਟਰ : ਸੋਸ਼ਲ ਮੈਡੀਸਨ ਅਤੇ ਕਮਿਊਨਿਟੀ ਹੈਲਥ

ਸੋਸ਼ਲ ਸਾਇੰਸਜ਼ ਸਕੂਲ

ਜਵਾਹਰ ਲਾਲ ਨਹਿਰੂ ਯੂਨੀਵਰਸਿਟੀ, ਦਿੱਲੀ.

ਅਧਿਐਨ ਦਾ ਸੰਖੇਪ ਵੇਰਵਾ:

ਮੇਰੀ ਖੋਜ਼ ਵਿਚ ਮੈ ਪੰਜਾਬ ਦੇ ਜਿਲਾ ਜਲੰਧਰ ਵਿਚ ਹੋ ਰਹੇ ਤੰਬਾਕੂ ਕੰਟਰੋਲ ਅਤੇ ਉਸ ਦੇ ਨੀਤੀ ਪ੍ਰਸੰਗ ਦਾ ਅਧਿਐਨ ਕਰਨਾ ਚਾਹੁੰਦੀ ਹਾ. ਭਾਰਤ ਸਰਕਾਰ ਵੱਲੋ ਅਬਾਦੀ ਵਿਚ ਤੰਬਾਕੂ ਦੀ ਵਰਤੋ ਅਤੇ ਇਸ ਨਾਲ ਸਬੰਧਤ ਰੋਗਾ ਨਾਲ ਨੱਜੀਠਣ ਲਈ ਕੋਸ਼ਿਸ਼ ਕੀਤੀ ਗਈ ਹੈ ਪਰ ਸਮਾਜਿਕ ਰੂਪ ਤੇ ਜਿੰਮੇਦਾਰ ਤਤਾ ਨੂੰ ਧਿਆਨ ਵਿਚ ਨਹੀ ਰਖਿਆ ਗਿਆ. ਤੰਬਾਕੂ ਦੀ ਵਿਕਰੀ ਫੈਲੇ ਹੋਏ ਆਧਾਰ 'ਤੇ ਹੋ ਰਹੀ ਹੈ ਅਤੇ ਕਈ ਛੋਟੇ ਖੋਖਾ ਧਾਰਕ ਜਨਤਾ ਨੂੰ ਤੰਬਾਕੂ ਦੀ ਵਿਕਰੀ ਵਿੱਚ ਇੱਕ ਅਹਿਮ ਭੂਮਿਕਾ ਅਦਾ ਕਰਦੇ ਹਨ . ਇਸ ਅਧਿਐਨ ਦੇ ਜ਼ਰੀਏ ਖੋਜਕਾਰ ਤੰਬਾਕੂ ਦੀ ਵਿਕਰੀ ਅਤੇ ਗਾਹਕ ਦੀ ਤੰਬਾਕੂ ਦੀ ਮੰਗ ਨੂੰ ਪੂਰਾ ਕਰਨ ਵਿਚ ਖੋਖਾ ਧਾਰਕ ਦੇ ਆਪਣੇ ਤਜਰਬੇ ਨੂੰ ਪਤਾ ਕਰਨਾ ਚਾਹੁੰਦਾ ਹੈ.

ਸਹਿਮਤੀ ਫਾਰਮ (ਭਾਗੀਦਾਰ / ਵਿਸ਼ੇ ਲਈ)

ਇਹ ਖੋਜ ,ਜਿਸ ਵਿਚ ਮੇਰੇ ਹਿੱਸਾ ਲੈਣ ਦੀ ਸੰਭਾਵਨਾ ਹੈ, ਉਸ ਦੇ ਫਾਇਦੇ ਅਤੇ ਨੁਕਸਾਨ ਮੈਨੂੰ ਸਮਝਾਏ ਗਏ ਹਨ .ਖੋਜ ਵਿਚ ਮਦਦ ਕਰਨ ਲਈ ਮੈ ਜਾਣਕਾਰੀ ਮੁਤਾਬਿਕ ਸਵਾਲਾ ਦੇ ਜਵਾਬ ਦੇ ਕੇ ਆਪਨਾ ਯੋਗਦਾਨ ਦੇਨਾ ਚਾਹੁੰਦਾ ਹਾ.

ਮੈਨੂੰ ਖ਼ੁਸ਼ੀ-ਖ਼ੁਸ਼ੀ ਬਿਨਾ ਕਿਸੇ ਦੇ ਦਬਾਅ ਹੇਠ

(I) ਇਸ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ, ਅਤੇ ਸਾਰੇ ਪੜਤਾਲ, ਜੋ ਮਨੁੱਖਜਾਤੀ ਦੇ ਭਲੇ ਲਈ ਗਿਆਨ ਹਾਸਲ ਕਰਨ ਵਿੱਚ ਮਦਦ ਕਰੇਗਾ, ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਸਹਿਮਤ ਹਾ.

(Ii) ਆਪਣੀ ਯੋਗਤਾ ਮੁਤਾਬਿਕ ਇੰਟਰਵਿਊ ਵਿਚ ਜਵਾਬ ਦੇਣ ਲਈ ਸਹਿਮਤ ਹਾ.

ਮੇਰੀ ਸਹਿਮਤੀ ਸਪਸ਼ਟ ਕੋਈ ਵੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ ਨਹੀ ਹੈ. ਮੈਨੂੰ ਅਤੇ ਮੇਰੇ ਨਾਲ ਸਬੰਧਤ ਪੜਤਾਲ ਕਰਕੇ ਪ੍ਰਾਪਤ ਕੋਈ ਵੀ ਅਜਿਹੀ ਨਿੱਜੀ ਜਾਣਕਾਰੀ ਦਾ ਖੁਲਾਸਾ ਕਰਨ ਲਈ, ਖ਼ੋਜਕਾਰ ਨੂੰ ਮੇਰੇ ਕੋਲੋ ਦੋਬਾਰਾ ਸਹਿਮਤੀ ਪ੍ਰਾਪਤ ਕਰਨੀ ਪਏਗੀ.

ਮੈਨੂੰ ਤੰਬਾਕੂ ਉਤਪਾਦ ਦੀ ਵਿਕਰੀਅਤੇ ਉਸੇ ਦੇ ਮੇਰੇ ਗਿਆਨ ਦੇ ਬਾਰੇ ਪੜਤਾਲ ਲਈ ਖੋਜਕਾਰ ਨੂ ਮੇਰੇ ਸਹਿਮਤੀ ਦੇਂਦਾ ਹਾ. ਮੈਨੂੰ ਸੂਚਿਤ ਕਰ ਦਿੱਤਾ ਗਿਆ ਹੈ ਕਿ ਜਵਾਹਰ ਲਾਲ ਨੇਹਰੂ ਉਨਿਵਰਸੀਟੀ ਅਤੇ ਖੋਜਕਾਰ (ਸ਼ਵੇਤਾ ਮੈਨਨ) ਇਸ ਖੋਜ ਤੋ ਲਾਭ ਖਿੱਚਣ ਤੋ ਪਿਹਲਾ ਮੇਰੇ ਕੋਲੋ ਸਹਿਮਤੀ ਲੈਣ ਲਈ ਵੱਚਨਬਦ ਹਨ.

ਦਸਤਖਤ

ਵਿਸ਼ਾ ਅਸੂਲ ਇਨਵੈਸਟੀਗੇਟਰ

ਮਿਤੀ :

ਸੰਪਰਕ ਵੇਰਵਾ

ਖੋਜਕਰਤਾ ਦਾ ਵੇਰਵਾ

ਪਤਾ

ਮੋਬਾਈਲ ਨੰ

ANNEXURE B: 52 HUKAMS IN SIKHISM

ਦਸਮ ਪਿਤਾ ਜੀ ਵੱਲੋਂ ਨਾਂਦੇੜ ਵਿਖੇ ਕੀਤੇ ੫੨ ਹੁਕਮ

੧. ਕਿਰਤ ਧਰਮ ਦੀ ਕਰਨੀ।
੨. ਦਸਵੰਧ ਦੇਣਾ।
੩. ਗੁਰਬਾਣੀ ਕੰਠ ਕਰਨੀ।
੪. ਅੰਮ੍ਰਿਤ ਵੇਲੇ ਜਾਗਣਾ।
੫. ਪਿਆਰ ਨਾਲ ਗੁਰਸਿੱਖਾਂ ਦੀ ਸੇਵਾ ਕਰਨੀ।
੬. ਗੁਰਸਿੱਖਾਂ ਪਾਸੋਂ ਗੁਰਬਾਣੀ ਦੇ ਅਰਥ ਸਮਝਣੇ।
੭. ਪੰਜ ਕਕਾਰਾਂ ਦੀ ਰਹਿਤ ਦ੍ਰਿੜ੍ਹ ਰੱਖਣੀ।
੮. ਸ਼ਬਦ ਦਾ ਅਭਿਆਸ ਕਰਨਾ।
੯. ਧਿਆਨ ਸਤਿ-ਸਰੂਪ ਸਤਿਗੁਰੂ ਦਾ ਕਰਨਾ।
੧੦. ਸਤਿਗੁਰੂ ਸ੍ਰੀ ਗੁਰੂ ਗ੍ਰੰਥ ਸਾਹਿਬ ਜੀ ਨੂੰ ਮੰਨਣਾ।
੧੧. ਸਭ ਕਾਰਜਾਂ ਦੇ ਆਰੰਭ ਵੇਲੇ ਅਰਦਾਸ ਕਰਨੀ।
੧੨. ਜੰਮਣ, ਮਰਨ, ਵਿਆਹ, ਆਨੰਦ ਆਦਿ ਸਮੇਂ ਜਪੁ ਜੀ ਦਾ ਪਾਠ ਕਰਕੇ, ਕੜਾਹ ਪ੍ਰਸ਼ਾਦਿ ਤਿਆਰ ਕਰਕੇ, ਅਨੰਦੁ ਸਾਹਿਬ ਦਾ ਪਾਠ, ਅਰਦਾਸ ਕਰਕੇ, ਪੰਜਾਂ ਪਿਆਰਿਆਂ ਅਤੇ ਹਜ਼ੂਰੀ ਗ੍ਰੰਥੀ ਸਿੰਘਾਂ ਦਾ ਵਰਤਾਰਾ ਵਰਤਾ ਕੇ ਰੱਖ ਉਪਰੰਤ ਸੰਗਤਾਂ ਨੂੰ ਵਰਤਾ ਦੇਣਾ।
੧੩. ਜਦ ਤਕ ਕੜਾਹ ਪ੍ਰਸ਼ਾਦਿ ਵਰਤਦਾ ਰਹੇ, ਸਾਰੀ ਸੰਗਤ ਅਡੋਲ ਬੈਠੀ ਰਹੇ।
੧੪. ਵਿਆਹ ਅਨੰਦੁ ਬਿਨਾਂ ਗ੍ਰਿਹਸਤ ਨਹੀਂ ਕਰਨਾ।
੧੫. ਪਰ-ਇਸਤਰੀ ਮਾਂ, ਭੈਣ, ਧੀ ਕਰ ਜਾਣਨੀ।
੧੬. ਇਸਤਰੀ ਦਾ ਮੂੰਹ ਨਹੀਂ ਫਿਟਕਾਰਨਾ।
੧੭. ਜਗਤ-ਜੂਠ ਤਮਾਕੂ ਬਿਖਿਆ ਦਾ ਤਿਆਗ ਕਰਨਾ।
੧੮. ਰਹਿਤਵਾਨ ਤੇ ਨਾਮ ਜਪਣ ਵਾਲੇ ਗੁਰਸਿੱਖਾਂ ਦੀ ਸੰਗਤ ਕਰਨੀ।
੧੯. ਜਿਤਨੇ ਕੰਮ ਆਪਣੇ ਕਰਨ ਦੇ ਹੋਣ, ਉਨ੍ਹਾਂ ਦੇ ਕਰਨ ਵਿੱਚ ਆਲਸ ਨਹੀਂ ਕਰਨਾ।
੨੦. ਗੁਰਬਾਣੀ ਦੀ ਕਥਾ ਅਤੇ ਕੀਰਤਨ ਰੋਜ਼ ਸੁਣਨਾ ਤੇ ਕਰਨਾ।
੨੧. ਕਿਸੇ ਦੀ ਨਿੰਦਾ, ਚੁਗਲੀ ਤੇ ਈਰਖਾ ਨਹੀਂ ਕਰਨੀ।
੨੨. ਧਨ, ਜੁਆਨੀ, ਕੁਲ-ਜਾਤ ਦਾ ਮਾਣ ਨਹੀਂ ਕਰਨਾ।
੨੩. ਮੱਤ ਉੱਚੀ ਤੇ ਸੁੱਚੀ ਰੱਖਣੀ।
੨੪. ਸ਼ੁਭ ਕਰਮ ਕਰਦੇ ਰਹਿਣਾ।
੨੫. ਬੁੱਧ ਬਲ ਦਾ ਦਾਤਾ ਵਾਹਿਗੁਰੂ ਨੂੰ ਜਾਣਨਾ।
੨੬. ਕਸਮ, ਸਹੁੰ ਚੁੱਕਣ ਵਾਲੇ ਤੇ ਇਤਬਾਰ ਨਹੀਂ ਕਰਨਾ।
੨੭. ਸੁਤੰਤਰ ਵਿਚਰਨਾ।
੨੮. ਰਾਜਨੀਤੀ ਵੀ ਪੜ੍ਹਨੀ।
੨੯. ਸ਼ੱਤਰੂ ਨਾਲ ਸਾਮ, ਦਾਮ, ਭੇਦ ਆਦਿਕ ਉਪਾਓ ਵਰਤਣੇ, ਉਪਰੰਤ ਯੁੱਧ ਕਰਨਾ ਧਰਮ ਹੈ।
੩੦. ਸ਼ਸਤਰ ਵਿੱਦਿਆ ਤੇ ਘੋੜ-ਸਵਾਰੀ ਦਾ ਅਭਿਆਸ ਕਰਨਾ।
੩੧. ਦੂਸਰੇ ਧਰਮਾਂ ਦੀਆਂ ਪੁਸਤਕਾਂ, ਵਿੱਦਿਆ ਪੜ੍ਹਨੀ, ਪਰ ਭਰੋਸਾ ਦ੍ਰਿੜ੍ਹ ਗੁਰਬਾਣੀ, ਅਕਾਲ ਪੁਰਖ ਉੱਤੇ ਹੀ ਰੱਖਣਾ।
੩੨. ਗੁਰੂ ਉਪਦੇਸ਼ ਧਾਰਨ ਕਰਨੇ।
੩੩. ਰਹਿਰਾਸ ਦਾ ਪਾਠ ਕਰ ਕੇ ਖੜੇ ਕੇ ਅਰਦਾਸ ਕਰਨੀ।
੩੪. ਸੌਣ ਸਮੇਂ ਸੋਹਿਲੇ ਦਾ ਪਾਠ ਕਰਨਾ।
੩੫. ਕੇਸ ਨੰਗੇ ਨਹੀਂ ਰੱਖਣੇ।
੩੬. ਸਿੰਘਾਂ ਦਾ ਪੂਰਾ ਨਾਮ ਲੈ ਕੇ ਬੁਲਾਉਣਾ, ਅੱਧਾ ਨਹੀਂ।
੩੭. ਸ਼ਰਾਬ ਨਹੀਂ ਪੀਣੀ-ਪਿਆਉਣੀ।
੩੮. ਭਾਦਨੀ (ਸਿਰ ਮੁੰਨੇ) ਨੂੰ ਕੰਨਯਾ ਨਹੀਂ ਦੇਵਣੀ। ਉਸ ਘਰ ਦੇਵਣੀ ਜਿੱਥੇ ਅਕਾਲ ਪੁਰਖ ਦੀ ਸਿੱਖੀ ਹੋਵੇ।
੩੯. ਸਭ ਕਾਰਜ ਸ੍ਰੀ ਗੁਰੂ ਗ੍ਰੰਥ ਸਾਹਿਬ ਜੀ ਦੀ ਤਾਬਿਆ ਤੇ ਗੁਰਬਾਣੀ ਅਨੁਸਾਰ ਕਰਨੇ।
੪੦. ਚੁਗਲੀ ਕਰ ਕੇ ਕਿਸੇ ਦਾ ਕੰਮ ਨਹੀਂ ਵਿਗਾੜਨਾ।
੪੧. ਕੌੜਾ ਬਚਨ ਕਰ ਕੇ ਕਿਸੇ ਦਾ ਹਿਰਦਾ ਨਹੀਂ ਦੁਖਾਉਣਾ।
੪੨. ਦਰਸ਼ਨ ਯਾਤਰਾ ਗੁਰਦੁਆਰਿਆਂ ਦੀ ਹੀ ਕਰਨੀ।
੪੩. ਬਚਨ ਕਰ ਕੇ ਪਾਲਣਾ।
੪੪. ਅਤਿਥੀ, ਪਰਦੇਸੀ, ਲੋੜਵੰਦ, ਦੁਖੀ, ਅਪੰਗ ਮਨੁੱਖ ਦੀ ਯਥਾਸ਼ਕਤ ਸੇਵਾ ਕਰਨੀ।
੪੫. ਧੀ ਦੀ ਕਮਾਈ/ਧਨ ਬਿਖ ਕਰ ਜਾਣਨਾ।
੪੬. ਦਿਖਾਵੇ ਦੇ ਸਿੱਖ ਨਹੀਂ ਬਣਨਾ।
੪੭. ਸਿੱਖੀ ਕੇਸਾਂ ਸੁਆਸਾਂ ਸੰਗ ਨਿਬਾਹੁਣੀ। ਕੇਸਾਂ ਨੂੰ ਗੁਰ ਸਮਾਨ ਜਾਣ ਅਦਬ ਕਰਨਾ।
੪੮. ਚੋਰੀ, ਯਾਰੀ, ਠੱਗੀ, ਧੋਖਾ, ਦਗਾ ਨਹੀਂ ਕਰਨਾ।
੪੯. ਗੁਰਸਿੱਖ ਦਾ ਇਤਬਾਰ ਕਰਨਾ।
੫੦. ਝੂਠੀ ਗਵਾਹੀ ਨਹੀਂ ਦੇਣੀ।
੫੧. ਝੂਠ ਨਹੀਂ ਕਹਿਣਾ/ਬੋਲਣਾ।
੫੨. ਲੰਗਰ ਪ੍ਰਸ਼ਾਦਿ ਇਕ ਰਸ ਵਰਤਾਉਣਾ।

ਆਉ ਅਸੀਂ ਪ੍ਰਣ ਕਰੀਏ ਜੋ ਸਮਾਂ ਲੰਘ ਗਿਆ ਸੋ ਲੰਘ ਗਿਆ ਅਸੀ ਭੁੱਲੇ ਰਹੇ ਹਾਂ ਅੱਜ ਤੋਂ ਦਸਮ ਪਿਤਾ ਸ਼੍ਰੀ ਗੁਰੂ ਗੋਬਿੰਦ ਸਿੰਘ ਜੀ ਦੇ ਹੁਕਮਾਂ ਤੇ ਪੂਰਾ ਉਤਰਨ ਦੀ ਕੋਸ਼ਿਸ਼ ਕਰਾਂਗੇ

ANNEXURE C: CASE SUMMARY SHEET

Group I: Punjabi oral cancer patients

Respondents	Socio demographic profile				
	Age	Gender	Religion	Occupation	Place of residence
Respondent 1	44	Male	Hindu	Daily wager	Rural
Respondent 2	44	Male	Hindu	Security guard	Urban
Respondent 3	45	Male	Hindu	Shopkeeper	Rural
Respondent 4	52	Male	Hindu	Securityguard	Rural
Respondent 5	38	Male	Sikh	Shopkeeper	Rural
Respondent 6	54	Male	Hindu	Defence	Rural
Respondent 7	40	Male	Hindu	Daily wager	Rural
Respondent 8	35	Male	Hindu	Daily wager	Rural
Respondent 9	42	Male	Hindu	Daily wager	Rural
Respondent10	40	Male	Hindu	Shopkeeper	Rural

Group IIAgriMix: Mixed labourers in agricultural sector

Respondents	Socio demographic profile			
	Age	Gender	Religion	Migrant(M) or local (L)
Respondent 1	45	Male	Hindu	M
Respondent 2	50	Male	Sikh	L
Respondent 3	55	Male	Sikh	L
Respondent 4	55	Male	Hindu	M
Respondent 5	50	Male	Hindu	M
Respondent 6	38	Male	Hindu	L
Respondent 7	42	Male	Hindu	M
Respondent 8	40	Male	Hindu	M
Respondent 9	42	Male	Hindu	L
Respondent 10	35	Male	Hindu	M
Respondent 11	45	Male	Hindu	M
Respondent 12	40	Male	Hindu	L

Group IIMigrant: Migrant labourers in urban area

Respondents	Socio demographic profile			
	Age	Gender	Religion	Occupation
Respondent 1	28	Male	Hindu	Mason
Respondent 2	30	Male	Hindu	Security guard
Respondent 3	22	Male	Hindu	Housekeeper
Respondent 4	30	Male	Hindu	Security guard
Respondent 5	25	Male	Hindu	Labourer
Respondent 6	50	Male	Hindu	Mason
Respondent 7	34	Male	Hindu	Labourer
Respondent 8	38	Male	Hindu	Mason

Group IIMigrant: Migrant labourers in urban area

Respondents	Socio demographic profile			
	Age	Gender	Religion	Occupation
Respondent 1	45	Male	Hindu	Security guard
Respondent 2	28	Male	Hindu	Housekeeper
Respondent 3	30	Male	Hindu	Labourer
Respondent 4	35	Male	Hindu	Mason
Respondent 5	45	Male	Hindu	Mason
Respondent 6	25	Male	Hindu	Security guard
Respondent 7	42	Male	Hindu	Labourer
Respondent 8	40	Male	Hindu	Security guard

Group IILocal: Local labourers in rural area

Respondents	Socio demographic profile			
	Age	Gender	Religion	Occupation
Respondent 1	20	Male	Hindu	Labourer
Respondent 2	28	Male	Sikh	Labourer
Respondent 3	42	Male	Sikh	Shopkeeper
Respondent 4	30	Male	Hindu	Labourer
Respondent 5	35	Male	Sikh	Labourer
Respondent 6	38	Male	Hindu	Security guard
Respondent 7	40	Male	Sikh	Labourer
Respondent 8	25	Male	Hindu	Shopkeeper