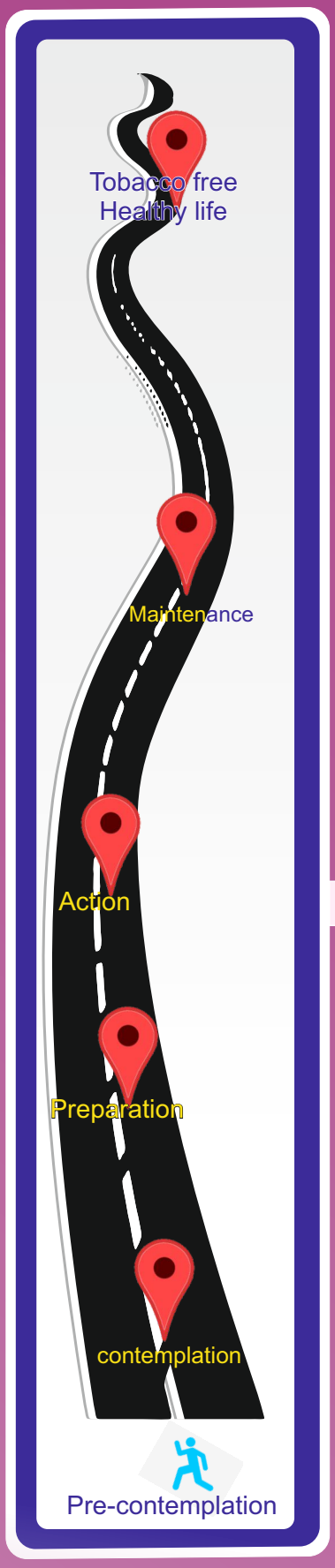

A Training Module on Tobacco Cessation

Prepared by -
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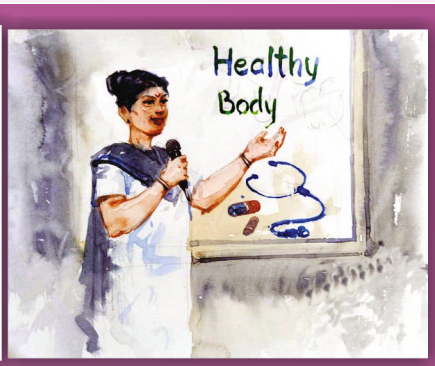
It isn't easy to quit tobacco - but it is possible!



Tata Memorial Centre
Department of Preventive Oncology

Publication No.6/2021

A Training Module on Tobacco Cessation

DEPARTMENT OF PREVENTIVE ONCOLOGY

It is estimated that there were 13,24,413 new cancer cases, 8,51,678 deaths and 27,20,251 people living with cancer, in India, in 2020, according to GLOBOCAN 2020 data. The five most common cancers affecting the Indian population are breast, lip, oral cavity, uterine cervix, lung and stomach. Cancers of major public health relevance such as breast, lip, oral cavity and uterine cervix contribute to 32.8% of all cancers among Indian population. These cancers can be prevented, screened for and/or detected early and treated at an early stage. This could significantly reduce the death rate from these cancers.

The commonest cancer among Indian men is lip and oral cavity cancer. This may be because of rampant use of smokeless tobacco in Indian population.The cancer toll in developing countries, especially India, is due to the fact that over 70% of cases are detected late and report for treatment in very advanced stages. Apart from the pain and misery that cancer inflicts on the patient and his family, the economic impact of this disease is catastrophic. Simple preventive measures, tobacco cessation services and regular screening can bring down these deaths drastically and even have other health benefits. With the principal objective of prevention and early detection of common cancers, the Tata Memorial Hospital set up the Department of Preventive Oncology in March 1993. Ever since, the Department of Preventive Oncology has been raising awareness and concern about cancer and affirming the prevention and curability of cancers, if detected early. As the level of cancer awareness rises, the health seeking behaviour towards early detection will increase and consequently the cancer load in the country will begin to decline.

The Department of Preventive Oncology, Tata Memorial Hospital, Mumbai, is a designated WHO Collaborating Centre for Cancer Prevention, Screening and Early Detection (IND 59), Region SEARO, since 2002. The Tobacco Cessation Clinic in the Department of Preventive Oncology, Tata Memorial Hospital, Mumbai, Maharashtra, has been one of the pioneers of Tobacco Cessation. It provides Clinic as well as Community based Tobacco Cessation services.
The main thrust areas of the department are:

- Information, Education and Communication (IEC)
- Clinic and Community-based, Opportunistic-Screening
- Health Manpower Development
- Advocacy, NGO-Training and Networking
- Research
- Tobacco Cessation Clinic

The department is housed on the third floor of the 'Service Block', Tata Memorial Hospital, Parel, Mumbai: 400012.
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A Training Module on Tobacco Cessation

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Preface

India is on the roll out mode of the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS). Health being a State subject, different States are at various stages of implementation.Tobacco has been identified as the foremost cause of death and disease that is entirely preventable.India launched the National Tobacco Control Program in 2007 - 08 under 11th Five Year Plan. There are directives to the State Government to roll out the NPCDCS and Tobacco Control Programme. However, the State Health Services manpower is not trained to implement either cancer awareness,common cancer screening or tobacco control programme. The Department of Preventive Oncology at the Tata Memorial Hospital is actively engaged in training the health services staff. This booklet will guide the paramedical staff Accredited Social Health Activist (ASHAs), Auxiliary Nurse Midwifery (ANMs), Anganwadi Workers (AWWs), Primary Health Workers (PHWs), Community Health Volunteers (CHVs), Medical Social Workers(MSWs) and other staff from the government and private sectors on conducting tobacco cessation activities and programmes. Our intent is to translate to as many Indian languages, so that it could be widely used.

Dr. Gauravi Mishra & Dr. Sharmila Pimple

Acknowledgements

The authors gratefully acknowledge the following personnel of Preventive Oncology Department, Tata Memorial Hospital for their valuable and tireless contribution in the preparation of this manual:

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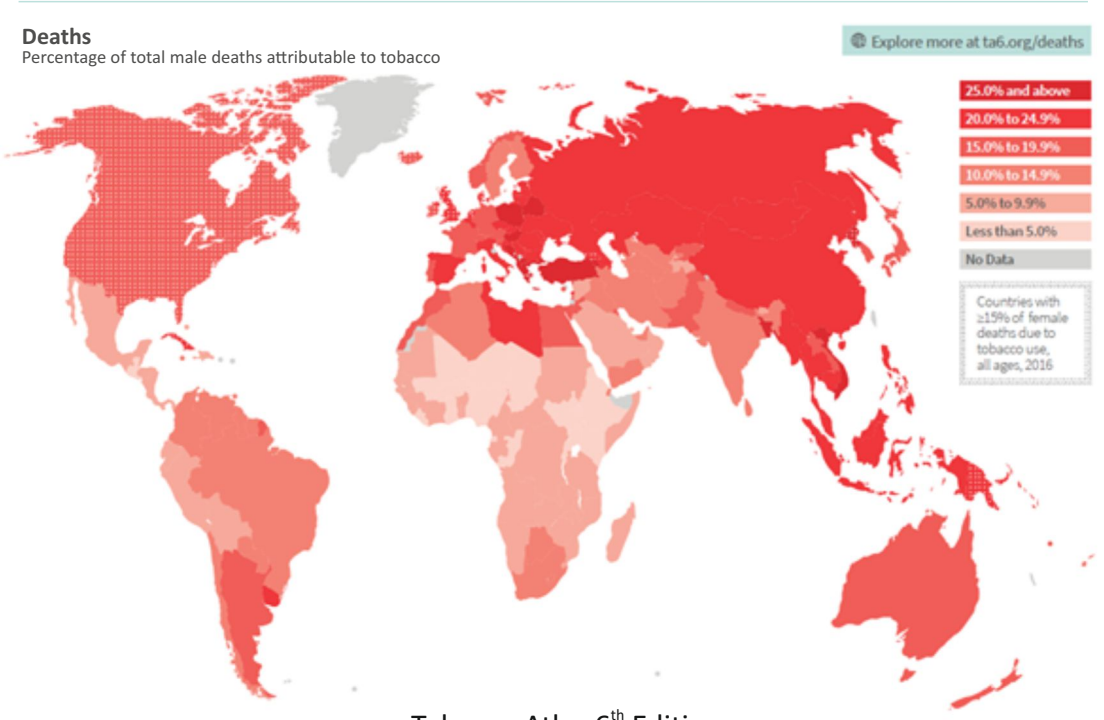
Introduction & Background

The tobacco epidemic is one of the biggest public health threats to the world. Tobacco use is a major preventable cause of premature death and disease. Globally, tobacco kills over 8 million people annually. More than 7 million of those deaths are the result of direct tobacco use while around 1.2 million are the result of non-smokers being exposed to second-hand smoke. An estimated 1.1 billion people and up to 1/3rd adult population, use tobacco in some form. Around 80% of the 1.1 billion smokers worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest. (1)



Tobacco Atlas 6th Edition

WHO's South East Asian Region has the highest rates of tobacco use. The economic costs of tobacco use are substantial and include significant health care costs for treating the disease.(1) India is third largest tobacco growing country and second largest consumer of tobacco products in the world. (2) 42.4% men, 14.2% women and 28.6% (266.8 million) adults in India, currently use tobacco either in smoking or smokeless forms.(3) India accounts for the highest tobacco-related mortality with about 7,00,000 annual deaths attributable to smoking in the last ten years, with an expected rise to one million in the coming decade.(4) India also has a high incidence of oral cancers, due to widespread use of smokeless tobacco. (5) These alarming trends of tobacco use and related deaths are likely to continue and even increase, if not controlled.

According to WHO, we will not be able to meet the global targets to reduce tobacco use and related deaths if we do not help people to quit. Among smokers who are aware of the dangers of tobacco, most want to quit. Counselling and medication can more than double a tobacco user's chance of successful quitting. (6)

The MPOWER measures were set up to facilitate delivery of the WHO Framework Convention on Tobacco Control (FCTC) at a country-wide level in 2007. The six measures include monitoring tobacco use and prevention policies, protecting people from tobacco smoke, helping users to quit, warning about the dangers of tobacco smoke, enforcing bans on advertising, sponsorship, and promotion, and increasing taxes. (1)

For the first time, the World Health Organization projects that the number of males using tobacco is on the decline, indicating a powerful shift in the global tobacco epidemic.(7) The findings, published in a new WHO report, demonstrate that government-led action can protect communities from tobacco, save lives and prevent people suffering tobacco-related harms.(6)

In India, 55.4% of current smokers are planning or thinking of quitting smoking and 49.6% of current smokeless tobacco users are planning or thinking of quitting smokeless tobacco use.(3) Efforts at tobacco cessation at a mass level can certainly help in relieving this grim situation. It is encouraging to know that 70% of the tobacco users would like to quit. Statistics reveal, however, that only 30% of tobacco users actually make an attempt to quit. Among these, only 3 to 5% ultimately manage to quit. This implies that people are likely to quit if provided with assistance and guidance for the same. Several studies have documented the effectiveness of cessation interventions for quitting tobacco habits. (8,9,10,11)

Tobacco Cessation in India

Tobacco Cessation was formally initiated in India in the year 2002. Thirteen clinics were set up in various states supported by World Health Organization Country Office and the Ministry of Health and Family Welfare, Government of India. The number of clinics later increased to 18. (12) Only 23 countries have comprehensive tobacco cessation policies and India is one amongst them. India has set an example for other LMICs. (13)

During the first five years, 8 clinics across the country, reported a quit rate of 31%, on an average, at six weeks. Also, almost 50% had substantially reduced their tobacco use. (14)

India has about 18 Tobacco Cessation Clinics (TCCs) across the country. They are inadequate taking into consideration the existing 250 million tobacco consuming population.(15)Hence, there is need of more trained tobacco cessation counselors.

Tobacco Cessation Clinic, Department of Preventive Oncology

The Tobacco Cessation Clinic in the Department of Preventive Oncology, Tata Memorial Hospital, Mumbai, Maharashtra, has been one of the pioneers of Tobacco Cessation. It provides Clinic as well as Community based Tobacco Cessation services. Workplace Cessation Programmes have been successfully conducted in urban and rural areas. (16,17,18,19,20)The department has also conducts several tobacco control programmes for underprivileged populations like the physically challenged, commercial sex workers, street children, Zari workers beggars etc.

Understanding tobacco dependency

Tobacco use is a complex phenomenon. The International Classification of Diseases (ICD-10) has documented that "tobacco dependence" is a disease. Tobacco Dependence is defined as, "Cluster of behavioral, cognitive and physiological phenomena that develop after repeated tobacco use and that typically include a strong desire to use tobacco, difficulties in controlling its use, persistence in tobacco use despite harmful consequences, a higher priority given to tobacco use than other activities and obligations, increased tolerance and sometimes a physical withdrawal state". (21) Nicotine is readily absorbable from the respiratory tract, buccal mucosa and skin. (22) Nicotine dependence produces symptoms related to CNS like irritability, anger, impatience, difficulty in concentrating. Craving plays an important role and may lead to relapses in smokers trying to quit (22).

The history of tobacco use in India in dates back to 1600. Its use has flourished in various forms since then, in our country. It is also deeply rooted in the Indian culture. The various states in India have their own rituals and practices related to tobacco use.Advocating change to break these traditional bondages of tobacco use is one of the major challenges for tobacco control.

The tobacco industry also has its role in perpetuating tobacco habits. They constantly make efforts to underplay the health hazards of tobacco use.

Peer pressure also can be a major influence for initiating tobacco use. On the other hand, family members also using tobacco may dissuade the tobacco user from attempting to quit. The tobacco user himself/herself can even encourage his/her family and friends to start using tobacco. At the same time support of family and friends can contribute towards quitting tobacco. Again, the factors such as availability of tobacco and health issues can also influence decisions related to tobacco use. The socio-cultural, political and legal aspects need to be addressed for tobacco control. These involve micro as well as macro level changes, both of which are significant. Socio-cultural changes, e.g., can be initiated at individual level, which can eventually lead to changing norms over a period of time. Similarly, taxation and laws related to tobacco have an influence at the individual level. More important are the enforcement of these regulations. The tobacco user may keep fluctuating like a pendulum, between the desire to quit and giving in to the temptation of using tobacco.Tobacco cessation intervention will definitely help tobacco user to strengthen his/her decision to quit and also gain confidence at his ability to do so.

Tobacco Cessation Interventions

These services can be provided by Doctors, Counselors, Nurses, Health workers or other health professionals. Tobacco cessation interventions can be simple advice by the Health Provider or intensive and repeated counseling sessions. Individual or group counseling can be provided as per suitability.

Group Counseling should be provided when possible. Members belonging to the same organization or a community can be counseled in groups. Group counseling has several advantages such as saving of time and energy. It brings tobacco users together on a common platform. They can get motivated to quit and learn from each other's experiences. Groups need to be handled effectively, as there can be distracters in the group who can demotivate others.

Tobacco Cessation Counseling

Counseling tobacco users is not just giving information about health hazards and advice to quit. It is a long process which includes the following:

1. Assessment
2. Intervention
3. Follow Up

Assessment of Tobacco user

Tobacco users need to be assessed on various aspects before providing interventions.

A) Socio-Demographic History:

It is important to assess personal details of users in relation to age, sex, education level, occupation, income, etc. All this is important as counseling intervention will be based on this information. An illiterate person, for example, may have to be explained in detail regarding health hazards of tobacco use. An educated person may be challenged by the need to quit. A housewife needs to be motivated in reference to care giving for family. Sometimes tobacco users attribute their tobacco use to their occupation. They need to be counseled with regards to their misconceptions.

B) Knowledge of health hazards of tobacco use:

Acquiring knowledge about the ill effects of tobacco use does not necessarily result in quitting tobacco use. The information available with the tobacco user regarding the health consequences of tobacco use may be vague. It may in be in a diluted form or his/her interpretation of the same may be different. It is important to give the right information without making it too scary. Also, appropriate information which is relevant to the tobacco user may help in increasing the motivation to quit. A married lady who is using tobacco may be informed about the effects of tobacco use and fertility problems. A young boy may be more receptive to counseling after knowing the relation between tobacco use and impotency.

Tobacco users who have Oral Precancerous conditions such as Leukoplakia, Erythroplakia, Sub Mucous Fibrosis or oral Ulcers need to be motivated to quit tobacco habits at the earliest. They need to be explained about the significance of quitting as it could reduce the risk oral cancers. Maintaining regular medical and counseling follow up also has to be emphasized.

C) History of tobacco use:

It is important to document all the details of tobacco including previous and current use.

i)Tobacco User/Non-User – A Non Tobacco User is one who has never used tobacco in his/her life. A tobacco user could be either Current User or Past User. The definition of a Current User could differ as per the objectives of the programme. Generally, a person could be identified as Current User if he/she has used tobacco during the past one month. A person has to be defined as a Current User even if he has quit other forms of tobacco but continuing at least one form.

ii)Tobacco History – Details of all the forms of tobacco used, smoked and smokeless, should be recorded. The average frequency of tobacco use in a day, the duration of tobacco use and quit history should also be asked. Duration of quitting need to be mentioned in Days/Months/ Years for every form.

It is advisable to inquire about the tobacco history at every contact. This would be helpful in assessing the progress regarding quitting. Documenting tobacco history also indirectly conveys the significance of quitting to the tobacco user. Previous attempts at quitting can also be assessed.

D) Severity Scale:

The Fagerstrom scale for Nicotine dependence is a standard tool for assessing the intensity of physical addiction to nicotine. The test was designed to provide an ordinal measure of nicotine dependence related to cigarette smoking. It contains six items that evaluate the quantity of cigarette consumption, the compulsion to use and dependence.

In scoring the Fagerstrom Test for Nicotine Dependence, yes/no items are scored from 0 to 1 and multiple-choice items are scored from 0 to 3. The items are summed to yield a total score of 0-10. This is for smokers.The higher the total Fagerstrom score, the more intense is the patient's physical dependence on nicotine.

A similar scale is also there for Smokeless Tobacco use. This has a total of nine questions and the maximum score is 16. The higher the score, the higher is the dependence on smokeless tobacco use. (23)

Every question in the Scale, whether for Smoking or Smokeless tobacco use, has to be understood properly. Again, the questions also have to be asked to tobacco users in a manner they would understand. The Addiction Scale for smokers has to be administered to people who are only smokers. The questionnaire for smokeless tobacco use should be used only for smokeless tobacco users. Both the questionnaires would be applicable to people who use smoked as well as smokeless tobacco.

E) Stages of Tobacco Cessation:

Prochaska and Di Clemente have given an understanding about the stages which a tobacco user passes through, before quitting the habit.

1. **Precontemplation Stage** – In this stage the tobacco user has never seriously thought about quitting the tobacco habit. It could also be that he is defiant and absolutely refuses to quit the tobacco habit. There could be different reasons why he/she may not want to quit. Explaining the logistics of quitting to a person belonging to this stage would make no sense unless he/she is motivated to quit. Such a person has to be brought to the next stage by counseling.

2. **Contemplation Stage–** In this stage the tobacco user is mentally prepared to quit the habit. He/she agrees in theory that tobacco use is harmful and he/she plans to quit in the near future. The catch is that the person may be satisfied to remain in this stage on a continual basis and not do anything further than this. He/she then has to be motivated to take some concrete steps towards quitting.

3. **Preparation stage –** In this stage the tobacco user makes some attempts for quitting tobacco habit. He/she may reduce the frequency of tobacco use for example, or may switch brands of tobacco or may change the form of tobacco. In this stage the person is very close to quitting. Sometimes people interpret this as actual quitting. They may believe or may want others to believe that they have quit tobacco habit. Positive reinforcement and encouragement would be helpful in quitting.

4. **Action stage –** In this stage the tobacco user has given up all forms of tobacco in all quantities. This is a very delicate stage wherein the temptation for tobacco is very high. The dilemma for using and avoiding tobacco may be still there. Counseling for relapse prevention at this stage may be helpful in continuing with the decision to remain quit.

5. **Maintenance stage –**In this stage the tobacco user has managed to remain abstained from tobacco use for a fairly long period of time. This could be more than six months of complete quitting.He/she is now fairly certain about the decision to remain quit. Influence of external environment, personal reasons such as stress, etc. may still initiate a relapse. The tobacco user could be motivated to regularly review the benefits he/she has had after quitting. Taking pride in the challenges he/she has overcome during quitting would be helpful in preventing a relapse.

6. **Relapse –** The tobacco user can relapse any time after quitting. The temptation or craving for tobacco use can always be there. The tobacco user has to be counseled for relapse prevention, after quitting.

F) Identifying misconceptions of tobacco users:

The tobacco user may have several misconceptions related to his/her tobacco use. For example he/she may feel "I use tobacco within limits". It is necessary to explain to the tobacco user that the use of tobacco in any quantity is harmful. The tobacco user may compare his/her tobacco use with others and justify use of tobacco. The tobacco user may have only reduced frequency or quit some form of tobacco. He or she may claim to be a quitter. These misconceptions have to be assessed and clarifications provided accordingly, during counseling.

Other excuses for continued tobacco use also have to be identified. Tobacco user may be using tobacco to gain relief from physical problems or stress. This also has to be assessed. The tobacco user has to be explained during counseling, that tobacco use will complicate problems instead of reducing them.

G) Identifying Social support available to the tobacco user:

Social support plays a very important role in the quitting process. The tobacco user may often be tempted to divert from his resolve to quit due to various temptations or other reasons. Family and friends can provide encouragement at weak moments and sustain the quitting efforts. This would be valid provided the family and friends themselves are non-tobacco users. If the tobacco user is in an environment surrounded by tobacco users then resistance skills need to be taught to the tobacco user. Going even further, the tobacco user can be advised to propagate tobacco cessation to others.

Dependency / Cotinine Tests

A) Carbon Monoxide Breath Test:

This test is done for smokers. It shows the amount of Carbon Monoxide in the breath (ppm). PPM, that is parts per million, is the Unit of Measure. As per this test, the Reading means one-part Carbon Monoxide in one million parts of air (breath). Carbon Monoxide Breath Test is an indirect, non-invasive measure to detect the level of Carbon Monoxide in the breath. This test will not give the exact number of cigarettes/beedies smoked. It can, however, suggest the smoker's dependence to nicotine.

This test is user friendly as the nicotine dependence can be identified by colour indication. The test is mainly used to motivate smokers to quit.

B) Diagnostic methods for detection of Cotinine level in tobacco users:

Most of the time tobacco history is based upon the self-reporting by people. Different methods could, however be used, for purpose of validation of self-history provided by tobacco users. There are different methods to measure cotinine level in blood, saliva and urine. These methods could be expensive as some of them may require trained personnel and laboratory set up. These tests could be administered at Pre and Post Intervention, as per requirement and fund availability.

Counseling Intervention

Counseling intervention is provided to tobacco users on the basis of assessment as described above. It would differ from person to person. Counseling will also vary depending upon whether it is first time counseling or follow up counseling. Involving family members during counseling would also be helpful.

Principles of counseling

A) Rapport building:
A professional relationship has to be built up with the tobacco user by the health care provider. The tobacco user should feel confident that the health care provider is genuinely interested in his/her well-being and wants to help the tobacco user to quit the habit. This trust is the basis of the counseling process. The best of interventions would be rendered useless if adequate rapport is not built up with the tobacco user.

B) Non-judgmental attitude:
The rapport building process is closely linked with the attitude of the health care provider towards the tobacco user. Personal prejudices would interfere with the rapport building and eventually the counseling process. The counselor needs to accept the tobacco user with his/her self-destructive tendencies. Enhancing the guilt feelings for the tobacco user would only make him/her defensive and the purpose of counseling would not be served. Arguments with the tobacco user should be avoided.

C) Positive approach:
It is preferable to start at the level of the tobacco user and appreciate whatever efforts he/she has ever made towards quitting tobacco. Expressing faith in the tobacco user's ability to quit and encouragement would revive his/her motivation to quit.

D) Listening carefully:
The tobacco user may have his/her own anxieties and problems. During counseling the tobacco user may get an opportunity to ventilate

feelings. A patient listening is required on part of the counselor, even if it may not be directly related to tobacco use. The counselor can then summarize what the tobacco user has said, to clarify. This establishes faith and concern on part of the counselor, for the tobacco user.

E) Facilitate decision making:
Encourage the tobacco user to take his/her own decision regarding quitting. Enable him to reflect on the pros and cons of continuing tobacco use. Inform him about the health and the social benefits of quitting.

Enabling preparation for quitting

Help the tobacco user to set a quit date. He/she is likely to keep postponing the quit date. Inform the tobacco user that the best time to quit is now. If he/she feels it is not feasible, then suggest the tobacco user to maximum take a week's time to quit. Remind him that he has already spent many years planning to quit. It is now time to take a firm decision, however uncomfortable it may be. Ask the tobacco user to think what change he/she would like to introduce in the daily routine. These would be especially related to the associations with tobacco use. The tobacco user may, for example, may feel the urge to use tobacco after tea, after lunch, being with friends, etc. Herein he may be advised to take milk instead of tea, avoid heavy meals and spend more time with family instead of friends. On the day before the decided quit date, the tobacco user should throw away the tobacco from the house. She can take the help of a family member or friend to support her in this process.

Coping with the urge for tobacco/ dealing with withdrawals

The sincerest resolutions may just evaporate within the fraction of a second, when the severe urge for tobacco use is experienced. The tobacco user may be suggested several techniques to cope with the urge for tobacco –

1. Drink water or fruit juice.
2. Chew 'Dry Coconut', 'Elaichi', 'Saunf', 'Dhanadal', 'Groundnuts' etc.
3. Engage yourself into an activity you enjoy.
4. Use distractions such as watching T.V., reading, playing with children and going for jogging or other sports.
5. Deep breathing.
6. Yoga, Pranayam and Meditation.
7. Congratulate yourself every time you manage to avoid tobacco use.
8. Highlight on the calendar each day you remain abstained.
9. Celebrate with your family the week you have passed without using tobacco.
10. Think about the physical benefits you are now experiencing after quitting.
11. Every morning maintain a resolution to indulge into healthy activities and habits.
12. Calculate the money saved after quitting tobacco use and plan to use it for better options.

Focusing on the positive sides of quitting help to maintain the motivation to remain abstained from tobacco use. Quitting tobacco use is certainly a very challenging job. Even the smallest of efforts towards quitting are to be appreciated. The tobacco user may expect positive reinforcement from others to maintain his/her quit stage. This may not always be possible. In fact, the family and friends may even be skeptical about sustainability of these efforts. The tobacco user needs to maintain patience in handling his own withdrawals as well as gaining the confidence and support of his family.

Follow up

Maintaining a regular follow up with the tobacco user is very crucial considering the challenges faced by him/her, as discussed above. The tobacco user's experiences of quitting can be discussed at follow up. Positive reinforcement needs to be provided on quitting. He/she can be encouraged to start or continue with the efforts, if not already quit. The motivation needs to be sustained in either case. Quitters also should be prepared for relapse prevention as well as dealing with relapse. Relapse can occur at any stage of quitting. A long period of abstinence cannot be considered as permanent quitting. The tobacco user cannot afford to be overconfident about his abstinence. Even one slip can be enough for a relapse. Every temptation to use tobacco has to be avoided. In the unfortunate instance of a relapse, the tobacco user has to go through the entire process of cessation all over again. Ideally, a weekly follow up for one month and a quarterly follow up till one year would be helpful. The follow up can be adjusted as per practical requirements.

Referral to Psychiatrist/Psychologist

There is a close association between tobacco use and mental illness. Tobacco users who do not seem to benefit by regular counseling should be referred to Psychiatrist or Psychologist. Tobacco users with symptoms of anxiety, depression, complain of lack of sleep need to be referred to Psychiatrist. These patients would be provided relevant treatment as per the psychological assessment. Pharmacotherapy could also be given to tobacco users.

A holistic approach has to be adopted in regards to helping tobacco users quit the habit. They have to be understood in their personal, socio-cultural and other contexts to facilitate quitting. This brings us to reflect on another aspect of the counseling process, which is, the barriers faced by the Counselor.

The Counselor's Barriers

It is thus evident that the tobacco user needs constant support in the entire quitting process. The Health Provider's role is very crucial not only for the tobacco user but to the society as a whole. The counselor may have personal barriers or beliefs, such as no one is really going to quit. Other belief maybe I am not good enough at helping people to quit. Promoting tobacco control is advocating social change, which is always a slow process. The results of your intervention may not always be tangible. It may not have an immediate effect on the individual, but the effects may perhaps be apparent at a later date. Helping even one individual to quit has immense benefits not only for the tobacco user but to the whole family. Skills at helping people quit can improve with experience. The counselor should always maintain the vision of promoting a tobacco free society. The sincere efforts of the Health Provider can never be undermined. The counselor has the double task of maintaining his own motivation as well as that of the tobacco user.

Tobacco related Legislation in India

Tobacco users often have an excuse that government should ban tobacco if it is so harmful. Many are not aware about the existing legislation in relation to tobacco control. The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and commerce, Production, Supply and Distribution) Act was passed in the year 2003. This a very comprehensive law, which encompasses various aspects of tobacco control for smoked and smokeless forms. The following are the highlights of the provisions of the law:

1. Prohibition of smoking in Public places
2. Prohibition of advertisements of cigarettes and other tobacco products
3. Prohibition of sale of cigarettes and other tobacco products to a person below age of 18 years
4. Prohibition of sale of cigarettes and other tobacco products in an area within a radius of 100 yards of any educational institute
5. Restrictions on Trade and Commerce, in and production, supply and distribution of cigarettes and other tobacco products
6. Warnings required on packages of cigarettes and other tobacco products

Conclusion

Tobacco use remains to be a serious public health problem leading to the preventable cause of morbidity and mortality globally. Implementation of tobacco control measure should be strictly followed to decrease the prevalence of tobacco use and thus reduce the disease burden and deaths due to tobacco consumption. Tobacco users need to be explained about the efforts being taken for tobacco control at Global and national level. It is equally important that each person takes responsibility for his/her own health. Total ban on tobacco is not so easy. In fact, the implementation of the existing law has many challenges. Tobacco users need to take initiative in quitting tobacco and adopting healthy lifestyle. Non users should maintain a resolve of abstaining from tobacco.

As 18 tobacco cessation clinics are not sufficient to cover millions of tobacco users in India. There is an urgent need to train more and more health care providers in tobacco cessation services. An ideal situation would be to create a mass movement by society, wherein there would be no demand for tobacco. The tobacco industry will die its own death and people will live longer and healthier!

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