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"Prevalence of the Tobacco Use in Rural Tea Industrial and Oil Operated Areas in Assam and Assessment of the Implementation of the Cigarette and Other Tobacco Products Act (Cotpa-2003) And Sequences of Assam Health Bill-2013"

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Abstract: *Tobacco use is a global socio-economic hazard and medical malady. Tobacco is all pervasive in the social life of our country. The incidence of tobacco is persisting and spreading in all walks of our modern society. The paper focuses on different dimensions of Tobacco and its harmful effects on the physical, social life of the country. The analysis portraits that 60% of the respondents were tobacco consumers with Betel Leave and Nuts /Zarda Pan out of which 71.43% % were female and 55.56% were male followed by 50% of them were tobacco buyer in the form of cigarette out of which 62.96% % are male and 16.67% are female. Use of cigarette was seen to be followed by Bidi (41.30%), Khaini (35.33%) and Gutkha (28%). It also studied attitude of respondents in causal and consequential dimensions, association of its use demography and role of civil society in controlling tobacco use. It found strong association between attitudes to deadly consequences. However, as respondents were unaware of ban on use. It also found that on role of civil society, 50% of respondents were in favour of NGO initiatives, while 34% wanted self awareness and self help to distract it. If civil society is interested in no tobacco zone and wants intervention through people's preference, psychological dynamics of change has to address accordingly. The Cigarettes and Other Tobacco Products (COTPA) Act was developed to curb this epidemic in India in 2003 and endorsed in Assam by establishing the State Nodal Cell at Metro Guwahati in October 2007. Simultaneously, two (2) District Nodal Cell was developed at Kamrup Metro and Jorhat district of Assam in November, 2008 as a Tobacco Cessation march in Assam. The Assam is the first state all over the India where the Government of Assam convinced to the Assembly in the month of July, 2013 to pass the Assam Health (Prohibition of Manufacturing, Advertisement, Trade, Storage, Distribution, Sale and Consumption of Zarda, Guthka, Panmasala etc, containing Tobacco) Bill-2013. The Anti-Tobacco Bill (Assam Health Bill-13) introduced by the Assam Government last year i.e. 2013 came into force from 13th February, 2014, Health Minister Dr. Himanta Biswa Sarma told. The Anti-Tobacco Bill (Assam Health Bill-13) introduced by the Assam Government last year i.e. 2013 came into force from 13th February, 2014 declared in assembly. There is lack of awareness programme at Digboi, Tinsukia district, Assam for implementation of COTPA & the sequences the Assam Health Bill-2013. With the growing evidence of harmful and hazardous effects of tobacco, the Government of Assam has played a leadership role in State Tobacco Control and enacted various initiatives to implement the COTPA in a comprehensive way to control the tobacco uses.*
Keywords: *Civil Society, Controlling Tobacco, social life*

I. Introduction:

With the import of tobacco from Portuguese to Mughal Empire, it became popular among the masses in India. The consequential attraction of tobacco made India after China as the second largest producer and consumer of the commodity in the world. [1]. The popularity of tobacco use among adults (15 years and above) is 35%. The overall tobacco user among males is 48 percent and that among females is 20 percent. Almost two out of five (38%) adults in rural areas and one out of four (25%) adult in urban areas use tobacco in some form. [2]
The recognition also invited challenge of tobacco use. The gravity of challenges reached such a fatal state that Bhutan (2004), Thailand (2006) and India (2008) implemented ban of smoking in public places. Bhutan is the first country in the world to impose a total ban on tobacco products-sale and use. [3]Some states like Maharashtra and Karnataka restricted smoking in public places. In the case of Maharashtra, specification of the size of boards in English and Marathi were prescribed, declaring certain premises as smoke free. [4] Tobacco smoking was prohibited in all health care establishments, educational institutions, domestic flights, air-conditioned coaches in trains, suburban trains and air-conditioned buses, through a Memorandum issued by the Cabinet Secretariat in 1990[5]Since these were mainly Government or administrative orders, they lacked the power of a legal instrument. Without clear enforcement guidelines and awareness of the citizens to their right to smoke-free air, the implementation of this directive remained largely ineffective. Under the Prevention of Food Adulteration Act (PFA) (Amendment) 1990, statutory warnings regarding harmful health effects were made mandatory for

pan masala and chewing tobacco. [6] The statutory word of warning "cigarette smoking is injurious to health" is known to all, yet without benefit and advantage. Tobacco smoking was forbidden in all Hospitals, educational establishment, domestic air travel, trains, buses However, it lacks a statute as a legal authority.

Tobacco use is a major public health challenge in India with 275 million adults consuming different tobacco products. In India, 800,000-900,000 people die annually due to diseases attributable to tobacco. The government of India has taken several measures, including legislation to control tobacco intake. [7] Government of India has taken various initiatives for tobacco control in the country. Besides enacting comprehensive tobacco control legislation (COTPA, 2003), India was among the first few countries to ratify WHO the Framework Convention on Tobacco Control (WHO FCTC) in 2004. The National Tobacco Control Programme was piloted during the 11th Five Year Plan which is under implementation in 42 districts of 21 states in the country. [8]

Assam (latitude 26.00 N and longitude 93.00 E) exhibits alarming rates of growth of tobacco use. About 23 % women, 72% man use any form of tobacco and 36% use cigarettes/bidis. (Source: NFHS-3, 2005-06). Looking into the gravity of harmful effect of tobacco use as may be seen in world and Indian Statistics, present study aimed in the following specific objectives:

1. To assess the prevalence and extent of tobacco use by the people of Tea Industrial and Oil Operated areas in Assam
2. Causal dimensions that facilitate extensive tobacco use.
3. Correspondence between Tobacco Use with Demography
4. Consequences of tobacco on social and economic life of the people and the country.
5. The role of civil society in controlling tobacco use.
6. The assess role of governmental and nongovernmental agencies in prevention of tobacco use in Assam.

Estimation of prevalence of tobacco with reference to state as a whole and locality as special case require carrying out a social research survey. The survey would enquire underlying social dynamics about the potential hazards and alteration of habit if possible.

The civil society has a great responsibility to curb the tobacco control effectively in each and every corner of the Assam in rural, semi urban and urban areas. Tobacco Cessation is not much easy as we think off. Sustainability is correlated to the complete cessation of the Tobacco. However after a long legal battle and interventions by the civil society, Revised Smoke-free Rules came into effect from 2nd October, 2008. [9] Subsequently the law pertaining to pictorial warnings on tobacco products packages was implemented with effect from 31st May 2009. After getting positive and supportive judgments in other court cases, the Government was forthcoming in notifying laws pertaining to ban on sale to and by minors and sale of tobacco products within 100 yards of educational institutions. For effective implementation and monitoring of anti-tobacco laws and initiatives the Tobacco Control Cells should have dedicated manpower to facilitate the agenda.

II. Methodology:

Digboi is a small semi industrial area in Tinsukia District of Assam famous for Oil Refinery run by Oil India Ltd. and Tea Estates. It is a rural industrial area. In order to study the problem, a structured questionnaire with Cronbach's Alpha reliability at 0.725 for Part 1 (18 items) and 0.799 for part II (17 items) and split half reliability 0.716 was attempted by personal interview of 150 respondents in the village of Borbill No-2 and the Hospital Tillah, the sub-urban area, Digboi, Tinsukia District were subjected to preparation of an Excel master sheet which was later on subjected to statistical analysis by SPSS 15.0. The data from master sheet was evaluated by descriptive and inferential statistics. Pearson correlation was used to estimate and test of degree of linear relationship, while Chi- square was used to find out the association between attitudes on prevalence with selected demographic variables. Role of NGO or other related suggestions obtained from respondents were also estimated from relative frequency of response from respondents. One open ended questionnaire for part III was structured by the investigator to assess the effectiveness of the implementation of control measures by State Nodal Cell, Assam and District Nodal Cell of Kamrup Metro and Jorhat district in the state of Assam.

FINDINGS:

The summary of attitudinal survey is presented in Table 1. It depicts that 60% of the respondents were tobacco consumers with Betel Leave and Nuts /Zarda Pan out of which 71.43% % were female and 55.56% were male followed by 50% of them were tobacco buyer in the form of cigarette out of which 62.96% % were male and 16.67% were female. Use of cigarette was seen to be followed by Bidi (41.30%), Khaini (35.33%) and Gutkha (28%).

In the present study, the most commonly reported tobacco consumers are male than female except tobacco consumers with Betel Leave and Nuts /Zarda Pan. The present study was supported by **the National Sample Survey 52nd Round and National Family Health Survey-2,** where the prevalence of male tobacco consumers was 51.3% in 1995.1996 and 46.5% in 1998.1999. The prevalence of tobacco use among females was 10.3% and 13.8%, respectively. The result is also supported by **the National Household Survey of Drug**

and Alcohol Abuse conducted in 25 states (excluding Jammu and Kashmir) in 2002 reports that 55.8% of males 12-60 years of age currently use tobacco. The same results were supported by **Global Adult Tobacco Survey India,** State Programme Implementation Plan 2011-12 **highlights** that the Current tobacco use in any form: 34.6% in adults; 47.9% in males and 20.3% in females, Current tobacco smokers: 14.0% of adults; 24.3% of males and 2.9%of females, Current cigarette smokers 5.7% of adults; 10.3% of males and O.8% of females, where bidi smokers: 9.2% of adults; 16.0% of males and 1.9% of females, user of smokeless tobacco: 25.9% of adults; 32.9% of males and 18.4% of females. [10]

Table 1: Frequency Analysis of Respondents Attitude on Tobacco Use

Substance	Response	Sex		Total
		Male	Female	
Cigarette	No	40(37.04%)	35(83.33%)	75(50.00%)
	Yes	68(62.96%)	7(16.67%)	75(50.00%)
Bidi	No	52(48.10%)	36(85.70%)	88(58.70%)
	Yes	56(51.90%)	6(14.30%)	61(41.30%)
Betel Leave and Nuts /Zarda Pan	No	48(44.44%)	12(28.57%)	60(40.00%)
	Yes	60(55.56%)	30(71.43%)	90(60.00%)
Gutkha	No	74(68.52%)	33(78.57%)	107(71.33%)
	Yes	34(31.48%)	8(19.05%)	42(28.00%)
	NR	0	1(2.38%)	1(0.67%)
Khaini	No	68(62.96%)	29(69.05%)	97(64.67%)
	Yes	40(37.04%)	13(30.95%)	53(35.33%)
Total		108(100.00%)	42(100.00%)	150(100.00%)

NR=Not Reported

Table 2 exposes user's preferences in consumption in recipes of different combination of tobacco products. The preference varied from Cigarette+Bidi (32%) followed by Cigarette+ Bidi+ Betel leaves and nuts /zarda pan (30%). The lowest preference was seen in 2% in Betel leaves and nuts /zarda pan+Gutkha, Cigarette+Bidi+ Khaini, Cigarette+Betel leaves and nuts /zarda pan+Gutkha+Khaini, Bidi+Betel leaves and nuts/zarda pan and Khaini (alone). The tobacco market is exploring the potentiality of this taste and preference dimension of users, which civil society has to a role to counter.

Table 2: Distribution of Tobacco Use by sample Respondents

Substance	Frequency	Percent
Cigarette	24	16.00
Betel leaves and nuts /zarda pan+Gutkha	2	1.33
Cigarette+Bidi	32	21.33
Cigarette+Bidi+ Khaini	2	1.33
Cigarette+Bidi+Betel leaves and nuts /zarda pan	30	20.00
Cigarette+Bidi+Betel leaves and nuts /zarda pan+Gutkha	13	8.67
Cigarette+Betel leaves and nuts /zarda pan	7	4.67
Cigarette+Betel leaves and nuts /zarda pan+Gutkha	9	6.00
Cigarette+Betel leaves and nuts /zarda pan+Gutkha+Khaini	2	1.33
Cigarette+Betel leaves and nuts /zarda pan+Khaini	3	2.00
Cigarette+Gutkha	3	2.00
Bidi+Betel leaves and nuts/zarda pan	2	1.33
Bidi+Betel leaves and nuts /zarda pan+Gutkha	3	2.00
Betel leaves and nuts /zarda pan	6	4.00
Betel leaves and nuts /zarda pan+Gutkha	3	2.00
Betel leaves and nuts /zarda pan+Gutkha+Khaini	3	2.00
Khaini	2	1.33
NR	4	2.67
Total	150	100.00

NR=Not Reported

The study also made an attempt to study interrelation of consumption of different tobacco product by Pearson correlation. Correlation analysis revealed significantly and positively association of Bidi (0.46) with cigarette which indicated that bidi users prefer entertainment in cigarette. While the cigarette negatively related

to khaini (-0.21) indicated that khaini users prefer a little in cigarette. Increase use in any one of them had an increased or decreased tendency to use of others. However, inversely correlated to khaini (-0.16) with Gutkha indicated that strong preference of Guthka has been dominating over Khaini. (Table-3)

Table 3: Pearson Correlations of Tobacco Substances

	Bidi	Betel Leave and Nuts /Zarda Pan	Gutkha	Khaini
Cigarette	.460(**)	-.109	.074	-.209(*)
Bidi		-.033	.075	-.054
Betel Leave and Nuts (Zarda Pan)			.086	-.023
Gutkha				-.161(*)

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Factors contributed to tobacco use as reported by respondents (Table 4) revealed that financial factor contributed mostly (31.33%) followed by psychological attitude (28.67%) and biological make-up (25.33%).

Table 4: Attitude of Respondents on underlying Factors of Tobacco Use

		Respondent's View					
		Not contributing	**Partially contributing**	**Most contributing**	Total	Means	Contribution (%)
Biological factors	Frequency	14	98	38	150	11.97±2.57	22.31
	Percent	9.33	65.33	25.33	100		
Psychological factors	Frequency	11	96	43	150	10.80±2.74	20.13
	Percent	7.33	64.00	28.67	100		
Interpersonal factors	Frequency	3	112	35	150	10.39±2.64	19.37
	Percent	2.00	74.67	23.33	100		
Financial factors	Frequency	14	89	47	150	10.01±2.78	18.66
	Percent	9.33	59.33	31.33	100		
Socio-Cultural factors	Frequency	3	114	33	150	10.49±2.70	19.55
	Percent	2.00	76.00	22.00	100		
Attitude Level	Frequency	21	105	24	150		100.00
	Percent	14.00	70.00	16.00	100		

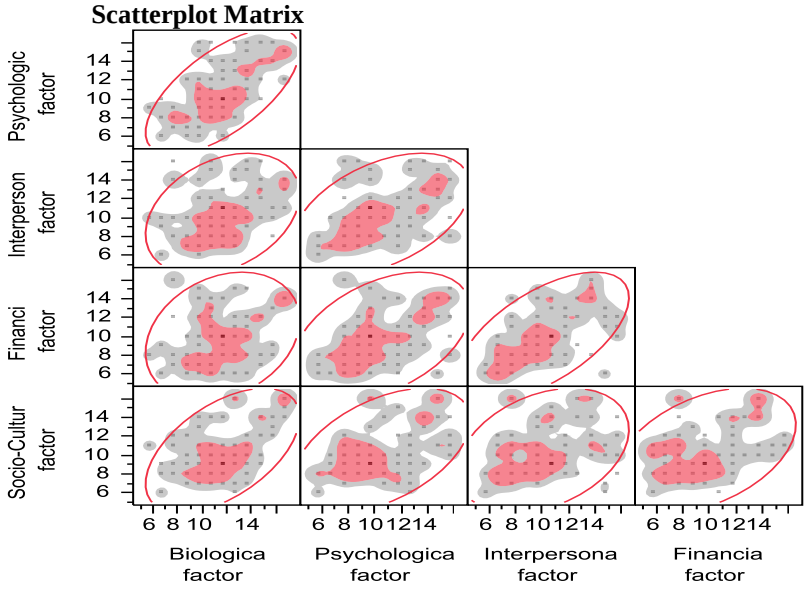
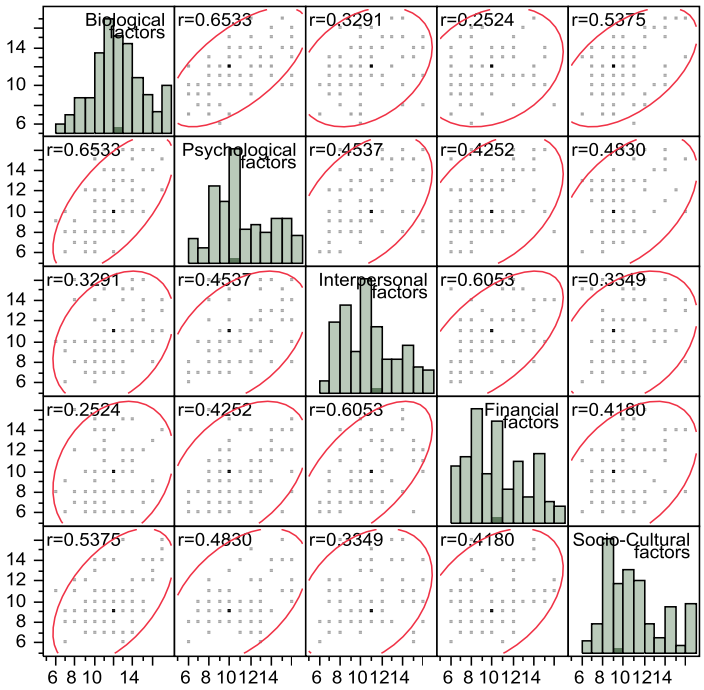


Figure-1: Attitude of Respondents on underlying Factors of Tobacco Use

Scatter plot Matrix



Correlation analysis (Table 5) also revealed that psychological, interpersonal, financial and socio-cultural factors were positively and significantly correlated to each other. It suggests that if policy is to be initiated, it must address all factors simultenously to mitigate the prevalence.

Table 5: Pearson Correlations of different factors in Tobacco Use

	Psychological factors	**Interpersonal factors**	**Financial factors**	**Socio-Cultural factors**
Biological factors	.653(**)	.329(**)	.252(**)	.537(**)
Psychological factors		.454(**)	.425(**)	.483(**)
Interpersonal factors			.605(**)	.335(**)
Financial factors				.418(**)

** Correlation is significant at the 0.01 level (2-tailed).

Knowledge of the tobacco users about the health risk revealed (Table 6) that public attitude is significantly associated with deadly impact of tobacco. However, their attitudes were insignificantly associated to awareness of statutory regulation on ban of tobacco in the state.

Table 6: Attitude Level and Awareness

		Attitude Level			Total			
Tobaco is		Not Contributing	Partially Contributing	Most Contributing		Chi_Square	df	P_Value
Deadly Practice to life	No	6	21	0	27	7.14*	2	0.03
	Yes	15	84	24	123			
Aware of ban of tobacco by law	No	9	53	13	75	3.55	4	0.47
	Yes	12	46	11	69			
	NR	0	6	0	6			

NR= No Response, * Significant at P (<0.05)

The Table 7 depicts that attitude was highly related to age, sex and marital status, residential area, educational status and current occupation. However it is unrelated to religion, type of family and income level. Policy makers may also address these demographic parameters if eradication measures has to undertaken. Awareness and its impact on tobacco consumption are poor among my study subjects. There is an urgent need for reconsideration for more effective awareness, enforcement programme initially.

Table 7: Association of Tobacco use with demography

		Attitude						
		Most Contributing	Not Contributing	Partially Contributing	Total	Chi Square	df	P_Value
Age	16-20 years	1	0	6	7	40.850**	8	<0.001
	20-30 years	9	3	16	28			
	30-40 years	2	5	33	40			
	>40 years	5	13	48	66			
	NR	7	0	2	9			
Sex	Male	12	18	78	108	7.993*	2	0.018
	Female	12	3	27	42			
Marital Status	Single	2	12	41	55	20.660**	6	0.002
	Married	16	9	58	83			
	Divorced	2	0	3	5			
	Widow/ widower	4	0	3	7			
Religion	Hindu	21	17	81	119	2.467	4	0.651
	Muslim	0	0	4	4			
	Christian	3	4	20	27			
Residential area	Rural	24	6	45	75	30.00**	2	0.000
	Semi Urban	0	15	60	75			
Educational status	Illiterate	10	0	16	26	34.69**	8	0.000
	Primary	12	5	44	61			
	Secondary	1	6	29	36			
	Graduate	1	10	14	25			
	Post graduate	0	0	2	2			
Current Occupation	Student	0	0	2	2	19.82*	8	0.011
	Unemployed	15	16	74	105			
	Government employee	1	3	8	12			
	Private employee	3	2	19	24			
	5	5	0	2	7			
Type of family	Joint	9	11	64	84	4.888	4	0.299
	Nuclear	14	9	39	62			
	Extended	1	1	2	4			
Family monthly income(Rs.)	< 5000	7	7	33	47	7.342	10	0.693
	5000-10000	12	7	57	76			
	10000-20000	4	4	9	17			
	>20000	0	1	2	3			
	NR	1	1	2	4			
	Refused	0	1	2	3			
Total		24	21	105	150			

NR= No Response

NC= Not contributing, PC= partially contributing MC= Most contributing

Role of civil society in controlling tobacco and prevent the social hazards as reported by respondents was presented in Table 8. Fig:2 It found that 50% of respondents were in favour of NGO initiatives while 34% preferred psychological intervention with self awareness and self help measures to repel from tobacco use. If the civil society wants a tobacco free zone and acts according to information about people's choice, psychological dynamics of change has to address in a hurry without delay. India has already taken many tobacco control initiatives including legislative measures, ratification of the WHO FCTC and implementation of the National Tobacco Control Programme. The Indian anti tobacco law is reasonably strong to comply with most of the provisions in the WHO FCTC

Table 8 Suggestion of Sample Respondents on remedial measure

	Frequency	Percent
No Response(Undecided)	18	12.00
Self Awareness & self help may repel from Tobaco Use (Psychological Intervention)	51	34.00
NGO Initiative	75	50.00
Strong Law	6	4.00
Total	150	100.00

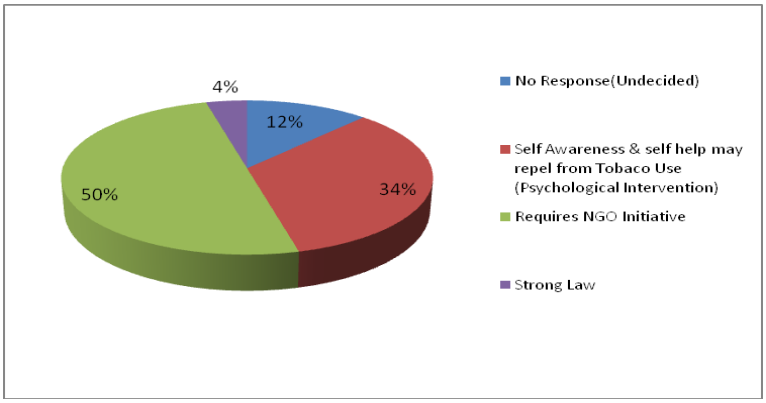


Figure-2 Suggestion of Sample Respondents on remedial measure

Implementation of COTPA and the Sequences of Assam Health Bill-13

In implementation of various provisions under COTPA lies mainly with the State Governments, effective enforcement of tobacco control law remains a big challenge. To strengthen implementation of the tobacco control provisions under COTPA and policies of tobacco control mandated under the WHO FCTC, the Government of the India piloted National Tobacco Control Programme (NTCP) in 2007-2008. [11] The programme is under implementation in **21 out of 35 States/Union territories** in the country. In total, **42 districts including Assam** are covered by NTCP at present. This was a major leap forward for the tobacco control initiatives in the country as for the first time dedicated funds were made available to implement tobacco control strategies at the central state and sub-state levels.

In spite of a comprehensive legislation being in place and implementation of NTCP by the Government, many of the states are not able to initiate effective measures for tobacco control. The internal monitoring of implementation of **COTPA in 21 States**, where the National Tobacco Control Programme is under implementation has revealed that only about half of the states (52%) have mechanisms for monitoring provisions under the law. Although 15 states have established challenging mechanism for enforcement of smoke-free rules, only **11 states collected** fines for violations of bans on smoking in public places. Similarly, a steering committee for implementation of section-5 (ban on Tobacco advertisements, promotion and sponsorship) has been constituted in 21 states but only 3 states collected fines for the violation of this provision. The total Fine collected by the state of Assam for violation of Section 4, 5, 6 is Rs. 94000 till 2013. (Annexure-I sample copy of Receipt) Similarly, enforcement of a ban on the sale of tobacco products to minors and bans on the sale of tobacco products within 100 yards of educational institutions also remains largely ineffective in many states including Assam. Less than half of the states under the programme have established tobacco cessation facilities at the district level. It is largely because of the failure of the states to recruit manpower under the programme. To facilitate the implementation of NTCP at state and sub state level, the Government developed various Training modules, guides, IEC and advocacy materials. [12] [13] [14] [15] [16]

Setting up of Tobacco Cessation Clinics in Assam has been one of the major highlights in Tobacco Cessation march. The network of Tobacco Cessation Clinics was expanded in 2005 to cover five new clinics in Regional Cancer Centres (RCCs) in 5 states of which two centers were in the North-Eastern States of Mizoram and Assam, having high prevalence of tobacco use. **Assam has three (3) Tobacco Cessation Clinics** out of 13 Tobacco Cessation Clinics in 12 states across the country. Two Centres for Nicotine Replacement Therapy were established in Metro Guwahati and Jorhat own. In Jorhat district two (2) villages was declared as Tobacco Free Villages and 3 are in under process. (Table:10)

The total awareness programme conducted in various parts of Assam was nearly 400 till December, 2013. The awareness programme on ill health effect of tobacco use were organised in schools with Audio Visual Aids. A well designed mega campaign i.e. Tobacco Free North-East Campaign was conducted on 1st and 2nd

March 2014 at the Metro City Guwahati with gracious presence of Mr. Tarun Gogoi, the Chief Minister, Government of Assam, Dr. Himanta Biswa Sarma, the Minister of Education, Health & F.W. and Implementation of Assam Accord Deptt., many more MLA's of North-Eastern State, all the Governmental Officials of North-East, Jeenat Aman, the film actress, the voice of India Mr. Devajit Saha, the boxer, Mr. Abhijit Baruah, the Guinness Book of record holder for throwing 329 punches on a boxing pad in a minutes and other celebrity of North Eastern State were enlightened the campaign. A mega rally with a slogan-"I Said No Tobacco" was organized in which Hon'ble Chief Minister; Mr. Tarun Gogoi administered "No Tobacco Use" pledge to youth & students. The rally was followed by a Pledge taking by around 2500 of people at 10:00 am and simultaneously at 10:30 am the same pledge was distributed to the schools/colleges of Assam to for the teachers and students. (Annexure-II Copy of Pledge signed by the Dr. Himanta Biswa Sarma, the minister of Education, Health & F.W. and implementation of Assam Accord Dept.) The aim was creating public awareness about tobacco use in the region & reduces health costs. The event created mass awareness & sensitised the stakeholder against tobacco use, the Regional Director of State Health services, Assam, Mr. Parthojyoti Gogoi, said.

Recently in 2014 a Food Safety cum District Nodal Officer, District Tobacco Control Cell Kamrup Metro, Mr. Samiran Baruah, watched a Bengali Drama in a Drama Festival at Rabindra Bhawan, Guwahati, Assam where a character was live cigarette smoker. He detained the director against the violation of Section-4 instantly. The Grant in aid for State Tobacco Control Cell including salary, training, IEC (Information, education and Communication), School Programme, Awareness Programme (Both privat and public sector) was about 10.00 lacs, (**Report of State Nodal Cell and District Nodal Cell of Assam**)

The state of Assam with population 26.6 million (Census, 2001) has two hundred and two (202) educational institutions out of which forty nine (49) are Nursing establishments (1 Health University, 8 Collegiate Programme, 21 GNM training School, 18 ANM training School, 1 LHV training centre Source: O/O Joint Director Nursing). Table: 9 illustrate that out of 202 educational establishments, the State Tobacco Control Celll declared 84 Tobacco Free educational establishments. Out of 12 Universities of Assam only one university was declared as Tobacco Free University ie, the Tezpur University and the Campus of Guwahati University was declared as Tobacco Free Campus. The Inter State Bus Terminus (ISBT), Guwahati was also declared as Tobacco Free Zone. The Vice-Cencellor of Dibrugarh University, Mr. Alok Borgohain with synchronization with District Tobacco Control Officer, the JorhatTobacco Control Cell, arranged a meeting in December, 2013 to instigate the Tobacco Free Training Programme with 113 Colleges under the Dibrugarh University.

Table: 9 List of Tobacco free zone

Sl. No.	District of Assam	Tobacco free University	Tobacco Free School/College	Tobacco Free Villages	Tobacco Free Zone	Remarks
1	Metro Guwahati	0	2	-	2	The following set-up was declared as Tobacco Free by Assam Tobacco Control Centre 1. The B. Baruah College 2. The Pandu College 3. The Gauhati University campus 4. The ISBT campus Seven (7) Educational Establishments are under Tobacco Free Process.
2	Jorhat District	-	82 Declared 15 Processing	2 Declared 3 Processing	-	**Declared:** 1. Sahpuria Village 2. Ganakabari village **In Process to make tobacco free village** 1. Pangiri village 2. Tiyak Jokdua 3. Nepali Bosti

Table-10 The Tobacco Quit Clinic in Assam

District	Tobacco Quit Clinic	Nicotine Replacement Therapy	NGO's Initiatives
METROPOLITAN GUWAHATI URBAN	1. Mohendra Mohan Choudhury Hospital (MMCH)--1 2. Dr. B. Borooah Cancer Institute (BBCI)-1	1) Mohendra Mohan Choudhury Hospital-1	1. The Voluntary Health Association of Assam 2. The Jagriti Cultural Centre 3. The Women Welfare society
JORHAT	1. Jorhat Medical College Hospitals	1) Jorhat Medical College Hospital	2) The Sankalpa Hikha 3) The Poribortan Natya Gusthi (Tiyak)
Total	3	2	5

The table 10 depicts that Assam has three (3) Tobacco Cessation Clinics, two (2) Nicotine Replacement Clinics. In Guwahati there are two (2) Tobacco Cessation Clinics viz. in Mohendra Mohan Choudhury Hospital (MMCH) and Dr. B. Borooah Cancer Institute (BBCI) out of which the BBCI is under grant in Aid of WHO. In Jorhat Medical College Hospital, Jorhat district, Assam the Tobacco Quit Clinic as OPD service and one Nicotine Replacement Clinic was established.

The table 10 also depicts that the total of five (5) NGO's are attached with the activity of State Nodal Cell and District Nodal Cell of Assam in the mean of Awareness programme, Enforcement and Monitoring of Tobacco use under the act of COTPA.

A voice of victim was raised by 10 numbers of patients from Dr. B. Borooah Cancer Institution, Guwahati, Assam to convince the assembly to pass the Assam Health (Prohibition of Manufacturing, Advertisement, Trade, Storage, Distribution, Sale and Consumption of Zarda, Guthka, Pan masala etc, containing Tobacco) Bill-2013. The bill was declared by the Governor, the President of India, Mr. Pranab Mukharjee on 13th February, 2014. It is the great privilege for me to represent the state of Assam for the affirmative and resourceful commencement and audacious initiatives and boldness towards the Cessation of Tobacco for the welfare of the health of the people in the state of Assam. I want to congratulate the government of Assam and the citizen of Assam for the big march for the Prohibition of Manufacturing, Advertisement, Trade, Storage, Distribution, Sale & Consumption of Zarda, Guthka, Panmasala etc. containing Tobacco.

III. Conclusion:

The statistics found in the survey of prevalence of tobacco use in the Tea Industrial and Oil Operated areas in Assam was found to be in alarming dimension of deadly evil. The dynamics of the users in manipulating tobacco product has widened possibility of gaining its momentous in future. The civil society has a great responsibility to face the evil with many faces and control effectively in in rural, semi urban and urban areas of the state. Saying no tobacco is much easier than done. Doing it is correlated to the complete cessation of the tobacco. For effective implementation and monitoring of it strengthening of Tobacco Control Cells under the anti-tobacco laws has no alternative. The Cigarettes and Other Tobacco Products Act (COTPA) has enacted to control tobacco as a major public health challenge in India. The state of Assam has implemented the tobacco control policies and programmes with various levels of success initially for two district of Assam which is planned to be extended to another 10-12 districts (viz. Barpeta, Dhemaji, Dibrugarh, Dhubri, Golaghat, Kamrup Rural, Kukrajhar, Kasar, Lakhimpur, Marigaon, Nagaon and Sunitpur). The first Health Bill initiation in India viz the Assam health Bill-2013 was awaited for his excellancy of Governor, the president of India, Mr. Pranab Mukharjee till 12th February, 2014 and came into force from 13th February, 2014 declared in assembly. Effective tobacco control is dependent on balanced operation of demand and reduction of supply strategies and inter and intra organisational coordination. The implementation of the Act, synergized with tobacco control initiatives by the civil society, community and NGO's are pivotal in reducing prevalence of tobacco consumption by the rural tea industrial and oil operated area of Digboi town, Tinsukia District, Assam. There is no single awareness programme at Digboi, Tinsukia district, Assam for implementation of COTPA & the sequences of Assam Health Bill-2013. A NGO initiated awareness plan is due at Digboi in targeting it as Tobacco Free Zone.

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