INTERNSHIP AND DISSERTATION

MONITORING AND EVALUATION

OF

NATIONAL TOBACCO CONTROL PROGRAMME

A report submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

By

ROHINI RUHIL

Roll No. PG/09/041

International Institute of Health Management Research

New Delhi -110075

APRIL, 2011

Dissertation Title

"Monitoring and Evaluation Of National Tobacco Control Programme"

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Roll No. PG/09/041

Dr Jagdish Kaur
Designation: Chief Medical Officer
Organisation:
Directorate General of Health Services,
Ministry of Health and Family Welfare

Dr Preetha G S
Designation: Asst. Professor,
IIHMR, New Delhi

International Institute of Health Management Research
New Delhi -110075
APRIL, 2011

ACKNOWLEDGEMENT

I hereby take this opportunity to thank Dr Dinesh Bhatnagar (Additional D G), Dr D C Jain (Deputy D G), Ms. Jagdish Kaur (CMO, DGHS) for granting me the opportunity to work in esteemed organization that gave me the scope for playing an active role in different activities, which was a learning experience for me.

I want to thank all the staff involved in National Tobacco Control Programme for all their help, support, interest & valuable hints.

My sincere acknowledgement goes to Dr Maitreyi R. Kollagal, Director, IIHMR, New Delhi, and Dr.Preetha G S (Mentor), IIHMR, who gave me the opportunity, encouragement and guidance.

A special vote of thanks to Mr K Chandramouli (Secretary), Mr Keshav Desi Raju (Additional secretary), Mr B K Prasad (Joint Secretary) and Mr R S Negi (Under Secretary) for their kind assistance during the study.

I also want to acknowledge thanks to Ms Vineet Gill Munish (NPO, TFI, WHO country office for India) who provided significant inputs to my project.

I would also like to thank all the state focal points, state consultants and district focal points under the programme.

Thanks are also due to my Professors Dr. Nittish Dogra, Mr. Indrajit Bhattacharya, Dr Dharmesh Lal, Dr Brig K J Singh, Mr Pawan Kumar Taneja, Miss Anupama, Ms Minakshi Gautam and Dr. S. K. Patel, for their kind assistance and support throughout my dissertation.

I would also like to acknowledge thanks to my friends for their support and would also like to thank all those who were associated with my study in direct or indirect way for sharing their experience and information to enhance my understanding.

Last but not the least; I would like to thank my family for being the pillar of support throughout my dissertation.

Thank You,

Rohini Ruhil

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ABBREVIATIONS

AFTC	Advocacy Forum for Tobacco Control
ASHA	Accredited Social Health Activist
CBO	Community Based Organisation
CBSE	Central Board of Secondary Education
CDC	Centre for Disease Control and Prevention
CMO	Chief Medical Officer
COTPA	Cigarettes and Other Tobacco Products Act
CWG	CommonWealth Games
DDG	Deputy Director General
DGHS	Directorate General of Health Services
FAO	Food and Agriculture Organization
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration
GATS	Global Adult Tobacco Survey
GDP	Gross Domestic Product
GHPSS	Global Health Professional Students Survey
GSPS	Global School Personnel Survey
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
HP	Himachal Pradesh
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
JHSPH	Johns Hopkins School of Public Health
M&E	Monitoring and Evaluation
MoHFW	Ministry of Health and Family Welfare
MP	Madhya Pradesh
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NPO	National Professional Officer

NPPDCS	National Programme for prevention of Diabetes, Cardiovascular diseases and Stroke
NRHM	National Rural Health Mission
NRT	Nicotine Replacement Therapy
NTCP	National Tobacco Control Programme
RCC	Regional Cancer Centre
RCH	Reproductive and Child Health
RCTC	Resource Centre for Tobacco Control
RNTCP	Revised National Tuberculosis Control Programme
S&E	Shops and Establishment
SHG	Self Help Group
SHS	Second Hand Smoke
TB	Tuberculosis
TCC	Tobacco Cessation Centre
TCI card	Tobacco Cessation Intervention card
TFI	Tobacco Free Initiative
TOT	Training Of Trainers
UP	Uttar Pradesh
UT	Union Territory
VAT	Value Added Tax
WHA	World Health Assembly
WHO	World Health Organization
WNTD	World No Tobacco Day

PART – A

INTERNSHIP REPORT

NATIONAL TOBACCO CONTROL PROGRAMME

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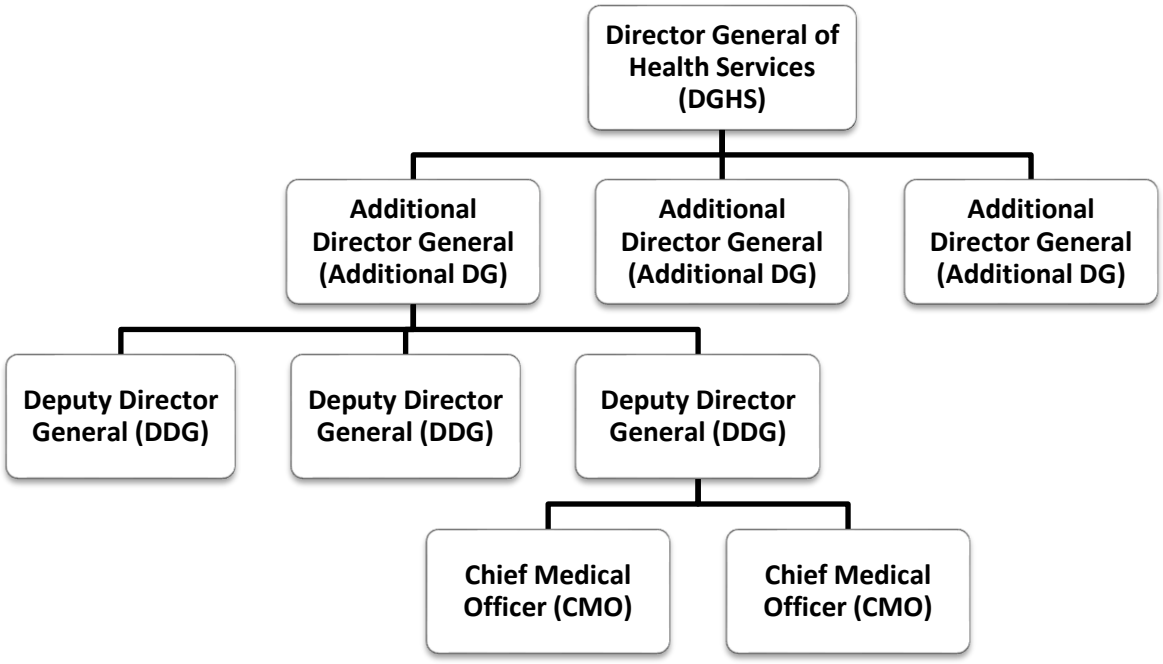
JAN – APRIL, 2011

1.1 – ORGANISATION AND ITS PROFILE

DIRECTORATE GENERAL OF HEALTH SERVICES (DGHS) :

The Directorate General of Health Services, a repository of technical knowledge, is an attached office of Ministry of Health and Family Welfare. The DGHS also renders technical advice on all medical and public health matters and in the implementation of various health schemes. It is headed by the Director General of health services who is the principal advisor to the union government in both medical and public health matters. He is assisted by an Additional Director General of health services, a team of deputies and a large administrative staff. The directorate comprises of three main units, e.g., medical care and hospitals, public health and general administration. Along with many other functions, the central directorate plays a very important part in planning, guiding and coordinating all the national health programmes in the country. DGHS is located at Nirman Bhawan on Maulana Azad Road near Central Secretariat.

ORGANOGRAM :



1.2 – ENGAGED IN NATIONAL TOBACCO CONTROL PROGRAMME

The Government of India launched National Tobacco Control Program (NTCP) in the 11th Five Year Plan (2007-12) to implement the Tobacco control laws and bring about greater awareness about the ill effects of tobacco, institute a regulatory mechanism including laboratory facility for effective monitoring and implementation of anti tobacco initiatives at State/ District level.

The pilot phase of the NTCP was launched in 2007– 08 covering 18 districts of 9 States (Assam, West Bengal, Madhya Pradesh, Tamil Nadu, Karnataka, Gujarat, Rajasthan, Delhi, Uttar Pradesh). Further in 2008-09, 12 new states covering 24 districts (Bihar, Jharkhand, Orissa, Sikkim, Arunachal Pradesh, Mizoram, Nagaland, Tripura, Maharastra, Goa, Uttarakhand, Andhra Pradesh.) have been added.

I was engaged in National coordination work and some specific tasks like finalization of training manuals and national guidelines; development of best practices report; monthly and quarterly review of programme and review of proposals. I visited various departments like CMO office, section, DDG office, WHO tobacco control cell. I met with various officials who include CMO (Chief Medical Officer), DGHS; DDG (Deputy Director General) and NPO (National Professional Officer), WHO, Country office for India.

1.3 – BRIEF ACTIVITY REPORT

During my internship in National Tobacco Control Programme, Ministry of Health and Family Welfare, I was involved in the following activities.

1. Finalisation of training manual for doctors : This manual has been developed with the objective to sensitize and update doctors working at the community level about the tobacco problem and initiatives undertaken by the government. It also aims at imparting skills in tobacco cessation to doctors, which can very well be implemented at the primary health care level. I was involved throughout the development of this module by giving various inputs; discussing the contents with editorial team; coordinating with the persons involved like editors, data entry operator, designer and printer.
2. Finalisation of a guide for teachers : The guide has been designed for the teachers to guide the students in conducting various activities related to tobacco control initiatives under the School Health Programme. It includes activities for sensitizing the students regarding health and environment hazards related to use of tobacco. The guide has been developed to motivate teachers and the students to declare and maintain a tobacco free environment within the school premises and at their homes. I was involved throughout the development of this module by giving various inputs, discussing the contents with editorial team, coordinating with the persons involved like editors, data entry operator, designer and printer.
3. Finalisation of "Tobacco dependence treatment guidelines" : "Tobacco dependence treatment guidelines" have been developed with an objective to sensitize and train tobacco cessation service providers and health care providers to play a proactive role in changing behavior of tobacco users. The guidelines would prove useful to doctors, social workers, psychologists, nurses or other tobacco cessation service providers who provide or are interested in providing tobacco cessation services. I was involved throughout the development of this document by giving various inputs, discussing the contents with editorial team, coordinating with the persons involved like editors, data entry operator, designer and printer. I also developed the foreword and preface for the document.

4. Development of Best Practices report : This report presents national best practices in the implementation of tobacco control measures and seeks to identify elements for effective policy enforcement. The report focuses on national enforcement practices for components of National tobacco control programme: trainings, IEC, implementation of tobacco control law, school programmes, tobacco cessation and monitoring. I collated the best practices of various states and organizations and of National programme in the form of this report. I discussed the contents with other officials and contributors.
5. Writing proposal for "Indian Tobacco Atlas" : A proposal for developing "Indian Tobacco Atlas" was written to WHO. The "Indian Tobacco Atlas" will be used by state tobacco cells, district tobacco cells, NGOs and other organizations working for tobacco control. The Atlas will guide them about specific tobacco related issues of each state so that they can prioritize their activities accordingly.
6. Monthly and Quarterly review of National Tobacco Control Programme : I was responsible for collecting monthly and quarterly reports from various states, compiling those reports in a single table and presenting the compiled monthly and quarterly reports to higher officials.
7. Review of proposals : I also undertook the task of reviewing proposals sent by various organizations and discussing these proposals with higher authorities.
8. Routine coordination work : I was also involved in doing some routine coordination work like coordination with persons involved in above stated activities and coordination with higher officials.
9. Attended an event named "Voice of Victims" on 11 February, 2011 : The event was conceived by cancer victims and hosted by Act India, Healis institute of public health, Salaam Bombay foundation, Voluntary health association of India. In this event cancer survivors told how cancer has changed their lives and also affected their families. The victims shared their experiences and encouraged others to stop tobacco abuse.

1.4 – REFLECTIVE LEARNING

During the finalization of training manual for doctors, I learnt various aspects of developing training manual. The doctors are too busy to read a thick manual. So we tried to make it brief and to the point. I learnt how to write the relevant information in minimum words. I also learnt how to make the manual effective with proper pictures and figures. It also added to my knowledge as I went through the contents and discussed the manual with editors. I learnt the importance of proof reading before final printing of manuals. I learnt the importance of proper coordination between the team developing the manual including designers and printers.

During the finalization of a guide for teachers, I learnt how the contents, language and design of manual vary according to audience. As the audience was school students and teachers, we incorporated various posters, activities and worksheets in the guide. The language was kept simple and use of jargons was avoided. Here also I learnt the importance of proof reading and coordination etc. It also added to my knowledge.

During the finalization of "Tobacco dependence treatment guidelines", I learnt the importance of having national guidelines for providing tobacco cessation services in the country. These guidelines will help the tobacco cessation service providers in providing evidence based behavioral counseling and pharmacotherapy. It also added to my knowledge regarding stepwise behavioral therapy and pharmacotherapy. I learnt that physician/ doctor should be well aware of correct dosage, side effects and contraindications of pharmacotherapy before prescribing it to the patient.

During the development of Best Practices document, I learnt about the various activities being done across the nation under National Tobacco Control Programme. I learnt how the practices adopted by one village or district or state could set an example for others. I learnt about various smoke free/ tobacco free villages, cities and states. I also learnt how the tobacco control laws have been effectively implemented at some places.

While doing the monthly and quarterly review of the programme, I learnt how to extract the relevant information from the reports and how to collate information from different sources. I learnt how to review a programme at national level.

While doing the review of proposals, I learnt how to examine relevance of activities being stated in the proposal; how to judge authenticity of proposal and how to examine

budget of the proposal. I also learnt how to correlate budget with the activities and to eliminate the unnecessary activities. I learnt that the project mentioned in the proposal should be able to bring some outcome and should not be carried out just for the sake of doing a process.

I learnt about the importance of coordination work in a job.

After attending the programme, “Voice of Victims”, I learnt how tobacco devastates the lives of people and their families. I also learnt that tobacco victims could help spreading the awareness about possible consequences of tobacco. The message of those who have gone through the ill effects of tobacco could be very effective especially to those tobacco users who think that tobacco will not harm them.

PART B – DISSERTATION

"Monitoring and Evaluation Of National Tobacco Control Programme"

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Dr Preetha G S

Designation: Asst. Professor,

IIHMR, New Delhi

International Institute of Health Management Research

New Delhi -110075

APRIL, 2011

ABSTRACT

National Tobacco Control Programme (NTCP) was started in 2007 as a pilot project covering 18 districts of 9 states. Further in 2008-09, 12 new states covering 24 districts have been added.[5] There are various components of programme at national, state and district level. The district level components include trainings; IEC; schools programme; enforcement of tobacco control laws and tobacco cessation centres.

It was felt that implementation status of National Tobacco Control Programme needed to be assessed under the present M&E (Monitoring and Evaluation) framework. There was also a need to develop a robust monitoring and evaluation system for the programme. Therefore the problem was stated as, **"Monitoring and Evaluation of National Tobacco Control Programme".**

The study design was descriptive cross-sectional. It was an applied research. The sampling design for this evaluation study was **purposive sampling**. The sampling frame for quantitative data included all the 21 state tobacco cells and 42 district tobacco cells in which programme had been implemented. The sample size for the qualitative data used the concept of **saturation.[9]** MS Excel was used for quantitative data analysis. Qualitative data was analysed through "grounded theory methodology".[10][11]

Major findings are following,

1. Total staff under NTCP is 74.
2. Anti tobacco television and radio advertisements and lot of trainings and IEC material has been developed at national level and has been translated in to vernacular language by several states.
3. Six tobacco products testing labs have been identified at various locations. Procurement of instruments and recruitment of manpower for the labs is under process.
4. Under TB-tobacco integration project, 1436 professionals were trained in Vadodara, Gujarat and 533 professionals were trained in Kamrup, Assam. Also 690 TB cases were given TCI (Tobacco Cessation Intervention) card in Vadodara, Gujarat and 378 TB cases were given TCI card in Kamrup, Assam.
5. Ministry of Health & FW (MoHFW) in collaboration with Central Tobacco Research Institute (Ministry of Agriculture) has launched a pilot initiative for

providing alternative cropping system to bidi/ chewing tobacco crops in 5 different agro-ecological sub-regions. An expert group has also been constituted for alternate vocations/ livelihoods with representations from different ministries.

6. The report was submitted by 17 states. The 4 states which did NOT submit their reports include Jharkhand, Uttarakhand, Rajasthan and Sikkim.
7. District tobacco cell have been set up by 15 states. The states where district tobacco cell has not been set up are West Bengal and Orissa.
8. IEC activities at district level were being conducted by 15 states. The states which did not conduct IEC activities at district level include West Bengal and Orissa.
9. Activities under school programme were conducted by 15 states. The 2 states which did not conduct activities under school programme include Bihar, Orissa.
10. The 6 states which did NOT collect fines under section 4 of COTPA include West Bengal, Assam, Nagaland, Tripura, Arunachal Pradesh, and Bihar.
11. The 3 states which collected fines under section-5 include Gujarat, TamilNadu, and Andhra Pradesh. The 5 states which collected fines under section 6 (a) of COTPA included Uttar Pradesh, Delhi, TamilNadu, Andhra Pradesh, and Gujarat. The 8 states which collected fines under section 6 (b) of COTPA included Uttar Pradesh, Delhi, TamilNadu, Mizoram, Andhra Pradesh, Gujarat, Assam and Maharashtra. The 5 states which collected fines under section 7 of COTPA included Tamil Nadu, Andhra Pradesh, Assam, Mizoram and Goa.
12. The 4 states where steering committee has NOT been constituted at state level include Tripura, Jharkhand, Uttarakhand and Maharashtra. The 5 states where steering committee has NOT been constituted at district level include Tripura, Jharkhand, Uttarakhand, West Bengal and Maharashtra.

After evaluation of programme, it has been found that the states which are performing well include Andhra Pradesh, Tamil Nadu, Gujarat, Goa, Mizoram, Assam, Uttar Pradesh and Delhi.

The states which are underperforming include Jharkhand, Uttarakhand, Rajasthan, West Bengal, Orissa and Sikkim.

1.0 – INTRODUCTION

1.1 – BACKGROUND

The World Health Organization's (WHO) report on the Global Tobacco Epidemic in 2008 highlighted that approximately 5.4 million deaths every year are related to tobacco use.[1] Tobacco is a risk factor for six of the eight leading causes of death in the world.[1] In India tobacco kills around 1 million people each year and about 2200 people each day.[2] There are 275 million tobacco users in India.[3] More than one third (34.6%) adults in India use tobacco in some form.[3]

TOBACCO CONTROL LAW

India is one such nation which took lead in fighting tobacco epidemic. In 2003, the Indian Parliament enacted "Cigarette and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA)" with comprehensive regulations against the serious threat of tobacco use.[5]

What the law mandates

Section 4: Prohibition on smoking in all public places. This law is in force since May 1, 2004. Fresh and effective rules were enforced since October 2, 2008.

Section 5: Prohibition on direct and indirect advertising, promotion and sponsorship of tobacco products. It is in force since May 1, 2004.

Section 6 (a): Prohibition on sale of tobacco products to and by minors (under the age of 18 years). It is in force since May 1, 2004.

Section 6 (b): Prohibition of sale of tobacco products within 100 yards of an educational institution. It is in force since May 1, 2004.

Section 7: Display of specified pictorial health warnings on all tobacco product packages. It is in force since May 31, 2009.

WHO FCTC

In 2004, the government of India ratified the treaty WHO- Framework convention on Tobacco Control (FCTC).[4] The WHO Framework Convention on Tobacco Control (FCTC) is the first treaty negotiated under the auspices of the World Health Organization. The FCTC is an evidence based treaty that reaffirms the right of all people to the highest standards of health. The FCTC represents a paradigm shift in developing a regulatory strategy to address addictive substances; in contrast to previous drug control treaties, the FCTC asserts the importance of demand reduction strategies as well as supply issues.

NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)

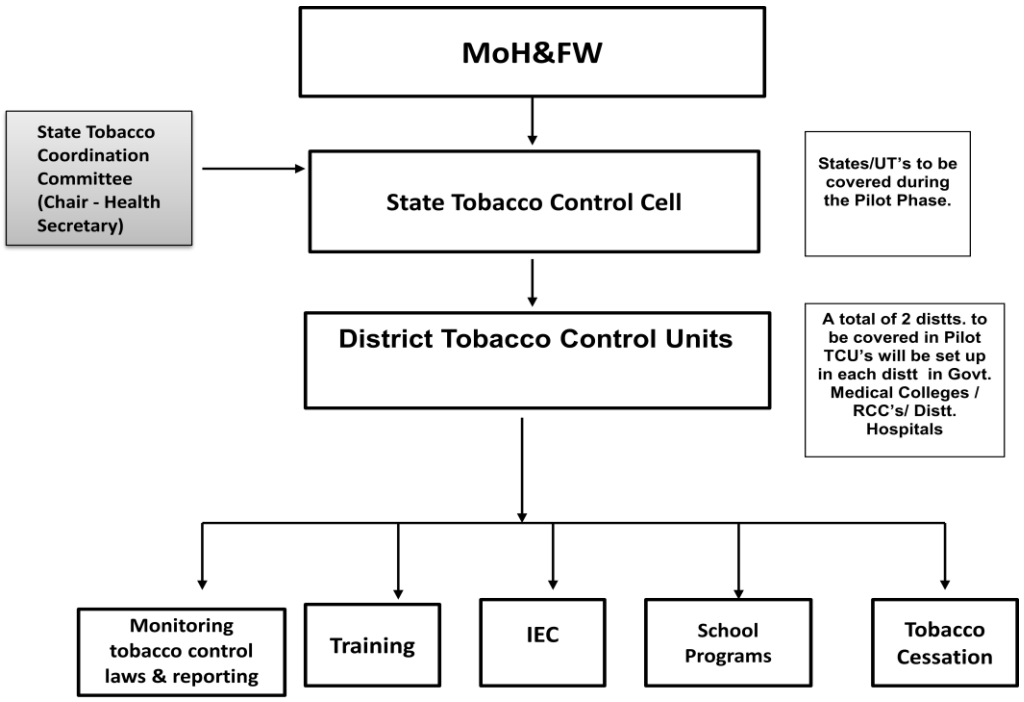
To fulfill the obligations under the COTPA act and WHO-FCTC, the Ministry of Health and Family Welfare, India proposed National Tobacco Control Programme (NTCP) in the 11th Five Year Plan (2007-08).[5] The pilot phase of the NTCP was launched in 2007 – 08 covering 18 Districts of 9 States. Further in 2008-09, 12 new states covering 24 districts have been added.[5]

Organization structure of NTCP

In phase I states, there are state tobacco control cells at state level to coordinate the activities of district tobacco control units through which the programme gets implemented.

In phase II states, funding has been provided only for district tobacco control cells and NOT for the state tobacco control cells.

In both, the phase I states and phase II states, there is a state nodal officer responsible for the coordination, monitoring and evaluation of the programme in its state.



Components of NTCP:

The main components of NTCP are as described below:

National level

- Public awareness/mass media campaigns for awareness building and for behavioral change.
- Establishment of tobacco products testing laboratories, to build regulatory capacity, as required under COTPA, 2003.
- Mainstreaming the programme components as part of the health delivery mechanism under the overall NRHM framework.
- Mainstreaming research and training- on alternate crops and livelihoods with other nodal ministries.
- Monitoring and evaluation including surveillance e.g. Global Adult Tobacco Survey (GATS India).

State level

- Dedicated tobacco control cell for effective implementation and monitoring of Tobacco Control Initiatives at state level.

District level

•**Training**: Training of School teachers, health workers, health professionals, law enforcers, NGO's, women SHG's on tobacco control in the districts.

•**Information Education, Communication (IEC):** Using local media, Nukkad/Street Corner Shows, Exhibitions, Melas, etc in regional languages at the grass root level.

•**School Programme**: As part of School Health Programme of the state govt. or with the help of NGOs to train school teachers and sensitize children on harmful effects of tobacco, SHS and provisions under the law. 50 Schools are covered in each district.

•**Monitoring Enforcement of Tobacco Control Laws**: The implementation of tobacco laws in the district is monitored by establishing mechanism for the same at various levels.

•**Tobacco Cessation Centers (TCC):** Setting up of Tobacco Cessation facilities at the District hospital level. A trained counselor provides these services.

1.2 – THE PROBLEM STATEMENT

One of the components of National Tobacco Control Programme is Monitoring and Evaluation. State Tobacco Control Cells are being set up under the programme in phase I states to facilitate, drive and monitor the proposed district tobacco control programme. The nodal officer at state level (in both phase I and phase II states) is responsible for the coordination, monitoring and evaluation of the programme at the district level. There are monthly and quarterly performas in which states submit their reports to centre. During my observation of the programme I had felt that implementation status of National Tobacco Control Programme needed to be assessed under the present M&E (Monitoring and Evaluation) framework since it had not been done so far. I also felt the need to develop a robust monitoring and evaluation system for the programme. Therefore I stated the problem as, **"Monitoring and Evaluation of National Tobacco Control Programme".**

1.3 – REVIEW OF LITERATURE

The establishment of a strong and sustainable foundation for conducting sound evaluation of multi-site programs requires three critical elements at the organizational level: dedicated funding, identification of performance measures, and a data collection system to measure progress.[6] Researchers should consider how to integrate tobacco content with other health-related surveillance. This integration should involve developing content to address interacting or associated behaviours, such as other drug use, and content to better understand the social context(s) in which consumption occurs.[7] The immediate results of tobacco control are the outputs from strategic components implemented as part of a comprehensive tobacco control strategy (i.e., the tobacco control inputs). Inputs are realized through the availability of sufficient capacity in tobacco control programs. These immediate program and policy outputs are posited to have subsequent impacts in the future. For example, in the short-term, knowledge and attitudes related to smoking may change; over a longer time span, smoking rates and consumption levels may change, with an ultimate impact on future human health.[7]

MONITORING OF TOBACCO CONTROL PROGRAMME IN MAYANMAR

In Myanmar the monitoring of the tobacco control activities is carried out at all levels of administration, by the township, State and Divisional and central levels. Reports of activities conducted is prepared by parties concerned and sent to the National Committee for Tobacco Control. This committee regularly monitors the progress of the programme. Surveys and research activities are also monitored by the National Committee and health personnel at various levels. **Monitoring visits** to different parts of the country are made regularly by the National Committee personnel to supervise education activities, advocacy campaigns and other activities. Progress on legislation and activities of other Ministries is also monitored. **Programme review meeting is conducted at the end of each year** to evaluate the strengths and weaknesses of the programme and to analyze the lessons learnt from the past to take action for the future.[8]

SCOTTISH SMOKING LAW

A significant feature of the Scottish smoking law is its use of a combination of proactive inspection approaches. The three types of proactive inspections engaged are:

a) Official inspection – whereby officers announce themselves and show identification to the manager of the inspected premises prior to assessing compliance;

b) Covert – whereby officers assess compliance by observation, then announce themselves to the managers at the end of the period of surveillance; and

c) Covert and leave – officers assess compliance, but wait until the following day to discuss their findings with the manager of the premise.[12]

ANTI-SMOKING LAW IN URUGUAY

Uruguay banned smoking in all enclosed public places, public and private workplaces, and places of common stay in 2006. A Presidential decree defined the inspection mechanism at various levels; fines collected for violations are dedicated to smoking prevention activities. Repetitive breaches of the ban could lead to the **closure of an establishment for 3 working days.** [13]

ENFORCEMENT POLICY OF BOROUGH

The risk-based approach of the Borough, which is of relevance to jurisdictions in India in terms of prioritizing inspections and 29rganizati enforcement outcomes, is elaborated in its policy as follows:

"Ballymoney Borough Council will endeavour to inspect premises on a ***risk-based*** *approach. Such factors may include:*

i. *Premises which are open to substantive numbers of people (for example, a night club will generally be considered a higher risk than a small office. Intervention in larger premises will have a greater impact in terms of public health protection.)*
ii. *Where there is an absence of pre-existing self imposed smoking controls. (Premises such as cinemas and shopping centers which are already known to be smoke free and self enforcing should generally be considered lower risk)*
iii. *Where complaints have been received regarding premises. (Any premises complained of should generally be considered higher risk)".*

Inspections in the Borough are to be incorporated into other programmed inspections, such as those of health and safety inspections, food safety, consumer safety, building control and licensing. This approach draws on existing infrastructure, human resources, mechanisms and enforcement force, and avoiding significant additional enforcement expenses. It is therefore useful for resource-restrained settings. District councils engage Licensing Officers, Technical Officers, and Environmental Health Officers in addition to dedicated Smoke-free Enforcement officers for inspections. [14]

ENFORCEMENT PROTOCOL OF ONTARIO

Ontario protocol involves the systematic collection of data on enforcement efforts and compliance levels. Officers record each inspection, compliance details, and action taken by the officer and the business in prescribed forms. Enforcement agencies in Ontario have found compliance data to be extremely useful to track compliance by businesses and enforcement action by enforcement agencies. [12] A significant feature of the Ontario enforcement strategy is a compliance check as distinct and compulsorily followed (within 3 months) by an enforcement check. **The compliance check involves purchase attempt by a test shopper,** which stops short of a legal charge even when the purchase is completed, but leaves a warning letter to the business. The follow-on

enforcement check on the other hand results in legal action upon completion of test purchase.[16]

MONITORING OF TOBACCO CONTROL LAW IN BANGLADESH

In Bangladesh, **NGOs are involved in monitoring** the law throughout the country. They regularly send information on law violations to local government (district commissioners or the Tobacco Nodal Officers) and ask them to call out a mobile court. If the local officials fail to respond, the media attention is drawn to attract help from higher authorities. The national alliance also supports to mobilize the enforcers. [15]

TOBACCO CONTROL POLICY ENFORCEMENT IN BRAZIL

ANVISA is the enforcement body that oversees tobacco control policy enforcement in Brazil. ANVISA, through its provincial chapters, has enforcement officers that regularly carry out food- and health-related inspections, including related to tobacco control. Brazil is reportedly developing a system for training and equipping these officers to enforce tobacco control policies. [12]

ENFORCEMENT OF PACK WARNING LAWS IN BELGIUM

Enforcement of pack warning laws in Belgium is the responsibility of the Department of Consumer Products Inspections in the Ministry of Health. The enforcement team is comprised of 22 officers (20 controllers and 2 inspectors), and each of these officers controls a section of the Belgian territory. The controllers are familiar with the laws and are trained to 30rganizat and identify improperly 30rganiz packs of cigarettes. Belgium's pack warning legislation is unambiguous and the controllers know what must and must not be shown on a pack of cigarettes. [12]

1.4 – AIM OF STUDY

To improve the National Tobacco Control Programme after evaluating strengths and weaknesses of programme.

1.5 – OBJECTIVES OF STUDY

GENERAL OBJECTIVE

To assess the implementation status of the different components of the National Tobacco Control Programme under the existing system of monitoring and evaluation and to provide inputs in the development of an efficient and effective monitoring and evaluation system.

SPECIFIC OBJECTIVES

1. To evaluate the capacity building component of the National Tobacco Control Programme which includes trainings of different health and other functionaries.
2. To determine the effectiveness of the IEC (Information, Education and Communication) activities done under National Tobacco Control Programme.
3. To assess the extent of implementation of "Schools Programme" under National Tobacco Control Programme.
4. To assess the status of enforcement of tobacco control laws.
5. To review the functioning of the Tobacco Cessation Centres at the district level under National Tobacco Control Programme.
6. To give recommendations/inputs for the improvement of existing monitoring and evaluation system and development of a robust monitoring and evaluation system.

1.6 – LIMITATIONS OF STUDY

The study does not include field visits to NTCP states which is a limitation of study. The existing monitoring system of programme do not include supervisory visits to states but data is collected by sending performas to state focal points via E-mail or post. In recommendations it is mentioned to have supervisory visits in the monitoring system of programme.

2.0 – DATA AND METHODS

2.1 – THE RESEARCH PROBLEM AND RESEARCH QUESTIONS

The research problem was, “Monitoring and Evaluation of National Tobacco Control Programme”.

The research problem could be explained with the help of following questions or Hypothesis:

1. What is the existing monitoring and evaluation system?
2. What are the results of evaluation done under existing system? It includes both the qualitative and quantitative results. It can further broken down in to subset of questions.
    a. What is the current status of trainings done under National Tobacco Control Programme?
    b. What is the current status of IEC activities done under National Tobacco Control Programme?
    c. What is the current status of implementation of “Tobacco Free Schools Programme” under National Tobacco Control Programme?
    d. What is the current status of enforcement of Tobacco Control Laws?
    e. What is the current status of Tobacco Cessation Centres under National Tobacco Control Programme?
3. Do the information obtained under existing monitoring and evaluation system is valid, reliable and sufficient to evaluate the programme or we need some modifications in the existing system?
4. How the existing monitoring and evaluation system could be developed in to a robust monitoring and evaluation system?

2.2 – THE STUDY DESIGN

The study design was descriptive cross-sectional. It was an applied research. It included evaluation of an existing programme so that some lessons could be learnt for future course of programme. It included both the quantitative as well as qualitative research.

2.3 – THE DATA SOURCE

The primary data sources included state tobacco cells and district tobacco cells of 21 states in which programme has been implemented (Assam, West Bengal, Madhya Pradesh, Tamil Nadu, Karnataka, Gujarat, Rajasthan, Delhi, and Uttar Pradesh, Bihar, Jharkhand, Orissa, Sikkim, Arunachal Pradesh, Mizoram, Nagaland, Tripura, Maharastra, Goa, Uttarakhand, & Andhra Pradesh). The data source also included officials and staff at national level to obtain data regarding national level components of programme.

2.4 – THE SAMPLING DESIGN AND SAMPLING FRAME

The sampling design for this evaluation study was **purposive sampling**. The sampling frame for quantitative data included all the 21 state tobacco cells and 42 district tobacco cells in which programme had been implemented. The sample size for the qualitative data used the concept of **saturation**.[9] This means that data collection continued until the researcher found that no new information about the research question could be obtained from additional cases.[9] The sample also included officials and staff at national level to obtain data regarding national level components of programme.

2.5 – THE DATA COLLECTION PROCEDURE

The primary data was collected at district level from district tobacco cells. Districts sent the data to states. In each state one focal point had been identified who coordinated the activities of the districts and monitored the programme at state level. These focal points were responsible for providing data to the centre for monitoring and evaluation of the programme at centre level. There were process and outcome indicators which had been arranged in the form of monthly and quarterly performas. These performas were sent to focal points at the states. The states then prepared the quarterly reports of their states in the given performa and sent it to centre. For National level components the data was collected from concerned officials and staff at national level using interview method of data collection.

2.6 – THE DATA ANALYSIS

The data analysis included both quantitative as well as qualitative data analysis. For e.g. amount of fine collected and number of persons challaned under COTPA act were known through quantitative data analysis but description of IEC activities done was analysed through qualitative data analysis. MS Excel was used for quantitative data analysis. Tables and graphs were generated. Qualitative data like best practices under National Tobacco Control Programme was analysed through **grounded theory methodology**.[10][11] With this methodology, theory development began with the data. Data was coded and categorized as the patterns emerged in the data. Theory was developed throughout the research process as data interpretation took place and comparison of that interpretation was made with new data that was collected. However, the important principle was that grounded theory tried to develop and elaborate theory by constant comparison with the data gathered during the research process.[10] [11]

3.0 – RESULT AND FINDINGS

The following results were obtained under each component of National Tobacco Control Programme :-

3.1 – HUMAN RESOURCE UNDER NTCP

Status of recruitment of human resource under NTCP (National Tobacco Control Programme) as on 28 February, 2011.

At National Level –

Full time		Senior Officials
Under Secretary	1	Additional Secretory
Assistant	1	Joint Secretory
Data Entry Operator	1	Additional DG
Office Assistant	1	DDG
Total	**4**	CMO

Table 1 : Staff at state and district level under NTCP (status as on 28 February, 2011) –

States	**State Consultant**	**State level Staff**	**District 1 staff**	**District 2 staff**
Phase I states				
UP	1	1	3	3
WB	1	In process	In process	In process
Gujarat	1	2	3	1
Karnataka	X	2	1	X
Delhi	1	In process	In process	In process
TamilNadu	1	2	X	X
Assam	1	1	3	3
Rajasthan	X	1	3	X
MP	1	1	X	X
Phase II states				
Mizoram	X	-	3	3

Nagaland	X	-	3	3
Tripura	1	-	3	3
Arunachal Pradesh	X	-	In process	In process
Goa	X	-	2	2
Andhra Pradesh	1	-	3	3
Jharkhand	X	-	X	X
Maharashtra	1	-	In process	In process
Uttarakhand	X	-	X	X
Sikkim	X	-		
Bihar	1	-	Interview in March,2011	Interview in march, 2011
Odisha	In process	1 (Under NRHM)	In process	In process
Total	**11**	**11**	**27**	**21**

Total staff at state and district level = 11+11+27+21 = **70**

Total staff under NTCP = 4 + 70 = 74

There is a need to recruit complete staff under NTCP. State consultants have been provided only in 11 states. There is a need also to provide state consultants in rest of 10 states. It has been found that in some states like Jharkhand, Uttarakhand and Arunachal Pradesh; there is no staff at all; neither at state level nor at district level. It may be difficult to implement all the components of programme in states without technical support of human resource.

3.2 – NATIONAL LEVEL COMPONENTS

3.2.1 – PUBLIC AWARENESS/MASS MEDIA CAMPAIGNS FOR AWARENESS BUILDING AND FOR BEHAVIORAL CHANGE.

3.2.1.1 – Anti-tobacco television and audio advertisements:

Under the MoH/WHO collaborative program, a repertoire of 12 anti-tobacco television and 6 radio advertisements (30 & 15 seconds) targeting the entire spectrum of tobacco products were developed in the period 2002-03. Other anti-tobacco spots featuring various popular film stars and youth role models such as Vivek Oberoi, Urmila Matondkar and Shashi Kapoor were developed in collaboration with Cancer Patient Aid Association. In collaboration with Indian Cancer Society, the Australian anti-tobacco campaign '*Each cigarette is causing you damage'* was adapted in Indian context and 3 anti-tobacco spots were developed focusing on damage caused to lungs, heart and the brain due to smoking. These anti tobacco spots are being disseminated to various stakeholders and aired through various media channels from time to time. These spots have been intensively used for mass media campaigns, schools/community based interventions at grassroots level and have also used by Tobacco Cessation Centers (TCC's) for screening in their OPD's, hospitals. These advertisements and infomercials have also been extensively used for campaigns around World No Tobacco Days.

3.2.1.2 – Anti-tobacco posters, stickers, brochures and mobile exhibition kits:

In 2002-03, under the collaborative program of MOH/WHO, support was provided to Nehru Yuvak Kendra (NYK) and Directorate of Audio Video Publicity (DAVP) to develop anti-tobacco IEC materials like posters, flip charts, brochures, mobile exhibition kits and stickers. In 2005, a new set of anti-tobacco posters developed by MOHFW in collaboration with WHO. In 2008-09, MOH/WHO developed a new series of posters in Hindi and English languages in partnership with an NGO, HRIDAY. **Since 2006, the Indian International Trade Fair (IITF) have been displaying the anti-tobacco posters and screening audio-visual spots in the exhibition stall of National Rural**

Health Mission. IEC materials were displayed in the exhibition stall on tobacco control during Surajkund Crafts Mela.

3.2.1.3 – Anti-tobacco campaign through Media Post:

The Department of Posts launched an innovative means of taking messages to the masses called Media Post in 2003. This media vehicle offers the option of printing health messages on postal stationery like postcards, inland letters and aerogramme. Anti-tobacco messages were printed on these post cards to reach rural masses. Subsequently, the Meghdoot Postcards were also used to disseminate anti-tobacco awareness.

3.2.1.4 – Kalyani- a weekly television programme:

In 2001–2002, the Ministry of Health, in collaboration with Prasar Bharti, launched a weekly television program called **"Kalyani"** which is telecast on various regional Doordarshan kendras. WHO Country Office provides technical inputs for this programme which provides in depth information to its viewers through panel discussions, expert interviews, success stories, quizzes and slogan writing/painting competitions on the issue of tobacco control along with other health issues. It covers issues related to six diseases including those related to tobacco use. Several anti-tobacco commercials are aired during the show and detailed discussions on the ill-effects of tobacco use are shown. This programme is largely for rural audiences in the Hindi-speaking belt, where tobacco prevalence is high. Resource persons from Tobacco Cessation Centers have been regularly participating in Kalyani programme through talk shows, panel discussions.

3.2.2 – ESTABLISHMENT OF TOBACCO PRODUCTS TESTING LABORATORIES, TO BUILD REGULATORY CAPACITY, AS REQUIRED UNDER COTPA, 2003.

Under section 7(5) of COTPA, 2003; it is mandatory to regulate contents and emissions of tobacco products. The tobacco products testing laboratories are required to set up to regulate the following parameters in tobacco products:-

- Tar and Nicotine in smoking tobacco products.
- Only Nicotine in smokeless tobacco products.

Till now six labs have been identified at the following locations:-

- Apex/ Research lab, National Institute of biologicals, Noida, UP.
- Food research and standardization laboratory, Ghaziabad.
- Central drug laboratory, Kolkatta.
- Central drug testing laboratory, Mumbai.
- Central drug testing laboratory, Chennai.
- Regional drug testing laboratory, Chandigarh.

Procurement of instruments required is under process.

Recruitment of required manpower is also under process.

3.2.3 – MAINSTREAMING THE PROGRAMME COMPONENTS AS PART OF THE HEALTH DELIVERY MECHANISM UNDER THE OVERALL NRHM FRAMEWORK.

Tobacco is a risk factor for six of the eight leading causes of death.[1] Thus it is imperative to integrate the National Tobacco Control Programme with other health programmes and mainstreaming it under overall NRHM framework. The programme has already been integrated with RNTCP (Revised National Tuberculosis Control Programme) as a pilot project in Assam and Gujarat. In this integration project, doctor will ask every patient with tuberculosis about his tobacco use status and would advise him to quit tobacco if he is a tobacco user. The evaluation of TB-Tobacco pilot project is following:

Table 2 : Evaluation of TB-Tobacco pilot project (status as on 28 Feb. 2011)

1. Trainings conducted under TB-Tobacco pilot project in 2010:
a. Vadodara district (Gujarat) – 1436 (Total professionals tained)
i. Doctors – 109
ii. Para Medical Staff – 507
iii. RNTCP staff – 35
iv. ASHA worker – 785
b. Kamrup district (Assam) – 533 (Total professionals trained)
i. Medical Officers – 67
ii. Health Workers – 466
2. Patients covered under the project from October,2010 to December,2010:
a. Vadodara (Gujarat) – 690 TB cases were registered and all were given TCI (Tobacco Cessation Intervention) Card.
b. Kamrup (Assam) – 378 TB cases were given TCI card.

The efforts are being made to integrate the programme with National Mental Health Programme, National Cancer Control Programme, Reproductive and Child Health (RCH) programme, Non communicable diseases (NCD) programme and other programmes.

3.2.4 – MAINSTREAMING RESEARCH AND TRAINING- ON ALTERNATE CROPS AND LIVELIHOODS WITH OTHER NODAL MINISTRIES.

Ministry of health is doing advocacy with other nodal ministries to suggest intermediate/ long term arrangements for alternate crops and livelihoods. Accordingly, the ministry of labour and employment initiated the pilot scheme of providing training to bidi workers so as to provide them alternative sources of employment through viable sources of livelihood. These trainings have been conducted in 6 regions of the country namely Banglore, Nagpur, Ajmer, Jabalpur, Hyderabad and Kolkata. Further, Ministry of Health & FW (MoHFW) in collaboration with Central Tobacco Research Institute (Ministry of Agriculture) has also launched a pilot initiative for providing alternative cropping system to bidi/ chewing tobacco crops in 5 different agro-ecological sub-regions viz West Bengal, Karnataka, Tamil Nadu, Andhra Pradesh and Gujarat.

Further, in order to address the issue on long term basis, the Ministry of Health & FW has constituted an expert group at National level with representation from different Ministries like Rural Development, Women & Child Development, National Dairy Development Board, Civil society etc. This group will look into the issue of alternative livelihood to the bidi rollers and chalk out a long term rehabilitation strategy.

3.2.5 – MONITORING AND EVALUATION INCLUDING SURVEILLANCE.

3.2.5.1 – Global Adult Tobacco Survey (GATS), India:

The Global Adult Tobacco Survey (GATS) is the global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators. Global Adult Tobacco Survey-India was conducted in 2009–2010 as a household survey of persons age 15 and above. The GATS India was unique in many ways. The survey was undertaken in huge and diverse geographical area covering 29 states and 2 Union Territories of India, with a sample size of nearly 70,000 households, which is by far the largest sample size for GATS in any country. India being a multi-lingual country, the questionnaire of GATS India was translated in English and as many as 19 regional languages for administration in different states and UT's. Another highlight of the GATS India is that the Govt of India funded the survey from the national budget under the National Tobacco Control Program with technical assistance from Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), the Johns Hopkins Bloomberg School of Public Health, and RTI International. GATS has been incorporated as one of the vital components under the National Tobacco Control Program for providing baseline data for program monitoring and evaluation.

3.2.5.2 – Global Youth Tobacco Survey (GYTS) and Global Health Professionals Survey (GHPS):

Global Youth Tobacco Survey (GYTS 2003, 2006 and 2009) highlights a very serious concern, regarding increase in tobacco prevalence in the 13-15 years age group. Likewise, the Global Health Professionals survey (GHPSS 2006 and 2009) highlights the high levels of ignorance amongst the Medical/Dental students, which again is a matter of concern.

India Global Youth Tobacco Survey (GYTS) 2006 and Global School Personnel Survey (GSPS) 2006 were undertaken region-wise, namely, North, South, East, West, Central and North East, covering 99.7% of the total population of India. Altogether, 12,086 students and 2,926 school personnel from 180 schools participated in the six regional surveys, with fieldwork completed during the first half of 2006.

Data from India GYTS 2003 and GYTS 2006 was analyzed to examine the change in different variables of tobacco control measures for monitoring and evaluation of process measures achieved on different provisions of Tobacco Control Act, 2003 and relevant Articles in the World Health Organization, Framework Convention on Tobacco Control (WHO FCTC).

3.2.5.3 – Air Nicotine Monitoring

Air Nicotine Monitoring" as a research project in collaboration with Johns Hopkins School of Public Health was undertaken in Ahmedabad, Delhi, Chandigarh and Tamilnadu.

3.3 – STATE LEVEL COMPONENTS

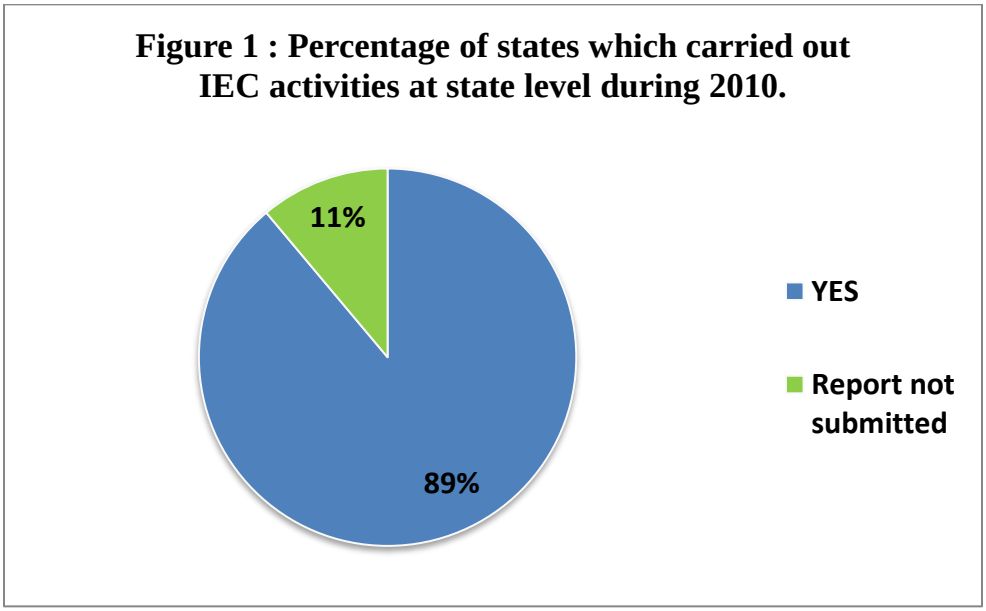
Out of 9 states which are phase I states and have funding for state tobacco cell, all the states have set up state tobacco cell with requisite infrastructure.

3.3.1 – IEC ACTIVITIES AT STATE LEVEL

Out of 9 states which are phase I states and have funding at state level, 8 states carried out IEC activities at state level during 2010. The states include Assam, West Bengal, Madhya Pradesh, Uttar Pradesh, Delhi, Gujarat, Tamilnadu and Karnataka. The report was not received from Rajasthan.

Table 3 : States which carried out IEC activities at state level during 2010.

	Number of states	Name of states
YES	8	Assam, West Bengal, Madhya Pradesh, Uttar Pradesh, Delhi, Gujarat, Tamilnadu and Karnataka.
NO	0	
Report not submitted	1	Rajasthan



The IEC activities included,

- Posters related to tobacco laws and health hazards of tobacco use were hanged in Durga Puja Pandals of Kolkata city.
- March with NCC cadets, march with school children, press conference, awareness sessions for SHGs and NGOs in Uttar Pradesh.
- Durga Pooja anti tobacco activities in Assam.
- Translation of IEC material in local languages.
- Campaign among students of government colleges in Madhya Pradesh.
- *Awareness on 'Tobacco cessation' for the prisoners, West Bengal –*

The programs were conducted at three central Jails of Alipur, Dum Dum, Presidency and one District Jail at Howrah during the period of January – March 2008. The numbers of participating prisoners were approximately 2000 i.e 500 prisoners per jail. Each jail was visited once a month (i.e 3 days for each prison).

- *Awareness generation during festivals in Gujarat –*

The state government of Gujarat integrated tobacco control messages in the popular festivals observed on a large scale in the state. Awareness generation campaign was undertaken during the festivities which were attended by millions of people.

On 23 October, 2010; Garba celebration was at AUDA park at Ahmedabad. In this event one of the main sponsors was State Tobacco Control Cell, Gujarat. In this event around 5000 people had participated. Different IEC material like logo, shop, billboards was placed. Live telecast of this event was done all over the Gujarat on E-TV Gujarati and ultimately massage was passed to the all people of Gujarat.

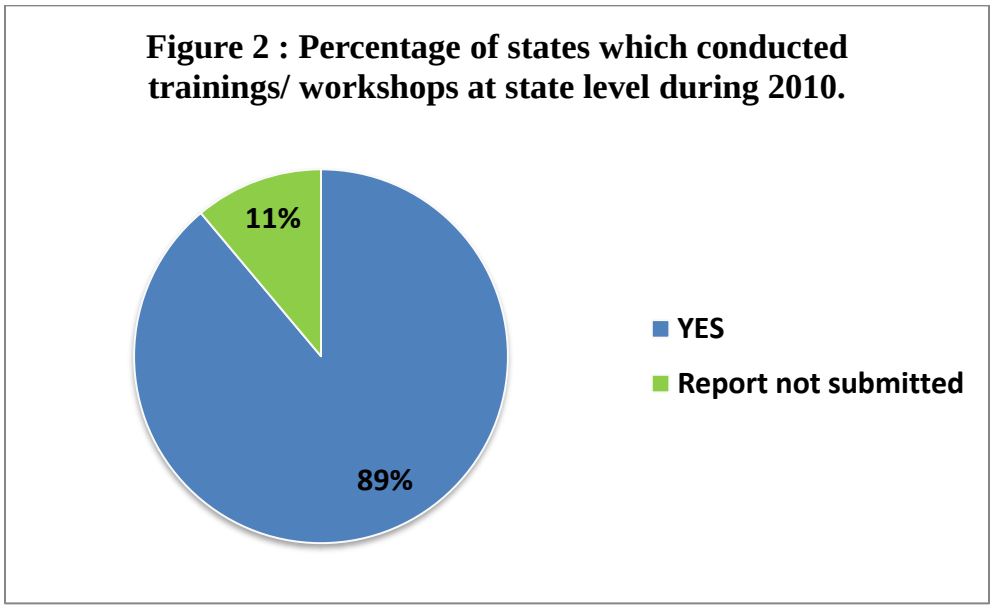
This event was declaimed smoke free and no incidence of smoking was reported.

3.3.2 – TRAININGS AND WORKSHOPS AT STATE LEVEL

Out of 9 states which are phase I states and have funding at state level, 8 states carried out trainings and workshops at state level during 2010. The states include Assam, West Bengal, Uttar Pradesh, Delhi, Gujarat, Tamilnadu, Madhya Pradesh and Karnataka. Rajasthan did not submit its report. The trainings are given to health care providers (medical officers, dentists), teachers, school headmasters, enforcement officials, NGOs and civil societies.

Table 4 : States which conducted trainings/ workshops at state level during 2010.

	Number of states	Name of states
YES	8	Assam, West Bengal, Uttar Pradesh, Delhi, Gujarat, Tamilnadu, Madhya Pradesh and Karnataka
NO	0	
Report not submitted	1	Rajasthan



3.3.3 – STATE STEERING COMMITTEE

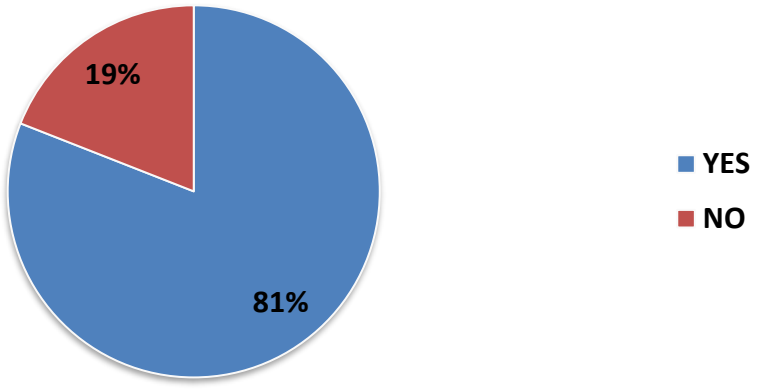
Steering committee for implementation of section – 5 of COTPA has been constituted in 17 states which are Assam, West Bengal, Madhya Pradesh, Uttar Pradesh, Delhi, Rajasthan, Gujarat, Tamilnadu, Karnataka, Nagaland, Mizoram, Arunachal Pradesh, Sikkim, Goa, Andhra Pradesh, Bihar and Orissa.

The 4 states where steering committee has NOT been constituted at state level include Tripura, Jharkhand, Uttarakhand and Maharashtra.

Table 5 : States with Steering committee set up at state level (status as on 28 Feb.2011)

	Number of states	Name of states
YES	17	Assam, West Bengal, Madhya Pradesh, Uttar Pradesh, Delhi, Rajasthan, Gujarat, Tamilnadu, Karnataka, Nagaland, Mizoram, Arunachal Pradesh, Sikkim, Goa, Andhra Pradesh, Bihar and Orissa.
NO	4	Tripura, Jharkhand, Uttarakhand and Maharashtra.

Figure 3 : Percentage of states with Steering committee set up at state level (status as on 28 Feb.2011)



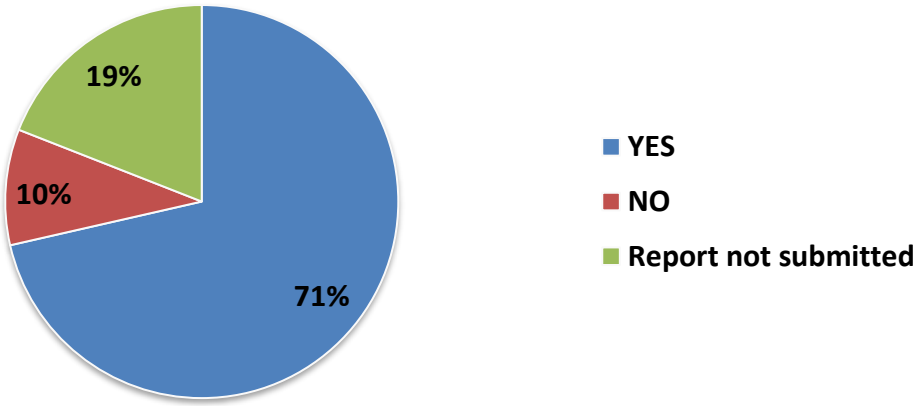
3.4 – DISTRICT LEVEL COMPONENTS

Out of 17 states which submitted their quarterly reports15 states have set up district tobacco cells at district level with requisite infrastructure. The states include Uttar Pradesh, Gujarat, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Goa, Andhra Pradesh, Delhi, Tamilnadu, Maharashtra, Assam, Madhya Pradesh, Bihar. The 2 states where district tobacco cell has not been set up are West Bengal and Orissa.

Table 6 : States which have set up District tobacco cells at district level (status as on 28 Feb. 2011)

	Number of states	Name of states
YES	15	Uttar Pradesh, Gujarat, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Goa, Andhra Pradesh, Delhi, Tamilnadu, Maharashtra, Assam, Madhya Pradesh, Bihar
NO	2	West Bengal, Orissa
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 4 : Percentage of states which have set up district tobacco cells at district level (status as on 28 Feb. 2011)



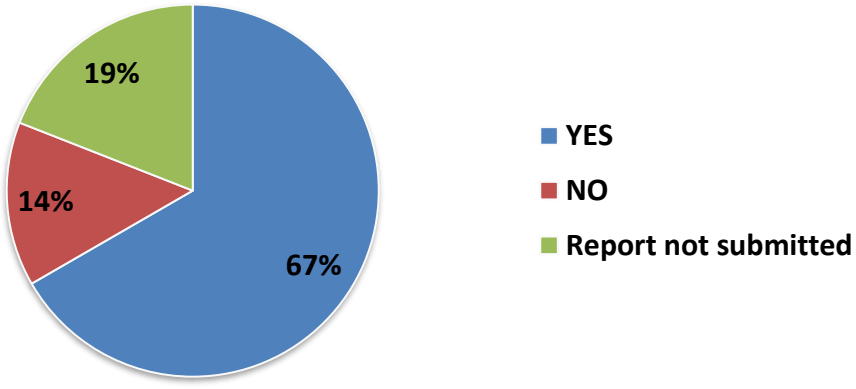
3.4.1 – TRAININGS AT DISTRICT LEVEL

Out of 17 states which submitted their quarterly reports, 14 states carried out trainings and workshops at district level. The states include Assam, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Tripura, Arunachal Pradesh, Maharashtra, Goa, Madhya Pradesh, Bihar and Andhra Pradesh. The 3 states which did not conduct trainings and workshops at district level include West Bengal, Mizoram and Orissa. The trainings were provided to health professionals, medical officers, paramedical staff, school teachers, health officials, ICDS & ASHA workers, health workers, NGOs & CBOs, religious leaders, principals of colleges, government stakeholders and community.

Table 7 : States which conducted trainings / Workshops at district level during 2010.

	Number of states	Name of states
YES	14	Assam, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Tripura, Arunachal Pradesh, Maharashtra, Goa, Madhya Pradesh, Bihar, Andhra Pradesh
NO	3	West Bengal, Mizoram, Orissa
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 5 : Percentage of states which conducted trainings/ Workshops at district level during 2010



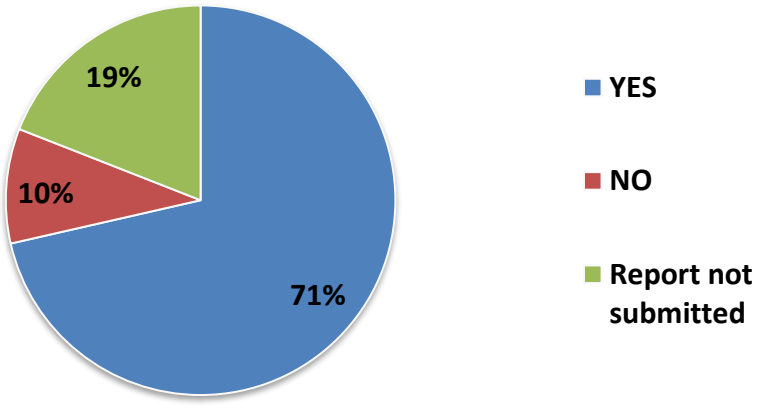
3.4.2 – INFORMATION EDUCATION, COMMUNICATION (IEC) AT DISTRICT LEVEL

Out of 17 states which submitted their quarterly reports, 15 states carried out IEC activities at district level. The states included Assam, Madhya Pradesh, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Bihar, Maharashtra, Goa, and Andhra Pradesh. The 2 states which did not conduct IEC activities include West Bengal and Orissa.

Table 8 : States which conducted IEC activities at district level during 2010

	Number of states	Name of states
YES	15	Assam, Madhya Pradesh, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Bihar, Maharashtra, Goa, Andhra Pradesh.
NO	2	West Bengal, Orissa
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 6 : Percentage of states which conducted IEC activities at district level during 2010



The IEC activities included,

- Display of signages and health warnings.
- Folk media
- Health talk
- Awareness generation during festivals like in Gujarat.
- Anti-tobacco billboards, posters
- All India Radio Programme in Tripura
- Sensitization of villagers.
- Motorcycle rally conducted in Goa
- Community awareness campaigns
- Oral cancer detection camp in Maharashtra
- Wall paintings in Orissa
- Awareness activities during tea tourism festival in Assam
- Village camps, exhibitions

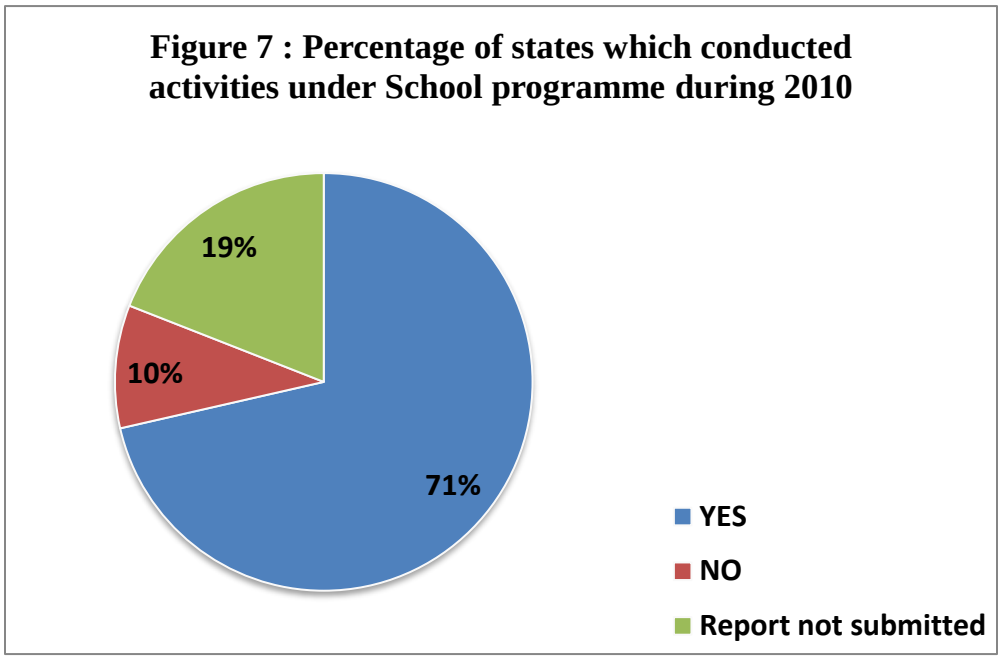
3.4.3 – SCHOOL PROGRAMME

Out of 17 states which submitted their quarterly reports, 15 states carried out activities under school programme at district level. The states included Assam, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Maharashtra, Goa, Andhra Pradesh, West Bengal and Madhya Pradesh. The 2 states which did not conduct activities under school programme include Bihar and Orissa.

Table 9 : States which conducted activities under School programme during 2010

	Number of states	Name of states
YES	15	Assam, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Maharashtra, Goa, Andhra Pradesh, West Bengal, Madhya Pradesh.
NO	2	Bihar, Orissa
Report not	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

submitted		



The activities carried out under schools programme included,

- Health checkups
- Slogans, debates and opinion polls
- Painting and drawing competitions
- Essay writing competitions
- Quiz
- Mass rallies
- Youth choupal
- Tobacco Control Committee formed in two schools in Tripura.
- Jorhat Charaibahi Higher Secondary School was declared the first tobacco free School of the North East.
- *Tobacco free schools in Punjab, Haryana and Chandigarh* –

State ministry of Health and Family Welfare, Chandigarh has issued orders to education board regarding tobacco free schools. Government schools stationary will be having anti tobacco slogans written on them. All the government schools and educational institutes will display tobacco free schools board in front of them. Any student, teacher, staff or

outsider will not be allowed to use tobacco in any form inside the school campus. There will be “no smoking” boards and “smoking is a punishable offence” boards inside the school campus. In addition to all this, there will be posters in the school depicting ill effects of tobacco use. According to DGI, the principal and head of schools and institutes will be having a copy of COTPA act 2003.

- *Display tobacco ban board or lose affiliation in Karnataka –*

It is compulsory for educational institutions of the state to display a board on tobacco ban at the entrance or face consequences.

The department of public instructions, Karnataka had insisted all schools and colleges to follow the guidelines of Prohibition of Smoking in Public Places Rules, 2008, and Guidance sheet for implementation of the “Smoker-free Rules” under Tobacco Control Laws.

The department had given the responsibility of implementing this effectively by visiting the institutions to local officials of the education department.

3.4.4 – MONITORING ENFORCEMENT OF TOBACCO CONTROL LAWS:

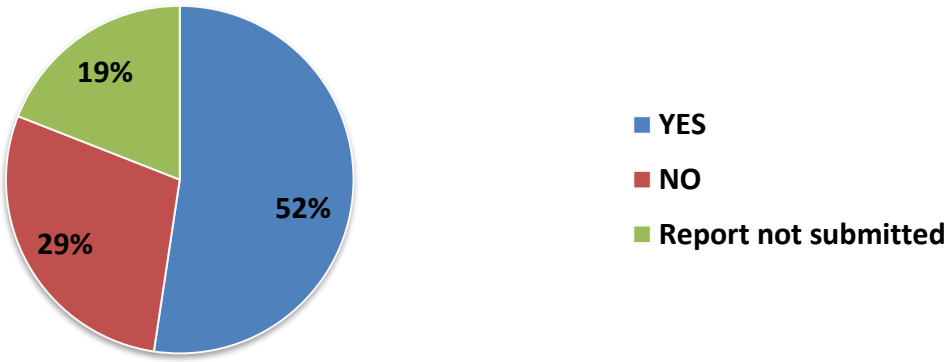
3.4.4.1 – Mechanism for monitoring provisions under the law and reporting :

Out of 17 states which submitted their quarterly reports, 11 states have mechanism for monitoring provisions under the law and reporting. The states include Assam, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Mizoram, Maharashtra, Goa, and Andhra Pradesh. The 6 states NOT having mechanism for monitoring provisions under the law and reporting include Bihar, West Bengal, Orissa, Madhya Pradesh, Tripura, and Arunachal Pradesh.

Table 10 : States having mechanism for monitoring provisions under the law and reporting (status as on 28 Feb. 2011).

	Number of states	Name of states
YES	11	Assam, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Mizoram, Maharashtra, Goa, Andhra Pradesh.
NO	6	Bihar, West Bengal, Orissa, Madhya Pradesh, Tripura, Arunachal Pradesh
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 8 : Percentage of states having mechanism for monitoring provisions under the law and reporting (status on 28 Feb.2011)



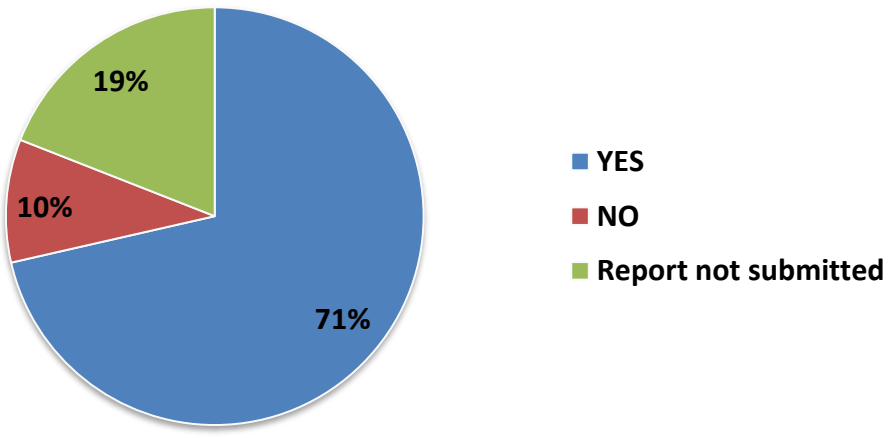
3.4.4.2 – Challaning mechanism established for smoke free rules :

Out of 17 states which submitted their quarterly reports, 15 states have challaning mechanism established for smoke free rules. The states include Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Mizoram, Arunachal Pradesh, Maharashtra, Goa, Orissa, Andhra Pradesh, West Bengal, Madhya Pradesh, Tripura and Bihar. The 2 states NOT having challaning mechanism established for smoke free rules include Assam and Nagaland.

Table 11 : States having challaning mechanism established for smoke free rules (status as on 28 Feb. 2011).

	Number of states	Name of states
YES	15	Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Mizoram, Arunachal Pradesh, Maharashtra, Goa, Orissa, Andhra Pradesh, West Bengal, Madhya Pradesh, Tripura, Bihar.
NO	2	Assam, Nagaland
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 9 : Percentage of states having Challaning mechanism established for smoke free rules (status as on 28 Feb. 2011)



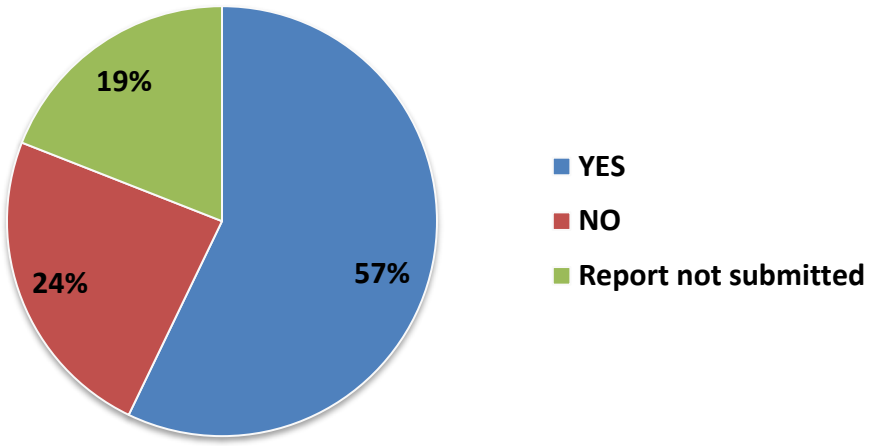
3.4.4.3 – Additional list of authorized persons notified by states for challans:

Out of 17 states which submitted their report, 12 states have notified additional list of authorized persons. The states include Assam, Madhya Pradesh, Uttar Pradesh, Gujarat, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Andhra Pradesh, West Bengal, and Orissa. The 5 states which have not notified additional list of authorized persons include Goa, Delhi, TamilNadu, Maharashtra, and Bihar.

Table 12 : States having notified additional list of authorized persons for challans (status as on 28 Feb. 2011)

	Number of states	Name of states
YES	12	Assam, Madhya Pradesh, Uttar Pradesh, Gujarat, Karnataka, Nagaland, Tripura, Mizoram, Arunachal Pradesh, Andhra Pradesh, West Bengal, Orissa.
NO	5	Goa, Delhi, TamilNadu, Maharashtra, Bihar
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 10 : Percentage of states having notified additional list of authorized persons for challans (status as on 28 Feb. 2011)



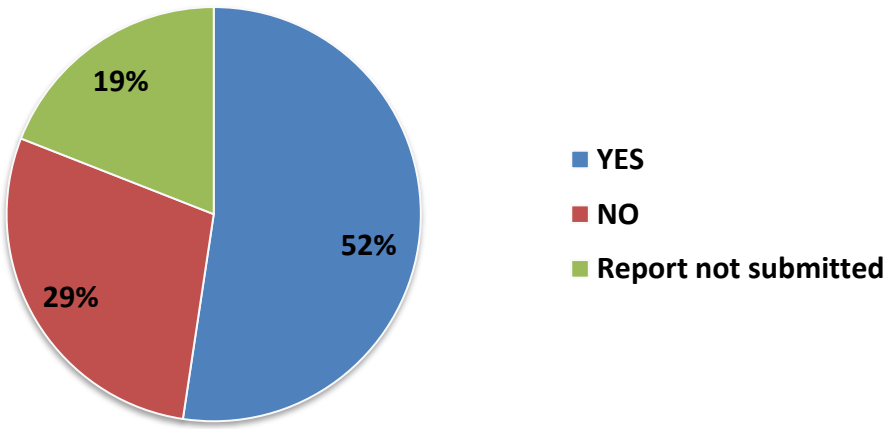
3.4.4.4 – Separate account for depositing challan money :

Out of 17 states which submitted their quarterly reports, 11 states have separate account for depositing the challan money. The states include Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Mizoram, Goa, Andhra Pradesh, West Bengal and Orissa. The 6 states not having separate account for depositing challan money included Maharashtra, Assam, Madhya Pradesh, Bihar, Tripura and Arunachal Pradesh.

Table 13 : States having separate account for depositing challan money (status as on 28 Feb. 2011)

	Number of states	Name of states
YES	11	Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Mizoram, Goa, Andhra Pradesh, West Bengal, Orissa.
NO	6	Maharashtra, Assam, Madhya Pradesh, Bihar, Tripura, Arunachal Pradesh.
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 11 : Percentage of states having separate account for depositing challan money (status as on 28 Feb. 2011)



3.4.4.5 – Toll Free Helpline

A national toll free helpline has been set up to report tobacco cessation laws violation. Reported violations are forwarded to state tobacco control cells for taking appropriate action. The helpline number is **1800110456.** A total of 3366 calls have been received in the period of May2010 to December 2010.

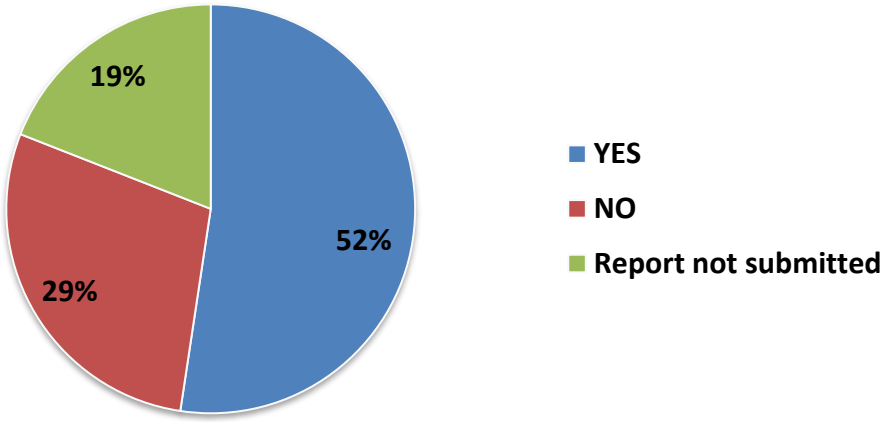
3.4.4.6 – Section 4: Ban on smoking in public places –

Out of 17 states which submitted their reports, 11 states collected fines under section 4 of COTPA. The states include Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Mizoram, Maharashtra, Goa, Andhra Pradesh, Madhya Pradesh and Orissa. The 6 states which did NOT collect fines under section 4 of COTPA include West Bengal, Assam, Nagaland, Tripura, Arunachal Pradesh, and Bihar.

Table 14 : States which collected fines under section 4 of COTPA during 2010.

	Number of states	Name of states
YES	11	Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Mizoram, Maharashtra, Goa, Andhra Pradesh, Orissa, Madhya Pradesh.
NO	6	West Bengal, Assam, Nagaland, Tripura, Arunachal Pradesh, Bihar.
Report not submitted	4	Jharkhand, Uttarakhand, Sikkim, Rajasthan

Figure 12 : Percentage of states which collected fines under section 4 of COTPA during 2010.

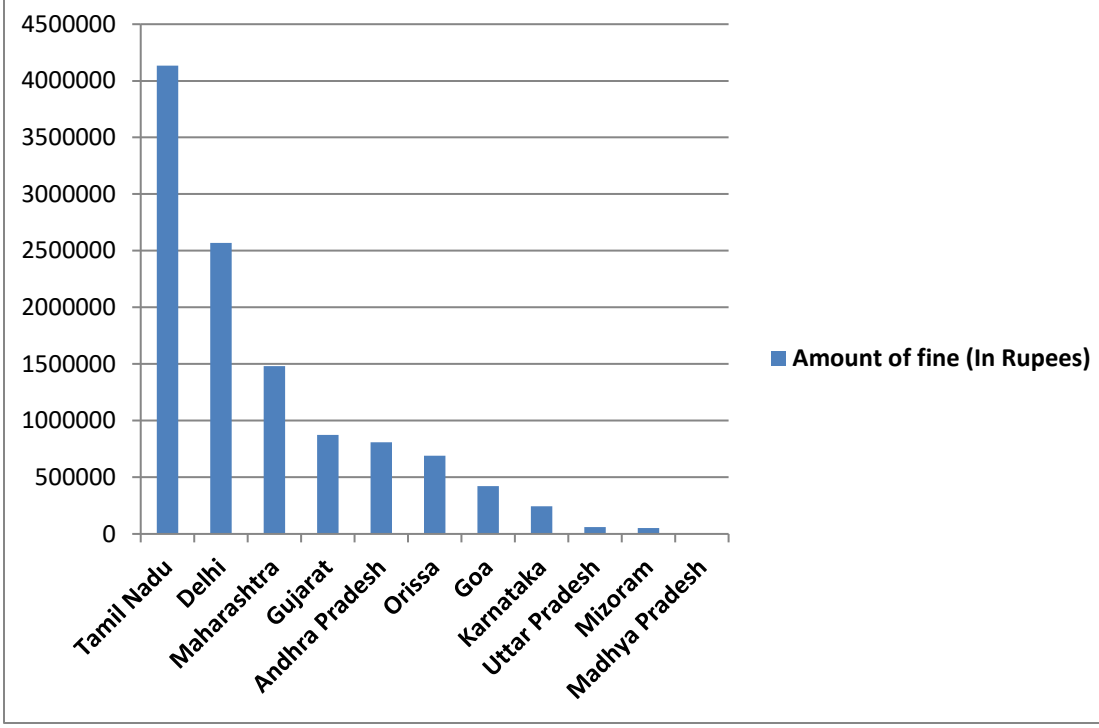


The following table represents amount of fine collected under section-4 of COTPA by various states till date.

Table 15 : Amount of fine collected under section 4 of COTPA by different states till 28 February, 2011.

Name of states	Amount of fine (In Rupees)	Name of states	Amount of fine (In Rupees)
Tamil Nadu	41,33,285	Maharashtra	14,80,258
Gujarat	8,74,449	Andhra Pradesh	8,09,930
Orissa	6,89,450	Goa	4,21,620
Karnataka	2,44,795	Delhi	25,69,566
Uttar Pradesh	60,929	Madhya Pradesh	660
Mizoram	52,620		

Figure 13 : Amount of fine collected under section 4 of COTPA by different states till 28 Feb. 2011.



Smoke free states –

The following states have been declared as smoke free :

- Sikkim

Smoke free cities –

The following cities have been declared as smoke free :

- Bhubaneswar, Chandigarh, Sangrur, Kottayam, Shimla

Smoke free/ tobacco free villages –

The following villages have been declared smoke free/ tobacco free :

- Chinchgohan village of district Khandwa, MP;
- Village Chikhali, Alirajpur, MP;
- Varanavasi Panchayat in Kancheepuram district in Tamil Nadu.

Smoke free/ tobacco free events –

- Commonwealth Games (CWG) 2010 was an excellent opportunity to showcase the Smoke free policy being implemented in public places in Delhi. In addition to

Smoke free, CWG 2010 were also Tobacco free i.e. use, supply and selling of Tobacco products was banned at all games venues, etc. A campaign was launched to create awareness about Smoke Free Delhi and Tobacco Free CWG 2010.

Smoke free/ tobacco free institutions/ organisations –

- Rajasthan police academy, Nirman Bhawan, Delhi University, Police stations Indore, Dugdh Sangh Indore.
- The Gauhati College, B.Borooah & Pandu College of Guwahati, Kamrup

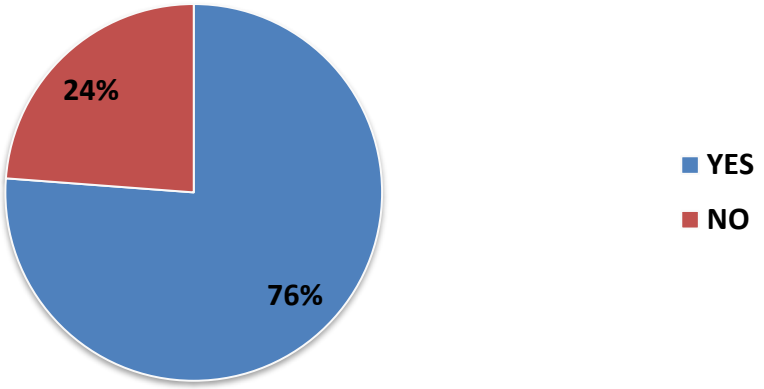
3.4.4.7 – Section 5 - Ban on direct/indirect advertisement and sponsorship of tobacco products

According to reports submitted by various states, the steering committee for implementation of section 5 has been constituted in 16 states at district level. The states include Assam, Madhya Pradesh, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Mizoram, Arunachal Pradesh, Bihar, Goa, Andhra Pradesh, Orissa, Rajasthan and Sikkim. The 5 states where steering committee has NOT been constituted at district level include Tripura, Jharkhand, Uttarakhand, West Bengal and Maharashtra.

Table 16 : States having steering committee set up at district level (status as on 28 Feb. 2011).

	Number of states	Name of states
YES	16	Assam, Madhya Pradesh, Uttar Pradesh, Delhi, Gujarat, TamilNadu, Karnataka, Nagaland, Mizoram, Arunachal Pradesh, Bihar, Goa, Andhra Pradesh, Orissa, Rajasthan, Sikkim.
NO	5	Tripura, Jharkhand, Uttarakhand, Maharashtra, West Bengal.

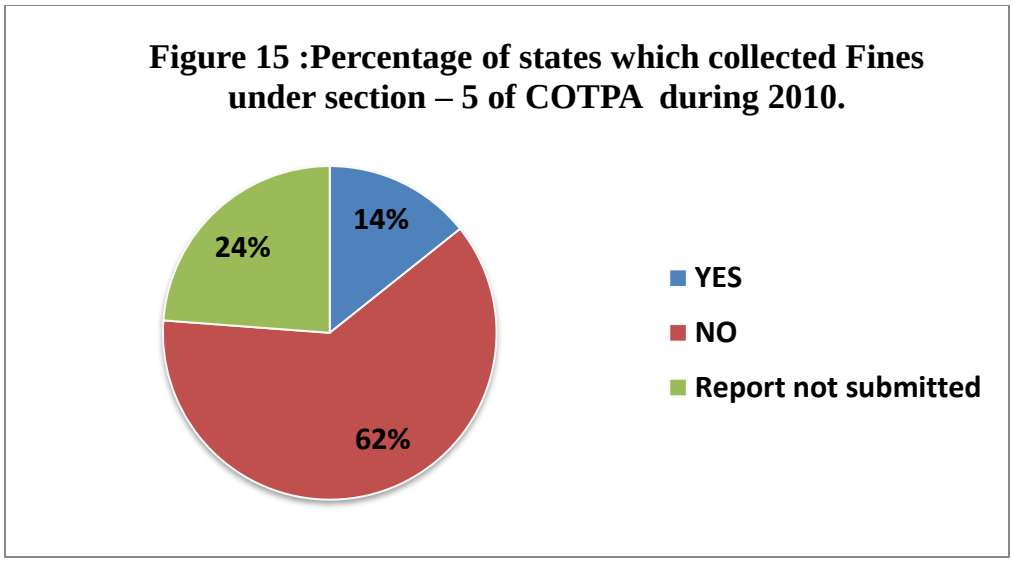
Figure 14 : Percentage of States having Steering committee set up at district level (status as on 28 Feb. 2011)



According to monthly reports, 3 states collected fines under section-5. The states include Gujarat, TamilNadu, and Andhra Pradesh. The states which did NOT collect fines under section – 5 include Assam, West Bengal, Madhya Pradesh, Uttar Pradesh, Delhi, Karnataka, Nagaland, Tripura, Mizoram, Bihar, Maharashtra, Orissa, and Goa.

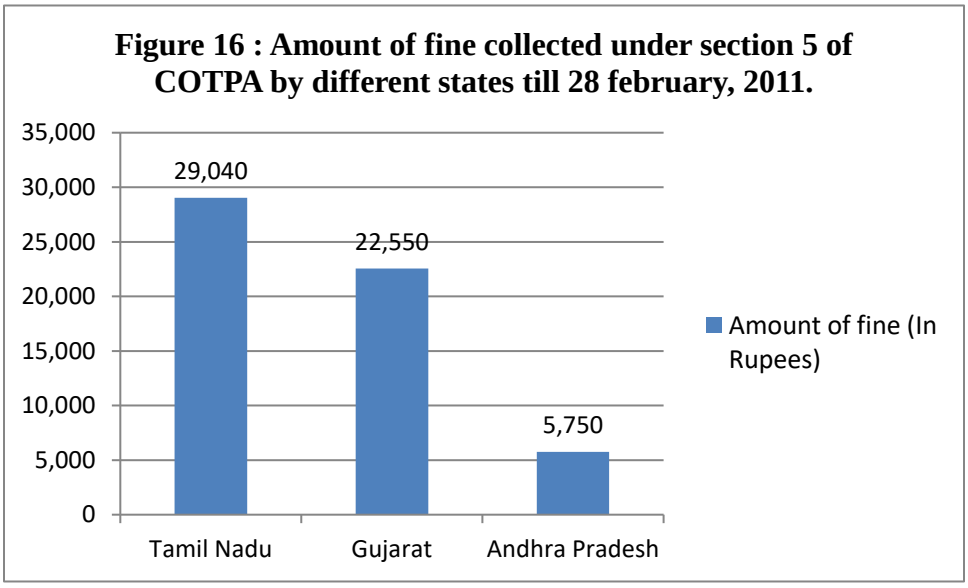
Table 17 : States which collected fines under section – 5 of COTPA during 2010

	Number of states	Name of states
YES	3	Gujarat, TamilNadu, Andhra Pradesh.
NO	13	Assam, West Bengal, Madhya Pradesh, Uttar Pradesh, Delhi, Karnataka, Nagaland, Tripura, Mizoram, Bihar, Maharashtra, Orissa, Goa.
Report not submitted	5	Rajasthan, Arunachal Pradesh, Sikkim, Jharkhand, Uttarakhand



The following table represents amount of fine collected under section-5 of COTPA by various states till date.

Table 18 : Amount of fine collected under section 5 of COTPA by different states till 28 February, 2011.			
Name of states	Amount of fine (In Rupees)	Name of states	Amount of fine (In Rupees)
Tamil Nadu	29,040	Gujarat	22,550
Andhra Pradesh	5,750		



- The FDA, Maharashtra has decided to push for an amendment to the Shops and Establishments (S&E) Act to prevent roadside tobacco stalls from coming up. Minister of state, FDA, plans to ask the state urban development department to introduce a new clause in the S&E Act that will disallow registration of tobacco stalls near schools. The FDA, along with the state home department and educational institutes, had conducted a drive against such shops from January 10 to 16, 2011. Over 1,343 shops across the state were found to be violating the rules.

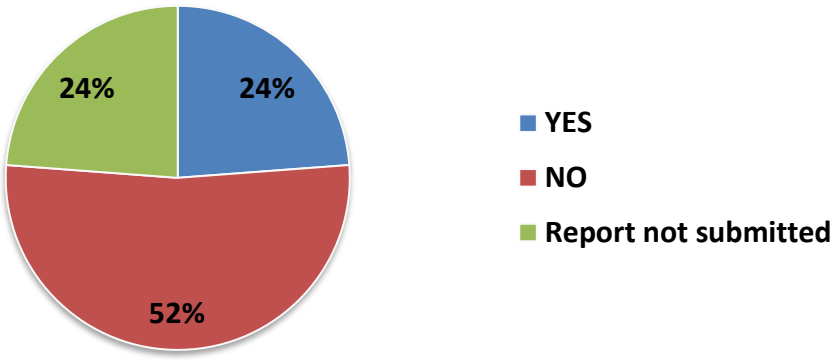
3.4.4.8 – Section 6 (a) - Ban on sale of tobacco products to and by minors (below 18 year of age)

According to monthly reports, 5 states collected fines under section 6 (a) of COTPA. The states included Uttar Pradesh, Delhi, TamilNadu, Andhra Pradesh, and Gujarat. The 11 states which did NOT collect fines under section 6 (a) included Assam, West Bengal, Madhya Pradesh, Karnataka, Nagaland, Tripura, Mizoram, Bihar, Maharashtra, Orissa and Goa.

Table 19 : States which collected fines under section – 6 (a) of COTPA during 2010

	Number of states	Name of states
YES	5	Uttar Pradesh, Delhi, TamilNadu, Andhra Pradesh, Gujarat.
NO	11	Assam, West Bengal, Madhya Pradesh, Karnataka, Nagaland, Tripura, Mizoram, Bihar, Maharashtra, Orissa, Goa.
Report not submitted	5	Rajasthan, Arunachal Pradesh, Sikkim, Jharkhand, Uttarakhand

Figure 17 : Percentage of states which collected fines under section – 6 (a) of COTPA during 2010



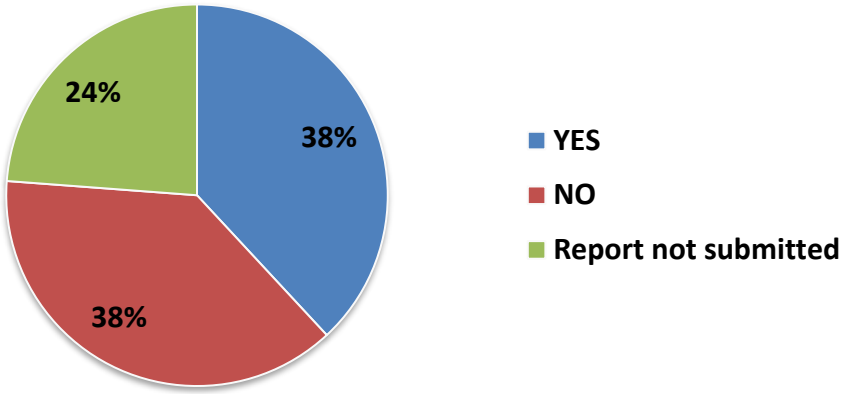
3.4.4.9 – Section 6 (b) - Ban on sale of tobacco products within 100 yards of the educational institutions

According to monthly reports, 8 states collected fines under section 6 (b) of COTPA. The states included Uttar Pradesh, Delhi, TamilNadu, Andhra Pradesh, Gujarat, Maharashtra, Assam and Mizoram. The 8 states which did NOT collect fines under section 6 (b) included West Bengal, Madhya Pradesh, Karnataka, Nagaland, Tripura, Bihar, Orissa and Goa.

Table 20 : States which collected fines under section – 6 (b) of COTPA during 2010.

	Number of states	Name of states
YES	8	Uttar Pradesh, Delhi, TamilNadu, Andhra Pradesh, Gujarat, Maharashtra, Assam, Mizoram.
NO	8	West Bengal, Madhya Pradesh, Karnataka, Nagaland, Tripura, Bihar, Orissa, Goa.
Report not submitted	5	Rajasthan, Arunachal Pradesh, Sikkim, Jharkhand, Uttarakhand

Figure 18 : Percentage of states which collected fines under section – 6 (b) of COTPA during 2010

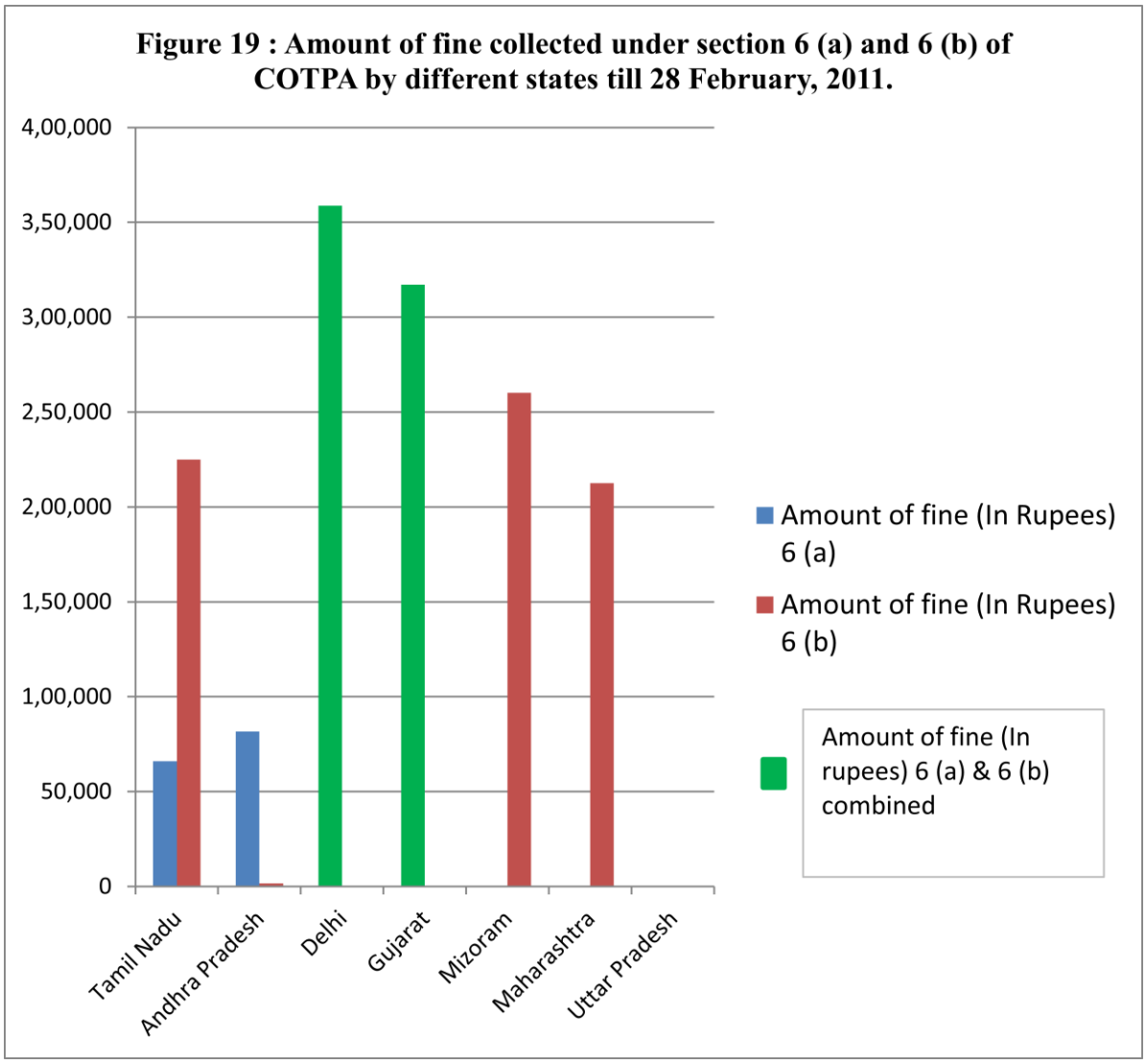


The following table represents amount of fine collected under section 6 (a) and 6 (b) of COTPA by different states till date.

Table 21 : Amount of fine collected under section 6 (a) and 6 (b) of COTPA by different states till 28 February, 2011.

Name of states	Amount of fine (In Rupees)		Name of states	Amount of fine (In Rupees)	
	6 (a)	6 (b)		6 (a)	6 (b)
Tamil Nadu	66,000	2,24,950	Gujarat	3,17,110	
Andhra Pradesh	81,630	1,600	Maharashtra	X	2,12,472
Delhi	3,58,845		Uttar Pradesh	100	280
Mizoram	2,60,224		Goa	18 Gadas punished	

Figure 19 : Amount of fine collected under section 6 (a) and 6 (b) of COTPA by different states till 28 February, 2011.

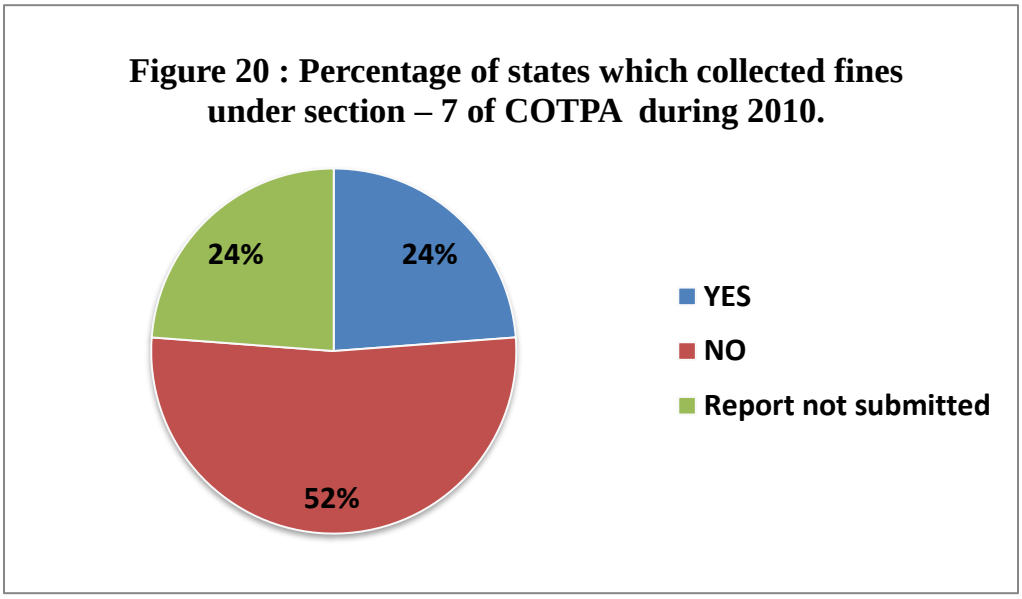


3.4.4.10 – Section 7 - Specified health warnings on tobacco products text and pictorial warnings

According to monthly reports, 5 states collected fines under section 7 of COTPA. The states included TamilNadu, Andhra Pradesh, Goa, Assam and Mizoram. The 11 states which did NOT collect fines under section 7 COTPA include Uttar Pradesh, Delhi, West Bengal, Madhya Pradesh, Nagaland, Tripura, Bihar, Orissa, Gujarat, Maharashtra and Karnataka.

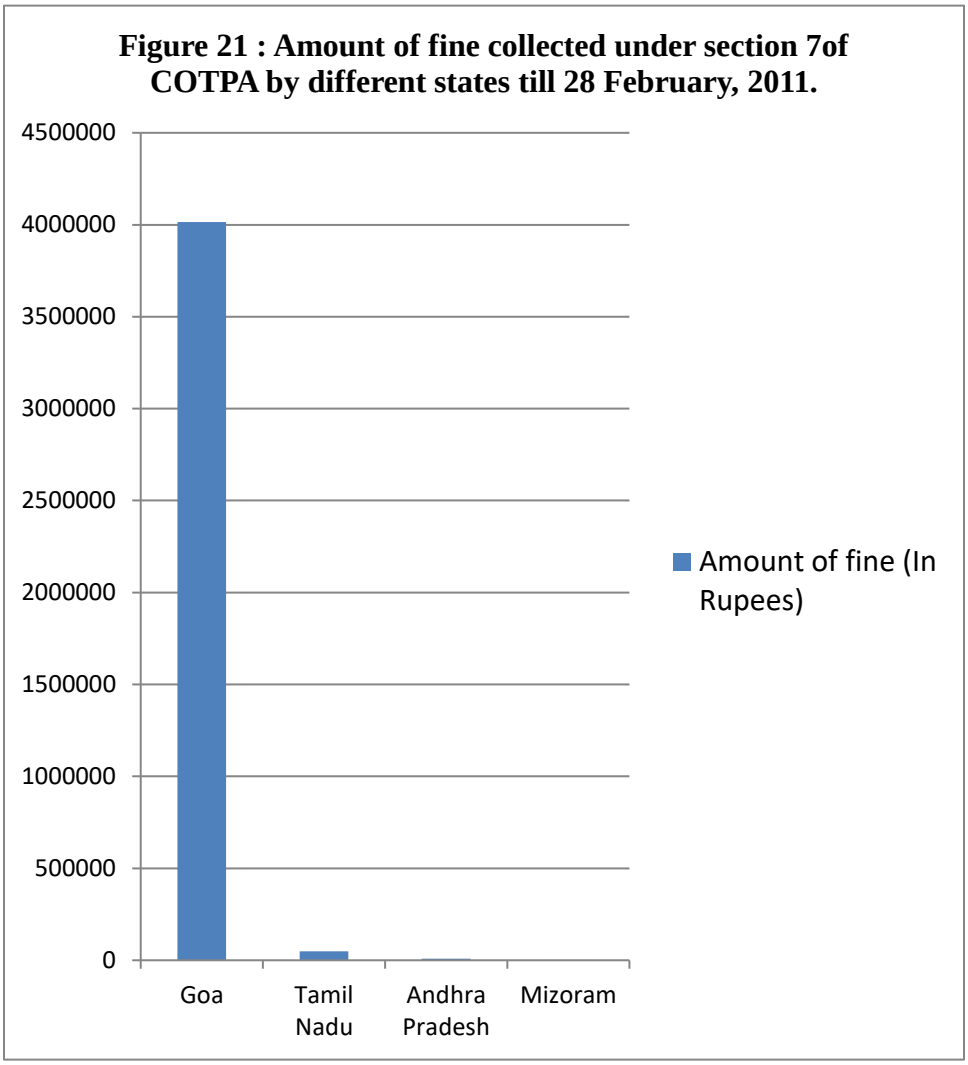
Table 22 : States which collected fines under section – 7 of COTPA during 2010.

	Number of states	Name of states
YES	5	TamilNadu, Andhra Pradesh, Goa, Assam, Mizoram.
NO	11	Uttar Pradesh, Delhi, West Bengal, Madhya Pradesh, Nagaland, Tripura, Bihar, Orissa, Gujarat, Maharashtra, Karnataka.
Report not submitted	5	Rajasthan, Arunachal Pradesh, Sikkim, Jharkhand, Uttarakhand



The following table represents amount of fine collected under section 7 of COTPA by different states till 28 Feb. 2011.

Table 23 : Amount of fine collected under section 7of COTPA by different states till 28 February, 2011.			
Name of states	Amount of fine (In Rupees)	Name of states	Amount of fine (In Rupees)
Goa	40,15,175	Tamil Nadu	48,020
Andhra Pradesh	8,500	Mizoram	1020



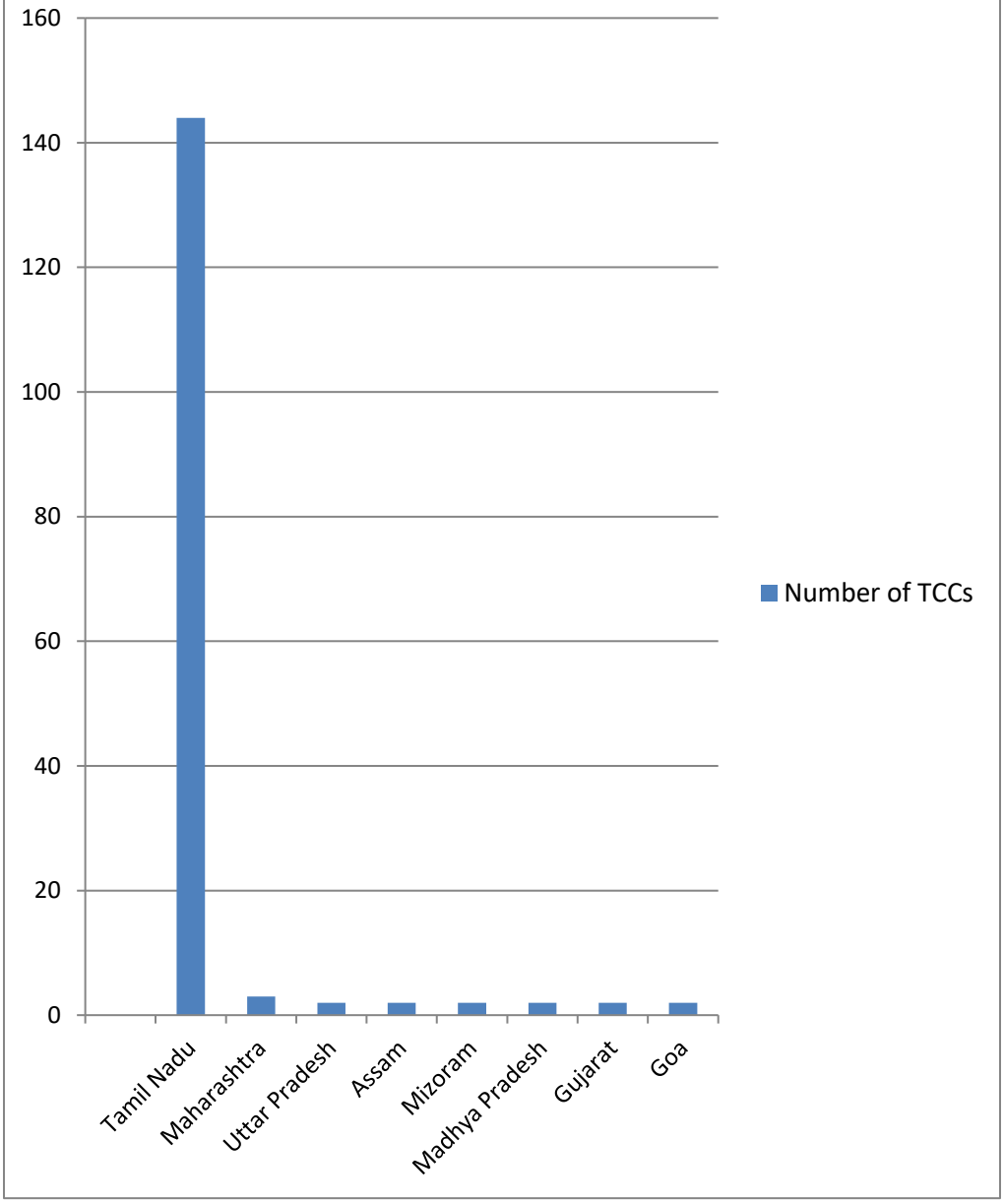
3.4.5 – TOBACCO CESSATION CENTERS (TCC)

The following table represents number of tobacco cessation facilities set up by states under NTCP.

Table 24 : Number of tobacco cessation facilities set up by states under NTCP

Name of states (Phase I)	Number of TCCs	Name of states (Phase II)	Number of TCCs
Assam	2	Nagaland	None
West Bengal	None	Tripura	None
Madhya Pradesh	2	Mizoram	2
Uttar Pradesh	2	Arunachal Pradesh	None
Delhi	None	Sikkim	Report not submitted
Rajasthan	Report not submitted	Jharkhand	Report not submitted
Gujarat	2	Bihar	None
Tamil Nadu	144	Uttarakhand	Report not submitted
Karnataka	None	Maharashtra	3
		Goa	2
		Andhra Pradesh	None
		Orissa	None

Figure 22 : Number of tobacco cessation facilities set up by states under NTCP



4.0 – CONCLUSION

4.1 – Table 25 : Summary of results and findings under monitoring and evaluation of National Tobacco Control Programme

States	Fund released (No. of installments)	Staff hired			Section 4 implementation		Section 5 (steering committee)		Section – 5 (Fines collected till date)	Section 6 implementation (Fines Collected/ raids conducted till date)		Section 7 implementation (Fines collected and Seizures done till date)	Schools program	IEC activities conducted		Trainings/ workshops organised		Cessation facilities set up by states (Number)	TC State Consultant in place
Phase I		state	District 1	District 2	Challaning mechanism	Fines Collected till date	State	Districts		6 (a)	6 (b)			State	District	State	District		
Assam	4	1	3	3	X	X	✓	✓	X	X	102 raids	17 raids	✓	✓	✓	✓	✓	2	✓
West Bengal	1	*	*	*	✓	NA	✓	X	X	X	X	X	✓	✓	X	✓	X	X	✓
Madhya Pradesh	1	1	*	*	✓	**660**	✓	✓	X	X	X	X	✓	✓	✓	✓	✓	2	✓
Uttar Pradesh	1	1	3	3	✓	**60,929**	✓	✓	X	**100**	**280**	X	✓	✓	✓	✓	✓	2	✓
Delhi	3	*	*	*	✓	**25,69,566**	✓	✓	X	**3,58,845**		X	✓	✓	✓	✓	✓	X	✓
Gujarat	3	2	3	1	✓	**8,74,449**	✓	✓	**22,550**	**3,17,110**		X	✓	✓	✓	✓	✓	2	✓
Tamil Nadu	2.5	2	*	*	✓	**41,33,285**	✓	✓	**29,040**	**66,000**	**2,24,950**	**48,020**	✓	✓	✓	✓	✓	144	✓
Rajasthan	1	1	3	0	No report recd														
Karnataka	2	2	1	0	✓	**2,44,795**	✓	✓	X	X	X	X	✓	✓	✓	✓	✓	X	

* In process

States	Fund released (No. of installments)	Staff hired		Section 4 implementation		Section 5 (steering committee)		Section – 5 (Fines collected till date)	Section 6 implementation (Fines Collected/ raids conducted till date)		Section 7 implementation (Fines collected and Seizures done till date)	Schools program	IEC activities conducted	Trainings/ workshops organized	Cessation facilities set up by states (Number)	TC State Consultant in place
Phase II		District 1	District 2	Challaning mechanism	Fines Collected till date	State	Districts		6 (a)	6 (b)						
Tripura	2	3	3	✓	X	X	X	X	X	X	X	✓	✓	✓	X	✓
Bihar	1	*	*	✓	X	✓	✓	X	X	X	X	X	✓	✓	X	✓
Maharashtra	1	X	X	✓	**14,80,258**	X	X	X	X	**2,12,472 (fine) & 5,41,984 (seizures)**	X	✓	✓	✓	3	✓
Andhra Pradesh	2	3	3	✓	**8,09,930**	✓	✓	**5,750**	**81,630**	**1,600**	**8,500**	✓	✓	✓	X	✓
Nagaland	2	3	3	X	X	✓	✓	X	X	X	X	✓	✓	✓	X	
Mizoram	2	3	3	✓	**52,620**	✓	✓	X	X	**2,60,224 (seizures)**	**1020**	✓	✓	X	2	
Arunachal Pradesh	1	X	X	✓	X	✓	✓					✓	✓	✓	X	
Sikkim	2	✓	✓	No report recd												
Jharkhand	1	X	X	No report recd												
Uttarakhand	1	X	X	No report recd												
Goa	1	2	2	✓	**4,21,620**	✓	✓	X	**18 Gadas punished**		**40,15,175**	✓	✓	✓	2	
Orissa	1	X	X	✓	**6,89,450**	✓	✓	X	X	X	X	X	X	X	X	Under process

NTCP Phase I states with Consultants

NTCP Phase I states with out Consultants

NTCP Phase II states with Consultants

NTCP Phase II states with out Consultants

4.2 – EVALUATION OF PERFORMANCE OF STATES UNDER NATIONAL TOBACCO CONTROL PROGRAMME –

The scores were given to states under each indicator of performance. Following criteria was used for giving scores :

Funds released :

Phase I states		Phase II states	
Number of installments	Scores	Number of installments	Scores
1	0	1	0
2	1	2	2
3	2	3	3

The phase II states are given higher scores because they came in 2009 whereas phase I states came in 2007. So if a phase II state has taken second installment, it means he has spent I installment in lesser time period than phase I state taking second installment.

Staff hired **:**

If staff is in place at state, district 1, district 2; 1 mark each is given and if staff is not in place, 0 mark is given. Again phase II states are given 1 additional mark if staff is in place because these states only have provision for staff at district level whereas phase I states have provision for staff at both district as well as state level. For the staff in process 1 mark is given overall.

Fines collected under various sections [4, 5, 6(a), 6(b), 7] of COTPA:

Amount of fine collected	Scores
> 1 lakhs	3
1000 to 1 lakhs	2
< 1000	1
NIL	0

Challaning mechanism, steering committee, schools programme :

Status	Scores
In place	1
Not in place	0

IEC activities and trainings/ workshops organized :

Phase I states		Phase II states	
Activities	Scores	IEC activities	Scores
In state	1	In district	2
Not in state	0		
In district	1	Not in district	0
Not in district	0		

Cessation facilities functioning in the state :

Number of cessation facilities	Scores
NIL	0
1-2	1
3 – 5	2
> 5	3

It has been found after scoring that,

The states which are performing well include Tamil Nadu, Andhra Pradesh, Gujarat, Goa, Mizoram, Assam, Uttar Pradesh and Delhi.

The states which are underperforming include Jharkhand, Uttarakhand, Rajasthan, West Bengal, Orissa and Sikkim.

Table 26 : Evaluation of performance of states by giving scores to each indicator

States	Scores for number of installments taken.	Scores for Staff hired	Scores for Section 4 implementation		Scores for Section 5 (steering committee)		Scores for Section – 5 (Fines collected)	Scores for Section 6 implementation (Fines Collected)		Scores for Section 7 implementation	Scores for Schools program	Scores for IEC activities conducted		Scores for Trainings/ workshops organised		Scores for Cessation facilities set up by states	**Total Scores**	TC State Consultant in place
Phase I			Scores for Challaning mechanism	Scores for Fines Collected	State	Districts		6 (a)	6 (b)			State	District	State	District			
Tamil Nadu	1.5	2	1	3	1	1	2	2	3	1	1	1	1	1	1	3	25.5	✓
Gujarat	2	3	1	3	1	1	2	3		0	1	1	1	1	1	1	22	✓
Assam	3	3	0	0	1	1	0	0	1	1	1	1	1	1	1	1	16	✓
Uttar Pradesh	0	3	1	2	1	1	0	1	1	0	1	1	1	1	1	1	16	✓
Delhi	2	1	1	3	1	1	0	3		0	1	1	1	1	1	0	16	✓
Karnataka	1	2	1	3	1	1	0	0	0	1	1	1	1	1	1	0	15	
Madhya Pradesh	0	2	1	1	1	1	0	0	0	0	1	1	1	1	1	1	12	✓
West Bengal	0	1	1	0	1	0	0	0	0	0	1	1	0	1	0	0	6	✓
Rajasthan	0	2			1	1											4	

States	Scores for number of installments taken.	Scores for Staff hired	Scores for Section 4 implementation		Scores for Section 5 (steering committee)		Scores for Section – 5 (Fines collected)	Scores for Section 6 implementation (Fines Collected)		Scores for Section 7 implementation	Scores for Schools program	Scores for IEC activities conducted	Scores for Trainings/ workshops organized	Scores for Cessation facilities set up by states	Total Scores	TC State Consultant in place
Phase II			Scores for Challaning mechanism	Scores for Fines Collected	State	Districts		6 (a)	6 (b)							
Andhra Pradesh	2	3	1	3	1	1	2	2	2	2	1	2	2	0	24	✓
Goa	0	3	1	3	1	1	0	1		3	1	1	2	1	19	
Mizoram	2	3	1	2	1	1	0	0	3	2	1	2	X	1	19	
Maharashtra	0	0	1	3	0	0	0	0	3	0	1	2	2	2	14	✓
Nagaland	2	3	0	0	1	1	0	0	0	0	1	2	2	0	12	
Tripura	2	3	1	0	0	0	0	0	0	0	1	2	2	0	11	✓
Bihar	0	1	1	0	1	1	0	0	0	0	0	2	2	0	8	✓
Arunachal Pradesh	0	0	1	0	1	1					1	2	2	0	8	
Sikkim	2	3			1	1									7	
Orissa	0	0	1	3	1	1	0	0	0	0	0	X	X	0	6	Under process
Jharkhand	0	0													0	
Uttarakhand	0	0			0	0									0	

4.3 – SWOT (STRENGHTHS, WEAKNESSES, OPPORTUNITIES AND THREATS) ANALYSIS

4.3.1 – EVALUATING INTERNAL RESOURCES AS STRENGTHS AND WEAKNESSES:

Strenghths

1. **Decentralization**: District tobacco control units have been setup in all the 21 states to implement the programme at district level.
2. **Training**: Training material has been prepared at the central level to train doctors, health workers and school teachers. Trainings are being conducted at state and district levels all over India.
3. **IEC** (Information, Education, Communication): There are lot of IEC activities being carried out by state and district tobacco control units, and NGOs involved in the programme. Some TV spots have also been started.
4. **School programme:** The guidelines for tobacco free schools have been prepared and have been adopted by CBSE to be implemented in CBSE schools.
5. **Tobacco Cessation:** Tobacco Cessation Centres (TCCs) are being setup by state governments. There are 19 TCCs which were set by WHO-MoHFW. These TCCs are functioning as Resource Centers (RCTC) and are providing trainings to professionals for setting up new TCCs. There are several private TCCs also.
6. **Intersectoral coordination:** NTCP is doing advocacy with ministry of agriculture to denounce the cultivation of Tobacco and provide alternatives to Tobacco farmers and also advocacy with ministry of women and child development to provide alternative vocations to women Beedi workers and Tendu leave pluckers.
7. **Integration with other programmes:** All efforts have been made to integrate NTCP activities into other ongoing national health programmes like RNTCP (Revised National Tuberculosis Control Programme), National Mental Health Programme (NMHP), National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPDCS), Reproductive and Child

Health Programme (RCH), School Health Programme etc. The programme has already been integrated with RNTCP and school health programme.

8. **Cigarette and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA):** It was enacted by the parliament in 2003 with comprehensive regulations against the serious threat of tobacco use.

Weaknesses

1. **Performance of the programme is uneven in different states.** Some states like TamilNadu, Andhra Pradesh and Gujarat are effectively implementing COTPA and are collecting fines under different sections. On the other hand several states like West Bengal, Nagaland, Tripura, Jharkhand, Bihar have not implemented COTPA and are not collecting fines under any section of COTPA. Also according to GATS 2009-10, Mizoram has 67% tobacco users while Goa has 9% tobacco users.
2. **Lack of robust monitoring and evaluation system:** Monitoring and Evaluation committee is required to be setup. Although there is a provision to collect information under monthly and quarterly performas, there are some gaps. There is a need to conduct supervisory visits and to collect first-hand information.
3. **Lack of TCCs:** Tobacco Cessation Centres need to be more in number.
4. **Lack of PPP (Public Private Partnership):** Partnership with private practitioners and hospitals is required. Corporates can be invited to contribute to the programme under CSR (corporate social responsibility).
5. **Tobacco free schools policies have been implemented in very few schools.**
6. **IPHS standards** have been modified but **have not been implemented** anywhere. There is need to implement modified IPHS standards. It can give leverage to the programme by giving cessation counseling at district hospitals and PHCs.
7. **Tax on tobacco products is very less.** It is only 38% on cigarettes and 9% on Bidis. **In some states there is no tax on Bidis.** According to WHO tax should be atleast 60% and it should be on all tobacco products so that user doesn't switch from one tobacco product to another.

8. **Pictorial Warnings are ineffective.** According to GATS 2009-10 only 64.5% tobacco users noticed the health warnings on tobacco packages and only 31.5% thought of quitting tobacco because of the warning label.
9. **Low awareness regarding legislation i.e. COTPA act and lack of proper enforcement of COTPA act.**
10. **Ban on advertisement and promotion of tobacco products is ineffective.** Acc. To GATS 2009-10 about 64.5% adults noticed advertisement or promotion of tobacco products. Also surrogate advertisements are very prevalent.

4.3.2 – APPRAISAL OF EXTERNAL FACTORS THAT MAY BE OPPORTUNITIES OR THREATS

Economic environment:

- Our economy (GDP) is growing at the rate of 6-7%. More and more youth is now getting employed. So people now have more money or more number of people have money to spend on tobacco products.
- Tax policies like tax on tobacco products and tax on tobacco cultivation also affect our programme. Although due to addictive nature of tobacco products its demand is price inelastic but it has differential price elasticity for youth who doesn't have regular income.
- Farmers are going for cash crops like Tobacco.

Technological changes:

- E-cigarettes, flavoured hukkas can be seen as potential threats.
- Technology can also be seen as opportunity like carbon mono oxide breath analyzers, nicotine replacement therapy (NRT) which helps in cessation therapy. Also the "nicotine passive monitors" which helps in air nicotine monitoring.

Legislation:

- There is a fine of Rs 200 on spitting in Delhi. It can helps in regulating chewing tobacco.

- The Supreme Court has banned plastic pouches for selling Gutkha and other tobacco products. It can hamper supply of tobacco.

Social factors:

- In some societies tobacco consumption is socially acceptable. Like in UP Paan is served at marriages. In Mizoram tobacco water (tibur) is consumed orally. In our villages hukka is smoked at panchayat meetings.

Demographic factors:

- India has large number of young population which is catchment area for tobacco companies. Tobacco companies are now targeting large youth market in India and also women.

5.0 – DISCUSSION

The strengths of the programme include decentralization, trainings, IEC (Information, Education, Communication), school programme, tobacco cessation, intersectoral coordination, integration with other programmes, Cigarette and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act (COTPA). At national level, public awareness component had been implemented very well. Other national level components were comparatively lagging behind and need to be addressed in coming years which include establishment of tobacco products testing laboratories; mainstreaming the programme as part of overall NRHM framework; alternative crops and livelihoods; monitoring and evaluation. The programme had very well implemented the trainings, IEC and school programme components. The states were conducting various activities under these components at state and district levels. Enforcement of tobacco control laws had not been implemented very well. Although 15 states had established challaning mechanism, only 11 states collected fines under section-4 COTPA. Further only 3 states took some action/ collected fines regarding section-5 COTPA. Only 5 states took some action/ collected fines regarding section 6(a), 8 states regarding section 6(b) and 5 states regarding section 7 of COTPA. For effective implementation of tobacco control law, some policies of other countries could be adopted. Covert inspections could be carried out to monitor compliance as done in **Scotland** [12] and **Ontario** [16]**.** One policy could be to close the establishment for few days if there are repetitive breaches of the ban. This is being done in **Uruguay**[13]**.** Also the fines collected for violations could be dedicated to smoking prevention activities as done in **Uruguay**[13]**.** Public places could be categorized as high risk, medium risk and low risk based on prevalence of smoking at those places and thus monitoring inspections could be prioritized. This policy has been adopted by **Borough**[14]**.** NGOs and other organizations could be involved in monitoring of tobacco control law as done in **Bangladesh**[15] and **Brazil**[12]**.** Pack warning laws could be enforced by department of consumer products inspections as done in **Belgium**[12]**.**

After evaluation of programme it had been found, the states which were underperforming include Jharkhand, Uttarakhand, Rajasthan, West Bengal, Orissa and Sikkim. The programme needs to focus on these states to improve their performance

6.0 – RECOMMENDATIONS

Following are some recommendations:

PROGRAMME DOCUMENT

It is recommended that there should be a programme document having clearly defined Vision, mission and programme goals. Some programme goals are suggested below:

1. To reduce tobacco use in any form from current 34.6% in adults to less than 30% by 2020.
2. To reduce tobacco use by children (<15 years) from current 14.6% to less than 10% by 2020.
3. To reduce exposure to second-hand smoke at home from current 52.3% to less than 25% by 2020.
4. To reduce exposure to second-hand smoke at workplace from current 29.9% to less than 10% by 2020.
5. To reduce exposure to second-hand smoke at any public place from current 29% to less than 10% by 2020.
6. To provide tobacco cessation services at 50% districts by 2015 and at every district by 2020.

MANAGEMENT OF FUNDS

There should be **division of funds for various components** of programme. While releasing funds to states, it should be released under different subheads like funds for training, funds for IEC, funds for school programme, funds for TCCs. It will ensure that states conduct activities under each component of programme. Funding for a particular component should be released only after 80% of previous funds for that component have been utilized and also when state has submitted quarterly report for previous quarter.

TOBACCO TESTING LABS

Assistance from some international sources should be sought to set up **tobacco testing labs.** Those who have already worked in setting up tobacco testing labs in foreign countries could be approached. On a pilot basis two tobacco testing labs could be started.

INTEGRATION WITH OTHER PROGRAMMES UNDER NRHM UMBRELLA

More number of states should be covered under TB-tobacco integration project.

The programme should be brought under NRHM umbrella and each patient coming to PHC, CHC, district hospital should be asked about his tobacco use status and should be provided brief counseling if he/ she is a tobacco user.

TAX ON TOBACCO PRODUCTS AS A COMPONENT OF PROGRAMME

Tax on all tobacco products is also very important to reduce the demand of tobacco products. Recently HP government has increased VAT on all tobacco products to a total of 21%. Gujarat government has also increased the tax on all tobacco products to 25%. We are getting this information via media and via E-mails and not through the proper channel of monitoring of programme. Tax is also not included in the components of the programme. Tax on tobacco products should also be a component of NTCP at national and state levels. We should also ask in the performas, "what is the tax structure on different tobacco products in their states?" The frequent meetings should be convened with **ministry of finance** for advocacy of **tax increase on all types of tobacco products and tax on tobacco cultivation.**

MASS-MEDIA CAMPAIGN WITH A CELEBRITY

Mass media campaigns should be more effective and some big celebrity should be persuaded for the campaign. If Amitabh Bachchan used to smoke on screen it influenced the youth and they imitated. Now if Amitabh Bachchan will do some tobacco control spot, then also it will influence the public like Pulse polio campaign.

EVIDENCE BASED DECLARATION AS SMOKE-FREE

The declaration of smoke-free cities, smoke-free states and smoke-free events should be evidence based. Air nicotine monitoring could provide evidence for declaring a state, city or event smoke-free.

SALE OF TOBACCO PRODUCTS SHOULD BE ADDED AS AN OUTCOME INDICATOR DURING EVALUATION OF PROGRAMME.

7.0 – MONITORING AND EVALUATION SYSTEM

For continuous **monitoring,** we have **monthly and quarterly Performa's** to collect the information from various states. For the month of December 2010, five out of 21 states submitted their monthly report. For the month of January 2011, five out of 21 states submitted their monthly report. For the month of February 2011, ten out of 21 states submitted their monthly reports. For the quarter ended December 2010, seventeen out of 21 states submitted their quarterly report. Thus default rate is high for the submission of monthly reports. In addition to this, the information collected monthly is also important for quarterly and annual evaluation. **Thereby It is recommended to merge the indicators of monthly and quarterly Performa's and to have only quarterly Performa.** It is also recommended to modify current Performa and to add some more indicators to it. Suggested quarterly Performa is given below.

7.1 – QUARTERLY PERFORMA

Activities	**Status**	**Remarks**
Activities under various provisions		
Section 4		
A) Number of public places having mandatory signages installed		
B) Whether challaning mechanism has been established for smoke free rules?		
C) Whether separate account for depositing challan money has been created?		
D) Number of challans issued and funds collected under section 4 **in this quarter.** (Information may be given monthwise)		
E) Whether additional list of authorized persons notified by the state (Provide the list)		
F) Number and names of cities/towns declared as smoke free/tobacco free **till now.**		
G) Number and names of villages declared as smoke free/ tobacco free **till now**.		
H) Number and names of events declared as smoke free/tobacco free **in this quarter.**		

Section 5		
A) Whether steering committee have been constituted for implementation of section 5 • At state level • At district level		
B) Number of Persons booked and amount of fine collected for violation of section 5 in the state **in this quarter.**		
Section 6		
A) Number of educational institutes where signages have been placed for implementation of section 6 (b)		
B) Number of Persons booked and amount of fine collected for violation of section 6 (a) in the state **in this quarter.**		
C) Number of Persons booked and amount of fine collected for violation of section 6 (b) in the state **in this quarter.**		
Section 7		
A) Action taken for implementation of section 7.		
B) Number and names of persons/industry booked for violation of section 7 and amount of fine collected..		
Tobacco Cessation Centres (TCCs)		
A) Number of TCCs set up by the state government **till now.**		
B) Number of government TCCs having adequate staff.		
C) Number of the TCCs set up in private sector by civil society **till now**.		
State		
Whether State Cell has been set up with requisite infrastructure **(only for phase I states)**		
Status of recruitment of staff in the State Cell **(only for phase I states)**		

-Programme Assistant (mention name) -Data Entry Operator (mention name)		
Whether training of staff has been conducted		
Whether IEC activities are carried out at State level? If Yes, a) Number of awareness programmes carried out in schools, colleges, offices, industries and other organizations in this quarter at state level and number of persons covered. b) Number of community based IEC activities carried out like street plays, folk media programme etc. in this quarter at state level and number of persons covered. • In cities • In villages c) Number of media campaigns carried out in this quarter at state level. d) Is there any anti tobacco spot telecasted in local television? If yes, then how many times in a day? e) Number of anti tobacco articles published in local newspapers and magazines in this quarter at state level.		
Whether trainings & workshops are carried out at state level? If yes, a) Number of trainings and workshops carried out for ASHAs, health workers and village level workers in this quarter at state level and number of persons covered. b) Number of trainings and workshops carried out for doctors, dentists and other health professionals in this quarter at state level and number of persons covered. c) Number of trainings and workshops carried out for other professionals like teachers in this		

quarter at state level and number of persons covered. d) Number of trainings and workshops carried out for NGOs and other social & voluntary organizations in this quarter at state level.		
Number of schools declared as tobacco free **till now in whole state.**		
Whether monitoring and evaluation mechanism has been established at state level?		
Whether programme review meeting was conducted for the last quarter at state level?		
Any other activity undertaken		
what is the tax structure on different tobacco products in your state		
District		
Whether District Cell has been established with requisite infrastructure		
Status of recruitment of staff -Psychologist (mention name) - Social Worker (mention name) - Data Entry Operator (mention name)		
Whether training of staff has been conducted		
Whether IEC activities are carried out at district level in each district? If Yes, a) Number of awareness programmes carried out in schools, colleges, offices, industries and other organizations in this quarter at district level in each district and number of persons covered. b) Number of community based IEC		

activities carried out like street plays, folk media programme etc. in this quarter at district level in each district and number of persons covered. • In cities • In villages c) Number of media campaigns carried out in this quarter at district level in each district. d) Is there any anti tobacco spot/scroll telecasted in local cable television? If yes, then how many times in a day? (In each district)		
Whether trainings & workshops are carried out at district level in each district? If yes, a) Number of trainings and workshops carried out for ASHAs, health workers and village level workers in this quarter at district level in each district and number of persons covered. b) Number of trainings and workshops carried out for doctors, dentists and other health professionals in this quarter at district level in each district and number of persons covered. c) Number of trainings and workshops carried out for other professionals like teachers in this quarter at district level and number of persons covered. d) Number of trainings and workshops carried out for NGOs and other social & voluntary organizations in this quarter at district level in each district.		
Whether activities are carried out under school programme at district level? (In each district) If Yes, a) Number of schools in which activities were		

carried out under school program at district level **in this quarter** in each district. b) Number of schools where anti-smoking signages have been placed **till now** in each district. c) Number of schools declared as tobacco free **till now in each district**		
Whether mechanism for monitoring provisions under the law and reporting has been established at district level?		
Whether programme review meeting was conducted at district level for the last quarter in each district?		
Others		
Details of NTCP budget & expenditure at State level.		
Details of NTCP budget and expenditure at District level.		
Best practices		
Remarks		

The information will flow from district cell to state cell to centre quarterly. The primary information will be collected at district level by district tobacco cells and at state level by state tobacco cells.

7.2 – SUPERVISORY VISITS

We should supplement the monitoring mechanism with supervisory visits. Supervisory visits could provide us with some firsthand information and could strengthen the monitoring system. S**upervisory visits** are recommended at state level as well as at centre level. For Example, state can supervise one district per month and will send the supervisory report to centre. Similarly, at central level, one state per month can be supervised. These supervisory visits can be surprise visits. There should be **supervisory**

checklist for the things to be observed during supervision. F**ollowing supervisory checklist is recommended.**

7.2.1 – SUPERVISORY VISIT CHECKLIST FOR SUPERVISION OF STATES BY CENTRE

Supervisory visit checklist for supervision of states by centre.
1. Whether state tobacco cell is in place with proper infrastructure?
2. Whether state tobacco cell has required staff?
3. Whether accounts have been maintained for budget and expenditures by state tobacco cell and do these accounts match the details send by state in quarterly reports?
4. Whether accounts have been maintained for number of persons challaned and fines collected under the COTPA act and does this information match the information provided in quarterly reports?
5. Whether state is reviewing the activities of district tobacco cell and review reports are present at state tobacco cell? Whether minutes of meeting of review meeting for the last quarter is available at state tobacco cell?
6. Whether state has conducted any supervisory visits to district and supervisory notes are there at state tobacco cell?
Supervisory visit to one public place in the state
1. Whether no smoking signages are there at public place?
2. Whether there is any mechanism to take challan from smokers at that public place? The compliance check may involve smoking attempt by a test smoker. He may just hold the cigarette without actually smoking it.
3. Whether cigarette or bidi stubs, tobacco pouches are lying on the ground at that public place.
4. Whether anybody is smoking at that public place?
5. Whether people present at that public place are aware of the fact that smoking is prohibited at public places?
Supervisory visit to one school
1. Whether tobacco free school signages or no smoking signages are there at school?
2. Whether school authorities are aware of the school programme of National Tobacco Control Programme?
3. Whether school has been carrying out any activity related to school programme like awareness generation among school children, campaigns etc.?
4. Whether teachers are aware of school programme of National Tobacco Control Programme?
5. Whether teachers carried out any activity related to awareness generation among school children?
6. Whether school children are aware of harmful effects of tobacco?
7. Whether there is any tobacco seller within 100 yards of school?

8. Whether anybody (including students, teachers and other staff) has been found smoking or using tobacco in the school premises during supervisory visit?
9. Whether cigarette/ bidi stubs/ tobacco pouches were found lying on the ground in the school during supervisory visit?
Supervisory visit to one tobacco cessation centre, if any.
1. Whether TCC has proper infrastructure?
2. Whether TCC has adequate staff?
3. Whether TCC open regularly? (In how many days a week and during which hours?)
4. Approximately how many patients come to TCC?
5. Whether TCC is maintaining records of patients visits?
6. Whether TCC is collecting required information from patients and maintaining record files?
7. Whether TCC is doing follow-ups with the patient?

7.2.2 – SUPERVISORY VISIT CHECKLIST FOR SUPERVISION OF DISTRICTS BY STATE

Supervisory visit checklist for supervision of districts by state
1. Whether district tobacco cell is in place with proper infrastructure?
2. Whether district tobacco cell has required staff?
3. Whether accounts have been maintained for budget and expenditures by district tobacco cell and do these accounts match the details send by district in quarterly reports?
4. Whether accounts have been maintained for number of persons challaned and fines collected under the COTPA act and does this information match the information provided in quarterly reports?
Supervisory visit to one public place in the district
1. Whether no smoking signages are there at public place?
2. Whether there is any mechanism to take challan from smokers at that public place? The compliance check may involve smoking attempt by a test smoker. He may just hold the cigarette without actually smoking it.
3. Whether cigarette or bidi stubs, tobacco pouches are lying on the ground at that public place.
4. Whether anybody is smoking at that public place?
5. Whether people present at that public place are aware of the fact that smoking is prohibited at public places?
Supervisory visit to one school in the district
1. Whether tobacco free school signages or no smoking signages are there at school?
2. Whether school authorities are aware of the school programme of National

Tobacco Control Programme?
3. Whether school has been carrying out any activity related to school programme like awareness generation among school children, campaigns etc.?
4. Whether teachers are aware of school programme of National Tobacco Control Programme?
5. Whether teachers carried out any activity related to awareness generation among school children?
6. Whether school children are aware of harmful effects of tobacco?
7. Whether there is any tobacco seller within 100 yards of school?
8. Whether anybody (including students, teachers and other staff) has been found smoking or using tobacco in the school premises during supervisory visit?
9. Whether cigarette/ bidi stubs/ tobacco pouches were found lying on the ground in the school during supervisory visit?
Supervisory visit to one tobacco cessation centre, if any in the district.
1. Whether TCC has proper infrastructure?
2. Whether TCC has adequate staff?
3. Whether TCC open regularly? (In how many days a week and during which hours?)
4. Approximately how many patients come to TCC?
5. Whether TCC is maintaining records of patients visits?
6. Whether TCC is collecting required information from patients and maintaining record files?
7. Whether TCC is doing follow-ups with the patient?

After conducting the supervisory visits, we could cross-check the information we have in the form of quarterly reports and we could update the information. We could put up the supervisory notes in the file of supervisory visits for taking desirable actions and for future reference at the time of evaluation of programme.

7.3 – OUTCOME EVALUATION AND ANNUAL REPORT

We could conduct **outcome evaluation** annually to know what have been achieved by our programme during the year. Whether we are in the direction of achieving our objectives and to what extent? We could compile all the quarterly reports and supervisory visits of the year to generate one **annual report.**

7.4 – MONITORING AND EVALUATION COMMITTEE

Monitoring and Evaluation committee should be set up that will visit states periodically to monitor their work. This committee will ensure that states submit quarterly report regularly. This committee will be responsible for preparing annual report

of the programme based on quarterly reports and supervisory visits. The committee will also monitor the work of various NGOs which are given grant under NTCP to conduct various projects.

7.5 – IMPACT EVALUATION

We can have **Impact Evaluation** after every three-four years to measure the impact made by our programme in society. In this we would like to know about the change in the prevalence of tobacco use, change in the exposure to second hand smoke, change in the level of awareness etc. We have GATS 2009-10 to serve as a baseline data. We can use this data to compare after 3-4 years. We can conduct the GATS again after three years to measure the changes and thus to measure the impact of National Tobacco Control Programme.

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