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SWASTH HIND

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WORLD NO–TOBACCO DAY

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What is World No-Tobacco Day?

IN view of the scientifically proven dangers of tobacco both for smokers and for non-smokers who inhale smoke produced by others, WHO has committed itself to fighting this menace. World No-Tobacco Day, celebrated on 31 May each year, is intended to discourage tobacco users from consuming tobacco and to encourage governments, communities, groups and individuals to become aware of the problem and to take appropriate action. In 1992, the emphasis was given to the place of work: "Tobacco-free workplaces: safer and healthier". In 1993, we will concentrate on the role of health services, including health personnel, and on the need for a dual approach as both example-setter and educator: "Health services: our window to a tobacco-free world".

This issue of **SWASTH HIND** is devoted to the theme.

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In this issue

Articles on health topics are invited for publication in this Journal.

State Health Directorates are requested to send in reports of their activities for publication.

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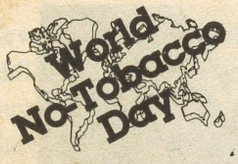


TOBACCO-RELATED DEATHS

—Role of Health Services in Educating Community

LT. COL. JASDEEP SINGH

Tobacco consumption accounts for 3 million global deaths per year. Smoking is not only injurious to health of smokers but also affects the non-smokers—members of the family, companions and the society. It is, indeed, an economic drain. Basically, it is the individual who has to take steps to quit this evil health hazard. The supportive actions by medical authorities and the government are only supplementary.

IN the modern globe television, radio, press and allied media is playing a remarkably favourable and encouraging role in disseminating information and knowledge on tobacco abuse and its related health, economic and social consequences amongst the masses of different walks of life. The health statisticians are presenting the realistic results of declining trends in terms of tobacco consumption and its resulting morbidity and mortality patterns in some parts of the world. However, the manufacturers and advertisers through their adventurous techniques are attracting many to join the world of smokers, and the government machinery is also caught between a substantial tax revenue and a health hazard of epidemic proportions.

Effects of smoking on health

The well known harmful components of cigarette smoke include tar, carbon monoxide and nicotine: 3:4, Benzpyrene is an established carcinogen: Carbon monoxide comes from incomplete combustion and nicotine is the active alkaloid of tobacco. These are responsible for a large number of disabilities and premature deaths.

Tobacco consumption is estimated to account for 3 million global deaths per year. Smoking is not only injurious to the health of smokers but also affects adversely the innocent non-smoker family members, companions and members of the society present around. Besides, it is a substantial economic drain on the smoker, his family, employers, and the society as a whole.

A smoke which is inhaled has its adverse effects not only in the mouth and lungs but also on other organs of the body such as heart, stomach, urinary bladder. Smoking is established to be responsible for 90% of lung cancers, 30% of all caners, 80% cases of chronic bronchitis and emphysema and 20—25% deaths from heart diseases and strokes. Other diseases that are significantly common among smokers are cancer of lip, tongue, mouth, larynx, pharynx, oesophagus and bladder. Gastroduodenal ulcers occur twice as frequently in smokers as in non-smokers. Cigarette smoking has been shown to accelerate gastric emptying which could be important in the pathogenesis of duodenal ulcer and for the well recognized delay in the healing of these ulcers.

Studies have shown that on cessation of smoking, the relative risk of developing lung cancer declines steeply so that after about 10 years the risk is almost as low as for the lifelong non-smoker. However, the risk of lung cancer increases remarkably among workers exposed to dust and uranium.

As with lung cancer, the risk of death from ischaemic heart disease decreases on cessation of smoking. The risk declines quite substantially within one year of stopping smoking and more gradually thereafter.

THE HEALTH CALL

Women appear to be less liable to ischaemic heart disease, however, if she smokes 35 or more cigarettes a day she runs 20 times the risk of dying of heart attack by the age 50. A woman of child bearing age, if she continues to smoke, she not only suffers the usual penalties of every smoker but also endangers her baby to be born. An average birth weight in such babies is less by 200g. Incidence of abortion, stillbirth, prematurity and neonatal death is high in such cases.

Studies have shown increased risk of congenital mal-formations in offsprings born to smoker mothers. Studies have also shown early onset of menopause among women who smoke.

Effects on pilots

Smoking is of particular significance among pilots, bus drivers, coalminers, office workers. A 45-year-old male pilot who smokes 20 cigarettes a day has a risk of sudden death 2.8 times greater than non-smoking pilot, irrespective of other risk factors. Studies have shown increased levels of thiocyanates in urine and plasma among smokers. Tobacco smoke significantly interferes with the physical and mental abilities that is so important for air-line pilots. The limitations include visual impairment, timing or temporal impairment, and impairment in decision making and coordination. Many of these impairments are due to increased carboxy-haemoglobin level in the blood.

Carbon monoxide

Carbon monoxide which is present in concentrations of 1 to 5% in the cigarette smoke plays an important role. The concentration of gas varies with temperature at which cigarette burns as well as with factors controlling oxygen supply such as porosity of the paper. The amount of carbon monoxide produced increases considerably towards the end of the cigarette. In the blood, haemoglobin has 250 times more affinity for carbon monoxide than oxygen.

In closed, ill-ventilated spaces, smokers expose others to harmful concentration of tobacco smoke and cause distress to asthmatic and other susceptible persons and impair cardiac functions of people with coronary heart disease.

Several studies have shown that the children of parents who smoke are more liable to chest diseases than the children of non-smoker and the risk is double during the first year of life.

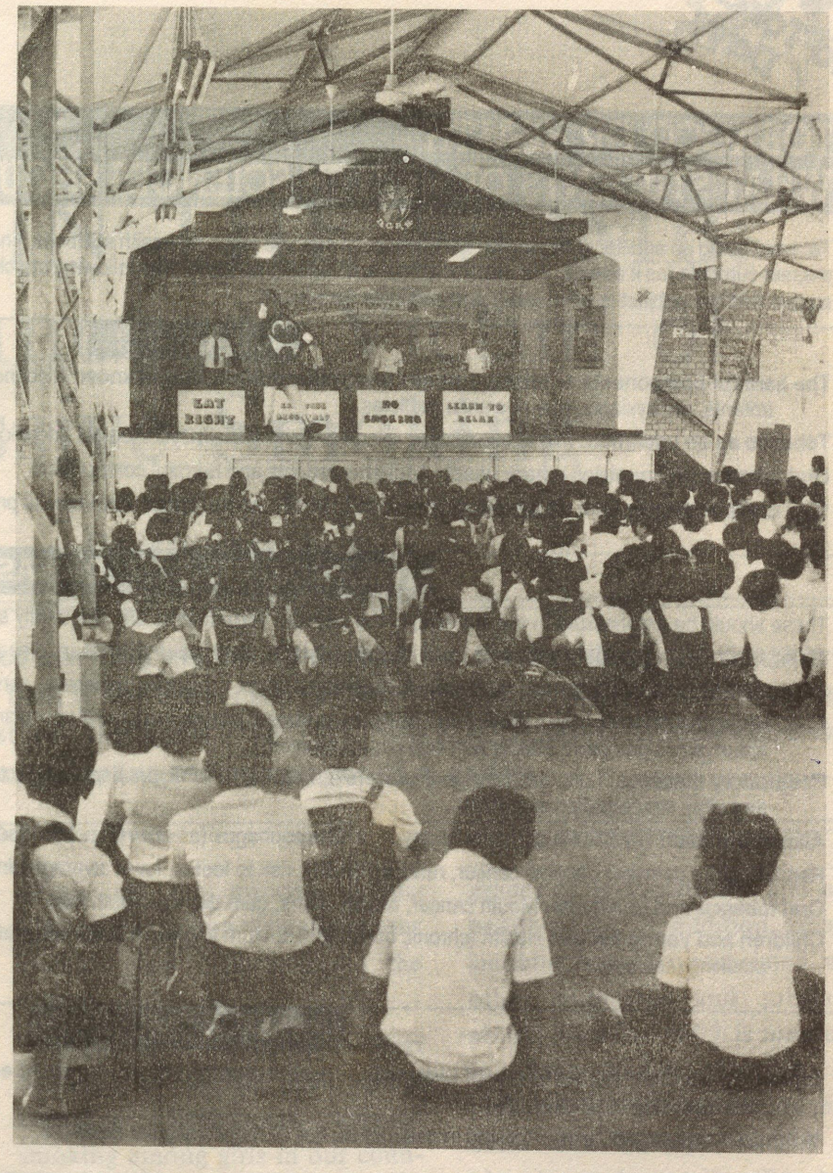
If tobacco were introduced to the world today, it would almost certainly be rejected as unsafe, in the same way as an unsafe medicinal product is rejected.

How to Combat the Menace

This is a real uphill task for health, voluntary government and non-government agencies. For a smoker it requires a great zeal and a firm determination to give it up.

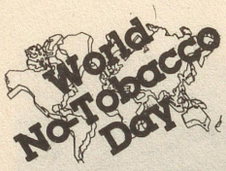
Nicotine produces dependence. When smoking is stopped, some people observe withdrawal symptoms such as anxiety, nervousness, fatigue, irritability, sleep is disturbed and there is fall in pulse rate and blood pressure. Studies carried out at the university of California in Los Angeles, USA indicate that sudden cessation of smoking reduces withdrawal symptoms. A smoker who cuts down on his cigarette smoking precipitates a chronic state of withdrawal. For those who find it difficult to stop smoking should switch over to low tar low nicotine cigarette for a while. Lobeline has been advocated as a nicotine substitute to help break the smoking habit.

Basically it is the individual who has to determine and adopt steps to quit this health hazard. Efforts by different supporting agencies needs strengthened by legislative support.



HEALTH EDUCATION

Knowledge related to smoking and its ill effects on health should be disseminated through organised campaigns using television, radio, press and other media as a means of communication. Doctors, teachers, leaders and other executives should not only preach about the hazards of smoking but also refrain from it. Ex-smokers can influence the smokers and can make the campaign successful. Smoking should be strictly prohibited in and around hospitals, schools, and colleges, working places and all the public places. Government should strictly secure the rights of the non-smokers. □



TOBACCO OR HEALTH
WHAT STUDENTS OF HEALTH SCIENCES SHOULD KNOW

To avoid being an additional burden on the curricula of schools teaching health sciences, knowledge of tobacco should be integrated into the present curricula (as it already is in many medical and nursing schools). The following check-list should enable schools of health sciences to ensure that the subject is adequately covered in its curriculum:

THE BASICS

The harmful components of tobacco smoke which the student should know: Nicotine, tar, potential carcinogens, carbon monoxide, irritants, asphyxiants, role of smoke particles.

Tobacco as an addiction: Physical addiction (nicotine), and social/psychological addiction.

Oral tobacco (in countries where used): Addictive aspects and harmful components.

Why children/people take up smoking: Influence of family, peers, public, commercial promotion, followed by addiction.

TOBACCO-RELATED DISEASES

These should be emphasized in the teaching of the relevant departments and are briefly summarized below:

Major killers: Lung cancer, ischaemic heart disease, chronic obstructive pulmonary diseases (COPD), including emphysema.

Other cancers: Larynx, pharynx, oral cavity, oesophagus, kidney, bladder, pancreas, cervix, and some forms of leukaemia.

Cardiovascular diseases: Ischaemic heart disease (as above), stroke, peripheral vascular disease such as thromboangeitis obliterans, and aneurysm. Cumulative effects with oral contraceptives.

Respiratory diseases: Lung and laryngeal cancers (as above), COPD, predisposing factor for lower respiratory tract infections (all ages), and often exacerbation of asthma.

Alimentary tract: Carcinoma of mouth, pharynx, and oesophagus (as above); peptic ulcers.

Reproductive system: Cervical cancer, reduced fertility, risk to foetus, lower average birthweight, increased perinatal mortality.

Oral tobacco and its effects: Mouth cancer, mouth ulcers, gum disease, tooth loss.

Children and young people: Health (chronic cough and sputum and more acute respiratory illnesses) and social consequences. Passive smoking (see below).

PASSIVE SMOKING

Effects on children: Increased rate of lower respiratory infections in infants, increased eczema/asthma in children, increased cot deaths, decrease in lung function, glue ear.

In adults: Lung cancer, exacerbations in asthmatics, risk of major vascular diseases.

BENEFITS OF QUITTING SMOKING

Benefits of quitting smoking to reduce the risk of acquiring a disease, and benefits of quitting in patients already having a disease.

PREVENTIVE MEASURES

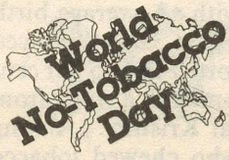
Action by health professionals:

In professional work: Knowing which diseases are smoking related, how to inform patients on the dangers of smoking, and how to advise all patients who smoke to quit (knowledge of counselling methods on smoking cessation).

As an opinion leader: How to encourage and support national anti-smoking organizations. Develop local programmes and campaigns ...

Governmental action: Description of the most effective measures to be taken by governments (resolution WHA39.14), such as price policy, tobacco control in public places and transport, bans on advertising and other socio-economic incentives ...

It is suggested that within health science schools, a coordinator be appointed for this training. An initial survey of students and staff attitudes would enable these schools to better target the training. The coordinator would then produce a written policy covering: smoke-free school premises and hospitality; teaching in relevant departments; examinations; and methods for monitoring progress.



BABY IN THE WOMB: The Innocent Victim of Passive Smoking

DR MEHARBAN SINGH

Cigarette smoking and tobacco chewing are no doubt bad for the health of the pregnant women. But they are equally bad, if not worse, for the well-being of the delicate life growing within them. The society must quit this habit FOR THE SAKE AND safety of their children who are the foundation of human resource development of a nation.

HEALTH hazards of smoking are now by and large well known to the society and have led to the printing of the statutory warning "Smoking is injurious to health" on all advertisements and cigarette packs. It has been estimated that an average of five-and-a-half minutes of life is lost for each cigarette smoked on the basis of an average reduction in life expectancy of cigarette smokers. It is generally not well appreciated that co-inhabitants, co-travellers and colleagues of smokers are also at increased risk to their health by virtue of passive inhalation of exhaled smoke and due to the smoke arising from the burning end of the cigarettes. What is least appreciated by the community is that tobacco smoking during pregnancy can produce profound adverse effects on the growing foetus. Maternal smoking virtually causes choking and suffocation to the unborn child.

Almost 25% women in the West continue to smoke during pregnancy. Fortunately, tobacco smoking among girls in our country is not very common or fashionable. Beedi smoking among women is prevalent in the countryside. Tobacco chewing in the form of tobacco or mixed as zarda in the *paan* (betel leaf) is prevalent both among boys and girls in several States in India and neighbouring countries.

How does smoking adversely affect the well-being of the foetus?

Smoking is prevalent among women belonging to poor socio-economic status having various grades of undernutrition and poor health status. In addition, tobacco smoking may be associated with other addictions and substance abuse. Nicotine which is contained in tobacco and smoke which has high concentration of carbon monoxide can adversely affect the placenta and may literally choke and suffocate the baby growing in the womb. The foetus will suffer from prolonged effects of oxygen depletion because carbon monoxide has 200 times greater affinity for hemoglobin as compared to oxygen. Nicotine by virtue of release of catecholamines causes narrowing or constriction of blood vessels of the uterus leading to poor transfer of oxygen and nutrients to the foetus. Tobacco smoking leads to deficiency of zinc in the mother and foetus and elevation of

nicotine level in the blood of the foetus which adversely affects its growth and development.

Pregnancy wastage

There is increased risk of abortions and fetal deaths due to antepartum hemorrhage as a result of lower placement of placenta (placenta previa) and premature separation of placenta (abruptio placentae) among women who smoke during pregnancy. Perinatal mortality rate is 35-65 per cent higher if more than one pack of cigarettes is smoked daily during later part of pregnancy.

Fetal growth and development

Maternal smoking adversely affects the growth and development of the foetus by virtue of its effects on the placenta which is the vital link to transfer oxygen and nutrients from the mother to the foetus. Several studies have shown that infants born to mothers who smoke during pregnancy are 120-430 g lighter and shorter at birth as compared to offsprings of mothers who are non-smokers. There is also increased risk of premature delivery of the baby before attainment of complete gestation of 40 weeks. The incidence of low birth weight babies (<2500 g) is almost double among offsprings of mothers who smoke during pregnancy thus increasing the risk of perinatal deaths. Even the postnatal growth and development of these infants is unsatisfactory. It has been observed on follow up studies that infants born to smoking mothers continue to remain small in size even at the age of 3 years. There is no convincing evidence that maternal smoking is a risk factor for development of congenital malformations though higher incidence of cleft palate and/or cleft lip has been documented in babies of smoking mothers in the Cardiff Births Survey.

Neuromotor disability

There is some evidence that infants of smoking mothers have increased risk of minimal brain dysfunction. These children have been found to have hyperactive behaviour, poor attention span and impaired auditory perception leading to reduced vigilance. Their cognitive abilities are compromised and they have lower scores of spelling and reading tests as compared to the matched control offsprings of mothers who are non-smokers. There is increased incidence of behaviour disorders and higher frequency of left-handedness as additional markers of pathological neuro-development in children of smoking mothers.

Cancer and maternal smoking

The increased risk of cancer of different organs such as oral cavity, larynx, lungs, esophagus, pancreas, urinary bladder, etc. is well known among adult smokers and accounts for large number of deaths due to smoking. During maternal smoking, her foetus is inadvertently exposed to the noxious agents emitted in the smoke which are potentially carcinogenic. Foetus is certainly more delicate and vulnerable to the adverse effects of its environment. In a case control study conducted in Sweden, Michael Stjernfeldt and his coworkers have shown that the risk of development of cancer during childhood was 50% higher among offsprings of mothers who smoked cigarettes during pregnancy as compared to control mothers who did not smoke. The risk of cancer was higher among those who smoked 10 or more cigarettes per day. These children are predisposed to develop all types of cancers but the risk for development of leukemia and lymphoma is most significant.

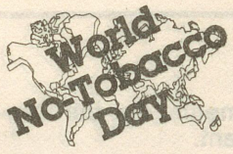
Tobacco chewing and its adverse effects on the foetus

Health and habits of the mothers have profound effects on the growing foetus. As opposed to tobacco smoking, chewing of tobacco leaves or eating of paan with zarda are more prevalent in India. In a study by R.C. Verma and his colleagues from Jabalpur, it has been shown that tobacco consumption exceeding 200 mg/day during pregnancy is associated with an average birth weight reduction of 395 g. Tobacco chewing is reported in 16.5 per cent of pregnant women in a study from Pune by Kewal Krishna. Among the mothers who chewed tobacco during pregnancy, stillbirth rate was three times higher, birth weight was around 500 g lower and there was low sex ratio adversely affecting male offsprings. There is certainly a need to undertake further studies in this area to identify other adverse effects of tobacco chewing on the pregnancy and its outcome.

Effects of passive smoking during early childhood

It has been documented that the adverse effects of maternal smoking continues during childhood. The growth and development of these children during early life is unsatisfactory. They have increased incidence of respiratory problems such as bronchitis, broncho pneumonia and bronchial-asthma. They are unable to compete with their peers and have poor school performance besides learning disabilities. In studies from the West, it has been shown that these infants are at increased risk from sudden death without any obvious illness (SID deaths).

It would appear that smoky environment is less healthy both for the foetus and young child. They are at increased risk of inadvertent exposure to tobacco smoke both during fetal life and after birth if one or both parents continue to smoke in their environment. Maternal smoking is harmful to foetal growth and development and adverse effects of smoking continue during early formative years of childhood. It must be realised that cigarette smoking and tobacco chewing are not only bad for the health of pregnant women but they are equally bad if not worse for the wellbeing of the delicate life growing within them. The society must quit this habit for the sake and safety of their children who are the foundation of human resource development of a nation. □



EPIDEMIOLOGY

Tobacco or Health in South-East Asia

THE WHO South-East Asia Region has an estimated population of 1340 million, including 850 million adults (15 years and over). This represents about one-third of the entire population of the developing world. Two-thirds of Region's population live in India alone. The Region is a net tobacco producer, with India (third), Indonesia and Thailand ranking among the world's 12 leading producers.

Between 1963 and 1990, manufactured cigarette consumption per adult (defined here as people aged 15 years and over) is estimated to have risen by 60 per cent from 230 to 370. Other forms of tobacco consumption are, however, much more important for countries of South Asia. In India, almost twice the amount of tobacco used in cigarettes is smoked in bidis and one-quarter of all tobacco consumed is used for chewing. Adult per capita consumption of cigarettes and bidis combined in India was about 760 in 1960 and has changed little since that time. The situation in Bangladesh is comparable to that in India, with adult per capita consumption being about 220 cigarettes and 700 bidis. In Sri Lanka, cigarettes are the most popular tobacco product, although bidis are also widely used. About 10 per cent of smokers also smoke cigars. Cigarette consumption in other countries of the Region, including Bhutan, Democratic People's Republic of Korea, the Maldives, Mongolia, Myanmar, and Nepal, is difficult to estimate due to paucity of data, but would appear to be in the range of 200-500 cigarettes per adult per year. Cigarette consumption is highest in Thailand and Indonesia with adult per capita consumption of the order of 1000-1200. Moreover, smoking prevalence among adult males is likely to be about twice these levels since female consumption is typically very low.

There are very few representative surveys of the prevalence of tobacco use in the Region, with Thailand being a notable exception. There, representative national surveys of smoking behaviour have been conducted periodically since 1976. In 1991, it was estimated that 49 per cent of males of 11 years and over and 4 per cent of females of the same age were smokers. The data available in other countries of the Region suggest that male smoking prevalence is typically in the range of 40-60 per cent, and possibly as high as 70 per cent in Nepal, Bangladesh and parts of India. While smoking among women is still relatively uncommon, chewing is much more widespread, particularly in India where up to half of all adult women regularly chew tobacco in some communities. Information on socio-occupational differences in tobacco use is sparse but tends to suggest that prevalence is highest among the lower socio-economic strata.

Reliable data to monitor trends in tobacco-related diseases are not generally available for countries in the Region. However, health surveys, hospital statistics, rural surveillance sites and cancer registries all point to a rise in tobacco-related morbidity and mortality. Thus, in Indonesia, cardiovascular diseases and cancer appear to have increased more than twofold between 1972 and 1980 and it has been reported that deaths from smoking-related diseases showed a significant increase between 1980 and 1986. In Mongolia, 1990, over six per cent of hospital deaths were from diseases caused by smoking (including several hundred lung

cancer deaths) and there are at least as many that never appear in hospital statistics. A study of the frequency of respiratory symptoms (for example, morning phlegm, wheezing) carried out in Bangladesh found a two to three fold higher prevalence among male smokers compared with non-smokers.

In India, tobacco chewing and reverse smoking have high risks for oral cavity cancer, and bidi smoking, either alone or in combination with chewing, has a high risk for cancer of the pharynx, larynx and lung. Specific consumption practices which are frequently practised among defined population groups have been found to significantly increase the risk of certain types of cancer. Thus, reverse dhumti smoking has been associated with palatal lesions in Goa; a relationship between reverse chutta smoking and carcinoma of the palate has been found in Hindu women in South India; and buccal and labial cancers have been attributed to pan chewing in Kerala. Oral cancers are the leading site of the disease in Sri Lanka, accounting for 10-20 per cent of all cases. On the other hand, the Parsis of Bombay, who do not indulge in tobacco habits, have a very low incidence of these cancers.

In Thailand, lung cancer is more prevalent in the Chiang Mai area where the strong "Khy Yo" are smoked. Moreover, lung cancer incidence is roughly the same for women and men in this region of the country, undoubtedly related to the much higher female smoking prevalence in this area than others. In the south of the country there is a higher incidence of oral cancer. Lung, oral and nasopharyngeal/laryngeal cancers can all be related to smoking habits in Thailand: the different types of cancer vary in importance in different regions of the country in a similar fashion to different tobacco consumption practices. There are no comparable data on prevalence or smoking-related mortality available to WHO for Bhutan, Democratic People's Republic of Korea, the Maldives and Myanmar.

From this brief review, it is evident that despite the limited availability of nationally representative mortality and morbidity data, there is substantial anecdotal evidence to suggest that tobacco is already a major cause of disease in the Region. However, in order to better monitor the evolution of the tobacco epidemic of the countries concerned, and to guide effective tobacco control policies, more detailed data, such as that from a prospective study of tobacco use and subsequent mortaility, are urgently required. □

IN INDIA

In India, the second-most populous nation on earth, there is an astonishing variety of forms of tobacco use. These include manufactured cigarettes, hand-rolled cigarettes, bidis, chutta, reverse chutta smoking, hookah, pan masala, khaini, various other forms of chewing tobacco and even tobacco toothpaste. It is noteworthy that manufactured cigarettes probably account for about 20 per cent of tobacco consumption in India, and that their multinational manufacturers are not a major economic or political force in India.

The problems involved in tobacco control in India are exemplified by the situation surrounding the use of bidis. Bidi smoking is very widespread, with consumption estimated at 900 billion sticks per year. Bidis are hand-rolled in small factories or in cottage industries by wrapping a small amount of tobacco in non-porous tendu leaves. The finished product resembles a narrow, tapered, brown, unfiltered cigarette.

Unlike cigarettes, bidis largely escape taxation and government regulation. The packages bear no health warnings and are taxed at a very low rate, or not at all. In Delhi, the retail price for a package of 25 bidis is two rupees, about one-fifth of the price of ten cigarettes for a product that is just as hazardous as manufactured cigarettes, if not more so. Prices may be even cheaper in other areas of the country. Regulation of bidi production presents a major challenge. The industry is largely cottage-based and highly decentralized. Moreover, bidi production and marketing, if controlled at all, is controlled by State Governments, not the Central Government.

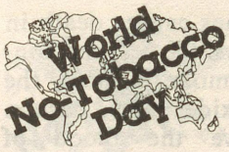
The public health reasons for imposing taxes high enough to discourage consumption on bidis are compelling. However, the people and institutions with an interest in the continued supply of cheap bidis are so numerous and they are likely to raise such strong objections to any initiative to effectively tax bidis, that it is unlikely that such taxes will be imposed in the near future.

Nevertheless, some effective tobacco control initiatives have been taken. In 1991, the Ministry of Health and Family Welfare sponsored a National Conference on Tobacco or Health that produced ten recommendations that, if fully implemented, would constitute a comprehensive national tobacco control policy. However, besides the difficulties involved in taxing bidis, the Ministry faces other daunting problems in attempting to control tobacco and only a few of the recommended measures have been implemented.

Among the effectively implemented recommendations is a ban, now in effect, on toothpaste and tooth powder containing tobacco.

Tobacco advertising has been banned in State-controlled electronic media, but continues without restriction on privately controlled electronic media, newspapers, magazines, and on posters and billboards throughout India.

The Government has also recently implemented a prohibition on smoking in Government offices, meeting rooms, Indian Airlines domestic flights and air-conditioned railway cars. Δ



PASSIVE SMOKING —More Risk of Death Among Non-smokers

DR S. MUKHOPADHYAY

Passive smoking, i.e., environmental tobacco smoke, affects all. From the unborn child in womb to an old nonagenarian all are invited to tomb by the burning tobacco.

THANKS to the media and health-education efforts of the government, that the people, by and large, have come to know the ill-effects of tobacco, especially smoking. Basu, A. *et al* in a survey in Calcutta, found that 90.41% smokers recognised the ill-effects of smoking. While conducting a study about the senior citizens in the industrial belt of Durgapur (West Bengal), under Prof. Dr. S.C. Ray, we have found that 28.25% of the people (15 to 18 + years of age) knew what passive smoking is; but, they could hardly imagine the ill-effects. This indicates that the time is ripe to let the people know the ill-effects of smoking among non-smokers. For this, the formation, composition, etc. of environmental tobacco smoke are to be known.

Passive smoking is involuntary inhalation of tobacco smoke by a non-smoker. This smoke is known as environmental tobacco smoke (ETS). Another form of passive smoking takes place when a pregnant woman smokes, or, is exposed to ETS. The baby in the womb smokes passively. We are now-a-days more concerned with both. International Agency for Research on Cancer (IARC) pointed out that passive smoking gives rise to cancer. Takashi Hirayama mentioned in a study from Japan that non-smoking wives of heavy smokers have a higher risk of lung cancer. The National Institute of Occupational Safety and Health of the United States also pointed out that the ETS has a carcinogenic (cancer producing) potential. The International Labour Organization (ILO) included the smoke, both active and passive, in the list of occupational hazards.

ETS, according to formation, may be grouped into two types. 1. Consumed and left-out smoke by a smoker, or, mainstream smoke, and, 2. The original smoke from burning cigarette, *bidi,* etc., or, sidestream smoke, which comes out in between puffs. More amount of organic constituents of smoke which may contain about 50 to 65 varieties of typical carcinogenic substances, depending upon the type of tobacco are there in sidestream smoke. Yet, the toxicity and carcinogenesity are more or less similar in both.

ETS mostly affects non-smokers in two places. 1. In household, or, indoor environment, and, 2. In workplace. Both are places of long exposure to tobacco smoke as we spend maximum time there. In our country, the household chemicals, the products of burning and heating fuels, the pet and dust allergens, etc. combine and interact with ETS, and exert ill-effects more than we can imagine. Similarly, in workplace, especially in industry, the vapours, or, aerosols of various hazardous substances join with the ETS and affects the non-smokers.

Ill-effects

We are mostly concerned with carcinogens along with tar, carbon monoxide, and nicotine, apart from

2—3/DGHS/93

cadmium, hydrogen cyanide etc. in the ETS. The ill-effects may be grouped under :— 1. Effects on children—it produces acute respiratory illness (ARI) itself, apart from micro-organisms, chronic cough, acute irritation of the eye, nose, ear, and throat. ARI, already produced by micro-organisms, is aggravated by it leading to more complications and death. Neonatal and perinatal infection may end in death. 2. Effects on adults—a pregnant woman exposed to ETS may have chance of spontaneous abortion and foetal death. Cancer of the lung and heart attacks are other causes of death among adults. Persons with high blood pressure exposed to ETS may have sudden fluctuation of blood pressure leading strokes elderly groups are more vulnerable to this complication. The conference on preventive cardiology in New Delhi (Dec., 1987), concluded that passive smoking is more harmful than active smoking, and if accompanied by high blood pressure can lead to sudden death through silent ischaemia (painless heart attack).

Cancer of the lung and cardio-vascular diseases were linked most with passive smoking. Both ultimately lead to death. Various studies show that about 25—30% more people are at risk of lung cancer and about 20—25% more are at risk of cardio-vascular catastrophe with passive smoking. It has also been pointed out that while excreting the toxic substances, the kidney and urinary bladder become victims. Cancer of the bladder is either formed or aggravated by the toxins of the ETS. Some of the toxins absorbed through the nasal passage and throat, go to gastro-intestinal tract and lead to peptic ulcer and cancer of various sites.

Poisonous character of tobacco

It is to be remembered that poisonous character of tobacco is enhanced when it burns. Concomitantly it burns the human health. ETS also invites death gradually and in an invisible way by acting as a slow poison. Being a mixture of many noxious substances, it induces enzyme changes; affects the rate of hepatic metabolism and lowers down the vitamin-c level of blood. The cumulative effects of these are more accumulation of toxic substances in the body due to less detoxification by liver, more chance of infection, and premature aging of various organs of the body and the body as a whole. Reticulo-endothelial system also is effected, thereby the defence of the body is weakened.

ETS sometimes causes death in some other ways, too. If the concentration of smoke is more, the carbon monoxide and carbon dioxide deprive the blood of oxygen to supply it to the brain. Alertness is altered leading to accident.

The effects of ETS depends upon the regularity and duration of exposure. Regular exposure produces more harm and the exposed person becomes to some extent, addicted to it.

Thus, passive smoking (ETS) affects us all. From the unborn child in the womb to an old nonagenarian, all are invited to tomb by the burning tobacco.

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PREPARATIONS FOR YEAR OF FAMILY, 1994

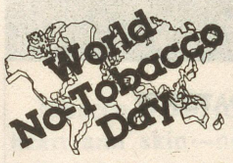
The first United Nations regional preparatory meeting for the International Year of the Family, scheduled for 1994, was held in Tunis from 29 March to 2 April.

Participants from 64 States in Africa and Western Asia, as well as observers from Organizations and other States, reviewed the situation of families in those regions and their place in the respective national social agenda.

The meeting's recommendations, together with those adopted at three other regional preparatory meetings to be held this year-in Veletta, for Europe and North America, in Beijing, for Asia and the Pacific, and in Cartagena, for Latin America and the Caribbean—will be submitted to the Regional Commissions of the UN.

The General Assembly proclaimed 1994 as the International Year of the Family in a resolution adopted in 1989, with the view to creating a greater awareness of the family as the 'national and fundamental unit of society.'

—UN Newsletter
3 April 1993



BEHAVIOURAL ASPECTS OF SMOKING

DR M.N. LAL MATHUR

In our society, smoking behaviour differs from individual to individual. Many people smoke whenever they are lonely or whenever they are with friends or whenever their work is associated with stress. Smoking is found to be common in all classes of the society.

IN any democratic society, the choice as to whether one should smoke or not ultimately rests with the individual. A great deal of information now shows that smokers, in addition to damaging their own health, harm others who are obliged to smoke passively. The growing awareness that smoking is an abnormal social behaviour is resulting in an increasing demand for smoke-free workplaces and public places. Tobacco kills approximately two-and-a-half million people every year throughout the world. It is the largest single preventable cause of death in the world today, responsible for many cancers, coronary heart disease, peripheral vascular disease, chronic bronchitis and emphysema. It is a dangerous, expensive and addictive habits. Clinical findings have shown that children whose parents smoke have more coughs and are more likely to have bronchitis and pneumonia than children of non-smokers, particularly in the first year of life.

Tobacco is strongly addictive. Young people begin to smoke because of social pressure, curiosity or a desire to feel grown-up. But, pharmacologically, tobacco acts like heroin is hooking its victims. They rapidly become dependent on nicotine, and then smoke to satisfy their addiction. People start smoking in company of their friends and many develop this habit pattern because it exists in their families.

Family History

Curiosity is found to be most important factor behind first cigarette smoking. Many people smoke for their mind relaxation and for the facilitation for social contact. Fun and pleasure are also found to be important factors behind smoking. In our society, smoking behaviour differs from individual to individual. Many people smoke whenever they are lonely or they are with their friends or their work is associated with stress. Smoking is found to be common in all the classes of the society. Family history of smoking appears to be a determinant factor in smoking behaviour.

Smoking harms more than just the smoker. Children of smokers suffer respiratory illness twice as often as those of non-smokers.

The habit of smoking has spread like an epidemic and our aim should be to control this habit by certain procedures. Behaviour therapy techniques, such as, aversion therapy, relaxation, assertive training, parental counselling have

CLINICAL OPPORTUNITIES TO TALK ABOUT SMOKING WITH PATIENTS

SYMPTOMS

- Cough
- Shortness of breath

TESTS

- Electrocardiography
- Pulmonary function tests
- Blood pressure measurements
- Auscultation of heart and lungs
- Blood analysis
- Pregnancy tests

DIAGNOSIS OF DISEASE AND RISK FACTORS IN PATIENTS

- Heart and peripheral vascular diseases
- Hypertension
- Emphysema
- Bronchitis
- Asthma
- Diabetes mellitus
- Peptic ulcer
- Allergy

PRESCRIPTION AND ADVICE

- Drug/tobacco smoke interactions
- Pharmacologic aids to smoking cessation
- Dietary and nutritional advice
- Rehabilitation

been quite useful in the treatment of smoking addiction. In the present situation, almost in every society, smoking is socially acceptable. Those who went on to become heavy smokers tended to be a bit more impulsive, adventuresome, extrovert and somewhat less tolerant of rules. In some studies the heavy smoker was found to be having change in behaviour more angry than the non-smoker or light smoker over the past few years. Cigarette smoking has become less socially acceptable. The major motives for initial use of tobacco are to identify themselves with friends who smoke and to signal an attitude toward life and values in general.

Focus on harmful effects

Most of those who start to smoke do not become dependent. The loss of flexibility and the development of dependence is gradual. In smoker's life puffing behaviour and withdrawal induced craving become conditioned. Smoking behaviour increases more in drinking parties, tea parties and in other social functions. Females also smoke in their parties or in male dominated parties. In rural areas women folk do smoke *bidi,* hukkha etc. in their company, due to their dependency, social life etc. Women smoking is more dangerous for their fertility and foetal growth. People are aware that smoking is a great threat to individual and family health. There is direct relationship between smoking and cardiovascular disease and deaths from coronary heart disease is related with this. Our aim should be to focus its harmful effects on active and passive smokers through medias, social awareness, publicity indicating that "Smoking is dangerous to your health" and it's advertisement should be banned. Anti-smoking campaign to educate the public on the seriousness of the cigarette issue, fight against smoking, change in social custom, strictly prohibiting of smoking to public places are some important steps to protect non-smokers health from the harmful effects of passive smoking.

Government and communities have to see that people don't smoke in public places such as restaurants, government offices, theatres, cinema halls, indoor sports arenas, bus stations, waiting rooms, clinics, retail stores, and so on.

Cigarette manufacturers are spending crores of rupees on their product advertisements and they only write statutory warning in small letters that 'Cigarette is injurious to health'. But, this is not enough to safeguard our youngsters. Cigarette manufacturers should also advertise these messages to warn that: Smoking causes lung cancer, heart disease and emphysema and may complicate pregnancy. Pregnant women who smoke risk foetal injury and premature birth. Cigarette smoke contains carbon monoxide. Quitting smoking greatly reduces serious health risks.

Making society free of smoking

Our aim should be to reduce the consumption of cigarettes and

What if smoking can make you blind

Tobacco is bad for the lungs, the heart and skin—no smokers can fail to be aware of this by now. But for smoking to be bad for the eyes is something new. Two studies recently published in the United States in the Journal of the American Medical Association nevertheless reveal quite unambiguously that cigarette smokers are at greater risk than non-smokers of developing cataracts. Nearly 50 million people in the world are afflicted with this eye disorder, caused by an opacity of the lens, and it is the leading cause of blindness. The two studies in question covered respectively 17,824 American males and 69,647 women. One of the findings to emerge is that people who smoke more than twenty cigarettes a day are at twice as much risk of developing a cataract as non-smokers.

In an accompanying editorial, Dr Shiela West, of the Johns Hopkins Hospital in Baltimore, estimates that 20 per cent of all cases of cataract recorded in the United States are connected with smoking and that people who give up smoking are thereby reducing the risk that they will one day get a cataract.

Scientists still do not know how tobacco affects cataracts, but according to one of the authors of the reports, Dr William Christen, cigarette smoke could reduce the blood concentration of certain nutrients that are needed to maintain the transparency of the lens.

Although cataract can be treated by surgery in the rich countries, this is a luxury that is inaccessible to most people with cataracts in the developing countries, who are often doomed to go blind. The fact that smoking is now recognized to be an avoidable cause of blindness should encourage the authorities to make even more vigorous efforts to curb this habit whose damaging effects become more and more evident as time goes by.

Epidemiological research in this field concords with the oldest of clinical observations; doctors have noted clouded vision in smokers since the middle of the eighteenth century, mainly among smokers of pipes and cigars, which were the most popular forms of tobacco consumption of the time. Since 1930, this condition has been identified as a specific disease entity, smoking-induced amblyopia.

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make society free of smoking. To achieve this objective public understanding and sympathy and many of our social, political and economic institutions have to work together. If we achieve this we can save hundreds of thousands of lives, and tens of billions of rupees. The rupees spent on the treatment of smoking-related illness could be spent on better housing, better education and better health care.

Government agencies and private organizations should work together at international level to provide the public with information concerning the adverse consequences of smoking.

We can reduce the number of smokers through public health education, media presentations, legislations and other activities.

Tips for quitting smoking

Here are a few useful tips for quitting smoking.

— List all the reasons why you want to give up.

— Set a target date for giving up;

— Involve a spouse or a friend;

— Start a diet programme while preparing to stop;

— First, cut down the number of cigarettes you smoke;

— On the day you stop, do something special to celebrate;

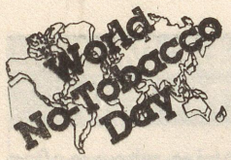
— Temporarily avoid situations you strongly associate with smoking;

— Never allow yourself to think that "One won't hurt", it will;

— Take time for daily exercise, walk and

— Pay attention to your appearance, look and feel sharp.

Cigarette smoke is not only deadly for the lungs, it can also damage teeth beyond repair. Smokers should clean their mouth, preferably after each meal, and eat less sugar. □



ROLE OF VOLUNTARY AGENCIES IN HELPING SMOKERS STOP SMOKING

—TAPOSH ROY

THE smoking epidemic is upon us. India has earned a dubious distinction where every year 6-8 lakhs of its citizens die of tobacco-related diseases and not to mention of other lakhs who fall ill because of the tobacco habit. Eradicating smoking and tobacco habit from this country is a near impossible task. As long as tobacco is a legal product, people will keep dying with impunity year after year. It is sad that in a country, where nearly half of its population lives below the poverty line, where malnutrition and communicable diseases are rampant, tobacco is being looked as a commodity that earns money for the exchequer.

The purpose of this essay is not to look into the reasons why tobacco in spite of its established hazardous nature, is still being allowed to be produced and consumed, but to see ways and means by which a voluntary agency can help those who are in the deadly habit of smoking to quit. To my mind it is the most difficult area to work and not much is being done about it in our country by the government or voluntary agencies.

Social sanction

Smoking is an addiction. Nicotine present in the tobacco smoke causes the addiction. Majority of the smokers do not know this. People take to smoking due to various reasons. Most of them are exposed to the habit at a very early age in their home and immediate environment. Some start smoking just for kicks, some due to peer pressure, some out of curiosity, some to feel grown up and imitate adults and some are influenced by the glossy dreams that are created by high-powered advertising and marketing. Whatever the reason, once in it, they stay in it. One will agree, that it is very difficult to convince a smoker to quit just by saying that 'Smoking is injurious to health'. Even the knowledge of tobacco's hazardous nature has not been able to persuade smokers to quit. Many doctors in spite of the knowledge that smoking is injurious to health are habitual smokers, let alone their role in convincing others to quit. These are some of the reasons that make it difficult for voluntary agencies to make any kind of intervention As long as smoking has a social sanction, asking smokers to quit will be a near impossible task.

> With adequate support from the government the non-government organisations can undertake, to begin with, a massive education drive in schools because it is here that the smoking habit begins. Once children are motivated enough, the task becomes simpler.

This does not mean that measures cannot be adopted to help smokers quit the habit. The smoking problem has to be looked in the broader context of socio-political, socio-cultural and socio-economic angle. If any anti-smoking campaign has been successful it is mainly because of the non-smoking majority's pressure on the smokers not to smoke and to demand for strict anti-smoking policies, especially in public places and transports.

Voluntary organisations can play a vital role in not only educating the masses but provide forums and HELP Groups to help smokers to quit the habit. Obviously, this will have to be backed by Governments' strong legislations and acts in terms of banning smoking in the public places, transports and work-places, making sale and consumption of tobacco by minors a legal offence and a massive education/ mass media campaign as in the case of drugs and alcohol.

Its not that in India we do not have such laws, but its implementation is questionable. Firstly, not many voluntary organisations would like to take this issue up as they are already burdened with the existing programmes and they do not see it as a priority area. There has to be positive government policy in terms of helping and encouraging voluntary organisations to take up programmes in terms of helping smokers quit the habit. In the areas of drug abuse and alcoholism a lot of help was forthcoming from the Government which made it easier for NGOs.

(Contd. on page 111)

"HEALTH SERVICES: OUR WINDOW TO A TOBACCO-FREE WORLD"

A study conducted by the Indian Council of Medical Research (ICMR) has indicated that the prevalence rate of smoking among males above 15 years of age is 90 per cent in a rural community in Meerut district of Uttar Pradesh. According to another study undertaken in 1981-82 in an urban situation, the prevalence of smoking was found to be 59.5 per cent among males of above 15 years of age. Since no countrywide analyses of smoking trends have been undertaken so far, these are simply the indicators of the prevalent situation. With the new brands of chewing tobacco being given wide publicity through different media the trends in respect of tobacco chewing are obvious to judge. Smoking of home-made cigars in reverse with the burning end inside the mouth is popular in some parts of Andhra Pradesh. India is the third largest producer of tobacco in the world and almost all types of tobacco are grown in our country. The tobacco produced in the country every year is about 440 million kilograms and out of it about four-fifths is consumed within the country.

It has been established that smoking and the use of tobacco in any other form is the cause of precipitating diseases such as coronary heart diseases, chronic obstructive pulmonary diseases, cancers and increased foetal and infant mortality rates.

Our Health Premises and Professionals

In India, we are unimpressed by the wealth of medical evidence linking tobacco with a wide spectrum of diseases. Tobacco consumption is very high in the Indian Medical fraternity.

People with health problems have always been looking to medical profession including those who are working in the field of health, not only for treatment but also for guidance to help develop and maintain healthy minds in healthy bodies.

Medical people of both traditional and modern systems have been violating the objective of their noble profession by consuming/using tobacco in one form or the other. The situation may arise when the patients may have to say "Physician, heal thyself".

Addressing the seventh world conference on smoking, Dr. Hiroshi Nakajima, Director General of the World Health Organization, had called upon "all health professionals and health workers to stop smoking, as an example to others, and to make health services tobacco-free". He further said that "Health service premises are our window to the world. When people look through the windows of hospitals, health centres, medical laboratories, ambulances, doctors' and dentists' surgeries, pharmacies or optician's offices, let them see no one smoking".

Our Health Infrastructure

The Govt. at the Centre is responsible for the implementation of numerous programmes of national importance like population control, provision of primary health care, prevention and control of major communicable and non-communicable diseases. States carry out activities in relation to public health, sanitation, setting up hospitals and dispensaries for their people.

With a view to provide primary health care and family welfare services to all people at their doorsteps, an integrated health care delivery system with the maximum community participation has been developed and is being implemented. These services are being provided through a network of link persons, sub-centres, primary health centres (PHCs), community health centres, various organisations of the national family welfare services, Central Govt. Health Scheme, state departments of health and family welfare, besides a good number of hospitals and dispensaries being run by the voluntary organisations, philanthropists, etc., and organised sectors like Railways, Defence, Posts and Telegraphs and other public sector undertakings.

Besides, we have a number of medical colleges, training and research institutes, state health and

family welfare training centres, dental colleges, nursing colleges, pharmacy institutes, schemes for training of medical and para-medical staff, training of specialists and para-medicals, etc.

Following is the available man-power in health sector in India, and training institutes imparting training in health sciences :

- Doctors 3,65,000; Dentists 11,011; Nurses 3,00,000; Registered nurse midwife (male and female) 2,64,504; HW(F)/ANM 1,41,191; Health Visitors and Health Supervisors 16,635; Village Health Guides (trained) 4,15,724; and Dais 5,99,556.
- There are 132 medical colleges in the country with a capacity of 14,000 admissions per annum.
- There are 471 ANM/HW(F) schools with a total admission capacity of 19,908 per annum and 46 LHV/Health Assistant (Female) promotional schools with an annual intake of 2,873 candidates.
- There are 229 institutions imparting diploma courses in Pharmacy which have an annual capacity of about 12,485 admissions and 45 institutions imparting degree courses in pharmacy and have the admission capacity of 1652 annually.

Facts for Action

We are to concentrate on these steps to make Health Sector a window to a tobacco-free world. This may comprise of four major elements:

1. **Tobacco-free hospitals, health centres, dispensaries etc. Doctors, patients and their relations, visitors and the staff do not smoke and/or use tobacco in any form in these places.**
2. **Ban on the sale or promotion of tobacco in and around the health premises.**
3. **Incentive/Encouragement of health personnel and students who do not smoke or chew tobacco.**
4. **Health promotion activities for a tobacco free society, including cessation support services for the patients and staff.**

Tobacco-free health premises

When we talk of tobacco-free health places, it usually brings to our minds the hospital buildings. But there are many more health premises that are visited by people and can play an exemplary role, and these are medical colleges, dispensaries, training centres for medical and para-medical persons, MCH Centres, Family Welfare Centres, PHCs, sub-centres, screening and pathological laboratories, medical practitioners of all systems, dental clinics, pharmacies, centres for the disabled, opticians, rehabilitation centres and many more places connected with health activities. All such places should be declared tobacco-free and the declaration should be strictly adhered to by one and all, and at all levels of work. Such an action is primarily concerned with occupational environment creating a healthier environment for all the personnel in the health premises. It will help in the following manner :

- Health premises staff will enjoy a healthy working environment.
- With staff not smoking, health and medical services will gain further credibility.
- the fact that smoking is not allowed will encourage everyone who wishes to quit.
- The newly employed and the young people will not be tempted to initiate smoking/chewing of tobacco.
- Moreover, the patients seeking medical attention will not be exposed to the harmful effects of smoking.
- The health personnel after setting example as non-smoking help people to learn/stop smoking.
- Once the health services become tobacco-free places it should be kept and maintained as tobacco-free place zones.

Health Personnel/Students

To act as a model in the society and to advise the people about the ill-effects of tobacco use, it is important that health personnel from highest to the lowest rank should abstain from smoking/chewing tobacco. We are at the pre-epidemic stage and the rate of smoking/chewing tobacco by our physicians, health leaders, and other health workers, especially males, appears to be higher than the general public. It is important to educate health workers on the dangers of tobacco consumption and it is better to catch them young in the schools through general education, during their studies at the medical colleges, nursing or specialised courses and other health science schools. Knowledge of tobacco should be integrated into the present curricula of the studies in health sciences. The following points need be emphasised :

- The harmful components of tobacco smoke/chewing like nicotine, tar, potential carcinogene, etc., present in tobacco.
- Physical addiction as a result of nicotine, and social and psychological addiction of tobacco use.
- Role of family, peer groups, other people, commercial promotion in initiating tobacco use in children/people leading to addiction.

— Knowledge about tobacco related diseases like cancers, cardiovascular diseases, respiratory diseases, diseases of the alimentary tract, effects on reproductive system, tobacco and its bad effects, health and social consequences of passive smoking.

— Benefits of quitting smoking/chewing to reduce the risks of acquiring diseases.

Since a large number of health professionals continue to smoke, there arises a need to educate them through inservice training and by organising cessation programmes. This will help to equip them with strategies to counter tobacco consumption and also in defining their own role in dealing with the tobacco related problem.

Health personnel and health promotion activities for a tobacco-free society :

Health professionals are important formal and informal opinion leaders in their communities, particularly in matters related to health. Hence, they have a responsibility to :

— Provide information to the people on the ill-effects and damage cause to health by tobacco and particularly on the reduction of risk when the patient quits smoking/ chewing.

— Help create a healthy environment and motivate people not to start using tobacco.

— Help tobacco users to quit the habit.

— Health professionals who are politicians also can strive for economic and legislative measures restricting and advertising of tobacco products through media.

— Specialists in health field, (such as dentists, general medical practitioners, midwife, psychologists, primary health care workers)—can find an opportunity to propagate non-smoking/ tobacco chewing by emphasising the ill-effects of smoking and tobacco.

TALKING POINTS

Some of the opportunities for specialists and other health personnel to talk about tobacco abuse are :

1. When the patient is having :
   — Cough &
   — Shortness of breath.
2. While undergoing certain tests during investigations
   — electro-cardiography (ECG)
   — Pulmonary function tests
   — Blood pressure check up
   — Other tests related to heart and lung functions
   — Blood analysis
   — Pregnancy tests.
3. On diagnosis of disease and ill-effects of tobacco in patients :
   — Heart and peripheral vascular diseases
   — Hypertension
   — Emphysema
   — Bronchitis
   — Asthma
   — Peptic ulcer
   — Diabetes mellitus
   — Allergy
   — Cancer.

All the peripheral health workers in our rural areas are respectfully referred to as 'doctors' and people rely on them for all health matters. The first opportunity for these health personnel to educate the community is when they see him. They should initiate or facilitate tobacco preventive activities in health premises and other allied such places.

Health personnel can help patients to stop the use of tobacco, if they can convince them.

— Enquire if the individual smokes or not. If yes, how many cigarettes/much tobacco he consumes per day. Encourage him to reduce the number of cigarettes/ quantity of tobacco.

— Congratulate smokers who have quit smoking.

— Advise a smoker to quit. Tell him some of the benefits of quitting tobacco.

— It is better to repeat some advice when they argue or give excuses for not quitting.

— Prepare smokers to quit by fixed time. Let them declare the date.

— Tell them that they can :
   (a) do something else instead of smoking/ chewing tobacco.
   (b) Avoid tempting situations; and
   (c) stick with their efforts to stop smoking/chewing.

— Resort to alternatives :

— Saunf (aniseed)

— Ilaichi etc. (cardomom)

— Refer the willing patients to 'smoking cessation' Centres in the area if available.

— Keep a regular contact with the patient and talk briefly about him/her smoking habit whenever he sees you.

Planning for a Campaign for Tobacco Free Halth Services

At the international level a concerted campaign for a tobacco free world is characterised by the active involvement of non-governmental organisations. When it comes to the creation of a tobacco free health system, a number of voluntary organisations have been formed at the national and international level they concentrate and campaign on the risks of use of tobacco. These organisations are in the form of hospital federation and medical societies.

Tobacco free health services campaigns be developed by the health and welfare departments in close collaboration with voluntary organisations, both at the national and State levels. All the medical and para medical educational institutions, hospitals and dispensaries up to the periphery level, both government and private, should be involved in making health services a tobacco free work place.

At the National and State levels

To make our health system tobacco free, the government and voluntary organisations should work together to mobilise the support of key persons at the national and state levels, political & religious leaders, doctors and other health professionals and medical faculty to work for the cause. These have exemplary role to play. It is desirable at this level that smoking should be banned in health departments, hospitals, health centres, etc. Besides, the emphasis should be on the strict enforcement of existing legislation, proper display of warning slogans on all tobacco products, protecting the rights of non-smokers by declaring public places no-smoking areas. Extensive educational programmes can be prepared and carried out for the health professionals and other exemplar groups.

Hospital and Primary Health Centres

- Message on the harmful effects of tobacco use should be displayed at prominent places.
- Exhibitions/displays on different aspects of tobacco use can be organised in the health premises.
- Educational materials like folders, pamphlets, etc. can be distributed. Novelties like stickers, bookmarks, car and scooter cards containing anti-tobacco messages can be very useful.
- Counselling and cessation services for tobacco users may be organised.

Medical Education

Teaching in the medical and para medical institutions, can prove to be highly influential in initiating programmes for tobacco-free health services. Such programmes need not be confined to the classroom teaching only. They can initiate and maintain active contacts with health workers, civic organisations, voluntary health agencies and parent-teacher associations. Some of the activities that can be used to motivate and maintain interest in the students include debates, talks, group discussions, lecture demonstrations, drama role play, quiz contests, symposium, small displays etc.

General Educational Activities

General educational activities related to different situations are listed here. Appropriate items may be selected depending upon the target group—health professionals, patient visitors and the general public—and subject to the available resources.

- Educational campaigns can be organised through electronic media like Radio/television by organising talks, discussions, plays, spot announcements, quiz programmes for doctors, paramedical personnel community based health workers, patients and the general public.
- Print media can disseminate information through news, feature articles and editorials and can help create public opinion in favour of tobacco free health services.
- The national and state level health and welfare departments and other voluntary organisations may give wide coverage to the need and importance of tobacco free health services in their periodicals such as magazines, newsletters, wall newspapers, etc.
- Educational and publicity materials written in simple and non-technical language can be prepared at the national and state levels for distribution through PHCs, MCH Centres, hospitals, Dte. of Field Publicity, State departments of Public Relations.
- Film shows and slide shows are very useful in educating the people.
- Advertisements related to the theme can also be issued to newspapers, magazines, etc.

Indian society's attitude to tobacco remains one of benign tolerance, verging on acceptance. It considers tobacco use as an undesirable habit and not a social evil. Are we going to discover the truth that tobacco use is the major killer only when we travel the whole length to become the victims of this epidemic.

Countries in which the dangers of smoking were first identified, reported a decline in prevalence of smoking amongst doctors from more than 60 per cent in the 1950s to less than 10 per cent today. What better example could we have ! It comes from the very people who have seen their patients die from lung cancer and other respiratory diseases, or cardiovascular diseases, which could have been prevented had these patients not smoked.

—M. S. Dhillon

□

(Contd. from page 106)

Smoking at that time was a non-issue and not much importance was given to it.

Package

Helping smokers to quit cannot be seen as an activity in isolation. It has to be a part of the whole package over number of years to bring down the smoking habit among the Indian population. With adequate support from the Government, the NGOs can undertake to begin with a massive education drive in schools, because it is here that the smoking habit begins. Once children are motivated enough, the task becomes simpler. When a child leaves school, he is coming into a very turbulant phase—where the child is subjected to various forms of pressures of day to day life.

Mass education campaigns

The *second* major area would be a mass education campaign, where the masses are continuously reminded of smoking being hazardous. For those who are already into the habit—care has to be taken. It is very important to isolate the addiction from the smoker. Smoking addiction is a disease, which can be cured with proper motivation and counselling, providing alternatives. HELP groups in the line of AA and NA can be started. Hot line or HELP lines can be established for smokers to call up and get advice and assurance. All this will only be possible if there has been adequate Mass Media campaigns and education backups.

'ACTION'

Voluntary organisations have to some extent been able to make some headway in this direction in terms of establishing anti-tobacco forums and networks. The Voluntary Health Association of India (VHAI) New Delhi, through its State Units have taken up educating school children. A national network called 'ACTION' (Action to Combat Tobacco-Indian Organisations Network) has been set up with its secretariat at VHAI, to act as a pressure group and to advice the Government as well as undertake education programmes. It is a network of 60 organisations spread throughout the country.

There are no hard and fast rules of quitting smoking. Some have given it up overnight, some over a period of time and many have tried but failed. With a high level of motivation a smoker can give up smoking, provided he receives help from people who are genuinely concerned and this has to be on a personal contact basis.

Benefits of quitting smoking for outweighs the continuance of the habit. The non-smoking population has to be educated enough in terms of hazards of passive smoking, only then will the 'No Smoking' in public places will have any meaning. Only over a period of time with interventions at different levels, *viz.*, policy, laws and education can smoking be made an undesirable social activity. Tobacco consumption will have to be made an illegal, social behaviour. Till then only one can be reminded of Mark Twain on how difficult it is to give up smoking—'It's very easy to give up smoking, I have done it hundreds of times'. □

(Contd. from page 119)

Culture symbols

Unfortunately, we seem to be in a reverse process of converting the People's programmes into Government programmes. National and international events including the India festivals abroad seem, designed to highlight only the cultural front of people's performances, subordinating its other dimensions. It is in this context that the performer has to take increased care not to hurt the culture and authenticity of his art medium. It is tragic to see that he has welcomed imitation as to make his art glassy and flashy at the cost of authenticity. It is even sadder that he has willingly allowed the onslaught of sound and sight technology into his art at the cost of its traditional ethos. And, while art into politics should be welcome, politics into art should be scrupulously forbidden.

It is time that we reminded ourselves that people's performances are indeed the living and vibrant cultural symbols of a country. They draw their very life blood from the functional relevance built into them. It is only too easy to convert them into museum pieces by not energising the functional potential in the medium.

—*Courtesy :* **Hygie, March 93.**

PHARMACISTS HELP SMOKERS TO QUIT

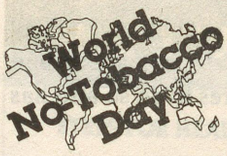
"Pharmacists helping smokers to quit" is a new joint concept created by the World Health Organization's Regional Office for Europe and the Danish Pharmaceutical Association. The accessibility and skilled staff of the community of 304 "public friendly" pharmacies in Denmark (150 000 consumer contacts a day) makes them well suited to participating in quit-smoking activities, not to mention their wealth of valuable experience in advising on health matters.

In 1991, the project included the following:

- creating training courses and course material for pharmacists;
- preparing and producing written information material targeted at the general public, mass media, group members, and health care professionals;
- enlisting 20 community pharmacies as pilot project participants;
- conducting a two-day training course for pharmacists;
- launching the campaign;
- creating diaries and questionnaires to evaluate the project.

The first four of the activities listed above were undertaken by the Danish College of Pharmacy Practice, the fifth one by the Danish Pharmaceutical Association in collaboration with the local pharmacies. Media interest in all the activities was very high from the beginning. The programme was so popular that it proved necessary to establish a waiting list. An evaluation will be carried out by a sociologist from the Danish Royal School of Pharmacy.

One of the purposes of World No-Tobacco Day is to provide an opportunity for all those who smoke to cease for at least twenty-four hours.



ROLE OF NURSES IN HELPING SMOKERS TO QUIT SMOKING

BANDANA BHATTACHARYA

For the Nurse in helping smokers to quit smoking is a challenge by itself, especially when she is working among her male colleagues and co-workers. Nevertheless, it is important that nurses must take a crucial role in the prevention of smoking and disseminate information, mobilize public opinion against smoking and also take active part in educating smokers to leave smoking.

"CIGARETTE Smoking is injurious to Health" is the statutory warning printed on each packet of cigarette. Yet how many of us do really take this as a warning for the prevention of many dreaded and chronic conditions which affect our body.

Nurses, being one of the largest group of health care workers, have the privilege and opportunity to be in close contact with the community. They are in a position to work as a major force in the prevention of social evils, such as Smoking. As a health care provider nurses deal directly or indirectly with smoking and the associated psychological and physical consequences. Smoking as we all know has a profound effect not only on the individual but also on his family, friends, and colleagues. Tobacco smoking in the form of cigarette, *bidi, hukkah,* pipe, cigar has very adverse effect on the health of the individual specially if it is of long standing.

Nicotine is the principal harmful pharmocological agent which is common to all forms of tobacco. It is a very powerful addicting drug. Nicotine as such is an extremely toxic substance and just two or three drops of pure alkaloid can rapidly kill an adult. The person already suffering from diseases of the arteries and blood vessels can make their conditions worse within a short time.

It is a well established fact that cigarette smoking is harmful not only in active smokers but affect people who are around the smoker and they get more harmed.

It is estimated that about three million people die every year from tobacco-related namely lung cancer, chronic bronchitis, and emphysema, stroke and cardiovascular diseases. Major cause of laryngeal, oesophayeal and cancer of the oral cavity is attributed to tobacco use.

The pregnant mothers who are habitual and heavy smokers give birth to low birth weight or growth retarded babies. These babies are at much greater risks especially, when their weight is less. The intrauterine growth retardation is due to the nicotine which results in the thickening of placental

membrane and formation of smaller blood vessels in the placenta and impairs the transfer of gases, nutrients and waste products across the placenta. The women smoker often have premature births, experience a greater incidence of miscarriage and still-birth.

Role of the Nurses

For the Nurse in helping smokers to quit smoking is a challenge by itself specially when she is working among her male colleagues and co-workers. Nevertheless, it is important that nurses play a crucial role in the prevention of smoking and help to disseminate information, mobilize public opinion against smoking and also take active part in educating smokers to quit smoking. She can also help non-smokers to wage a war against smoking. She can be instrumental in mobilizing the community to help smokers leave smoking. Moving a common unity toward a healthier lifestyles and attitudes requires partnership with key agents of change within the community, *i.e.,* voluntary agencies, parents, teachers, housewives, youth clubs, medical men. She can approach the community leaders, Sarpanches etc. for the health education campaigns in the community in helping smokers to quit smoking. Nurses' role thus can be summarized as follows:—

1. *Health Promotion:* The approach should be centered on encouraging healthful living, adopting healthy lifestyle which has been shown to have an effect on reducing diseases like carcinoma and heart disease. She can suggest and encourage alternative activities such as regular physical exercise, recreational activities, yoga, reducing stress etc. Alternatives to smoking such as chewing gum, *souf, ilaichi* also helps.

2. *Show personal concern for the smoker:* This can be done by having more dialogues and to pinpoint the problems/reasons which makes the client continue to smoke. This may include low self-esteems, coping skills, poor ability to communicate, adjustment problems, stress at workplace and so on. This also means that she has to take the role of a counsellor. She needs to work along with the family members particularly the wife, mother or father in order to have a better effect. Many habitual smokers lack self-confidence, and are easily upset in a stress situation. Helping the person to develop a more positive attitude towards life, self assertiveness and how to handle stress will go a long way in making the smoker leave smoking. Importance of a free and frank discussion, mutual trust and acceptance cannot be overemphasized.

3. *Highlight the ill effects of smoking:* It is helpful to scare the smokers and people around him on the dangerous effect of smoking which will persuade him/her to leave smoking.

The author has seen quite a few cases of habitual or chain-smokers leave smoking overnight with the help of self-determination. Quite a few have left smoking when they have taken it as a challenge to say that "it is possible to leave a bad habit if one desires to do so and has the willpower".

4. *Health Awareness:* Since non-smokers are also at danger of ill health due to the bad effect of smoking, the nurse can help to raise public consciousness about factors that determine their health. She can help people become self aware of their feelings or beliefs about certain health issues, such as smoking. Exploring clients' values about their health and then helping them to change attitude and the result is acceptance of healthier lifestyles. It may be seen to be a difficult thing to do but if one is convinced about the strength of social and public pressure then mobilizing the public against smoking will go a long way to remove the bad habit of smoking. No opportunity should be missed by her whenever she has a forum to speak or a chance to speak and to show her concern as a health team member. The nurse is in a better position to influence the public whether she is working in the hospital or community setting. She should utilize health education material to help her convey her message better and in an effective way. Awareness should also be raised among her colleagues from all sectors of the community regarding bad effects of smoking.

In conclusion it can be said that although nurses can take active part in helping the patient/client leave smoking but it is important to remember that the "Willpower" and self-determination of the smoker is crucial to help a person to quit smoking. □

HELP YOUR PATIENTS TO STOP USING TOBACCO

STEPS FOR HEALTH PERSONNEL INTERVENTION

All health workers should be convinced that they can make the difference, here are some tips to start today.

■ **Ask all patients if they smoke**

- Congratulate smokers who have quit.
- Document patients' smoking or non-smoking status in your notes or other forms.

■ **Advise all smokers to quit**

- In the presence of the patient, review some of the benefits of smoking cessation you feel would be meaningful.
- Give a firm, simple no-smoking message such as: "I am concerned about your smoking. I must strongly recommend that you quit".
- Repeat your recommendation when smokers give excuses for not quitting. Never argue about the excuses or accept them.

■ **Prepare smokers to quit**

- Ask the patient to set a target quit date within the next one to four weeks. Ask patients who are not ready to quit to think seriously within the next week about the reasons for quitting.
- Have the patient write down his/her quit date.
- Mention that they should: (a) do something else instead of smoking, (b) avoid tempting situations, and (c) stick with their effort to stop smoking.
- Tell patients they will experience withdrawal symptoms for about 2-4 weeks after quitting.
- Offer information on local smoking cessation programmes.
- Tell all patients you are very interested in hearing how they do.

■ **Follow-up: Let your patients know you care**

- Talk with all patients briefly about their smoking the next time you see them.
- Work with health professionals in other settings to stay in contact with patients and reinforce no-smoking messages.

STATEMENT ABOUT OWNERSHIP AND OTHER PARTICULARS ABOUT NEWSPAPER SWASTH HIND TO BE PUBLISHED IN THE FIRST ISSUE EVERY YEAR AFTER LAST DAY OF FEBRUARY

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I, Dr V. S. Wadhwa hereby declare that the particulars given above are true to the best of my knowledge and belief.

Sd/-
DR V. S. WADHWA
DIRECTOR

NEW DELHI, 17th March, 1993

Indian Culture—Symbols as Communication Tools

H. K. RANGANATH

Traditional folk media have come to play a significant role in informing, educating and even motivating the rural masses of developing countries to action.

TRADITIONAL folk media can make significant contributions towards changing the mass mind as they create a face-to-face situation in communication. They are also capable of achieving a balanced blend of entertainment and information as live media and provide a native base to mass media programmes with colour and costume, song and acting.

These tools of sung and enacted communication are so sensitive and pulsating that they demand careful handling by the communicator in order to achieve the desired results in a communication strategy.

This article gives a background of traditional performing arts in India during the last 2 centuries and relates the country's attempts to harness the various forms of traditional performing arts for use in development work, particularly relating to its use in family planning promotion.

At the turn of the last century, the developing countries of the world had two extraordinary factors to contend with. The first and negative factor was what was later called the population explosion; the second and positive factor was the media boom. It was felt necessary and urgent to inform, educate and motivate the vast multitudes of the illiterate, ignorant, superstitious, poverty stricken people of the third world to limit their growing numbers. The right to information was to become a fundamental, though unwritten right. Information had to be authentic, precise, palatable and convincing to the less fortunate in the global village. Information had to be imparted in great hurry and be transmitted by every means. The vast rural masses which were left alone for centuries, suddenly had to rapidly come to grips with the power of print, radio, film and even TV—all too foreign to their cultural ethos. Although each of these media had its attraction, they all had their limits in terms of effective communication for behaviour change concerning health in general, and family planning in particular. Hence the need for something different, something intimate, something personal and culturally oriented in order to bring conviction towards personal and community action.

Live performances come to the fore

Half a century ago, live performances were at the cross roads between culture and communication. Many of them were considered culture-symbols and "museum pieces" without any functional relevance to contemporary needs of the industrial and mass media age. At best, they were means of an evening's entertainment in colour and costume, song and dance. Supported by charitable contributions, they were performed at fairs and festivals, marriages and religious functions, harvests and community celebrations. They were taken for granted as crude entertainment.

Did they have communication potential for development?

For national plans and programmes? Could they be shaped to play a positive role in development when confronted with the new world of electronic media?

Some ground had already been covered to focus the world attention on the rich heritage and vast powers of people's performances in the so called Third World. UNESCO had convened a meeting of practitioners, and media and communication specialists in London in 1972 to discuss the *pros and cons* of theatric performances of the third world as viable communication tools on vital themes such as family planning. The London seminar, produced a Document designed to guide communication planners in their utilisation of traditional theatre and is relevant to this day.

The London seminar itself was inspired by the unmistakable indications of the power of traditional performing arts in different parts of the world. In the Philippines the Kalimagana theatre groups under the fiery leadership of the famed Cecile Guidote had roused the mass mind against the martial law of Marcos; the Black "Kakaku" comic performances had brought a new awareness of the rights and privileges to the African downtrodden; the street plays of Pauline Stone had altered the traditionally set attitudes and behaviour patterns of the Carribbean peoples. People's performances had proved that they were not mere museum pieces. Under the circumstances, the new world of electronic media could hardly ignore the living and pulsating presence of people's performances.

The India experience

India, with its vast and varied wealth of traditional theatre understood its communication potential as early as the 1820's. The lavani* and geegee* songs of North Karnataka have been recorded as intimate channels of communication among the masses in the uprising against the British.

In Gandhiji's times, it is said that mass communication was achieved by non-mass media. The then six radio stations in the country were in control of the "Establishment", but traditional live folk performances succeeded in rousing the sentiment of the entire nation against the British rule and drowning the sound of the radio. There could not have been a more clear signal of the power of the people's performance.

Almost immediately after Independence, the National Government opened a fulfledged department—the Song and Drama Division—in 1954 in order to identify, train and utilise the services of traditional performers to inform the rural masses about the various development programmes in the country. A decade later, the Amarnath Vidyalankar Committee which was appointed to measure the communication potential of different media, recorded that:

"from the point of view of its great appeal to the masses and its quality of touching the deepest emotions of the illiterate millions, the medium of song and drama is matchless".

—Amarnath Vidyalankar Committee Report 1964.

Three M's : Medium, Message, and the Masses

Field experience and behaviour of traditional folk performances and family planning

Incorporating health and development messages into traditional and folk performances required care and consideration. Although many song patterns, community dances and rural dramas seemed to present potential and received initial enthusiastic responses, further large scale incorporation of messages into ethnic dances, religious plays, traditional shadow theatre and the temple based Rod puppets* were considered as going too far. Audiences became hostile as they saw new and irritating messages on family planning being integrated into the old tunes which, in fact, originally promoted childbearing.

This experience necessitated an evaluation of the various types of "peoples' performances" in order to determine which would most effectively and appropriately vehicule health messages such as those on family planning. This analysis resulted in distinguishing three categories of traditional communication:

(1) ritualistic and hard core religious performances which rejected the integration of new messages;

(2) traditional performances built on themes drawn from ancient classics and "puranas"* which proved semiflexible in that

only some of their stock characters could be permitted to integrate new messages;

(3) folk performances—which include various celebrations expressed in song, dance, and drama, and which readily assimilate new messages whose impact are often reflected in the field. The most flexible of these were the Kathakirtan with its many side stories which could handle the new message and the puppet, particularly the string and glove puppet.

Folk performances could therefore be identified as the most appropriate medium for health education through traditional communication channels.

Identification of an appropriately designed message was fundamental to its success. Family planning messages needed to be carefully worded, dialogued suitably and versed convincingly. The message proved to be at least as important as the selected medium itself and demanded very careful handling to suit the medium.

Pre-media field survey

Even when both the medium and message were "right", communication often failed as the communicator was frequently too busy with the medium and the message, and ignored the field for which the communication package was intended. It was like a physician who worked on his medicines without any knowledge of the patient. An objective study of the field was therefore determined absolutely essential before the message carrying-medium was applied to it. In fact, a programme package could be prepared only after obtaining a first hand knowledge of the field, in regard to its literacy level, community composition, socio-economic structure, behaviour pattern, susceptibility factors, resistant elements and other influences prevalent at the periphery.

Sometimes even a pre-assessed field presented surprising situations. The "psychology of slum dwellers" could be understood only after such a situation arose in a slum pocket in the outskirts of Madras. The occasion was the *Intensive Fortnight for Family Planning Publicity and Service.* A carefully planned ballad programme was to be presented by a highly popular artist. The slum pocket consisted of about three hundred thatched huts, each having more children that the family could afford. Almost two hundred huts had "eligible couples". Procreation seemed the only recreation of the slum dwellers.

In order to provide both recreation and information at the same time, a concert which contained messages on family planning was presented at 7 p.m., but the readied arena was found crowded mostly by noisy children. Their elders slowly showed up much later, half way through the programme. It was found that the couples had "driven" the children out to witness the performance and stayed back to enjoy a little privacy. The result could have been a child boom in the slum area during the year of an intensive family planning campaign.

Often, the artists' personal experiences helped reinforce their messages. One such instance is that of a Katha artist (story-teller in songs and sayings) who was sent to present a performance in a coastal village of Karnataka. He was to convey the message of family planning through an ancient classical theme. Half was through the programme a heckler stood up and asked the performer as to how many children he had:

"Eight" was the answer. The result was an all-round giggle among the audience.

Oh! You had a merry-go-round! (laughter).

No Sir, all my children were born at home! (more laughter).

"Anyway, how could a person like you advise us to have a small families?" was the next question of the heckler.

"Because I am best qualified by hard experience" was the spontaneous answer which stunned the audience.

The performer then went on the narrate the many privations a large family person like himself had to brave through. This turn of events in the middle of a performance largely contributed to drive home the message.

Communication models thus ingeniously used by individual performers made the intended message go home, because the message was rendered personal, informal and convincing. In whatever medium, the characters presented by skilled artists with innovative capacity held sway over rural audiences and successfully educated them in a most informal way for health.

Even when the three "M"s, i.e. the **Medium**, the **Message** and the **Masses** were carefully studied and programmes designed accordingly, the communication often drew a blank. The gaps between (1) media service (invariably multimedia service) to support up the programme, (2) inter-personal action/reaction and (3) the availability of essential and effective service (medical and social in the case of health and family planning) were considered responsible for such failures. The gaps needed to be filled.

Role of the change-agent

Even when these gaps were filled and "package deals" offered, communication sometimes produced opposite results than those desired/expected. The cause for such failures was the ineffectiveness of the change-agent in influencing the target community. A promise of "the ultimate good" did not lure the rural Indian whose attitudes were conditioned by tradition. He feared that any suggested change was meant to remove much regarded traditional (often superstitions) beliefs and value systems. This was particularly true in regards to a question like planning one's own family, the Governments' interest in the personal affairs of its people was considered as highly suspicious. To attempt to remedy these reticences, the choice of change-agents is of fundamental importance.

Other than the folk artist himself, there are three categories of potential change-agents who are inextricable entities in the structure of the village society itself:

(1) Local dignitaries such as the Village Priest, the old teacher of the village school, the traditional healer, and others;

(2) Functionaries who are unavoidable in the daily life of a village such as the mid-wife, the barber, the Mantravadi, and others;

(3) Frequent highly respected visitors such as the postman, Bangle Seller and others.

The above categories of persons habitually spend considerable lengths of time with the villagers either in group/family or individual situations. They are informal and are held in high esteem because of their services to the village. There can be no denying that they possess great potential for change-agents at the village level, once they themselves are convinced of the importance of an issue. The media designer is then left with the challenge of involving these influential forces. When he succeeds in motivating them even a highly personal message such as that of family planning can become palatable for the villager.

In retrospect, the entire process of converting a Government health programme into a people's programme using traditional art forms was an exhilerating experience. Tending and cultivating viable categories of live performances for health communication was as fascinating as it was challenging. To watch the artist fill dry messages with cultural life and convert the medium into "sung communication" and "enacted information" often brought a sense of fulfilment to the media designer. And, it was indeed a marvel that a talented singer, actor and dancer, in his abandon, became the "medium of message". For the past quarter of a century people's performances have played a meaningful role in the communication of vital themes of health development.

Today, however, it seems as if a stalemate has set, leaving current rural communication much to be desired. Lacking in adventure and creativity, it seems stale. Playing safe seems to have become the order of the day. There are yet undiscovered dimensions with people's performances to be exploited, including "cross-culture-fertilisation" of viable types like *Kabigaan, Bhavai, Ottam Thullal, Lavani, Geegee,* not to forget the *Katha Kirtan,* the most engaging and convincing communication medium which never fails to bring light and delight to the rural masses.

Reference List - Traditional Terms

Lavani :	ballad performances of rural artists on historical themes.
Geegee :	a stylished song pattern of Karnataka.
Rod puppet:	traditional temple-based puppet performances.
Puranas :	treatises of heroic deeds of Indian gods and godesses.
Mantravadi:	Soothsayer.
Kabigaan :	popular ballad song system of West Bengal when opposite sides of an issue are debated.
Bhavai :	popular rural humour play of Gujarat.
Thullal :	rural performances of Kerala.

(Contd. on page 111)

NEWS

FIVE INDIAN COMPANIES WIN BRITISH SAFETY COUNCIL AWARD

THE British Safety Council's supreme award, the Sword of Honour, has been won by five Indian companies. The five companies are : Shriram Industrial Enterprises Ltd; Salem Steel Plant (SAIL); Straw Products Ltd; Mahindra and Mahindra; and Madras Refineries.

The award to the five companies in India is in recognition by the British Safety Council of the safety awareness and attitude to safety management shown by both management and staff of the companies.

The Sword of Honour is the highest award that the British Safety Council gives and it was won in the face of stiff competition. Companies world wide may apply for the award which gives recognition to those countries in which industrial safety is held to be an important part of everyday life. It represents the ultimate accolade for outstanding safety performance. —**BIS**

Plastic Welding Process Offers Environmental Benefits

A new method of welding flexible plastics opens the door to better containment of hazardous chemicals at landfill sites or after spillage.

Developed by the TWI welding institute from Cambridge, eastern

PROFESSIONAL ORGANIZATIONS AND TOBACCO CONTROL ...

. . . INTERNATIONAL COUNCIL OF NURSES POSITION STATEMENT, APPROVED IN 1989

"The "Code for Nurses" adopted by the **International Council of Nurses** states that two of the fundamental responsibilities of the nurse are "to promote health and to prevent illness", and that "the nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public". Smoking is regarded as one of the world's most preventable health problems.

.....

Although the health consequences of tobacco are now well known, measures to deal with them are so far woefully inadequate. Therefore, the International Council of Nurses and its member associations make a commitment to develop methods to reduce and eliminate smoking among nurses and to prevent the initiation of the smoking habit among student nurses.

Member nurses' associations are to bring to the attention of their governments the negative effects of tobacco on health; and encourage their governments to reduce, discourage and eradicate the use of tobacco.

ICN member associations should also commit themselves to encourage their governments to develop policies that ban tobacco advertising and promotion, require prominent and significant tobacco warnings on all tobacco products, provide public education campaigns aimed at eliminating tobacco use and provide incentives to tobacco farmers to make the transition from tobacco to alternative crops."

England, in collaboration with the Key Tech company, the resistive implant tape welding (RITW) process involves heating an implant element at the joints of sheet materials to form high quality welds.

The secret is in a polymer tape that contains a copper conducting element and a thermoplastic that melts during welding. The polymer tape grips the material to be welded and exerts pressure. The tape also provides additional welding material to avoid thin coating problems. Welds up to 100 metres can be made in about three minutes.

Trials carried out at TWI on a range of polymeric material have not only proved welds to be to engineering levels of strength, but also to have guaranteed repeatability. The technique means more reliable joints in safety critical areas and a number of applications have already been identified.

Landfill sites are often at the centre of public concern. The RITW process offers an advance in containing hazardous chemicals by forming a continuous membrane which protects the environment. Other applications include "plastic-lined" tankers for oil spillage containment and lining of aged sewers and water mains.

After further development, applications could include geomembranes and other sheet thermoplastics, as well as a variety of products which call for high strength/high speed welding procedures.

Science and Technology News
No. 04/93

PROFESSIONAL ORGANIZATIONS AND TOBACCO CONTROL ...

. . . EUROPEAN CHARTER FOR HEALTH PROFESSIONALS, proposed by the European Medical Association Smoking or Health (EMASH) (1991)

"AS A DOCTOR OR HEALTH PROFESSIONAL

I. I AM AWARE OF THE **DAMAGING EFFECT** OF TOBACCO:
- for the smoker
- for those who live with smokers
- for society in general

II. I KNOW THAT TOBACCO IS A **DRUG** WHICH ENTAILS **DEPENDENCE** BOTH **PSYCHOLOGICAL** AND **PHARMACOLOGICAL**

III. I AM READY TO **HELP SMOKERS** WHO WISH TO STOP:
- to encourage them to break the habit
- to offer them suitable treatment
- to help them psychologically during the difficult period of giving up smoking

IV. I WANT TO **DISCOURAGE SMOKING** AMONGST MY PATIENTS:
- by stopping smoking myself and thus presenting a model of the non-smoker
- by not permitting smoking in the waiting room
- by strongly advising non-smoking for my patients and their families
- by taking part in health education particularly with young people
- by promoting non-smoking in my social contacts

V. I REALIZE THAT I HAVE A GREAT **RESPONSIBILITY** NOT ONLY TO PATIENTS BUT ALSO TO THE **PUBLIC IN GENERAL**

I AM URGING THE GOVERNMENT TO UNDERTAKE THE **APPROPRIATE PREVENTIVE MEASURES**

■ ■ ■

WE, EUROPEAN DOCTORS AND HEALTH PROFESSIONALS ARE FIRMLY RESOLVED TO UPHOLD THE COMMITMENTS OF THIS CHARTER AND TO UNITE IN ORDER TO REDUCE SMOKING WHICH IS THE SINGLE LARGEST PREVENTABLE FACTOR IN PREMATURE DEATH, DISABILITY AND DISEASE."

A ONE WAY STREET?

Street Children and Substance Abuse

AMONG the estimated 100 million street children worldwide, the use of alcohol and other drugs is an immense problem according to a report[1] of the World Health Organization.

In the first study of its kind, the WHO Programme on Substance Abuse has just completed the first phase of an innovative project investigating substance abuse amongst street children in 10 cities around the world; Rio de Janeiro, Alexandria, Cairo, Tegucigalpa, Montreal, Toronto, Manila, **Bombay,** Mexico City and Lusaka.

The project has identified promising strategies which may be used to prevent the emergence of substance abuse problems within groups of street children and to ease the misery of their lives. Interest in the project has been expressed by a wide range of governments, non-governmental organizations and international agencies.

The strategies are based on assisting and strengthening organizations which work with street children. The overall aim is to protect the children from drugs and alcohol through community development, empowerment, education and activities which offer them a healthier, safer and more constructive lifestyle. For example, in Lusaka, street children have established a brick-making enterprise and carpentry workshop; in Bombay drop-in centres for street children have been planned; and in Tegucigalpa, resources have been prepared for training street educators.

Although the very existence of street children is not new, the adverse economic situation, political upheavals, civil unrest, increasing family disintegration and natural disasters of recent decades have triggered off a much greater exodus of children from the countryside to the streets of large cities. Some are born on the streets, some come from poverty-stricken families, others are orphaned. It is feared that in Africa alone early next century there will be 16 million children orphaned by AIDS. While by all accounts boys constitute an overwhelming majority of street children around the world—from 71% to 97%, girls often experience much greater difficulties. They seem to be even more marginalized and exploited.

Over 550 street children from the 10 cities participated in the WHO study. Indepth interviews revealed previously unknown details of their marginalized and disturbed lives. The children in the study included those working in the markets in Tegucigalpa, those in juvenile detention centres in Cairo and Alexandria, those living at railway stations and in the slums in Bombay, those from favelas in Rio de Janeiro and street vendors from Lusaka and Mexico City.

Regular Use

The regular use of alcohol and other drugs by a significant proportion of street children was reported from all cities, with almost 100% of street children using drugs in Toronto and Montreal. Across all cities the most widely used substances were those which were cheap and easily available including alcohol, tobacco, cannabis, glue, solvents and pharmaceuticals. The use of cocaine, heroin, amphetamines, combinations of drugs and drug injecting were also reported. Of particular concern was that new substances and different ways of using drugs were also described by the youths.

Often the lives of street children are intimately entwined within the illicit drug industry. The report shows that street children are used in the production and marketing of cocaine and the trafficking of cannabis and heroin. It also says that certain groups of street children are being exploited by terrorist and criminal organizations and recruited to carry out subversive and disruptive activities. They are further exploited by the commercial sex industries, often from a very young age.

Physical and Sexual Abuse

Most street children describe major losses in their lives and of the daily stresses of day to day living. Many have lost family members through diseases such as AIDS, natural disasters, murder and even death squads. Many have attempted or contemplated suicide, in Rio de Janeiro 55% of those interviewed claimed that they had attempted suicide. Everyday they search for food, shelter and care, often fearful for their lives. Although poverty and rapid urbanization are major contributing factors to the problem of street children, many children claim that physical and sexual abuse were the reasons for their leaving home. The use of drugs is often quoted as a means of coping with this stress, pain and suffering.

Although confronted with such an unforgiving social and physical environment, and often no person to turn to for support, these children have dreams. A youth from Montreal stated "Our dream is to be all right one day". Just as other children, they play and laugh and long for the opportunity to just be children. It is apparent that in most countries with regard to street children, the United Nations Convention on the Rights of the Child is being blatantly breached.

(Contd. on page 124)

[1] A One Way Street? A Report on Phase I of the Street Children Project. Programme on Substance Abuse, WHO. A copy of the report can be obtained from the Office of Information, WHO.

SMOKING CONTROL WORLD-WIDE

MANY countries around the world are controlling smoking, one of the biggest killers of modern times. The following are some of the major programmes in different countries.

France

Under a tough new anti-smoking law in France, cigarettes are banned in all enclosed public places, including theaters and railway stations. Smoking is prohibited in office, reception areas and meeting rooms, and restaurants must have ventilation equipment and adequate space for non-smokers. The new law marks a major change for the French. Penalties are severe : An individual who violates the law can be fined the equivalent of up to $ 260 (in U.S. dollars); businesses can be charged upto $ 1,200.

U.K.

The British Medical Authority is asking local governments in Scotland to bar events sponsored by tobacco companies from their premises. The move follows growing concern that tobacco companies are circumventing advertising restrictions by promoting their products at youth-oriented events such as fashion shows and discos.

U.S.A.

A man in California has filed a suit against six U.S. Tobacco companies for emotional distress he has suffered from long-term exposure to second-hand smoke. The case is unusual in that the man is suing the tobacco companies for an indirect effect of their products. He is a non-smoker.

The Coalition on Smoking or Health, comprised of the three largest voluntary health organisations in the United States—the American Heart Association, American Cancer Society and American Lung Association—has announced its public policy agenda for 1993.

The coalition believes that strong efforts should be made to discourage tobacco use in all segments of the population, including youth, women and minority populations who increasingly are targeted by the tobacco industry. To accomplish this goal, and to continue working towards the U.S. Surgeon General's goal of a Tobacco Free Society by the Year 2000, the coalition has identified the following seven major areas for action :

* Advertising and promotion of tobacco products
* Sale and distribution of tobacco products
* Tax and pricing policy
* Clean indoor air and environmental tobacco smoke
* Regulation of tobacco products
* Government tobacco use prevention and cessation activities
* Elimination of federal support for tobacco.

In the U.S., the state of Massachusetts has adopted the highest cigarette tax in the nation. The 25-cent increase, bringing the tax to 51 cents per pack, calls for revenue to be placed into a Health Protection Fund and directed towards health education programmes for youth and pregnant women on the dangers of smoking.

A 14-Year-old effort to end Virginia Slims Sponsorship of women's tennis got a boost when former cigarette model Janet Sackman led a protest of this year's tournament at Madison Square Garden, New York.

Sackman, 61, was the glamorous, young pitchwoman for Lucky strike and Chesterfield as a teenager. But she got throat and lung cancer after 33-years of smoking. She had her voice box and part of her right lung removed.

Sackman was joined last evening by a group of women doctors and anti-smoking activists, many of whom have lobbied since 1978 to ban Virginia Slims cigarettes from women's tennis tournaments.

Canada

The Ontario provincial government is planning to announce steps to restrict the use of tobacco, backing up its pledge to achieve a 50 percent reduction in smoking in the province by the end of the decade. Officials with smoking control groups said the government would make Ontario one of the most restrictive jurisdictions in the world for the sale of tobacco, with a particular focus on actions that would reduce sales to minors.

The international Civil Aviation Organisation meeting in Montreal, voted October 8th to adopt a resolution prohibiting smoking on international passenger flights by 1996.

The resolution requests the ICAO Council to intensify its studies into the safety aspects of banning smoking on board aircraft; requests the ICAO Council, with the assistance and cooperation of the World Health Organisation, to take appropriate measures to promote a smoke-free travel environment on all international flights.

Lithuania

A draft Tobacco Act has been prepared in Lithuania by the Health Research Centre and the Ministry of Health Care and is expected to be passed in Parliament before the end of the year. The main sections of the draft law deal with cigarette production, sales, advertising, price increases and taxation, including tobacco tax revenue allocation for health education needs, the banning of smoking in schools, on health premises, at work sites and in other public places.

Russia

Prices for Russian cigarettes have gone up again, this time an average 40 percent, reports IZVESTIA. The brand Belomorye, for example, went from 6 roubles to 10 roubles per pack. Stolichnaya brand cigarettes from 15 to 27 roubles; and Kosmos brand from 18 to 32 roubles. Still, these prices are about half the cost of the lowest priced American-style cigarettes.

Japan

In Japan, the Finance Ministry is considering the possibility of raising the national tobacco tax by Y0-50 to Y1 per cigarette effective next April, according to THE JAPAN TIMES. It would be the first increase in the tax since fiscal year 1986, when a Y0.45 per cigarette increase was implemented.

Singapore

Lawyers and others who slip out of the courtrooms here for a smoke were enjoying their last legal puffs in the corridors today, reports AP.

A regulation called the Smoking (Prohibition in Certain Places) amendment comes into effect from 1st December, banning smoking in the Supreme Court and all lesser courts of law.

Violators face a maximum fine of 1,000 Singapore dollars (614 US dollars).

The closing of this legal loophole is the latest step in a campaign to make this the world's first smoke-free city.

Australia

Canberra (AP): Nearly all tobacco-industry sponsorship of sporting events will be outlawed by the end of 1995, the Government said today.

Australian Federal Health Minister Peter Staples said legislation agreed on by the Labour Party caucus would break the nexus between tobacco advertising and sports in Australia.

The legislation, expected to be passed through Parliament before Christmas, means tobacco advertising on stadium billboards will be phased out between June 1993 and December 1995.

No new contracts for this type of tobacco advertising will be permitted.

—*Courtesy:* **Heart News, Jan. 1993**

(Contd. from page 122)

Next Phase

The next phase of the project will bring together a range of partners from different countries and international organizations. It is proposed that the project will be developed in association with United Nations and other organizations, including the Commonwealth Secretariat and Street Kids International. Particular attention will be given to the training of street educators and supporting local street children organizations in their activities. In the words of Dr Hans Emblad, Director of WHO Programme on Substance Abuse, "This is a global problem and it should be addressed globally. The future of millions of children is at stake. Unless we have a strong and influential network of individuals and agencies to work with street children firmly in place, the current tragic situation will continue, and drugs will go on damaging more and more young lives".—**WHO.**

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Book Review

Readings on Diarrhoea

Student Manual

1992, vii+147 pages (available in English; French in preparation), ISBN 92 4 154444 9, Sw.fr.20.-/US $18.00, In developing countries: Sw.fr. 14.—Order no. 1150386

This book provides a collection of eight teaching units conveying essential information about the pathophysiology, clinical features, diagnosis, epidemiology, treatment and prevention of diarrhoea in children. Addressed to medical students undergoing clinical training in paediatrics, the manual aims to equip students with all the knowledge needed to assess patients, plan treatment, and prevent deaths through proper case management. Information, which is specific to conditions in developing countries ranges from an explanation of the clinical features seen in different forms of dehydration, through advice on how to communicate with mothers, to a discussion of the role of feeding in the management of diarrhoea. Recommended lines of action draw their authority from published research and extensive WHO experience in programmes for the treatment and prevention of diarrhoea.

The first two teaching units provide fundamental information about the epidemiology, clinical types of diarrhoea, causative agents, modes of transmission, pathophysiology, and implications for treatment. Subsequent units explain how the clinical assessment of patients should be performed and interpreted, discuss ways of teaching mothers to treat diarrhoea at home, describe clinical measures for the treatment of dehydrated patients, and discuss the special procedures to be followed during the treatment of dysentery, persistent diarrhoea, and diarrhoea associated with other illnesses. The remaining units cover the nutritional management of diarrhoea in children, including those suffering from severe malnutrition, and explain how physicians can promote prevention, particularly through the education of mothers and other family members. Each unit concludes with a list of exercises for testing the knowledge acquired.

Further practical information is presented in a series of annexes, which set out guidelines for determining whether a child is malnourished, list antimicrobial agents for the treatment of specific causes of diarrhoea, and provide illustrated, step-by-step instructions for intravenous rehydration and nasogastric rehydration. □

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FUTURE WORLD NO-TOBACCO DAYS

1994: "The media against tobacco"

1995: "The economics of tobacco control"

1996: "Sports and the arts without tobacco"

1997: "The United Nations and specialized agencies against tobacco".

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