

**National Tobacco Control Program (NTCP) : A Study of
Knowledge, Attitude and Practices (KAP) of Tobacco
Users and Sellers**

A Thesis

Submitted in partial fulfillment of the requirement for the degree of

Doctor of Philosophy

IN

Social Work

Under the Faculty of Arts

By

PRAMOD KUMAR SINGH

Under the Supervisor

Prof. Dr. MAHALAXMI JOHRI

Department of Social Work



Year of Submission:2024

**P.K. University
NH-27, Vill. Thanara (P.O. Dinara)
Shivpuri M.P. India-473665
www.pkuniveristy.edu.in**

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A handwritten signature in black ink, appearing to be "M. Johari", written over a horizontal line.

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ACKNOWLEDGEMENT

I extend my heartfelt acknowledgements to my esteemed guide, **Prof. Dr. Mahalaxmi Johri**, for her unwavering support, timely responses to my queries, and invaluable time, which played a pivotal role in facilitating the successful completion of my thesis.

I express my sincere gratitude to the **Chancellor Shri Jagdish Sharma**, **Vice-Chancellor Prof. Dr. G. Pawan Kumar**, **Administrative Director Dr. Jitendra Mishra**, **Dean Academics Dr. Aiman Fatima** and **Dr. Deepesh Namdev (Registrar)** and of P.K. University. Their constant stream of knowledge served as a guiding force, not only as mentors but also as spiritual mentors. The moral teachings and spiritual inspiration received from them will serve as a steady source of strength and blessings in my future endeavors.

Special thanks to **Dean Research Prof. Dr. Bhaskar Nalla** for his unwavering guidance and support during challenging moments encountered in the completion of my thesis work.

I am indebted to the staff and librarian **Ms. Nisha Yadav** of P.K. University and staff & librarians of other visited universities, whose eagerness to witness the completion of this work was truly motivating.


The completion of this work would not have been possible without the enthusiastic encouragement, good wishes, and moral support of my beloved wife, **Mrs. Sushma Singh**. I extend my earnest thanks to my mother **Smt. Gayatri Singh**, father **Shri Ramayan Singh**, mother-in-law **Smt. Usha Singh**, and father-in-law **Shri N.K. Singh** for their heartfelt blessings and motivation. A special tribute to my late elder brother, **Shri Ashok Kumar Singh**, whose guidance and inspiration have been invaluable. I am also grateful to my younger brothers, **Mr. Pradeep Kumar Singh** and **Mr. Praduman Kumar Singh**, for their exceptional tolerance and patience. My

daughter, **Smriti Singh**, has been a steadfast pillar of emotional support, shouldering her responsibilities with sincerity and patience.

I extend my appreciation to all my colleagues, friends, and mentors in the Community Empowerment Lab, as well as my friend and advisor, **Dr. Bharat Ranjan**, whose encouragement consistently pushed me to deliver high-quality work.

I wish to place on record my heartfelt appreciation for all my loving family members, friends, and well-wishers, whose unwavering support has been instrumental in this journey.

Sincerely


Pramod Kumar Singh

List of Tables

Sl. No.	Table No.	Page No.
1.	Table for Tobacco Users	83
2.	Table for Tobacco Sellers	83
3.	Table-1	92
4.	Table-1.1	94
5.	Table-1.2	95
6.	Table-1.3	97
7.	Table1.2	98
8.	Table1.2.1	100
9.	Table1.2.2	101

10.	Table1.2.3	103
11.	Table1.2.4	105
12.	Table1.2.5	106
13.	Table1.2.6	108
14.	Table1.2.7	109
15.	Table 2.8	111
16.	Table 2.9	112
17.	Table 2.10	114
18.	Table 2.11	115
19.	Table 3	117
20.	Table 3.1	118
21.	Table 3.2	120
22.	Table 3.3	121

23.	Table 3.4	123
24.	Table 3.5	124
25.	Table 3.6	126
26.	Table 3.7	127
27.	Table 3.8	129
28.	Table 3.9	130
29.	Table 3.10	132
30.	Table 3.11	133
31.	Table 4	135
32.	Table 4.1	136
33.	Table 4.2	138
34.	Table 4.3	139
35.	Table 4.4	141

36	Table 4.5	042
37	Table 4.6	044
38	Table 4.7	045



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ABSTRACT

The present venture is concerned with the study of Knowledge, Attitude and Practices (KAP) of Tobacco Users and Sellers regarding National Tobacco Control Program (NTCP).

The present investigation which is entitled, “**National Tobacco Control Program (NTCP) : A Study of Knowledge, Attitude and Practices (KAP) of Tobacco Users and Sellers**” tried to study the Knowledge level of Tobacco users towards NTCP, their attitude towards NTCP and their Practice level of tobacco consumption. The study also tried to study the Knowledge level of Tobacco sellers towards NTCP, their attitude towards NTCP and their Practice level of tobacco selling. There were five objectives of this study. On the basis of review of related literature and objectives of the study two research Hypotheses were formulated. Later on to analyse further the research hypotheses, sub-hypotheses were formulated for each of the research hypothesis.

For the purpose of this research a 320 tobacco users and 160 tobacco sellers were selected through purposive sampling. The sample of tobacco users was taken from rural and urban background. Both literate and illiterate participants were selected from each background, equal number of male and female participants were selected. The sample of tobacco sellers were also from rural and urban background with equal number of literate and

CONTENTS

CHAPTER	PAGE NO.
1. INTRODUCTION	1-20
2. REVIEW OF RELATED LITERATURE	21-58
3. RESEARCH METHODOLOGY	59-90
4. RESULT, DISCUSSION & INTERPRETAION	91-146
5. SUMMARY, FINDINGS, SUGGESTIONS & IMPLICATIONS	147-163

CHAPTER 1

INTRODUCTION

**National Tobacco Control Program (NTCP): A Study of
Knowledge, Attitude and Practice (KAP) of Tobacco users
and sellers.**

**“Tobacco is a slow poison which kills us and kills our loved ones
gradually every day.... Let us save the lives of our loved ones from
this poison which is ruining our lives and murdering our happiness
and health.” - Anonymous**

Introduction

Tobacco use is a global epidemic that kills 5.4 million people annually; tragically, more than 80% of those deaths occur in the developing world (WHO MPOWER, 2008). India is the second largest tobacco consumer, and third largest tobacco producer, in the world (The Tobacco Atlas 2014).

Mortality due to tobacco in India is estimated at upwards of 1.3 million. Out of these, one million are attributed to tobacco smoking and the rest to smokeless tobacco use. One feature of tobacco related mortality in India is the high incidence of oral cancer, exceeding even that of lung cancer and accounting for almost half of all oral cancers in the world. India has the highest burden of both tuberculosis (TB) and Multi-Drug Resistant (MDR) TB based on estimates reported in Global TB Report 2016. Smoking increases the risk of TB by more than two-and-a-half times. Smoking is also contributing in a major way to India's increasing burden of non-communicable diseases. The problem is worsening, and by current trends, tobacco use will cause 13% of deaths in India by 2020 (WHO report on the global tobacco epidemic, 2011).

The variety of tobacco products used in India is greater than elsewhere, and associated with additional complications including a high burden of oral cancers from smokeless tobacco use (Goel S. India, 2012). The prevalence of diseases adversely affected by second hand smoke (SHS) exposure—in particular childhood respiratory infections and tuberculosis—are higher than in many parts of the world (Mathew JL et al, 2011 and WHO Global tuberculosis report, 2012).

The challenges of the tobacco epidemic in India are markedly more complex due to the diversity in forms of tobacco used and marked variations in prevalence and

patterns of tobacco use. Huge economic losses are incurred due to the health care costs of these diseases.

In India, tobacco prevalence among males is higher compared to females, among older age groups compared to the younger age groups, and in rural areas compared to urban areas. As per GATS 2, currently in India there are 266.8 million tobacco users aged 15 or above. Among current users, 202.0 million are men and 64.8 million are women; 68.2 million are from urban areas and 198.6 million are from rural areas.

The National Family Health Survey (NFHS), in its fourth round, found that tobacco use among males was 45.5% and 7% among females aged 15 years and above. The Indian component of the Global Youth Tobacco Survey (*GYTS, 2009*) conducted among school going youth (aged 13- 15) estimated nearly 14.6% young people (data among aged 13-15 years) currently use any tobacco product (Boy = 19.0%, Girl = 8.3%) and 4.4% currently smoke cigarettes (Boy = 5.8%, Girl = 2.4%). Nearly 12.5% currently use other tobacco products (Boy = 16.2%, Girl = 7.2%). A study conducted by HRIDAY (Health Related Information Dissemination Amongst Youth) in two large cities of India - Delhi and Chennai - found that students in sixth grade use two to four times more tobacco than those in eighth grade (Reddy *KS et al, The Lancet, 2006*).

The *GYTS (2016-17)* reported that in Uttar Pradesh current tobacco use in any form among adults above 15 yrs. is 35.5% (52.18% males and 17.7% females). The current tobacco smoking is reported 13.5% among adults (23.1% males and 3.2% females). The current use of smokeless tobacco in Uttar Pradesh is estimated 29.4% in adults (42.6% males and 15.2% females). Average age at daily initiation of tobacco use is reported 18.9 years in adults (18.8 years in males and 21.2 years in females). Almost 38.7% of adults were exposed to second hand smoke at home and 25.2% of adults were exposed to second hand smoke at public places.

The Government of India, in compliance with the FCTC (Framework Convention on Tobacco Control) and the COTPA (Cigarettes and other tobacco products Act)-2003, has launched the National Tobacco Control Program (NTCP), under the 11th Five Year plan, to build capacity of the states to effectively implement the tobacco control laws, and also to bring about greater awareness about the ill effects of tobacco.

The Government of India has responded to this epidemic due to tobacco by initiating several measures to contain the same. Regulatory action of Government of India towards tobacco control began in 2003 with the enactment of the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA). India has

been one of the earliest nations to ratify the World Health Organization Framework Convention on Tobacco Control (WHO FCTC) in 2004.

The National Tobacco Control Program (NTCP) was launched by the Ministry of Health and Family Welfare (MoHFW), Government of India in 2007-08, during the 11th five-year plan, with two key objectives i.e. i) To bring about greater awareness about the harmful effects of tobacco use and about the Tobacco Control Laws, and ii) To facilitate effective implementation of the Tobacco Control Laws. By legal provision smoking is completely banned in most public places and work places. All forms of tobacco advertising, promotion and sponsorship are prohibited. It is mandatory to have pictorial and text health warning labels on the tobacco product packages. On October 15, 2014, the government notified new larger warnings that increased the warning size from 40 percent of one side of tobacco product packaging to 85 percent of both front and back panels of tobacco packaging.

Though the Government of India's response through its National Tobacco Control Program (NTCP) is a step towards addressing this epidemic problem but there is a need to strengthen this program. The proposed evaluative study aims to understand individual users, providers and policy implementation-level factors that are responsible for the current sub-optimal NTCP outcomes.

National Tobacco Control Programme (NTCP)

Government of India launched the National Tobacco Control Programme (NTCP) in the year 2007-08 during the 11th Five-Year-Plan, with the aim to (i) create awareness about the harmful effects of tobacco consumption, (ii) reduce the production and supply of tobacco products, (iii) ensure effective implementation of the provisions under “The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003” (COTPA) (iv) help the people quit tobacco use, and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control .

During the 11th Five Year Plan, NTCP was implemented in 21 states covering 42 districts. To carry forward the momentum generated by the NTCP during the 11th Five Year Plan and baseline data generated through the Global Adult Tobacco Survey (GATS) India 2009-2010, indicating high level of prevalence of tobacco use, it was upscaled in the 12th Five Year Plan with a goal to reduce the prevalence of tobacco use by 5% by the end of the 12th FYP. As per the second round of GATS, the number of tobacco users has reduced by about 81 lakh (8.1 million).

The main thrust areas for the NTCP are as under:

- Training of health and social workers, NGOs, school teachers, and enforcement officers;
- Information, education, and communication (IEC) activities;
- School programmes;
- Monitoring of tobacco control laws;
- Coordination with Panchayati Raj Institutions for village level activities;
- Setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at district level.

NTCP is implemented through a three-tier structure, i.e.

(i) National Tobacco Control Cell (NTCC) at Central level

(ii) State Tobacco Control Cell (STCC) at State level &

(iii) District Tobacco Control Cell (DTCC) at District level. There is also a provision of setting up Tobacco Cessation Services at District level.

NTCP has resulted in provision of dedicated funds and manpower for implementation of the Programme. State/District Tobacco Control components viz.

STCC and DTCC Plan have been subsumed in the Flexi-pool for Non-Communicable Disease (NCDs) under National Health Mission (NHM) for effective implementation since 12th Five Year Plan.

Currently, the Programme is being implemented in all 36 States/Union Territories covering around 612 districts across the country.

National Tobacco Control Cell (NTCC)

The National Tobacco Control Cell (NTCC) at the Ministry of Health and Family Welfare (MoHFW) is responsible for overall policy formulation, planning, implementation, monitoring and evaluation of the different activities envisaged under the National Tobacco Control Programme (NTCP). The National Cell functions under the direct guidance and supervision of the programme in-charge from the MoHFW i.e. Joint Secretary. The technical assistance is provided by the identified officers in the Directorate General of Health Services.

The programme broadly envisages;

National level:

- Public awareness/mass media campaigns for awareness building and behavioural change

- Establishment of tobacco product testing laboratories.National level:
- Mainstreaming research and training on alternative crops and livelihood with other nodal Ministries.
- Monitoring and evaluation including surveillance
- Integrating NTCP as a part of health-care delivery mechanism under the National Health Mission framework.

State Level:

Dedicated State Tobacco Control Cells for effective implementation and monitoring of tobacco control initiatives. The key activities include;

- State Level Advocacy Workshop
- Training of Trainers Programme for staff appointed at DTCC under NTCP.
- Refresher training of the DTCC staff.
- Training on tobacco cessation for Health care providers.
- Law enforcers training / sensitization Programme

District Level:

Dedicated District Tobacco Control Cells for effective implementation and monitoring of tobacco control initiatives. The key activities include;

- Training of Key stakeholders: health and social workers, NGOs, school teachers, enforcement officers etc.
- Information, Education and Communication (IEC) activities.
- School Programmes.
- Monitoring tobacco control laws.
- Setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at the district level.
- Co-ordination with Panchayati Raj Institutions for inculcating concept of tobacco control at the grassroots.

If this program is implemented successfully it will lead to quitting tobacco consumption.

Benefits of quitting tobacco

- In 8 hours: Oxygen levels return to normal.
- In 24 hours: Risk of heart attack begins to decrease.

- In 72 hours: Lung function improves.
- In 1-9 months: Coughing and shortness of breath decreases.
- In 12 months: Risk of heart disease is half as compared to tobacco user.
- In 5 years: Stroke risk is reduced.
- In 10 years: Risk of lung cancer is less than half as compared to tobacco user.
- In 15 years: Risk of heart disease is similar to a person who never smoked.
- Reduced risk of diseases attributable to tobacco use
- Reduced health care expenditure means more money for other essential expenditures
- You become a role model for your children as well as for your society

Major Achievements of this program are given below

- The prevalence of tobacco use has reduced by six percentage points from 34.6% to 28.6% during the period from 2009-10 to 2016-17. The number of tobacco users has reduced by about 81 lakh (8.1 million).
- The Government launched the National Tobacco Cessation Quitline Services (**1800-112-356**) which aims to guide tobacco addicts to quit tobacco.

- Large specified health warnings on tobacco products covering 85% on both side of the principal display area of tobacco product packs and inclusion of Quitline Number (1800112356) in the specified health warnings for creating awareness among tobacco users, and give them access to counseling services to effect behavior change.
- 'mCessation' initiative is being supported by Ministry to support tobacco users towards successful quitting through text-messaging via mobile phones (011 22901701).
- Regulation of the use of Cigarettes and other tobacco products in films and TV programmes.
- Acceded to the Protocol to Eliminate Illicit Trade in Tobacco Products under the Article 15 of WHO FCTC.
- Issued an Advisory to ban Electronic Nicotine Delivery System (ENDS) including e-Cigarettes, Heat-Not-Burn devices, Vape, e-Sheesha, e-Nicotine Flavoured Hookah, and the like devices that enable nicotine delivery except for the purpose & in the manner and to the extent, as may be approved under the Drugs and Cosmetics Act, 1940 and Rules made thereunder.
- Established three National Tobacco Testing Laboratories
- Enacted The Prohibition of Electronic Cigarettes (Production, Manufacture, Import, Export, Transport, Sale, Distribution, Storage and Advertisement) Act, 2019

Achievement of the Division National Tobacco Control Cell (NTCC)

- Operational Guidelines for implementation of National Tobacco Programme developed and disseminated to all the states and Districts.
- Guidelines for Implementation of pictorial health warnings and sale to minors and around educational institutions developed and disseminated to states.
- Implementation of the Food Safety and Standards Authority of India Regulation in the States.
- Communication to Director Generals of Police (DGP) in states to strengthen and institutionalize enforcement of COPTA.
- Communication to Transport Secretaries in the States to make compliance to COPTA
- Communication to Principal Secretaries (Health) in the States to make compliance to COPTA.
- The National Tobacco Control Cell (NTCC) coordinated with all 15 state consultants for collection of data related to price of key brand of tobacco products.
- The NTCC organised a one day national level multi - stakeholder consultation on „Closing the Gaps in TAPS“ in collaboration with HRIDAY and WHO India Office.

- The NTCC assisted in soliciting proposals from the district administration of Anand and Kheda in the state of Gujarat on a systemic, time bound plan to reduce tobacco cultivation areas in these two districts.
- The NTCC furnished inputs on the concerned issues of the draft agenda of the 13 th Session of the „Organization for Economic Co - operation and Development (OECD).
- The NTCC furnished India’s stand on the draft resolution on a „United Nations Interagency Task Force“ on the prevention and control of non - communicable diseases.
- The NTCC got the approval of the 1 st National Level Mass media campaign for the year 2013 - 14.
- The NTCC participated and facilitated in the Technical Advisory Committee for the National Family Health Survey - 4 (NFSS).
- The “Guidelines for Law Enforcers, 2013” for effective implementation of tobacco control was developed and released by Secretary Health and Acting WR.

To make this program more successful and help in cessation of tobacco use it is very important to conduct researches in the field. KAP can be very useful in this. A Knowledge, Attitude and Practices (KAP) survey is a quantitative method (predefined questions formatted in standardized questionnaires) that provides access

to quantitative and qualitative information. KAP surveys reveal misconceptions or misunderstandings that may represent obstacles to the activities that we would like to implement and potential barriers to behavior change. Note that a KAP survey essentially records an “opinion” and is based on the “declarative” (i.e., statements). In other words, the KAP survey reveals what was said, but there may be considerable gaps between what is said and what is done.

Uses: A KAP survey can:

- Measure the extent of a known situation; confirm or disprove a hypothesis; provide new tangents of a situation’s reality.
- Enhance the knowledge, attitude, and practices of specific themes; identify what is known and done about various health-related subjects.
- Establish the baseline (reference value) for use in future assessments and help measure the effectiveness of health education activities ability to change health-related behaviors.
- Suggest an intervention strategy that reflects specific local circumstances and the cultural factors that influence them; plan activities that are suited to the respective population involved.

In the present context it is necessary that people must have **K**nowledge about this NTCP program this knowledge can build their **A**ttitude to avoid the use of tobacco and only then this **P**ractice of avoiding use of tobacco be strengthen. This KAP is very important for the success of any program.

A KAP means Knowledge, Attitude and Practices. It is important to establish a basic premise and provide definitions for each word.

K: Knowledge is a set of understandings, knowledge and of “science.” It is also one’s capacity for imagining, one’s way of perceiving. Knowledge of a health behaviour considered to be beneficial, however, does not automatically mean that this behaviour will be followed. The degree of knowledge assessed by the survey helps to locate areas where information and education efforts remain to be exerted.

A: Attitude is a way of being, a position. These are leanings or “tendencies to....”. This is an intermediate variable between the situation and the response to this situation. It helps explain that among the possible practices for a subject submitted to a stimulus, that subject adopts one practice and not another. Attitudes are not directly observable as are practices, thus it is a good idea to assess them. It is interesting to note that numerous studies have often shown a low and sometimes no connection between attitude and practices.

P: Practices or behaviours are the observable actions of an individual in response to a stimulus. This is something that deals with the concrete, with actions. For practices related to health, one collects information on consumption of tobacco or alcohol, the practice of screening, vaccination practices, sporting activities, sexuality etc.

Thus there is a need to do a KAP study to assess the reach and effect of NTCP.

Need for the Study:

Tobacco consumption is a bigger issue in India especially in rural areas. But urban areas are not in much better condition than the rural areas as far as tobacco consumption is concerned. Government of India is running number of programs to control the tobacco consumption. Tobacco consumption is found in people of almost age group more than 5 years of age. This is affecting badly the young generation. This future generation of India needs to be healthy and happy. Cessation of tobacco consumption can save the future of India.

National Tobacco Control Program is one of the most ambitious program of Government of India. This program is working incessantly at almost every level to control the consumption of Tobacco in India, but results seemed to be missing the desired results. The researcher felt the need to conduct a KAP study to see the effect of this program on tobacco consumers and sellers. Besides the need to identify the problems faced by program implementers in implementing the NTCP.

Statement of The Topic:

“National Tobacco Control Program (NTCP): A Study of Knowledge, Attitude and Practice (KAP) of Tobacco users and sellers.”

Objectives of Research:

- i. To study the National Tobacco Control Program (NTCP).
- ii. To understand the implementation strategy of National Tobacco Control Program (NTCP).
- iii. To assess the Knowledge, Attitude and Practice (KAP) of tobacco users.
- iv. To assess the Knowledge, Attitude and Practice (KAP) of tobacco sellers.
- v. To study the perception of challenges faced by the program implementers

1. Proposed Hypothesis:

1. No Hypothesis is required for objective-1
2. No Hypothesis is required for objective-2

For Objective 3

- Hypothesis 3.1 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between rural and urban tobacco users.
- Hypothesis 3.2 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between male and female tobacco users.
- Hypothesis 3.3 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between literate and illiterate tobacco users.

For Objective 4

- Hypothesis 4.1 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between rural and urban tobacco sellers.
- Hypothesis 4.2 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between literate and illiterate tobacco sellers.

5. No Hypothesis is required for objective 5.

Delimitations:

- 1. Only National Tobacco Control Program is covered in this study.**
- 2. Only Tobacco Consumers are covered in this study.**
- 3. Tobacco consumers and sellers of Lucknow and Barabanki are studied.**
- 4. Only Knowledge, Attitude and Practice (KAP) survey is done for the study.**

Review of Related Literature

Study of Related Literature

A literature review is a comprehensive summary of previous research on a topic. Literature reviews survey scholarly articles, books, and other sources relevant to a particular area of research. The review should clearly enumerate, describe, summarize and objectively evaluate these past researches.

This study of related literature gives a theoretical basis for research and helps you (the researcher) to determine the nature of your research. The literature review acknowledges the work of previous researchers, and in doing so, assures the researcher of the current research that you have conceived your work well. It is assumed that the researcher has read, evaluated and assimilated that work, referring to previous work in the field of study.

A literature review creates a "scenario" for the reader, giving him a more complete understanding of the development of his research area. This scenario indicates that the researcher has actually absorbed all (or the vast majority) of previous, important work in his or her field of research.

In writing a literature review, the aim is to describe what knowledge and ideas have been established on a topic, and what their strengths and weaknesses are. The literature review should be defined by a guiding concept (for example your research objective, the problem or issue you are discussing, or your reasoned thesis). It is not simply a descriptive list of available material or a set of summaries. .

Related literature review is the process of collecting, selecting, and reading books, periodicals, reports, abstracts, and other reference materials. The following information may be collected while conducting review :

1. Background knowledge of the problem and related concepts.
2. Theories that explain the existence of a problem and the possible relationship between certain factors and the problem
3. Data that confirms the existence and severity of the problem
4. General and specific findings of the study related to the problem
5. Recommendations for further study given in related studies

Why Review Literature?

Review of related literature is essential in research. Following are some obvious reasons-

1. It helps the researcher to identify and define a research problem
2. It helps to justify the need for study of a problem
3. It prevents unnecessary duplication of a study
4. It can be the source of the theoretical basis of the study
5. It enables the researcher to learn how to conceptualize a research problem and properly identify and operationally define study variables
6. It helps in creating and refining research equipment
7. It provides guidance for analysis and interpretation of data.

When to start reviewing related literature?

While the research problem is still being conceptualized, the researcher should start reviewing the literature in advance. In identifying and defining a research problem, the researcher must be able to show evidence that the problem actually exists and is worth investigating.

It is important that the researcher knows what is already known about the problem or what earlier researchers have found about it and what questions need to be answered before finalizing the research questions or objectives.

The theories that researchers use to explain the existence of a research problem and are used as a basis in the analysis of relationships between variables can be derived from references, books on theories, or from related studies. Therefore, the researcher should read enough literature already at the beginning of the research activity.

What material to choose to review?

1. General Reference

Examples are indexes, reviews and abstracts.

2. Primary Source

Examples are research found on published journals.

3. Secondary Source

It is a publication where, authors cite the works of others. Examples are books, encyclopedias. Secondary sources are good references for an overview of the problem.

The function of the review is to provide an insight into the trend to be followed in the area in which the research is to be carried out - it also helps to avoid

inadvertent duplication of well-established finding and to provide a path through which research can be conducted effectively; It also helps to delineate and helps to define the problem.

The review gives an understanding of the research methodology which refers to the way the study is conducted. It helps to know about the tools and related tools that have been shown to be useful and promising in previous studies.

The main objective of this chapter is to provide a systematic survey of the current study area / past research carried out in the relevant area.

Reviewing the literature means that it is able to identify the following points:

- ✓ What is established, rejected and accepted in your area'
- ✓ areas of conflict or conflict between different theories of thought
- ✓ Problems or issues that remain unresolved
- ✓ Emerging trends and new perspectives
- ✓ How your research builds on and differs from previous research.

Literature review offers much more than a summary of relevant sources. The task of review involves evaluating individual sources as well as synthesizing these sources to obtain a comprehensive view of the field. At this 'field level', a literature review discusses common and emerging perspectives, notable patterns and trends, areas of conflict and controversy, and gaps within the relevant literature. When you can see these things clearly, you will be able to set up your own research and contribute to the ongoing debate within the field.

In other words, when reviewing literature not only do you need to engage with a set of literature, you also need to be able to compare, contrast, synthesize and argue against that literature to make a contribution, indicate readiness.

Literature review exists within a variety of scholarly works with varying focus and importance. Short or short literature reviews may be presented in journal articles, book chapters or research work to set the background for the research work and provide a general understanding of the research topic.

However, the focus of a literature review in a research thesis is to identify gaps and argue for the need for further research. Depending on the author's purpose and the context in which the literature review will be presented, a selective or comprehensive approach may be taken.

In the selective approach, one or a limited number of sources are reviewed (for example an annotated bibliographic assignment, or the introduction of a journal article).

A comprehensive approach requires the review of multiple books and articles (such as in a review article), which can be submitted as a key chapter in a research thesis or self-published as a scholarly review article. can be done.

Reviewing literature is a continuous, non-linear and iterative process. Your literature review will help your questions, theories, and methods determine the parameters of your literature review - it is a cyclical process.

It is usually one of the first tasks that the research student undertakes and also one of the last that must be done before the research work can be completed. A literature review written in the early stages of research is prone to change because you need to review and revise it from time to time and make sure it is up to date. You will probably find yourself engaging with related literature in different ways at different stages of your research.

Global Adult Tobacco Survey – Round two 2016 – 17 report concludes that Between GATS 1 to GATS 2, the prevalence of each of the tobacco products—

cigarette, bidi, cigar/ cheroot/ cigarillo, hukkah, betel quid with tobacco, khaini, gutka and tobacco for oral application— has decreased significantly.

Ailsa J. McKay, Raju K. K. Patel, Azeem Majeed(2015-16) did a systematic review of strategies for tobacco control in India and concluded that Tobacco-use outcomes could be improved by school/community-based and adult education interventions, and cessation assistance, facilitated by training for health professionals and schoolteachers. Smoke-free policies appear to have become more widespread post-FCTC, but further, more up-to-date data describing this, SHS exposure, tobacco advertising/promotions, and availability to minors, would be useful. To date, data relating to taxation/pricing and tobacco packaging appear to be few, and we did not identify any studies of product regulation, alternative employment strategies, or illicit trade. Further investigation of these tobacco control measures would be of use.

A comparative analysis of WHO Framework Convention on Tobacco Control and The Indian law regulating Tobacco 2008 report concludes that to strengthen tobacco control initiatives and to channelize resources to proper use, there is need for an anti-tobacco coalition comprising of all the stakeholders with public and private partnership.

Gyan Chandra Kashyap and S.K.Singh (2015–16) did a study on the topic- “Progression in Tobacco use in India: An Application of Survival Function Analysis” and found that The analysis reveals that the overall prevalence of tobacco use as well as prevalence of tobacco smoking is the highest in the North-Eastern states, especially Mizoram and the lowest in Goa. On the other hand, the prevalence of the use of smokeless tobacco is the highest in the EAG states, especially in Bihar and the lowest in Himachal Pradesh. The Kaplan Meier Survival estimates pointed out that the probability of quitting is higher among women than among men and that it is relatively higher in urban areas as compared to rural areas, both for smokers as well as users of smokeless tobacco. Further, educational attainments have a strong negative association with tobacco use as the probability of quitting is the highest among those with secondary education and above than among those with no former schooling. There has been profound regional variation, where the probability of quitting is the highest in the southern states both among smokers as well as users of smokeless tobacco.

- i. Implementation of the Framework Convention on Tobacco Control (FCTC) 2010
- ii. CATCH THEM YOUNG, Kapil H Agrawal, National Journal of Community Medicine Vol 2 Issue 3 Oct-Dec 2011
- iii. Tobacco use by Indian adolescents, Chadda RK, Sengupta SN, Department of Psychiatry, Institute of Human Behavior & Allied Sciences, Delhi, India 2002

- iv. BASELINE SURVEY to understand the adherence of COTPA and Knowledge & Attitude levels regarding Tobacco Control, among kiosks operating in the proximity of Educational Institutions: PHFI, 2012
- v. Making the Tobacco and Poverty- Link: Results from Research for Advocacy Projects in Africa, Asia, and Latin America Written by Lori Jones and Debra Efroymsen Health Bridge Foundation of Canada, Ottawa, August 2011
- vi. Examining Implementation of Tobacco Control Policy at the District Level: A Case Study Analysis from a High Burden State in India 2015
- vii. Descriptive evaluation of cigarettes and other tobacco products act in a North Indian city 2017
- viii. Compliance assessment of cigarette and other tobacco products act in public places of Alwar district of Rajasthan
- ix. Assessment of implementation of COTPA-2003 in Bengaluru city, India: A cross-sectional study 2015
- x. Compliance with India's Cigarette and Other Tobacco Products Act (COTPA) 2014

V. Parish Majmudar, A. Gauravi Mishra, V. Sheetal Kulkarni, R. Rohit Dusane, and S. Surendra Shastri (2015) found that Tobacco use is an important

health issue globally. The aim of their research work was to assess changes in pre and post-intervention tobacco-related knowledge, attitudes, and practices among women from urban low socioeconomic strata, after three rounds of interventions.

A structured questionnaire was used to interview women living in low socioeconomic housing clusters in Mumbai, regarding their tobacco consumption, attitudes, and practices, by Medical Social Workers. These data were entered into IBM SPSS Statistics, version 20 and analysed. Interventions for tobacco cessation were provided 3 times over a span of 9 months, comprising of health education and counseling. Post-intervention questionnaire was introduced at 12 months.

There was statistically significant improvement in the knowledge of women, following the interventions, with particular reference to poor oral hygiene and tobacco use being main cause of oral cancer, knowledge of ill effects of second hand smoke, knowledge about possibility of early detection of oral cancer, perception of pictorial and written warnings on tobacco products, and availability of help for quitting tobacco. The prevalence of smokeless tobacco use is very high among urban women from lower socioeconomic strata. Therefore, tobacco awareness programs and tobacco cessation services tailor made for this group of women must be planned and implemented.

Aiswarya Vijayakrishna et.al. (2022) study mainly aimed to assess the knowledge, attitude, and practice of subjects who attend the smoking cessation clinic and thereby, study and document the drug management in smoking cessation. This was an observational study conducted among 160 patients for 8 months. A knowledge, attitude, and practice questionnaire was prepared and validated.

Majority of the participants had a good knowledge of the harmful effects of tobacco consumption. Around 96% knew that smoking could heighten their risk for different types of cancer and 93.8% were aware that smoking was a leading cause of many serious diseases. Majority of the patients (98.1%) had an attitude that quitting smoking was an individual choice and 96.3% were supportive of the fact that smoking in public places is an offense. Concerning their practice, 89.4% have attempted to quit smoking in the past and 78.8% have received advice from physicians earlier to cease smoking. The study revealed the good knowledge of patients and the majority of them tried to quit smoking as advised by their physician.

The purpose of **L. Sharif, A. Qandil, A. Alkafajei (2013)**'s cross sectional study was to explore university students' knowledge, attitude and practice towards smoking and to compare these factors between smokers and non-smokers. A sample of 2793 students was randomly selected to complete a self-administered questionnaire about knowledge, attitude and practice of smoking at three universities in Irbid, Jordan. The Majority of the smoking students (75.2%) knew the adverse

effects of smoking. Rates of non-smoking students who knew the adverse effects of smoking were significantly higher than that of students who smoke. A high rate of students showed an opposing attitude towards the assumption that smoking females would have more friends (89.6%), have stronger personality (93.4%), and be more attractive (90.6%) than nonsmoking females. Similar higher rates of negative attitude were also observed towards the smoking male. About 50% of smokers have a misguided belief that smoking helps them concentrate while studying and 37.7% believe that smoking helps in avoiding obesity. Students that started smoking before enrollment in a university had a significantly higher rate of heavy smoking as compared to those who started smoking after being enrolled. Students smoke not because they lack the knowledge about the risk of smoking but due to misguided beliefs and attitudes.

Siyu Dai et.al. (2021) aimed to document parental KAP regarding tobacco use, smoking cessation and children's ETS exposure, and to analyse how knowledge and attitude relate to practice. Self-administered KAP questionnaires were distributed to smoking parents recruited from the pediatric unit at the Prince of Wales Hospital, which provides pediatric service to a population of 1.2 million in Hong Kong. The 60-item questionnaire had a range of 0–38 for knowledge, 0–44 for attitude, and 0–40 for practice. Descriptive analyses were performed for KAP response, regression analyses were performed for the exploration of associations and identification of predictive indicators. 145 smoking parents (mean age: 38.0 ± 6.7 yrs.; male: 85.5%) were included. Less than half (39.3%) of them reported a smoke-free policy at

home. Among those parents who had private cars, less than half (45.2%) of them had smoke-free policy in their car that they never smoked in the car. Only 25.5% of the participants correctly answered $\geq 70\%$ of the knowledge questions, and 11.8 % of the participants gave favorable responses to $\geq 70\%$ of the attitude questions. The total knowledge and the total attitudes score were positively associated ($r = 0.49$, 95% CI: 0.35–0.79, $p < 0.001$), yet they were only modestly correlated with parental practice on children's ETS exposure. By multivariate regressions, potential predictive factors for more favorable parental KAP included higher household income, lower parental nicotine dependence level and breastfeeding practice. Parental KAP related to tobacco use and children's ETS exposure needs improvement to address the significant gap between recommended and actual practice. The weak association between knowledge and practice suggested that parental education alone is not adequate to combat ETS exposure in children.

J. Manju et.al. (2020) conducted to assess the knowledge, attitude and practice (KAP) of factors associated with initiation and cessation of tobacco among patients using tobacco products. A KAP study was conducted among patients using tobacco products of various age groups attending the outpatient department in a dental college in Chennai, Tamil Nadu. A self-constructed questionnaire by our team was framed and distributed to 100 subjects. The data collected was then analysed with SPSS software (version 21) statistically to obtain the results. In this study, predominantly 69% of the subjects started the habit of using tobacco products in the age group of 15-25 years. Most commonly used tobacco product was cigarette

(56%) and the frequency of tobacco usage was 5-10 times per day (50%). About 68% of the questioned subjects are aware of passive smoking and 94% are aware of the consequences of using tobacco products. High prevalence of tobacco usage was observed among younger age group. This calls for the need that educational institutions mandate the inclusion of awareness of health hazards of cigarette smoking in their curriculums. This is a much needed intervention to extricate them from this habit.

K. Sunday (2017) conducted a cross-sectional study among 200 students, who were selected with multistage random sampling technique. The results show that most of the respondents (83.50%) had heard of the term tobacco smoking, with 60.0% actually smoking tobacco. Almost one third of the respondents (30.80%) smoke tobacco at least thrice daily with an average of 3 sticks per day. More than one third of the respondents (35.80%) had been smoking for a year and 23.30% were introduced to smoking by senior colleagues. More than one fourth of the respondents (27.50%) will feel depressed if they do not take tobacco, while 62.0% and 50.50% believes tobacco smoking has significant effects on health status and behavioural patterns of undergraduate students respectively. There was a significant association between level of study and smoking of tobacco ($P=0.00$), with those in 400 level more likely to smoke tobacco than students in other levels (OR= 12.987 95% CI= 4.449-37.912). The study recommended, among other strategies, health education on the dangers of tobacco smoking among undergraduate students.

Pragati Sharma et. al. (2021) observed that the load on general processor is increasing. For Fast Operations it is an extreme importance in Arithmetic Unit. The performance of Arithmetic Unit depends greatly on its multipliers. So, researchers are continuously searching for new approaches and hardware to implement arithmetic operation in a huge efficient way in terms of speed and area. Vedic Mathematics is the old system of mathematics which has a different technique of calculations based on total 16 Sutras. Proposed work has discussion of the quality of Urdhva Triyakbhyam Vedic approach for multiplication which uses a different way than the actual process of multiplication itself. It allows parallel generation of elements of products also eliminates undesired multiplication steps with zeros and mapped to higher level of bit using Karatsuba technique with processors, the compatibility to various data types. It is observed that a lot of delay is required by the conventional adders which are needed to have the partial products so in the work it is further optimized the Vedic multiplier type Urdhva Triyakbhyam by replacing the traditional adder with Carry save Adder to have more Delay Optimization. The proposed work shows improvement of speed as compared with the traditional designs. After the proposal discussion of the Vedic multiplier in the paper, it is used for the implementation of Arithmetic unit using proposed efficient Vedic Multiplier. It is not only useful for the improvement of efficiency of the arithmetic module of ALU but also it is useful in the area of digital signal processing. The RTL entry of proposed Arithmetic unit done in VHDL is synthesized and simulated with Xilinx ISE EDA tool. At the last the proposed Arithmetic Unit is validated on a FPGA device Vertex-IV.

Ajoe Kattoor et. al. (2017) conducted an anonymous survey among internal medicine residents of a large University medical center between August and October 2016 to examine the self-reported proficiency, exposure to formal education, use of cessation interventions, and barriers to implementation of tobacco cessation programs.

Of the 56 residents (44.4% women) surveyed, only 10.7% of the residents rated their competency as “good” (64.2% and 21.4% rated their competency as “average” or “fair” respectively). One-half of the residents reported that they did not receive any formal education regarding smoking cessation interventions. Although all residents offered counseling and/or medications (nicotine replacement, bupropion, or varenicline) for tobacco cessation, only 55.4% of residents offered both counseling and medications to their patients. (Figure1). Lack of interest among patients, shortage of time, and limited resources were reported as major barriers to implement tobacco cessation interventions by 67.3%, 58.2% and 38.2% of residents respectively.

Findings demonstrate need to include tobacco cessation education in resident training curriculum and address barriers to implementation of tobacco cessation programs.

Hedley Knewjen Quintana et. al. (2018) conducted to assess the knowledge, attitudes and perceptions (KAP) of tobacco-associated diseases, and how it is influenced by tobacco products' advertisement, promotion and sponsorship (TAPS) while enforcing a strong and comprehensive ban. It was an international standardised cross-sectional survey study done on National Panamanian population aged between 15 years and 29 years old. There were 4796 responding participants. An index was developed using factorial analysis using TAPS and KAP variables. The primary outcomes were: (1) The national median index value. (2) The index value stratified by sex, age, occupation, income quintile and geographical areas. (3) The first and second factor loadings (FFL and SFL, respectively) for variables included in the KAP index.

Fifteen out of the 16 variables comprising the index were variables related to KAP and one variable was related to TAPS. The top three variables according to their FFL were 'KAP that cigarette is associated to (1) 'bladder cancer'. (2) 'breast cancer'. (3) 'stomach cancer'. The top three variables according to the SFL were 'KAP that cigarette is associated to': (1) 'chronic bronchitis'. (2) 'myocardial infarction'. (3) 'lung cancer'. Illegal tobacco advertisement in posters was the only TAPS variable included in the index. The national KAP index value was 0.26. Our results show that current smokers, teens, men, people with the lowest income quintile, and those living in Guna Yala Indigenous Territory (health region with the highest smoking prevalence) had a lower median value than the national median.

Men, young adults and deprived youth had the lowest median KAP index. Illegal TAPS had no influence on the KAP of tobacco-associated diseases when a strong and comprehensive ban is enforced.

Demaio et. al. (2014) explored the smoking-related findings of the Knowledge, Attitudes and Practices Survey (KAPS). A nationally representative sample size was calculated using methodologies aligned with the WHO STEPS surveys. As a result, 3450 people from across Mongolia were selected using a multi-stage, random cluster sampling method from permanent residents aged between 15 and 64 years. The KAP survey questionnaire was interviewer-administered on a door-to-door basis. Results: In Mongolia at 2010, 46.3% of males and 6.8% of females were smokers. This practice was especially dominant among males and urban dwellers (MOR 2.2), and more so among the middle-aged (45–54) (MOR 2.1) while still displaying a high prevalence among Mongolian youth (15.5%). The probability of smoking was independent of the level of education. Although the level of awareness of the health hazards related to tobacco smoking was generally very high in the population, this was influenced by the level of education as more people with a primary and secondary level of education believed that smoking at least one pack of cigarette per day was required to harm one's health (MOR 5.8 for primary education and 2.5 for secondary). Finally, this knowledge did not necessarily translate into a behavioural outcome as 15.5% of the population did not object to people smoking in their house, and especially so among males (MOR 4.1). Conclusion: The findings of this KAP survey corroborate the 2009 WHO STEPS Survey findings with regards to the

prevalence of tobacco smoking in Mongolia. It identifies males, urban dwellers and Mongolian youth as groups that should be targeted by public health measures on tobacco consumption, while keeping in mind that higher levels of awareness of the harms caused by tobacco smoking do not necessarily translate into behavioural changes.

Jambaiah B et. al. (2019) carried on the study with the objectives: 1. To study the knowledge, attitude & practice of all forms of tobacco & its consumption in 1st year medical students. 2. To assess the need of health education about the adverse effects of tobacco consumption to the students participating in the study. This cross-sectional study was conducted in S. Nijalingappa Medical college in Bagalkot city between July - September 2013. The 1st year medical students answered a pre-structural, close ended questionnaire on Knowledge, Attitude & Practice regarding tobacco & its consumption. 114 1st year medical students participated in the study. The data was tabulated by using Microsoft Excel 2010 and analyzed by using OPENEPI software.

In the present study, of total 114 students participated, 24% were using the tobacco products. Most of them (75%) were using tobacco occasionally. Among tobacco users, 57% used only cigarettes, 25% used only chewing products and 18% used both the products. Among the smokers, 71% of them were smoking 1-2 cigarettes, and remaining 29% of them smoked half pack per day. Among tobacco chewers,

66% of them used 1-2 sachets, 34% of them used about 3-4sachets per day. Situations which increased the frequency of usage were mainly (64%) examination stress, friends company (28%) and out of city (8%). 53% of the users tried to quit after being motivated by their parents and teachers but only 4% were successful. About 24% of the students in the present study had consumed some form of tobacco. Cigarette is major tobacco product consumed. Majority of the current consumers (53.57%) had attempted to quit but only 4% were succeeded in quitting the tobacco consumption. Addiction was the cause for not quitting the habit among of current consumers. These future health professionals, who play a major role in tobacco use control and cessation and it becomes their duty to promote oral and general health and healthy life styles among their patients.

D Prathikantham Manmohan Raju (2021)'s study deals with Knowledge Attitude Practice and determinants of tobacco product consumption in high school students. Study objectives were to assess knowledge attitude and practice on tobacco products among urban high school students and to assess determinants of tobacco consumption in urban high school students. A Cross-sectional study was done in urban govt and private high school students. Schools were selected by random sampling method (50% of entire schools in urban turkapally), all students who attended schools on the date of interview were included. Ethical committee clearance, consent from school head and assent from children were obtained. Data collected by interview method (sociodemographic details and knowledge, attitude and practice on tobacco consumption) in 532 students using pre design semi

structured questionnaire and analysed using Microsoft excel 2007 and SPSS version 20. Chi-square statistic was used.

Results revealed that prevalence of tobacco consumption was 7.7% in the current study. Only 23% of the students know it is illegal to smoke in public places. Knowledge on de-addiction centres/ help line (0.3%) was very poor. Proportion of tobacco consumption was statistically more in the age group of 14-16years, males (12.5%), in students belonging to government school, 10th standard and in students from joint family. Family and school (30.3%) are having very little role as source of antitobacco messages in contrast 10.5%, 7.5% and 3.8% were influenced to consume tobacco by parents/ guardians, friends/ siblings and role model respectively.

Phagava, H et. al (2022) mentioned in the study that the tobacco epidemic is one of the biggest public health threats the world has ever faced, killing more than 8 million people a year around the world. The young people are the easiest target for the risky behavior. This study aimed to assess knowledge, attitude and practice (KAP) regarding tobacco smoking among medical students in Georgia.

KAP questionnaire containing 44 questions was developed in Georgian. Sampling frame consisted of students of the 1st and 4th year of the Tbilisi State Medical University (TSMU) – Faculty of Medicine, Faculty of Public Health Management and Faculty of Public Health. Random cluster sampling was used and total number

of participants was 242: 1st year students 39.51% (96), 4th year students 60.08% (146); Faculty of Medicine 62.96% (153), Faculty of Public Health 36.63% (89); female 183 (75.31%), male 59 (24.48%). Mean age was 20.63 (SD=2.2). Cross-sectional study was performed. The survey was anonymous and self-administered. Principles of Declaration of Helsinki were followed. Data analysis was done in Stata 14.0.

Based on the knowledge component, most students do not have complete information about tobacco products and the diseases they cause. Statistically higher number of the students of the Medical Faculty and male students had correct information about the harm of tobacco. 20.6% of respondents smoke, male 33.9%, female 16.4%. The main reason for starting smoking was cited as interest and the influence of friends. 32.1% of respondents stopped smoking after the quitting attempt. The maximum length of time to smoking after quitting was 7.9 months on average (SD = 7.8).

Obtained results are mainly in line with the international findings. There was seen a statistically significant difference between public health and medical faculties and male and female in responses on knowledge and attitude. Taking into account that we have studied medical students it is less probable that the students of other specializations will be more knowledgeable in this regard. It is advisable to increase awareness activities in this regard.

Rajiv Kumar Singh (2016) mentioned that smoking is a leading cause of preventable death, killing more than 5 million yearly. Smoking among health care personnel such as medical students is an important public health issue. This study was done to understand and in future find effective measures to reduce tobacco smoking among medical students. This study aimed to find the prevalence and to assess knowledge, attitude and practice of tobacco smoking among students of a Private Medical College in Central Kerala. Cross-sectional study, using pretested, anonymous questionnaire, was conducted in a private medical college in central Kerala and proportions, test of significance like χ^2 and t test were used.

Out of 342 students, 26 (7.6%) were smokers; Males 25 (21.0%, out of 119), females 1 (0.44% out of 223), 72 (21.1%) had ever smoked; of which 60 were males (50.42%) and 12 (5.38%) were females; 82 (24%) had family members who smoked; 196 (57.3%) had relatives who smoked; and 184 (53.8%) had a smoker in their friend circle. 68.4% of students do not like to socialize or engage in activities with smokers. 17 (53.2% of smokers) want to quit smoking; 17 (51.5% of smokers) claimed to have a relapse.

Smokers are predominantly more between 21-26 years of age. Most of students started the habit of smoking between 16-20 years of age, therefore it is necessary to bring positive behavioral changes through adoption of comprehensive awareness programs on harmful effects of smoking among adolescent school going children.

Soumya Ramachandra Naik, Hitendra S Naik(2021) found that Tobacco and alcohol use in adults have an impact on physical, social and economic aspect of an individual. Different strategies like counselling, behavioural intervention psychotherapy are used for de-addiction. This study aimed to assess Knowledge Attitude and Practice among tobacco and alcohol addicts before and after psychological intervention

This study was a prospective experimental study carried out on individuals who were found to be addictive to tobacco or alcohol. Baseline information of addiction was noted. Psychological intervention included game therapy, story therapy and physical activity. The information on KAP related to tobacco and alcohol was collected from all the eligible participants before and after intervention.

Mean age of the patients was 35.5 ± 9.3 years. Majority of the patients belonged to Upper middle socioeconomic class (46.67%). Majority of the patients were having addiction for 11- 15 years (36.66%). At baseline we found that majority of the patients (63.33%) had inadequate KAP but after intervention majority of them (68.34%) had adequate KAP. There was significant increase in mean KAP score after intervention in tobacco addicts and alcohol addicts. ($p < 0.001$)

Monark J. Vyas, Amul B. Patel (2016) found that Tobacco is identified as the single most lethal agent known to humanity. Objective of the study was to assess the knowledge, attitude and practice of adolescents towards tobacco use. A cross sectional study was conducted among adolescents studying in various schools of Ahmadabad city. The study population was 2000 students of class VIII to XII from 532 schools. The Study duration was one year from 1st January 2011 to 31 December 2011. Data obtained were analyzed by Epi-info software version 7.

95% of study respondents knew that tobacco leads to cancer. None of the study respondents knew about tobacco control act. 40% told that passive smoking/second hand smoke is harmful to their body. 96% believed that smoking should be banned from public places. Majority of current tobacco users (80%) want to quit their habit of tobacco consumption. Majority of students were aware of health hazards due to tobacco consumption, knew that it is illegal in public places and wanted to quit.

Shrestha, R. (2018) aimed to study with the objective to assess the Knowledge, Attitude and Practice regarding use of tobacco among medical students of a Medical College, Dharan. A descriptive, cross-sectional study design was adopted with total of 100 sample size in this study. Stratified proportionate random sampling technique was used. Pre-designed, pretested, self-administered research instrument was used for the study. Descriptive and inferential statistics were used appropriately to analyze the data.

The median percentage score of knowledge of the respondents was 66.67%. More than half (51%) of the respondents had adequate knowledge regarding use of tobacco. Almost all (93%) had positive attitude against use of tobacco. It was found that 24% of the respondents were tobacco users either smoking or smokeless (chewing tobacco). There was significant association of knowledge regarding use of tobacco with residence (0.012). Attitude regarding use of tobacco was also significantly associated with age (0.022). Study findings also depicted that there was no relationship between knowledge and attitude. There was no significant association of knowledge with practice but attitude was found to be significantly associated with practice (0.01).

Knowledge was adequate in more than half of the respondents and almost all had positive attitude. Despite this, there was still practice of use of tobacco in one fourth of the respondents. This symbolizes that the awareness regarding use of tobacco, its harmful effects and different tobacco cessation programs needs to be implemented in the medical students.

Mohammad Naeem et. al. (2018) conducted a study with objective to find the knowledge, attitude and practices regarding tobacco smoking in medical students of Khyber Pakhtunkhwa (KPK). This descriptive study was based on convenient sampling in 5 major medical colleges. The study took place from January 2016 to April 2016. A self-administered questionnaire was used to collect data about

knowledge, attitude, and practices regarding smoking and demographic profile.

Out of 1071, 248 (23.1%) had smoked at least once in their life while 176 (16.54%) were current smokers. Out of 248 smokers the major causes for initiating smoking were “on insistence of friends” 92(37.1 %), curiosity 73(29.4%) and stress relief 43(17.3 %). Among current smokers (n=176) the most common reasons for not quitting smoking were addiction (n=71, 40.0%) and stress relief (n=36, 20.7%). One forty-eight (59.6%) of smokers wanted to quit smoking. Most Students had positive attitudes like giving help to their smoking patients, supporting bans in public places and on advertisements. Majority students had knowledge on famous hazards of tobacco smoking like lung cancer and heart diseases but insufficient knowledge on other hazards.

Smoking in medical students is still a matter of concern. Strict measures should be taken to discourage smoking.

Abdul Hameed and Daud Malik (2021) conducted this research work to assess smokers’ knowledge and behavior vis-à-vis combustible smoking cessation, prevalence, and risk, and the use of alternative nicotine delivery systems to quit smoking. A mixed-method approach utilizing cross section primary survey data and comprising descriptive and s-KAP index analysis has been adopted to ascertain the relationship between dependent and independent s-KAP variables; the principal

component analysis methodology has been used to determine the use of alternative nicotine delivery systems. Most of the smokers were aged between 15 and 35 years. A predominant 69.8% of the smokers came from middle-class background. Moreover, 71.3% were unaware of any alternative Tobacco Harm Reduction product. A majority of the respondents (68.2%) were keen to quit smoking. However, when asked why they had not succeeded, 52.9% reported addiction to nicotine as the main impediment. In Pakistan, lack of smoking cessation services is the weak link in the fight against the tobacco epidemic. Smokers are generally unaware of the Tobacco Harm Reduction products available in Pakistan; moreover, only 10.9% of the respondents were willing to spend more than Rs. 4000 per month on Tobacco Harm Reduction products. The average s-KAP score for young adults below the age of 20 was much lower than the national average but improved with the level of education. Interestingly, the score of smokers who had ever tried to quit smoking was slightly higher than that of those who had never tried to quit. There is intent to quit combustible smoking but the policy and infrastructure necessary for successful quitting are missing. Pakistan needs to concentrate on two fronts: a large scale awareness campaign against the use and harms of combustible smoking and simultaneously providing affordable and accessible smoking services across the country. Pakistan should look at the use and regulation of safer nicotine products in the UK. The country should carefully weigh the options of ensuring how to incorporate the use of safer nicotine delivery systems in its tobacco control efforts.

Maretalinia Maretalinia, Elvi Juliansyah, Suyitno Suyitno, Aris Yulianto & Dyah Suryani (2021) said that Tobacco use is one of the predicting factors of non-communicable diseases. In 2003, cigarette consumption was the main factor contributing to 4.9 million deaths in developing countries. In 2020, Bureau of Statistics Indonesia reported 31.5% of Indonesian population were tobacco users. Particularly, in West Kalimantan province, more than one-fourth of men are smokers. Specifically, in the working area of Sungai Durian Primary Healthcare Center, third-fourth of men are smokers. This study was conducted to examine the relationship between Knowledge, Attitude, and Practice (KAP) with tobacco use. This cross-sectional study employed 218 respondents of 4,321 male population. The predicting factors in this study were knowledge, attitude, and practice. The statistical test was done using univariate, bivariate (Chi-Square), and multivariate (binary logistic regression) analyses. The bivariate analysis test showed that knowledge and practice were significantly associated with tobacco use. Regarding the multivariate analysis results, practice was the strongest factor affecting tobacco use (AOR= 4.25, CI 95% (1.93 – 9.36)), and the second strongest factor was knowledge (AOR= 2.46, CI 95% (1.00 – 6.04)). Tobacco use in the working area of Sungai Durian Primary Healthcare Center was mostly affected by practice. Primary healthcare centers as the nearest healthcare facility in the community need to improve health education and decrease tobacco consumption. A tobacco control can be implemented by banning smoking indoors to reduce smoking behavior.

Shakeel Mohan, Binu Margaret, Manjula (2022) found that tobacco usage has become a major public health problem. It is a leading cause of preventable disease and death. The hazard related to tobacco consumption is also increasing. Therefore, the present study aimed to assess the perception towards tobacco consumption and the pattern of usage of tobacco products among auto-rickshaw drivers. A cross-sectional study was conducted from November 2019 to August 2020 among 161 auto-rickshaw drivers of Udupi Taluk, Karnataka using the purposive sampling technique. A pretested, valid and reliable self-administered questionnaires were used to collect data on usage of tobacco and perception towards tobacco consumption. Data were analysed using SPSS version 16.

A total of 99 (62%) auto-rickshaw drivers were users of smoking tobacco products and 38 (24%) were smokeless tobacco products users. The majority 118 (73%) were daily tobacco users and 83 (52%) auto-rickshaw drivers did not use any tobacco products in the work area. Nearly 52 (32%) participants consumed tobacco products due to work pressure. Around 91 (57%) auto-rickshaw drivers were not interested to quit tobacco products. Mean perception score of 139.81 ± 11.45 shows that the majority of them perceive tobacco consumption as hazardous for health.

Different forms of tobacco products were used despite knowing the hazardous effect on health. Intervention programs to control tobacco consumption should be planned

by the health care professionals and strict enforcement of tobacco control policy is critical to address tobacco-related morbidity and mortality.

Ashwaghosha Parthasarathi, Rahul Krishna Puvvada, Jayaraj Biligere Siddaiah, Padukudru Anand Mahesh (2022) observed that the prevalence of tobacco consumption is increasing globally and in South-east Asian countries. Despite the government's efforts in passing the laws for monitoring tobacco consumption, their effectiveness is questionable. The study's objectives are to investigate the association of tobacco use among the study participants as a function of community, interpersonal and individual factors. A conceptual framework was drawn based on Bronfenbrenner's theory of the ecology of human development, the social learning theory, and the social control theory. An observational study was conducted in 13 government and 26 private pre-university colleges in the Shimoga district of Karnataka, India. The study was conducted in two stages. First at the student level and the second at the tobacco vendor level. Ethical approval from the institutional board and informed consent from the participants were obtained. A descriptive, comparative and multivariate analysis was performed.

Of the 726 participants, 19.6% had used tobacco at least once. The most common type being flavoured cigarettes (54.3%). The average compliance of permanent tobacco outlets was 6.1/10, while the mobile tobacco outlet scored 3.8/10. Active tobacco use was strongly associated with peer tobacco use ($r = -0.439$, $p < 0.001$), community compliance ($r = -0.365$, $p = 0.004$), family educating against tobacco use ($r = -0.269$, $p < 0.038$) and age of initiation of tobacco use ($r = -0.327$, $p = 0.011$). The study shows us that the issue of adolescent tobacco use is multipronged. It centres on community, interpersonal and individual factors. It is needed a mixed-methods approach focusing on improving compliance with COPTA laws and effective anti-tobacco education in schools and immediate interpersonal surroundings.

Mustafa N, Bashir A, Sohail R, et al. (2023) found that cigarette smoking acknowledged as the foremost contributor to preventable illnesses and deaths, has steadily risen since its inception, evolving into a global health crisis of paramount significance, particularly within the context of medical students who represent the future healthcare workforce. This study, conducted at Quaid-e-Azam Medical College, Bahawalpur, aimed to comprehensively evaluate current students' knowledge, attitudes, and practices concerning cigarette smoking. Employing a web-based cross-sectional observational descriptive study design over the study period from June 15, 2020, to August 1, 2020, a sample of 200 medical students drawn from the first to fifth year was examined using stratified sampling. Data collection involved the distribution of a meticulously designed and pre-tested questionnaire through social media platforms, encompassing

inquiries about participants' biodata and research-related topics. The subsequent data analysis utilized Google Spreadsheets, Microsoft Excel, Microsoft Word, and SPSS software to calculate percentages, create graphical representations, construct tables, and apply the chi-square test. The survey findings illuminated a remarkably high level of awareness, with 99% of respondents recognizing the harmful effects of smoking, including elevated cancer risk, and 94% acknowledging its addictive nature. A substantial 93% regarded passive smoking as equally detrimental as active smoking. In comparison, 98.5% were aware of the heightened risk of respiratory illnesses in children exposed to smoking. The majority exhibited a responsible stance towards discouraging smoking, with 90.5% feeling a duty to encourage cessation and 71.5% considering maintaining good health a sufficient incentive to quit. Additionally, 97% concurred that smoking in the presence of children should be avoided. Concerning smoking cessation, 64.5% believed high taxes were effective, and 97.5% deemed public smoking bans effective measures. Notably, 74% thought professional advice had limited influence on a smoker's attitude. Active smokers constituted a mere 20% of the sample, with a mere 2% commencing smoking before age 16 and 10% succumbing to peer pressure or media influence as instigating factors. Furthermore, 13.5% reported exam-related anxiety as a trigger for smoking, and 10% admitted to smoking in the company of non-smokers. Encouragingly, 19.5% expressed a desire to quit, with 5% seeking professional guidance in their cessation attempts. In conclusion, most participants exhibited commendable knowledge and a positive attitude towards cigarette smoking, contributing to a low prevalence of tobacco consumption among them. Nevertheless, the study underscores the need for ongoing improvements through targeted educational initiatives and governmental regulations to further mitigate tobacco use among future healthcare professionals and the broader population.

Vijaykrishna A, Chand S, Nandakumar UP, Prabhu S, Dikkatwar MS, Vinay BC, et al. (2022) conducted a study that mainly aims to assess the knowledge, attitude, and practice of subjects who attend the smoking cessation clinic and thereby, study and document the drug management in smoking cessation.

This was an observational study conducted among 160 patients for 8 months. A knowledge, attitude, and practice questionnaire was prepared and validated. All the details and directions for filling out the questionnaire were explained to the patients by the investigator. The questionnaire was given to the patients and all the required data were collected and analyzed.

A total of 160 male patients were enrolled in the study. Majority of the participants had a good knowledge of the harmful effects of tobacco consumption. Around 96% knew that smoking could heighten their risk for different types of cancer and 93.8% were aware that smoking was a leading cause of many serious diseases. Majority of the patients (98.1%) had an attitude that quitting smoking was an individual choice and 96.3% were supportive of the fact that smoking in public places is an offense. Concerning their practice, 89.4% have attempted to quit smoking in the past and 78.8% have received advice from physicians earlier to cease smoking.

The study revealed the good knowledge of patients and the majority of them tried to quit smoking as advised by their physician.

Teshima, A., Shatnawi, A. A., Satyanarayana, S., Khader, Y. S., Maia, I. F., Wilson, N. C. (2023) found that Continued smoking by patients with tuberculosis (TB) and people living with HIV (PLHIV) leads to adverse treatment outcomes. Estimates of tobacco use among the population are scarce in the Eastern Mediterranean region, where the burden of TB and HIV is also low but highly variable. This study determined the prevalence of current smoking and assessed factors associated with current smoking among patients with TB and PLHIV in Jordan.

Data was analyzed from the Jordan Knowledge, Attitude, and Practices survey in 2021. Information on current tobacco use, including products and frequency of smoking, was collected from 452 patients with TB and 152 PLHIV. We performed multivariable logistic regression to assess the sociodemographic characteristics independently associated with current smoking.

Prevalence of current smoking was 43.8% among TB patients and 67.8 % among PLHIV, and conventional cigarettes were the most used tobacco products. The prevalence of current smoking among patients with TB was higher among males (AOR=8.20; 95% CI: 5.05–13.32), Jordanians (AOR=5.37; 95% CI: 2.66– 10.86) and Syrians (AOR=4.13; 95% CI: 1.60–10.67), and those experiencing financial difficulties (AOR=2.83; 95% CI: 1.69–4.74). The prevalence of current smoking among PLHIV was higher in those with financial difficulties (AOR=3.13; 95% CI: 1.19–8.27).

Nearly half of the patients with TB and PLHIV were current tobacco smokers, higher than the general population. There is an urgent need to investigate the reasons for such a high smoking prevalence and introduce and strengthen smoking cessation services under the TB and HIV control programs.

Kattimani S, Thimmegowda U, Nagarathna C. (2022) believes that “Today's adolescents are tomorrow's citizens.” Tobacco use in children and adolescents is reaching pandemic levels as they are the most vulnerable population to initiate tobacco use. It is well established that most of the adult users of tobacco, start the use of tobacco either in their childhood or adolescence. Parents are the best route to reach a child and can help lead to bring better outcomes for children. Hence, the aim of this study is to assess the knowledge, attitude, and behavior regarding the hazards of tobacco use and Cigarette and Other Tobacco Products Act (COTPA) among the parents visiting pediatric dental clinic.

A cross-sectional survey was conducted using a self-administered questionnaire regarding knowledge, attitude, and behavior regarding the hazards of tobacco use and COTPA law. Samples size of 400 parents of adolescents aged between 10 and 16 years visiting to the department of Pediatrics and Preventive Dentistry were included in the study, data thus obtained was subjected to statistical analysis.

Smoking tobacco product known to the parent population in the present study is cigarette (88.8%) and smokeless tobacco product is *pan masala* (65.2%). The tobacco health hazard known is cancer by 70.5 and 85.3% parent populations were

aware of mandatory display of pictorial health warnings in COTPA law. Strict implementation of COTPA law was opted by 61.8%.

Knowledge, attitude, and behavior of parents is required to educate and motivate adolescents. Parents have given their positive attitude regarding the strict implementation of COTPA law in India and realize the role of tobacco as a causative factor for health hazards both in children and adults. COTPA law should be made aware for both young and old to educate and motivate and to prevent the use of tobacco in India.

Thus the studies observed revealed the fact that tobacco consumption is one of the serious issue of the world. KAP studies are used widely to know the knowledge attitude and practices related to tobacco consumption and the ill effects of the tobacco consumption. It has also been found that awareness programs can play a vital role in reduction of tobacco consumption. Law related to tobacco control can be more effective if implemented in effective manner.

Research Methodology

Research is actually a voyage of discovery. We all possess the vital instinct of inquisitiveness for, when the unknown confronts us, we wonder and our inquisitiveness makes us probe and attain full and fuller understanding of the unknown. This inquisitiveness is the mother of all knowledge and the method, which man employs for obtaining the knowledge of whatever the unknown, can be termed as research.

The process of deciding how to systematically design research and conduct it is called Research Methodology. A research methodology is an outline of how a given piece of research is carried out. It defines the techniques or procedures that are used to identify and analyse information regarding a specific research topic. The research methodology, therefore, has to do with how a researcher designs their study in a way that allows them to obtain valid and reliable results and meet their research objectives.

Research methodology is the overall strategy or approach used by researchers to conduct research. It encompasses the theoretical and philosophical underpinnings of the research, the research design, data collection methods, data

analysis techniques, and the overall framework within which the research is conducted.

Methodology of research is an essential aspect of researching to ensure that the research process is systematic, rigorous, reliable, and valid. Here are some reasons why methodology in research is important:

1. Clarity and precision:

It provides a framework and guidelines for researchers to clearly define their research questions, objectives, and hypotheses. It helps researchers identify the most appropriate research design, sampling techniques, data collection methods, and data analysis procedures to ensure that the research is conducted with precision and clarity.

2. Validity and reliability:

Research methodology helps researchers ensure that their research findings are valid and reliable. Validity helps identify accuracy and truthfulness of research results, while reliability refers to the consistency and stability of research findings over time. Proper methodology helps in minimizing biases, errors, and confounding factors that may affect the validity and reliability of research results.

3. Ethical Considerations:

It provides ethical guidelines and principles that researchers must follow while conducting research involving human subjects, animals, or sensitive data. It helps researchers ensure that their research is conducted ethically, respecting the rights and dignity of research participants, and following appropriate ethical standards and regulations.

4. Replicability:

Research methodology emphasizes the importance of replicability of research findings. Replicability means that other researchers should be able to repeat the research study using the same methods and obtain similar results.

5. Representative:

This means that research findings can be applied to a broader population or context. Proper research methodology helps in designing research studies that are replicable and generalizable, enhancing the credibility and robustness of research findings.

6. Efficiency and resource utilization:

It helps researchers in planning and organizing their research study efficiently, optimizing the use of time, resources, and efforts. It ensures that

researchers use appropriate data collection methods, sample sizes, and statistical techniques to obtain meaningful results while minimizing unnecessary costs and efforts.

Research is a scientific investigation. Investigation means a search for new facts and ideas in any branch of knowledge. Thus, we can say that research is a search for knowledge. Research may be considered as a movement, a movement from the unknown to the known. It is actually a voyage of discovery.

Research is carried out for two purposes; one is the discovery of new facts and the second, verification of the old ones. The object of every research, of course, is the discovery of new facts, new relationship, and new laws governing the phenomena. But constant verification of the old concepts is also needed especially in dynamic world.

Common sense knowledge, based on the accumulated experiences, prejudices and beliefs of the people is often contradictory and inconsistent. On the other hand, scientific observations are based on verifiable evidence or systematic body of proof that can be cited. For example, some common sense statements are: man is more intelligent than woman; married men remain happier than single people; rural people are more hardworking than urban people etc. Contrary to this,

the scientific research or scientific inquiry finds that woman is as intelligent as man; there is no association in happiness and marriage; hard work is not related to environment alone. Thus, a statement based on common sense is just a guess or prejudice or mistaken interpretation, though at times it may be true, wise and a useful bit of knowledge. But it is not based on any scientific evidence. A scientific statement is based on accumulated systematic knowledge through research.

The word research is derived from the Latin word meaning to know. It is a systematic and a replicable process, which identifies and defines problems, within specified boundaries. It employs well-designed method to collect the data and analyses the results. It disseminates the findings to contribute to generalizeable knowledge.

A research study plays a very vital role in studying, understanding and solving a problem related to any field. Research is a process of obtaining dependable solutions through systematic and scientific investigations. In the modern environment where operational problems are of complex nature, research provides a solution oriented carefully designed procedures. Research helps us to discover the functional relationships among various phenomena that exist in any field of life. Decision-making under uncertainty is a fact in every sphere of a life. Research provides us inferences and generalizations that help in forecasting the future happenings in any field.

Types of Research

Research is a multidimensional activity. It comes in various forms and is used in all social, behavioral, educational, economical and management sciences. According to the approach and method involved in a research, one can classify the following types of research.

1. Descriptive v/s Analytical (Experimental) research

Descriptive research basically describes what is. It mainly involves collection, recording, describing and analyzing the facts related to the study. It tries to find the existing status, trend and state of affairs in a phenomenon. Descriptive research involves surveys, but they are not merely data collection as they also involve measurement, classification, analysis, comparison and interpretation. In this type of research the variable under study are uncontrollable. One can only observe and report what is happening in a situation. Analytical research, on the other hand deals with what will be. In this type of research, the variables involved are carefully and scientifically controlled and manipulated. Analytical research is also known as experimental research and is a very sophisticated technique. This kind of research is based on four important characteristics namely; control, manipulation, observation and replication.

2. Applied v/s Fundamental research

Applied research is action oriented or solution oriented. The main goal of an applied research is to obtain an immediate, specific and practical solution of a problem that a business or educational organization is facing right now. It gives here and now solutions in actual problem situations. It involves scientific investigations but the methods are not so rigorous as in fundamental research. It finds solutions to be applied in local environment and they may not be universally acceptable. Applied research does not promise to add new knowledge to the discipline. Fundamental research is carried out to scientifically enhance the organized body of knowledge of a discipline. Also known as basic research, it is concerned with formulation of theory and generalizations of principles. To evaluate and expand a formulated theory it may use empirical data. Basic research involves systematic, highly sophisticated scientific techniques. Fundamental research may not suggest the solutions of immediate problems, it rather draws long term conclusions.

3. Quantitative v/s Qualitative research

Quantitative research is based on quantitative variables, which can be measured in appropriate units. These involve objects and individuals that vary in size, quantity, amount, scale or degree. For example, prices of commodity can be measured in rupees, weight of a product is measured in kilograms and the mileage of vehicle is measured in kilometers per liter. Qualitative research, on the other hand, is based on qualitative variables, which vary in quality of type. These variables cannot be

measured on a scale or in any units. Social scientists use qualitative research for studying human behaviour. In market research surveys qualitative research is carried out to investigate the likes and dislikes of customers. It helps in understanding the current pattern of demand of a company's products.

4. Conceptual v/s Empirical research

Conceptual research involves the development of new theories, abstract ideas, and generalized principles. Philosophers, intellectuals and thinkers carry out this kind of research. On the basis of their conceptual knowledge they build theoretical models. Conceptual research is an intellectual process to develop and verify knowledge. Empirical research is based on observation and experimentation. The information collected in the form of facts develops the conclusions and theories about a phenomenon. The models, so developed, can again be verified by a replication of data collection. To test a given hypothesis empirical research is most popular and powerful tool in the modern world.

5. Other types of research:

Any research study is derivation of one or the other of above four types of research. One can further classify a research on the basis of its purpose, time taken and the discipline of knowledge it relates to. For example, Historical research is the study of past events, historical documents, remains and relics. Clinical research is employed

to study the effects of a new drug. Market research is performed to forecast the potential demand of a product. One- time research is carried out on a small scale in short period with a specific purpose. Educational research is directed towards the study and development of educational system. Social research is concerned with the social problems of the society. Field research is done by going out in the field or market, where as Laboratory research is carried out with in four walls of a laboratory.

The present research work is a The proposed study is Analytical and Descriptive research. Survey Method will be used for data collection. Half part of this research work is analytical in nature where as half part is Descriptive in nature. In this research work there has been analysis of National Tobacco Control Program, in this way it is analytical. After this a sample of tobacco consumers, Tobacco seller was selected and KAP (Knowledge, Attitude and Practice) survey was done on them, in this way it is descriptive research. Data collection was done through survey method.

Thus the researcher followed the basics of both types of research in carrying out the research work. A very clear distinction between both types of research can be seen in this work.

Once the type of research work is decided related literature review is done.

Related Literature Review:

Related literature review is the process of collecting, selecting, and reading books, periodicals, reports, abstracts, and other reference materials. The following information may be collected while conducting review :

1. Background knowledge of the problem and related concepts.
2. Theories that explain the existence of a problem and the possible relationship between certain factors and the problem
3. Data that confirms the existence and severity of the problem
4. General and specific findings of the study related to the problem
5. Recommendations for further study given in related studies

Reason for Review Literature

Review of related literature is essential in research. Following are some obvious reasons-

1. It helps the researcher to identify and define a research problem
2. It helps to justify the need for study of a problem

3. It prevents unnecessary duplication of a study
4. It can be the source of the theoretical basis of the study
5. It enables the researcher to learn how to conceptualize a research problem and properly identify and operationally define study variables
6. It helps in creating and refining research equipment
7. It provides guidance for analysis and interpretation of data.

While the research problem is still being conceptualized, the researcher should start reviewing the literature in advance. In identifying and defining a research problem, the researcher must be able to show evidence that the problem actually exists and is worth investigating.

It is important that the researcher knows what is already known about the problem or what earlier researchers have found about it and what questions need to be answered before finalizing the research questions or objectives.

The theories that researchers use to explain the existence of a research problem and are used as a basis in the analysis of relationships between variables can be derived

from references, books on theories, or from related studies. Therefore, the researcher should read enough literature already at the beginning of the research activity.

Sources to review

1. General Reference

Examples are indexes, reviews and abstracts.

2. Primary Source

Examples are research found on published journals.

3. Secondary Source

It is a publication where, authors cite the works of others. Examples are books, encyclopedias. Secondary sources are good references for an overview of the problem.

The function of the review is to provide an insight into the trend to be followed in the area in which the research is to be carried out - it also helps to avoid inadvertent duplication of well-established finding and to provide a path through which research can be conducted effectively; It also helps to delineate and helps to define the problem.

The review gives an understanding of the research methodology which refers to the way the study is conducted. It helps to know about the tools and related tools that have been shown to be useful and promising in previous studies.

The main objective of this chapter is to provide a systematic survey of the current study area / past research carried out in the relevant area.

Reviewing the literature means that it is able to identify the following points:

- ✓ What is established, rejected and accepted in your area'
- ✓ areas of conflict or conflict between different theories of thought
- ✓ Problems or issues that remain unresolved
- ✓ Emerging trends and new perspectives
- ✓ How your research builds on and differs from previous research.

Literature review offers much more than a summary of relevant sources. The task of review involves evaluating individual sources as well as synthesizing these sources to obtain a comprehensive view of the field. At this 'field level', a literature review discusses common and emerging perspectives, notable patterns and trends, areas of conflict and controversy, and gaps within the relevant literature. When you can see

these things clearly, you will be able to set up your own research and contribute to the ongoing debate within the field.

In other words, when reviewing literature not only do you need to engage with a set of literature, you also need to be able to compare, contrast, synthesize and argue against that literature to make a contribution, indicate readiness.

Literature review exists within a variety of scholarly works with varying focus and importance. Short or short literature reviews may be presented in journal articles, book chapters or research work to set the background for the research work and provide a general understanding of the research topic.

However, the focus of a literature review in a research thesis is to identify gaps and argue for the need for further research. Depending on the author's purpose and the context in which the literature review will be presented, a selective or comprehensive approach may be taken.

In the selective approach, one or a limited number of sources are reviewed (for example an annotated bibliographic assignment, or the introduction of a journal article).

A comprehensive approach requires the review of multiple books and articles (such as in a review article), which can be submitted as a key chapter in a research thesis or self-published as a scholarly review article. can be done.

Reviewing literature is a continuous, non-linear and iterative process. Your literature review will help your questions, theories, and methods determine the parameters of your literature review - it is a cyclical process.

It is usually one of the first tasks that the research student undertakes and also one of the last that must be done before the research work can be completed. A literature review written in the early stages of research is prone to change because you need to review and revise it from time to time and make sure it is up to date. You will probably find yourself engaging with related literature in different ways at different stages of your research.

Review of related literature of the present study has also been done. Review from various sources including offline and online sources were investigated and relevant reviews were presented and discussed in chapter-2 of the thesis work. These reviews gave an insight to the researcher which helped in carrying out this research work successfully.

Research Procedure

The research procedure for the present research work may be described under five major headings. These are - (i) Sampling Procedure, (ii) Construction of tools, (iii) Scheme of data Collection & (iv) Program for processing & analysis of data.

1. Sampling Procedure

Population:

Regardless of the technique to be used in selecting a sample, the first step in sampling is definition of the population. In research terminology the Population can be explain as a comprehensive group of individuals, institutions, objects and so forth with have a common characteristics that are the interest of a researcher. The common characteristics of the groups distinguish them from other individual, institutions, objects and so forth. The term universe is also used as synonyms to population.

In a research study once the problem is defined and a research design is prepared, the next step is to collect data on items or individuals related to the study.

Collecting information on all the items, objects, individuals or organizations is a huge task involving a lot of money, time and staff. It is a therefore, sounds reasonable to study a portion of these items and try to draw conclusions on all of them. This is called Sampling.

A population is defined as the totality of all possible values (measurements or counts) of a particular characteristic of interest for a specified group of objects or persons. This specified group of objects is also called a ‘universe’.

A population is called finite if it consists of a finite and fixed number of individuals or elementary units. A population will be called infinite if this number is infinite or statistically very large. For example, students in your university in a particular year constitute a finite population, whereas the number of leaves on a big tree will constitute an infinite population. As mentioned above it is not always possible, or very expensive and time consuming to study the whole population. We therefore, take out a representative portion of the population, called a sample, and investigate all the items in the sample thoroughly. It results in saving time, money and staff and leads to more accuracy in observation.

For the study in hand Tobacco users, Tobacco sellers and concerned authorities of NTCP implementation of Lucknow city have been taken as the realistic/ accessible population.

Sampling Techniques:

After identifying and defining the research problem and determining specific information required to solve the problem, the task is to look for the type and sources of data which may yield the desired results.

There are two types of sources of data (i) Primary data and (ii) Secondary data, available for the research. Primary data generated when a particular problem at hand is investigated employing mail questionnaires, telephone surveys, personal interviews, observations and experiments. Secondary data include those data which are collected for some earlier research work and are applicable or usable in the study, presently undertaken.

Regardless of the method used to obtain the primary data, it has to be, decided whether the information is to be obtained from every unit of the population under study or only a portion of the population will be used. The first approach, that is, collecting data about each and every unit of the population is called “census

method” the latter approach, where only few units of population under study considered for analysis, is called sampling method/technique.

Sometimes it is difficult/not necessary/not required (as per the need of the study) to collect information about each of the population units as is done under complete method. *As per the need of the study undertaken by the researcher, the sampling approach was used.*

The process of selection or the drawing of the accurate representation of a unit, group or sample from a population of interest is called as sampling. Sampling can be done through various sampling techniques in accordance with the nature of the sample as well as the subject matter of the study. It is the Sampling procedure, which will decide the accurate representation of the sample selected for the study as well as the relevance of generalization made from the research.

There are two main categories of sampling (i) Probability Sampling (ii) Non-Probability Sampling, under which various sampling methods/techniques are included.

(i) Probability Sampling

A probability sample is chosen in such a way that each member of the universe/population has a known chance of being selected. It is this condition known

chance-that enables statistical procedures to be used on the result to estimate sample errors. The most frequently used probability samplings are:

- (a) Simple Random Sampling
- (b) Systematic Sampling
- (c) Stratified Sampling &
- (d) Cluster Sampling

(ii) Non- Probability Sampling

In this the chance of any particular unit of population being selected is unknown. Since randomness is not involved in the selection process, an estimate of the sampling error cannot be made. But this does not mean that the findings obtained from non-probability sampling are of questionable value. If properly conducted, findings can be as accurate as those obtained from probability sampling. The three most frequently used non-probability sampling designs are:

- (a) Purposive/Judgement Sampling
- (b) Convenience Sampling
- (c) Quota Sampling

As the nature of the method picked for the research it was decided to go for the non probability sampling method. Here arose the question of selection of type of non probability method of sampling. The researcher decided to go for Purposive Sampling.

The sample selection procedure involved purposive sampling. Tobacco users were selected keeping in view their being Literate and Illiterate living in Lucknow City. Equal number of Literate and Illiterate Tobacco users was selected from different areas of city to remove the possibility of being biased.

Then the sample of Tobacco sellers was selected. They were selected from different areas of the Lucknow City just to remove the possibility of being bias.

Only those **NTCP** implementing authorities were selected as sample who agreed to share their views (but anonymously).

1.3 Sample Size

Sample size refers to the number of participants or observations included in a study.

The sample size is a term used in research for defining the number of subjects included in a sample size. By sample size, we understand a group of subjects that are selected from the general population and are considered a representative of the real population for that specific study. Sample size of the population plays a vital role in making a study more precise.

For the research purpose (Keeping in view the objective of the study) total 320 Tobacco Users, 160 Tobacco sellers have been selected. Only 3 concerned authorities related to implantation of National Tobacco Control Program have been the part of sample. The sample size is given in the table given on next page:

Table for Tobacco Users

Rural				Urban				Total
160				160				
Literate		Illiterate		Literate		Illiterate		
80		80		80		80		
Male	Female	Male	Female	Male	Female	Male	Female	
40	40	40	40	40	40	40	40	
								320

Table for Tobacco Sellers

Rural				Urban				Total
80				80				
Literate		Illiterate		Literate		Illiterate		
40		40		40		40		160

2. Construction of Tool

Tools are used for measurement of various variables included in the study. Tools are very important aspect of research work. Tools have the various methods to reach the respondent for collecting primary data. Primary data can be collected by three basic methods, viz. surveys, observations and experiments. Survey method is the systematic gathering of data from respondents through rating scales/questionnaires /opinionnaires. The survey method is to facilitate understanding or enable prediction of some aspects of behaviour of the population being surveyed.

As per the need of the research work it was decided to resort to survey method. For data collection a KAP (Knowledge, Attitude and Practice) survey tool was constructed.

Construction of KAP (Knowledge, Attitude and Practice) survey tool

This tool was used to study Knowledge, Attitude and Practice related to National Tobacco Control Program and tobacco products consumption/selling. For both categories (Tobacco Consumers and Tobacco Sellers) Knowledge contains same questions where as attitude and practice questions varies. The following procedure was followed for construction of tool for both the groups.

Framing of Items:

Keeping in view the objectives of the study and the focus area of the research items were framed for the tool construction.

The first blueprint of the tool was prepared with 90 statements i.e. 30 statements from each Knowledge, Attitude and Practice.

Editing of the first Blueprint:

The first blueprint of the tool was handed over to the experts of the field and their suggestions were sought on the following aspects:

- (i) Language of the statements
- (ii) Relevance of the items in context to concerned factors
- (iii) Relevance to be categorised under heading- more relevant, average & least relevant.
- (iv) Sequence of the items
- (v) Is there any item in any factor which is overlapping to any other factor.?

After receiving each one's suggestions and comparison of the suggestions given by each of the expert 60 items were selected for the tool that was prepared for the try out.

The basis of the rejection of items, before preparing tool, for try-out has been following:

- (i) Those items which have been mentioned least relevant by each expert. These were around 16 items
- (ii) Then those items have been rejected which have been mentioned least relevant by majority of the experts. These were around 9 items.
- (iii) Then 5 items have been rejected on the basis of being having overlapping content.

Total 30 items were rejected.

Try-out of the Second level of Tool:

At this stage rating scale was containing 60 items. For the purpose of try-out the same sample of 160 Tobacco Users and 100 Tobacco Sellers was chosen. The respondents' responses were taken personally.

Scoring:

The items that have answers in YES/NO got 1 mark for YES and 0 for NO. For Negative statements the scoring reversed. Such statements were 20 in number thus 20 maximum marks for these 20 statements.

The statements that have answers in 3 multiple choice got 3 marks for most relevant answer and 1 for least relevant answer and 2 marks for second relevant answer. Such statements were 40 in number thus 120 maximum marks for these 40 statements.

The scores of all items have been added to obtain a total score for each respondent. The score of the respondents ranged from 40 to 140.

Item Analysis:

Item analysis of each the item was done to decide as to which are the best items for the final form of the tools

To do the item analysis, following steps were taken:

- (i) Arranged the total scores of the respondents from lowest to the highest scores

- (ii) Selected the top 25 percent of the scores and bottom 25 percent of scores
- (iii) Selected the top 25 percent extreme groups as criterion groups for evaluating individual items.
- (iv) Calculated the mean scores for each item among the high scores and the low scores.
- (v) Tested the significance of difference between the item mean of the high-score group and that of the low-score group by calculating 't' value.
- (vi) Retained only those items which had the highest 't' values .

Final Form of The Tool:

Thus 10 items each for Knowledge, Attitude and Practice were selected and the final form of tools containing 30 items was prepared.

Reliability of the Final Tool:

To determine the reliability of the final rating tool (containing 30 items) to study the KAP, Split-Half method of reliability was adopted. The following steps were taken to get the reliability of the tool:

- (i) The final tool was administered on 160 tobacco users and 100 tobacco sellers.
- (ii) On the basis of an odd-even split, in which the odd numbered items form one half of the tool and the even-numbered items form the other, the tool was divided into two halves.
- (iii) Found the correlation coefficient .69 between two halves by Pearson 'r' formula.
- (iv) The correlation between these two split halves is used in estimating the reliability of the test. This halves reliability estimate is then stepped up to the full test length using the Spearman-Brown prediction formula: $r = \frac{2r}{1+r}$.

Using the above formula $r = \frac{2 \times .69}{1 + .69}$

Reliability level of the rating scale was calculated to be .81

Validity:

Validity is the extent to which a test measures what it claims to measure. It is vital for a test to be valid in order for the results to be accurately applied and interpreted.

The face validity of the tool was obtained. Face validity is a property of a test intended to measure something. It is the validity of a test at face value. In other words, a test can be said to have face validity if it "looks like" it is going to measure what it is supposed to measure. For instance, if one prepares a test to measure whether students can perform multiplication and the people you show it to all agree that it looks like a good test of multiplication ability, one has shown the face validity of one's test.

The final tool was handed over to the experts to get the face validity of the tool. They all agreed to the fact that the tool has the face validity.

Thus the tool was finalized for the proposed research. Total statements 30 maximum score -70 Minimum Score-20.

Background Sheet:

A response sheet to collect personal information about the respondents was also prepared to collect background information about the tobacco users and tobacco sellers participating in the study.

3. Scheme of Data Collection

The data was collected personally. Tobacco users were identified while consuming tobacco products or buying and consuming tobacco products from tobacco products sellers. They were contacted and requested to spare some time to answer some questions that could be helpful for them also. Those who agreed became the part of sample of the study. This way sample was identified from rural and urban areas of Lucknow city.

Before administering the test a brief introduction was given to the respondents regarding replying the statements, given in the tests.

The data was collected from the selected sample of tobacco product consumers. First, response sheet to collect background information of tobacco consumers was given to fill in and then the statements were told to them with possible replies and their responses were recorded on the sheet.

Tobacco product sellers were also requested to spare some time to answer certain questions. Data was collected in the same way data was collected from tobacco consumers.

Concerned authorities related to National Tobacco Control Program were asked just two open-ended questions, which they answered anonymously.

4. Program for Processing & Analysis of Data.

First of all on the basis of scores on both the test Mean and Sd. Value were computed as per whole group and gender of both the groups. In the second stage to study the significant difference for each of the group 't' values were computed. The significance of 't' value was tested at .05 and .01 level of significance.

Result, Discussion & Interpretation

Keeping in mind the objectives of the research this chapter deals with the analysis and interpretation of data. In order to arrive at certain conclusions and to achieve the objective of the study a systematic treatment of data is needed which consists of three stages namely tabulation of the data, testing of the hypothesis using appropriate statistical techniques and discussion of the results. This chapter if not presented in a proper way the whole hard work of doing research work and preparing thesis report goes in vain.

To get the answer of the two hypothesis, data has been presented in the tabular form and to further analyse these hypothesis some sub hypothesis have been formulated for each of the hypothesis keeping in view the objective of the research. Related data is represented in the tables giving N, Mean, S.D. and t values. If the t value has been found significant at .01 or .05 level of significance hypothesis is rejected, and if not found significant at both level it is accepted.

Objective 3.

To assess the Knowledge, Attitude and Practice (KAP) of tobacco users.

Hypothesis for Objective- 3

Hypothesis 3.1 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between rural and urban tobacco users.

Table-1

KAP	N	M	Sd	t
Rural Tobacco Users	160	35.2	9.32	1.99
Urban Tobacco Users	160	48.6	8.36	p<.05

Result:

Table 1 shows that the mean values of scores of test on KAP of Rural Tobacco Users and Urban Tobacco Users are 35.2 and 48.6 respectively, with S.D. value of 9.32 and 8.36 respectively. 't' value between two means is 1.99, which is statistically significant ($p < .05$). Thus hypothesis 3.1 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between rural and urban tobacco users.

The mean score of KAP for Urban Tobacco Users is more than Rural Tobacco Users which means that Urban Tobacco Users are better in KAP score than Rural Tobacco Users

Sub-Hypothesis 3.1.1

There will be no significant difference of Knowledge between rural and urban tobacco users.

Table-1.1

Knowledge (about NTCP)	N	M	Sd	t
Rural Tobacco Users	160	3.22	1.34	3.23 p<.01
Urban Tobacco Users	160	6.82	2.32	

Result:

Table 1.1 shows that the mean values of scores of test on Knowledge level of Rural Tobacco Users and Urban Tobacco Users are 3.24 and 6.82 respectively, with S.D. value of 1.34 and 2.32 respectively. ‘t’ value between two means is 3.23, which is statistically significant (p<.01). Thus sub-hypothesis 3.1.1 is rejected which means that there is significant difference of Knowledge between rural and urban tobacco users.

The mean score of Knowledge for Urban Tobacco Users is more than Rural Tobacco Users which means that Urban Tobacco Users are better in knowledge level score than Rural Tobacco Users

Sub-Hypothesis-3.1.2

There will be no significant difference of Attitude between rural and urban tobacco users.

Table-1.2

Attitude (Towards NTCP)	N	M	Sd	t
Rural Tobacco Users	160	11.38	6.35	2.03 p<.05
Urban Tobacco Users	160	24.78	7.68	

Result:

Table 1.2 shows that the mean values of scores of test on Attitude of Rural Tobacco Users and Urban Tobacco Users are 11.38 and 24.78 respectively, with S.D. value of 6.35 and 7.68 respectively. 't' value between two means is 2.03, which is statistically significant ($p < .05$). Thus hypothesis 3.1.2 is rejected which means that there is significant difference of Attitude between rural and urban tobacco users.

The mean score of Attitude for Urban Tobacco Users is more than Rural Tobacco Users which means that Urban Tobacco Users have better attitude towards NTCP than Rural Tobacco Users

Sub-Hypothesis 3.1.3

There will be no significant difference in Practice between rural and urban tobacco users.

Table-1.3

Practice (To consume Tobacco)	N	M	Sd	t
Rural Tobacco Users	160	20.58	8.56	2.11 p<.05
Urban Tobacco Users	160	17.00	8.53	

Result:

Table 1.3 shows that the mean values of scores of test on Practice (to consume tobacco) of Rural Tobacco Users and Urban Tobacco Users are 20.58 and 17.00 respectively, with S.D. value of 8.56 and 8.53 respectively. ‘t’ value between two means is 2.11, which is statistically significant (p<.05). Thus hypothesis 3.1.3 is rejected which means that there is significant difference in Practice (to consume tobacco) between rural and urban tobacco users.

The mean score of Practice (to consume tobacco) for Urban Tobacco Users is less than Rural Tobacco Users which means that Rural Tobacco Users Practice to consume tobacco is more Urban Tobacco Users.

Hypothesis 3.2 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between male and female tobacco users.

Table- 2

KAP	N	M	Sd	t
Male Tobacco Users	160	47.40	10.88	2.32
Female Tobacco Users	160	36.60	8.93	p<.05

Result:

Table 2 shows that the mean values of scores of test on KAP of Male Tobacco Users and Female Tobacco Users are 47.40 and 36.60 respectively, with S.D. value of 10.88 and 8.93 respectively. 't' value between two means is 2.32, which is statistically significant ($p < .05$). Thus hypothesis 3.2 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between male and female tobacco users.

The mean score of KAP for male Tobacco Users is more than female Tobacco Users which means that Male Tobacco Users are better in KAP score than Female Tobacco Users

Sub-Hypothesis 3.2.1 There will be no significant difference of Knowledge between male and female tobacco users.

Table- 2.1

Knowledge (About NTCP)	N	M	Sd	t
Male Tobacco Users	160	6.70	4.94	2.60
Female Tobacco Users	160	3.36	2.11	p<.01

Result:

Table 2.1 shows that the mean values of scores of test on Knowledge level of Male Tobacco Users and Female Tobacco Users are 6.70 and 3.36 respectively, with S.D. value of 4.94 and 2.11 respectively. ‘t’ value between two means is 2.60, which is statistically significant (p<.01). Thus hypothesis 3.2.1 is rejected which means that there is significant difference of Knowledge between male and female tobacco users.

The mean score of Knowledge for male Tobacco Users is more than female Tobacco Users which means that Male Tobacco Users are better in Knowledge score than Female Tobacco Users.

Hypothesis 3.2.2 There will be no significant difference of Attitude between male and female tobacco users.

Table- 2.2

Attitude (Towards NTCP)	N	M	Sd	t
Male Tobacco Users	160	21.36	9.22	2.18 p<.05
Female Tobacco Users	160	14.80	7.13	

Result:

Table 2.2 shows that the mean values of scores of test on Attitude of Male Tobacco Users and Female Tobacco Users are 21.36 and 14.80 respectively, with S.D. value of 9.22 and 7.13 respectively. 't' value between two means is 2.18, which is statistically significant ($p < .05$). Thus hypothesis 3.2.2 is rejected which means that there is significant difference of Attitude between male and female tobacco users.

The mean score of Attitude for male Tobacco Users is more than female Tobacco Users which means that Male Tobacco Users are better in Attitude score than Female Tobacco Users.

Hypothesis 3.2.3 There will be no significant difference of Practice
between male and female tobacco users.

Table- 2.3

Practice (To consume Tobacco)	N	M	Sd	t
Male Tobacco Users	160	21.38	9.08	2.05
Female Tobacco Users	160	16.20	6.98	p<.05

Result:

Table 2.3 shows that the mean values of scores of test on Practice of Male Tobacco Users and Female Tobacco Users are 21.38 and 16.20 respectively, with S.D. value of 9.08 and 6.98 respectively. ‘t’ value between two means is 2.05, which is statistically significant (p<.05). Thus hypothesis 3.2.3 is rejected which means that there is significant difference of Practice between male and female tobacco users.

The mean score of Practice for male Tobacco Users is more than female Tobacco Users which means that Male Tobacco Users practice to consume tobacco is more than Female Tobacco Users.

To analyse further sub-hypothesis have been formulated and tested.

Sub-Hypothesis 3.2.A There will be no significant difference of Knowledge, Attitude and Practice (KAP) between Urban male and Rural male tobacco users.

Table-2.4

KAP	N	M	Sd	t
Urban Male Tobacco Users	80	52.00	10.38	2.09
Rural Male Tobacco Users	80	42.80	8.23	p<.05

Result:

Table 2.4 shows that the mean values of scores of test on KAP of Urban Male Tobacco Users and Rural Male Tobacco Users are 52.00 and 42.8 respectively, with S.D. value of 10.38 and 8.23 respectively. 't' value between two means is 2.09, which is statistically significant ($p<.05$). Thus hypothesis 3.2.A.1 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between urban and rural male tobacco users.

The mean score of KAP for Urban male Tobacco Users is more than Rural Male Tobacco Users which means that Urban Male Tobacco Users are better in KAP score than Rural Male Tobacco Users

Sub-Hypothesis 3.2.A.1

There will be no significant difference of Knowledge between Urban Male and Rural Male tobacco users.

Table-2.5

Knowledge (about NTCP)	N	M	Sd	T
Urban Male Tobacco Users	80	8.92	2.67	2.68 p<.01
Rural Male Tobacco Users	80	4.64	2.03	

Result:

Table 2.5 shows that the mean values of scores of test on Knowledge level of Urban Male Tobacco Users and Rural Male Tobacco Users are 8.92 and 4.64 respectively, with S.D. value of 2.67 and 2.03 respectively. 't' value between two means is 2.68, which is statistically significant ($p < .01$). Thus sub-hypothesis 3.2.A.1 is rejected which means that there is significant difference of Knowledge between Urban Male and Rural Male tobacco users.

The mean score of Knowledge for Urban Male Tobacco Users is more than Rural Male Tobacco Users which means that Urban Male Tobacco Users are better in knowledge level score than Rural Male Tobacco Users

Sub-Hypothesis-3.2.A.2

There will be no significant difference of Attitude between Urban Male and Rural Male tobacco users.

Table-2.6

Attitude (Towards NTCP)	N	M	Sd	T
Urban Male Tobacco Users	80	27.46	9.73	2.12 p<.05
Rural Male Tobacco Users	80	16.26	7.47	

Result:

Table 2.6 shows that the mean values of scores of test on Attitude of Urban Male Tobacco Users and Rural Male Tobacco Users are 27.46 and 16.26 respectively, with S.D. value of 9.73 and 7.47 respectively. ‘t’ value between two means is 2.12, which is statistically significant ($p<.05$). Thus hypothesis 3.2.A.2 is rejected which means that there is significant difference of Attitude between Urban Male and Rural Male tobacco users.

The mean score of Attitude for Urban Male Tobacco Users is more than Rural Male Tobacco Users which means that Urban Male Tobacco Users have better attitude towards NTCP than Rural Male Tobacco Users.

Sub-Hypothesis 3.2.A.3

There will be no significant difference in Practice between Urban Male and Rural Male tobacco users.

Table-2.7

Practice (To consume Tobacco)	N	M	Sd	T
Urban Male Tobacco Users	80	18.98	7.82	1.98 p<.05
Rural Male Tobacco Users	80	23.78	8.26	

Result:

Table 2.7 shows that the mean values of scores of test on Practice (to consume tobacco) of Urban Male Tobacco Users and Rural Male Tobacco Users are 18.98 and 23.78 respectively, with S.D. value of 7.82 and 8.26 respectively. 't' value between two means is 1.98, which is statistically significant ($p < .05$). Thus hypothesis 3.2.A.3 is rejected which means that there is significant difference in Practice (to consume tobacco) between Urban Male and Rural Male tobacco users.

The mean score of Practice (to consume tobacco) for Urban Male Tobacco Users is less than Rural Male Tobacco Users which means that Rural Male Tobacco Users Practice to consume tobacco is more than Urban Male Tobacco Users.

Sub-Hypothesis 3.2.B There will be no significant difference of Knowledge, Attitude and Practice (KAP) between Urban female and Rural female tobacco users.

Table-2.8

KAP	N	M	Sd	t
Urban Female Tobacco Users	80	45.20	11.02	2.24
Rural Female Tobacco Users	80	28.00	7.89	p<.05

Result:

Table 2.8 shows that the mean values of scores of test on KAP of Urban Female Tobacco Users and Rural Female Tobacco Users are 45.20 and 28.00 respectively, with S.D. value of 11.02 and 7.89 respectively. 't' value between two means is 2.24, which is statistically significant ($p < .05$). Thus hypothesis 3.2.B is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between urban and rural female tobacco users.

The mean score of KAP for Urban female Tobacco Users is more than Rural female Tobacco Users which means that Urban Female Tobacco Users are better in KAP score than Rural Female Tobacco Users

Sub-Hypothesis 3.2.B.1

There will be no significant difference of Knowledge between Urban Female and Rural Female tobacco users.

Table-2.9

Knowledge (about NTCP)	N	M	Sd	T
Urban Female Tobacco Users	80	4.68	2.21	1.86 p>.01
Rural Female Tobacco Users	80	2.04	1.13	

Result:

Table 2.9 shows that the mean values of scores of test on Knowledge level of Urban Female Tobacco Users and Rural Female Tobacco Users are 4.68 and 2.04 respectively, with S.D. value of 2.21 and 1.13 respectively. 't' value between two means is 1.86, which is statistically not significant ($p > .05$). Thus sub-hypothesis 3.2.B.2 is accepted which means that there is no significant difference of Knowledge between Urban Female and Rural Female tobacco users.

The mean score of Knowledge for Urban Female Tobacco Users is more than Rural Female Tobacco Users which means that Urban Female Tobacco Users are better in knowledge level score than Rural Female Tobacco Users but not in significant manner.

Sub-Hypothesis-3.2.B.2

There will be no significant difference of Attitude between Urban Female and Rural Female tobacco users.

Table-2.10

Attitude (Towards NTCP)	N	M	Sd	T
Urban Female Tobacco Users	80	22.10	8.87	2.19 p<.05
Rural Female Tobacco Users	80	07.50	4.26	

Result:

Table 2.10 shows that the mean values of scores of test on Attitude of Urban Female Tobacco Users and Rural Female Tobacco Users are 22.10 and 07.50 respectively, with S.D. value of 8.87 and 4.26 respectively. ‘t’ value between two means is 2.19, which is statistically significant ($p<.05$). Thus hypothesis 3.2.B.2 is rejected which means that there is significant difference of Attitude between Urban Female and Rural Female tobacco users.

The mean score of Attitude for Urban Female Tobacco Users is more than Rural Female Tobacco Users which means that Urban Female Tobacco Users have better attitude towards NTCP than Rural Female Tobacco Users.

Sub-Hypothesis 3.2.B.3

There will be no significant difference in Practice between Urban Female and Rural Female tobacco users.

Table-2.11

Practice (To consume Tobacco)	N	M	Sd	T
Urban Male Tobacco Users	80	15.02	7.35	1.85 p>.05
Rural Male Tobacco Users	80	17.38	8.12	

Result:

Table 2.11 shows that the mean values of scores of test on Practice (to consume tobacco) of Urban Female Tobacco Users and Rural Female Tobacco Users are 15.02 and 17.38 respectively, with S.D. value of 7.35 and 8.12 respectively. 't' value between two means is 1.85, which is statistically not significant ($p > .05$). Thus hypothesis 3.2.B.3 is accepted which means that there is no significant difference in Practice (to consume tobacco) between Urban Female and Rural Female tobacco users.

The mean score of Practice (to consume tobacco) for Urban Female Tobacco Users is less than Female Male Tobacco Users which means that Rural Female Tobacco Users Practice to consume tobacco is more than Urban Female Tobacco Users but not significant.

Hypothesis 3.3 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between Literate and Illiterate tobacco users.

Table-3

KAP	N	M	Sd	t
Literate Tobacco Users	160	48.45	8.46	2.21
Illiterate Tobacco Users	160	35.35	7.39	p<.05

Result:

Table 3 shows that the mean values of scores of test on KAP of Litrate Tobacco Users and Illiterate Tobacco Users are 48.45 and 35.35 respectively, with S.D. value of 8.46 and 7.39 respectively. 't' value between two means is 2.21, which is statistically significant (p<.05). Thus hypothesis 3.3 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between Literate and Illiterate tobacco users.

The mean score of KAP for Literate Tobacco Users is more Illiterate Rural Tobacco Users which means that Literate Tobacco Users are better in KAP score than Illiterate Tobacco Users.

Sub-Hypothesis 3.3.1

There will be no significant difference of Knowledge between Literate and Illiterate tobacco users.

Table-3.1

Knowledge (about NTCP)	N	M	Sd	t
Literate Tobacco Users	160	7.36	3.86	2.91 p<.01
Illiterate Tobacco Users	160	2.70	3.37	

Result:

Table 3.1 shows that the mean values of scores of test on Knowledge level of Literate Tobacco Users and Illiterate Tobacco Users are 7.36 and 2.70 respectively, with S.D. value of 3.86 and 3.37 respectively. 't' value between two means is 2.91, which is statistically significant ($p < .01$). Thus sub-hypothesis 3.3.1 is rejected which means that there is significant difference of Knowledge between Literate and Illiterate tobacco users.

The mean score of Knowledge for Literate Tobacco Users is more than Illiterate Tobacco Users which means that Literate Tobacco Users are better in knowledge level score than Illiterate Tobacco Users.

Sub-Hypothesis-3.3.2

There will be no significant difference of Attitude between Literate and Illiterate tobacco users.

Table-3.2

Attitude (Towards NTCP)	N	M	Sd	T
Literate Tobacco Users	160	24.18	9.29	2.27 p<.05
Illiterate Tobacco Users	160	11.98	7.58	

Result:

Table 3.2 shows that the mean values of scores of test on Attitude of Literate Tobacco Users and Illiterate Tobacco Users are 24.18 and 11.98 respectively, with S.D. value of 9.29 and 7.58 respectively. ‘t’ value between two means is 2.27, which is statistically significant ($p<.05$). Thus hypothesis 3.3.2 is rejected which means that there is significant difference of Attitude between Literate and Illiterate tobacco users.

The mean score of Attitude for Literate Tobacco Users is more than Illiterate Tobacco Users which means that Literate Tobacco Users have better attitude towards NTCP than Illiterate Tobacco Users

Sub-Hypothesis 3.3.3

There will be no significant difference in Practice between Literate and urban tobacco users.

Table-3.3

Practice (To consume Tobacco)	N	M	Sd	T
Literate Tobacco Users	160	16.91	7.56	2.23 p<.05
Illiterate Tobacco Users	160	20.67	6.33	

Result:

Table 3.3 shows that the mean values of scores of test on Practice (to consume tobacco) of Literate Tobacco Users and Urban Tobacco Users are 16.91 and 20.67 respectively, with S.D. value of 7.56 and 6.33 respectively. 't' value between two means is 2.23, which is statistically significant ($p < .05$). Thus hypothesis 3.3.3 is rejected which means that there is significant difference in Practice (to consume tobacco) between Literate and urban tobacco users.

The mean score of Practice (to consume tobacco) for Literate Tobacco Users is less than Illiterate Tobacco Users which means that Illiterate Tobacco Users Practice to consume tobacco is more than Literate Tobacco Users.

To analyse further following sub-hypothesis have been formulated and tested.

Hypothesis 3.3.A.1 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between Urban Literate and Rural Literate tobacco users.

Table-3.4

KAP	N	M	Sd	t
Urban Literate Tobacco Users	80	58.68	10.42	2.68 p<.01
Rural Literate Tobacco Users	80	38.22	8.22	

Result:

Table 3.4 shows that the mean values of scores of test on KAP of Urban Literate Tobacco Users and Rural Literate Tobacco Users are 58.68 and 38.22 respectively, with S.D. value of 10.42 and 8.22 respectively. 't' value between two means is 2.68, which is statistically significant ($p < .01$). Thus hypothesis 3..3.A.1 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between Urban Literate and Rural Literate tobacco users.

The mean score of KAP for Urban Literate Tobacco Users is more than Rural Literate Tobacco Users which means that Urban Literate Tobacco Users are better in KAP score than Rural Literate Tobacco Users

Sub-Hypothesis 3.3.A.2

There will be no significant difference of Knowledge between Urban Literate and Rural Literate tobacco users.

Table-3.5

Knowledge (about NTCP)	N	M	Sd	t
Urban Literate Tobacco Users	80	9.13	4.52	1.97 p<.05
Rural Literate Tobacco Users	80	5.59	3.43	

Result:

Table 3.5 shows that the mean values of scores of test on Knowledge level of Urban Literate Tobacco Users and Rural Literate Tobacco Users are 9.13 and 5.59 respectively, with S.D. value of 4.52 and 3.43 respectively. 't' value between two means is 1.97, which is statistically significant ($p < .05$). Thus sub-hypothesis 3.3.A.2 is rejected which means that there is significant difference of Knowledge between Urban Literate and Rural Literate tobacco users.

The mean score of Knowledge for Urban Literate Tobacco Users is more than Rural Literate Tobacco Users which means that Urban Literate Tobacco Users are better in knowledge level score than Rural Literate Tobacco Users.

Sub-Hypothesis-3.3.A.3

There will be no significant difference of Attitude between Urban Literate and Rural tobacco users.

Table-3.6

Attitude (Towards NTCP)	N	M	Sd	t
Urban Literate Tobacco Users	80	29.27	10.34	2.82 p<.01
Rural Literate Tobacco Users	80	19.09	7.98	

Result:

Table 3.6 shows that the mean values of scores of test on Attitude of Urban Literate Tobacco Users and Rural Literate Tobacco Users are 29.27 and 19.09 respectively, with S.D. value of 10.34 and 7.98 respectively. ‘t’ value between two means is 2.82, which is statistically significant ($p<.01$). Thus hypothesis 3.3.A.3 is rejected which means that there is significant difference of Attitude between Urban Literate and Rural Literate tobacco users.

The mean score of Attitude for Urban Literate Tobacco Users is more than Rural Literate Tobacco Users which means that Urban Literate Tobacco Users have better attitude towards NTCP than Rural Literate Tobacco Users

Sub-Hypothesis 3.3.A.4

There will be no significant difference in Practice between Urban Literate and Rural Literate tobacco users.

Table-3.7

Practice (To consume Tobacco)	N	M	Sd	T
Urban Literate Tobacco Users	80	18.36	8.44	1.83 p>.05
Rural Literate Tobacco Users	80	15.46	7.87	

Result:

Table 3.7 shows that the mean values of scores of test on Practice (to consume tobacco) of Urban Literate Tobacco Users and Rural Literate Tobacco Users are 18.36 and 15.46 respectively, with S.D. value of 8.44 and 7.87 respectively. 't' value between two means is 1.83, which is statistically not significant ($p > .05$). Thus hypothesis 3.3.A.4 is accepted which means that there is no significant difference in Practice (to consume tobacco) between rural Literate and urban Literate tobacco users.

The mean score of Practice (to consume tobacco) for Urban Literate Tobacco Users is less than Rural Literate Tobacco Users which means that Rural Literate Tobacco Users Practice to consume tobacco is more than Urban Literate Tobacco Users but not significant.

Hypothesis 3.3.B.1 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between Urban Illiterate and Rural Illiterate tobacco users.

Table-3.8

KAP	N	M	Sd	T
Urban Illiterate Tobacco Users	80	38.52	8.57	2.19 p<.05
Rural Illiterate Tobacco Users	80	32.18	8.34	

Result:

Table 3.8 shows that the mean values of scores of test on KAP of Urban Illiterate Tobacco Users and Rural Illiterate Tobacco Users are 38.52 and 32.18 respectively, with S.D. value of 8.57 and 8.34 respectively. ‘t’ value between two means is 2.19, which is statistically significant ($p<.05$). Thus hypothesis 3..3.B.1 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between Urban Illiterate and Rural Illiterate tobacco users.

The mean score of KAP for Urban Illiterate Tobacco Users is more than Rural Illiterate Tobacco Users which means that Urban Illiterate Tobacco Users are better in KAP score than Rural Illiterate Tobacco Users

Sub-Hypothesis 3.3.B.2

There will be no significant difference of Knowledge between Urban Illiterate and Rural Illiterate tobacco users.

Table-3.9

Knowledge (about NTCP)	N	M	Sd	t
Urban Illiterate Tobacco Users	80	4.51	2.12	1.81 p>.05
Rural Illiterate Tobacco Users	80	1.03	1.43	

Result:

Table 3.9 shows that the mean values of scores of test on Knowledge level of Urban Illiterate Tobacco Users and Rural Illiterate Tobacco Users are 4.51 and 1.03 respectively, with S.D. value of 2.12 and 1.43 respectively. 't' value between two means is 1.81, which is statistically not significant ($p>05$). Thus sub-hypothesis 3.3.B.2 is rejected which means that there is no significant difference of Knowledge between Urban Illiterate and Rural Illiterate tobacco users.

The mean score of Knowledge for Urban Illiterate Tobacco Users is more than Rural Illiterate Tobacco Users which means that Urban Illiterate Tobacco Users are better in knowledge level score than Rural Illiterate Tobacco Users but not significant.

Sub-Hypothesis-3.3.B.3

There will be no significant difference of Attitude between Urban Illiterate and Rural Illiterate tobacco users.

Table-3.10

Attitude (Towards NTCP)	N	M	Sd	t
Urban Illiterate Tobacco Users	80	20.27	10.34	2.93 p<.01
Rural Illiterate Tobacco Users	80	5.04	3.92	

Result:

Table 3.10 shows that the mean values of scores of test on Attitude of Urban Illiterate Tobacco Users and Rural Illiterate Tobacco Users are 20.27 and 5.04 respectively, with S.D. value of 10.34 and 3.92 respectively. ‘t’ value between two means is 2.93, which is statistically significant ($p<.01$). Thus hypothesis 3.3.B.3 is rejected which means that there is significant difference of Attitude between Urban Illiterate and Rural Illiterate tobacco users.

The mean score of Attitude for Urban Illiterate Tobacco Users is more than Rural Illiterate Tobacco Users which means that Urban Illiterate Tobacco Users have better attitude towards NTCP than Rural Illiterate Tobacco Users

Sub-Hypothesis 3.3.B.4

There will be no significant difference in Practice between Urban Illiterate and Rural Illiterate tobacco users.

Table-3.11

Practice (To consume Tobacco)	N	M	Sd	T
Urban Illiterate Tobacco Users	80	17.64	6.39	1.99 p<.05
Rural Illiterate Tobacco Users	80	25.70	7.83	

Result:

Table 3.11 shows that the mean values of scores of test on Practice (to consume tobacco) of Urban Illiterate Tobacco Users and Rural Illiterate Tobacco Users are 17.64 and 25.70 respectively, with S.D. value of 6.39 and 7.83 respectively. 't' value between two means is 1.99, which is statistically significant ($p < .05$). Thus hypothesis 3.3.B.4 is rejected which means that there is significant difference in Practice (to consume tobacco) between rural Illiterate and urban Illiterate tobacco users.

The mean score of Practice (to consume tobacco) for Urban Literate Tobacco Users is less than Rural Literate Tobacco Users which means that Rural Literate Tobacco Users Practice to consume tobacco is more Urban Literate Tobacco Users.

Objective 4.

To assess the Knowledge, Attitude and Practice (KAP) of tobacco sellers.

Hypothesis for Objective- 4

Hypothesis 4.1 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between rural and urban tobacco sellers.

Table-4

KAP	N	M	Sd	t
Rural Tobacco Sellers	80	30.4	8.21	2.20
Urban Tobacco Sellers	80	42.6	8.76	p<.05

Result:

Table 4 shows that the mean values of scores of test on KAP of Rural Tobacco sellers and Urban Tobacco sellers are 30.4 and 42.6 respectively, with S.D. value of 8.21 and 8.76 respectively. 't' value between two means is 2.20, which is statistically significant ($p<.05$). Thus hypothesis 4.1 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between rural and urban tobacco sellers.

The mean score of KAP for Urban Tobacco sellers is more than Rural Tobacco sellers which means that Urban Tobacco sellers are better in KAP score than Rural Tobacco sellers

Sub-Hypothesis 4.1.1

There will be no significant difference of Knowledge between rural and urban tobacco sellers.

Table-4.1

Knowledge (about NTCP)	N	M	Sd	t
Rural Tobacco Sellers	80	3.26	1.47	2.25 p<.05
Urban Tobacco Sellers	80	8.4	3.66	

Result:

Table 4.1 shows that the mean values of scores of test on Knowledge level of Rural Tobacco sellers and Urban Tobacco sellers are 3.26 and 8.4 respectively, with S.D. value of 1.47 and 3.66 respectively. 't' value between two means is 2.25, which is statistically significant ($p < .05$). Thus sub-hypothesis 4.1.1 is rejected which means that there is significant difference of Knowledge between rural and urban tobacco sellers.

The mean score of Knowledge for Urban Tobacco sellers is more than Rural Tobacco sellers which means that Urban Tobacco sellers are better in knowledge level score than Rural Tobacco sellers.

Sub-Hypothesis-4.1.2

There will be no significant difference of Attitude between rural and urban tobacco sellers.

Table-4.2

Attitude (Towards NTCP)	N	M	Sd	t
Rural Tobacco sellers	80	10.54	3.17	2.32
Urban Tobacco sellers	80	19.80	7.83	p<.05

Result:

Table 4.2 shows that the mean values of scores of test on Attitude of Rural Tobacco sellers and Urban Tobacco sellers are 10.54 and 19.80 respectively, with S.D. value of 3.17 and 7.83 respectively. 't' value between two means is 2.32, which is statistically significant ($p < .05$). Thus hypothesis 4.1.2 is rejected which means that there is significant difference of Attitude between rural and urban tobacco sellers.

The mean score of Attitude for Urban Tobacco sellers is more than Rural Tobacco sellers which means that Urban Tobacco sellers have better attitude towards NTCP than Rural Tobacco sellers

Sub-Hypothesis 4.1.3

There will be no significant difference in Practice between rural and urban tobacco users.

Table-4.3

Practice (To Sell Tobacco)	N	M	Sd	t
Rural Tobacco sellers	80	16.6	5.56	1.13 p>.05
Urban Tobacco sellers	80	14.40	5.43	

Result:

Table 4.3 shows that the mean values of scores of test on Practice (to sell tobacco) of Rural Tobacco sellers and Urban Tobacco sellers are 16.6 and 14.40 respectively, with S.D. value of 5.56 and 5.43 respectively. 't' value between two means is 1.13, which is statistically not significant ($p > .05$). Thus hypothesis 4.1.3 is accepted which means that there is no significant difference in Practice (to sell tobacco) between rural and urban tobacco sellers.

The mean score of Practice (to sell tobacco) for Urban Tobacco sellers is less than Rural Tobacco sellers which means that Rural Tobacco sellers Practice to sell tobacco is more Urban Tobacco Users but this difference is not significant.

Hypothesis 4.2 There will be no significant difference of Knowledge, Attitude and Practice (KAP) between Literate and Illiterate tobacco sellers.

Table-4.4

KAP	N	M	Sd	t
Literate Tobacco Sellers	80	42.8	8.33	2.08
Illiterate Tobacco Sellers	80	26.2	6.42	p<.05

Result:

Table 4.4 shows that the mean values of scores of test on KAP of Literate Tobacco sellers and Illiterate Tobacco sellers are 42.8 and 26.2 respectively, with S.D. value of 8.33 and 6.42 respectively. 't' value between two means is 2.08, which is statistically significant ($p < .05$). Thus hypothesis 4.2 is rejected which means that there is significant difference of Knowledge, Attitude and Practice (KAP) between Literate and Illiterate tobacco sellers.

The mean score of KAP for Literate Tobacco sellers is more than Illiterate Tobacco sellers which means that Literate Tobacco sellers are better in KAP score than Illiterate Tobacco sellers

Sub-Hypothesis 4.2.1

There will be no significant difference of Knowledge between Literate and Illiterate tobacco sellers.

Table-4.5

Knowledge (about NTCP)	N	M	Sd	t
Literate Tobacco Sellers	80	6.8	4.68	2.01 p<.05
Illiterate Tobacco Sellers	80	3.4	2.17	

Result:

Table 4.5 shows that the mean values of scores of test on Knowledge level of Literate Rural Tobacco sellers and Illiterate Tobacco sellers are 6.8 and 3.4 respectively, with S.D. value of 4.68 and 2.17 respectively. 't' value between two means is 2.01, which is statistically significant ($p < .05$). Thus sub-hypothesis 4.2.1 is rejected which means that there is significant difference of Knowledge between Literate and Illiterate tobacco sellers.

The mean score of Knowledge (About NTCP) for Literate Tobacco sellers is more than Illiterate Tobacco sellers which means that Literate Tobacco sellers are better in knowledge level score than Illiterate Tobacco sellers.

Sub-Hypothesis-4.2.2

There will be no significant difference of Attitude between Literate and Illiterate tobacco sellers.

Table-4.6

Attitude (Towards NTCP)	N	M	Sd	t
Literate Tobacco sellers	80	22.2	7.25	2.36 p<.05
Illiterate Tobacco sellers	80	12.60	5.43	

Result:

Table 4.2 shows that the mean values of scores of test on Attitude of Literate Tobacco sellers and Illiterate Tobacco sellers are 22.2 and 12.60 respectively, with S.D. value of 7.25 and 5.43 respectively. 't' value between two means is 2.36, which is statistically significant ($p<.05$). Thus hypothesis 4.2.2 is rejected which means that there is significant difference of Attitude between Literate and Illiterate tobacco sellers.

The mean score of Attitude for Literate Tobacco sellers is more than Illiterate Tobacco sellers which means that Literate Tobacco sellers have better attitude towards NTCP than Illiterate Tobacco sellers

Sub-Hypothesis 4.2.3

There will be no significant difference in Practice between Literate and Illiterate tobacco sellers..

Table-4.7

Practice (To Sell Tobacco)	N	M	Sd	T
Literate Tobacco sellers	80	13.80	4.73	1.53 p>.05
Illiterate Tobacco sellers	80	10.20	4.63	

Result:

Table 4.7 shows that the mean values of scores of test on Practice (to sell tobacco) of Literate Tobacco sellers and Illiterate Tobacco sellers are 13.8 and 10.20 respectively, with S.D. value of 4.73 and 4.63 respectively. 't' value between two means is 1.53, which is statistically not significant ($p > .05$). Thus hypothesis 4.2.3 is accepted which means that there is no significant difference in Practice (to sell tobacco) between Literate and Illiterate tobacco sellers.

The mean score of Practice (to sell tobacco) for Literate Tobacco sellers is more than Illiterate Tobacco sellers which means that Literate Tobacco sellers Practice to sell tobacco is more than Illiterate Tobacco Users but this difference is not significant.

Summary, Findings, Suggestions and Social Implications

In the present chapter Summary, Findings, Suggestions and Educational Implications are discussed in details.

Summary :

The present venture is concerned with the study of **National Tobacco Control Program (NTCP): A Study of Knowledge, Attitude and Practice (KAP) of Tobacco users and sellers**. An attempt is made to find whether Tobacco users and sellers have the knowledge of NTCP, what is there attitude towards it and towards consumption of tobacco products and their practice trend of consuming tobacco products. Cessation of tobacco products, has always been of importance concern, but despite many efforts of Government of India people are not very much aware and indulged in consumption of tobacco for many reasons.

The present investigation which is entitled, “**National Tobacco Control Program (NTCP): A Study of Knowledge, Attitude and Practice (KAP) of Tobacco users and sellers**” tried to identify the knowledge level of tobacco users and sellers regarding the Indian Government Project- NTCP. There were five objectives of this study. On the basis of review of related literature and objectives of the study 5 research Hypotheses were formulated. Later on to answer the research hypotheses and get the in-depth view, sub-hypotheses were formulated for each of the research hypothesis.

For the purpose of this research a KAP survey tool was used, to identify the level of Knowledge, attitude and practice of tobacco users and sellers. On the basis of the score on KAP tool each of the three factors viz. Knowledge, Attitude and Practice, the sample of tobacco users was selected from rural and urban background and divided on the basis of gender i.e. Male & Female and being literate and illiterate. Then the scores on KAP were computed and then Mean, SD and ‘t’ value was computed. Significance Level of ‘t’ value became the basis of acceptance/ rejection of Hypothesis and sub-hypothesis. This

acceptance/rejection of the hypothesis decided their level of Knowledge, Attitude and Practice. This also helped in deciding whether knowledge level plays any role in practice of consumption of tobacco products and to know what are the issues related with attitude which affects their practice of consumption of tobacco products.

The sample of tobacco sellers was also analysed on the basis discussed above.

Efforts have also been made to identify the problems faced by the NTCP implementers at ground level.

Findings :

Objective wise findings of the present study are given here:

Objective-1

To study the National Tobacco Control Program (NTCP).

A detailed study of National Tobacco Control Program (NTCP) has been studied by various sources and official website of the program. This program has been started with wide vision and positive attitude to make people aware of the ill effects of the tobacco products, change their attitude regarding consumption of tobacco products and cease the practice of consumption of tobacco products for the good health of public. Detailed discussion presented in Chapter-1 of the thesis report.

Reliability level of the rating scale was calculated to be .81 and the face validity was established.

Objective-2.

To understand the implementation strategy of National Tobacco Control Program (NTCP).

To study this objective again official website and other sources have been studied and analysed to understand strategies that have been implemented by National Tobacco Control Program (NTCP). Chapter-1 covers in detail the implementation strategy of NTCP.

To study the objective 3 and 4 KAP survey tools was prepared reliability and validity has been established and then it has been administered on Tobacco Users and Tobacco Sellers.

The findings of Objective-3 and 4 are given below point wise. These findings are the outcomes of the testing of hypothesis and sub-hypothesis related to objective-3 and objective-4.

Objective-3

To assess the Knowledge, Attitude and Practice (KAP) of tobacco users.

1. Urban tobacco users are significantly better in KAP than Rural tobacco users as reflected by significant 't' value ($p < .05$) and mean value.
2. Knowledge level about NTCP of Urban tobacco users is significantly better than Rural tobacco users as reflected by significant 't' value ($p < .01$) and mean value.
3. Attitude towards NTCP of Urban tobacco users is significantly better than Rural tobacco users as reflected by significant 't' value ($p < .05$) and mean value.
4. Practice (to consume tobacco products) of Rural tobacco users is significantly more than urban tobacco users as reflected by significant 't' value ($p < .05$) and mean value.
5. Male Tobacco Users are significantly better in KAP than Female Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
6. Male Tobacco Users are significantly better in Knowledge level about NTCP than Female Tobacco Users as reflected by significant 't' value ($p < .01$) and mean value.

7. Male Tobacco Users are better in Attitude towards NTCP than Female Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value..
8. Male Tobacco Users' practice to consume tobacco is more than Female Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value..
9. Urban Male Tobacco Users are better in KAP score than Rural Male Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
10. Urban Male Tobacco Users are better in knowledge level about NTCP than Rural Male Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
11. Urban Male Tobacco Users have better attitude towards NTCP than Rural Male Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
12. Rural Male Tobacco Users Practice to consume tobacco is more than Urban Male Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.

- 13.**Urban Female Tobacco Users are better in KAP score than Rural Female Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
- 14.**Urban Female Tobacco Users have better attitude towards NTCP than Rural Female Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
- 15.**Literate Tobacco Users are better in KAP score than Illiterate Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
- 16.**Literate Tobacco Users are better in knowledge level about NTCP than Illiterate Tobacco Users as reflected by significant 't' value ($p < .01$) and mean value.
- 17.**Literate Tobacco Users have better attitude towards NTCP than Illiterate Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
- 18.**Illiterate Tobacco Users Practice to consume tobacco is more than Literate Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.

- 19.**Urban Literate Tobacco Users are better in KAP score than Rural Literate Tobacco Users as reflected by significant 't' value ($p < .01$) and mean value.
- 20.**Urban Literate Tobacco Users are better in knowledge level about NTCP than Rural Literate Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
- 21.**Urban Literate Tobacco Users have better attitude towards NTCP than Rural Literate Tobacco Users as reflected by significant 't' value ($p < .01$) and mean value.
- 22.**Urban Illiterate Tobacco Users are better in KAP score than Rural Illiterate Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.
- 23.**Urban Illiterate Tobacco Users have better attitude towards NTCP than Rural Illiterate Tobacco Users as reflected by significant 't' value ($p < .01$) and mean value.
- 24.**Rural Literate Tobacco Users' Practice to consume tobacco is more Urban Literate Tobacco Users as reflected by significant 't' value ($p < .05$) and mean value.

25.

Objective 4.

To assess the Knowledge, Attitude and Practice (KAP) of tobacco sellers.

1. Urban Tobacco sellers are better in KAP score than Rural Tobacco sellers as reflected by significant 't' value ($p < .05$) and mean value.
2. Urban Tobacco sellers are better in knowledge level about NTCP, than Rural Tobacco sellers as reflected by significant 't' value ($p < .05$) and mean value.
3. Urban Tobacco sellers have better attitude towards NTCP than Rural Tobacco sellers as reflected by significant 't' value ($p < .05$) and mean value.
4. Literate Tobacco sellers are better in KAP score than Illiterate Tobacco sellers as reflected by significant 't' value ($p < .05$) and mean value.
5. Literate Tobacco sellers are better in knowledge level about NTCP than Illiterate Tobacco sellers as reflected by significant 't' value ($p < .05$) and mean value.

6. Literate Tobacco sellers have better attitude towards NTCP than Illiterate Tobacco sellers as reflected by significant 't' value ($p < .05$) and mean value.

Objective 5: To study the perception of challenges faced by the program implementers.

On the basis of discussion held with the concerned authorities the following challenges have been perceived by them:

1. Difficult to aware illiterate people.
2. Despite of creating awareness, tobacco consumption is being adopted as a fashion in youngsters. Difficult to handle this issue.
3. Difficult to reach in remote areas.
4. Difficult to motivate females to quit tobacco, as they consume it to just match with males.
5. Difficult to motivate tobacco sellers to reduce selling such products as it affects their profitability.

Besides the above findings some results were not found significant, which are given below:

For Objective 3

1. Urban Female Tobacco Users are better in knowledge level about NTCP than Rural Female Tobacco Users but not in significant manner.
2. Rural Female Tobacco Users Practice to consume tobacco is more than Urban Female Tobacco Users but not significant.
3. Rural Literate Tobacco Users Practice to consume tobacco is more Urban Literate Tobacco Users but not significant.
4. Urban Illiterate Tobacco Users are better in knowledge level about NTCP than Rural Illiterate Tobacco Users but not significant.

For Objective 4:

1. Rural Tobacco sellers Practice to sell tobacco is more Urban Tobacco Users but this difference is not significant.
2. Literate Tobacco sellers Practice to sell tobacco is more than Illiterate Tobacco Users but this difference is not significant.

Suggestions:

On the basis of the findings of the study conducted, the researcher found it suitable to suggest the concerned ones. These may be for different people of society viz. Policy makers, Community leaders, Consumers and other stakeholders of the society and the future researchers.

Suggestion for the Policy-makers:

- Policy makers and planners have an important role in deciding the path to ensure that tobacco consumption should be reduced markedly. Policy makers must remember that the consumers especially growing children and teenagers are the future of the nation and world nation. Thus Policy makers should plan effectively to implement the policies especially in remote areas and illiterate people.

Suggestion for Community Leaders:

- Community leaders from every level should come forward to make people aware about the ill effects of tobacco consumption. Leaders from every walk of life have to join hands to eradicate this social evil from the society.

Suggestion for Community:

- Community should also join hands to ask tobacco consuming people living nearby or come into their contact to shun the habit of tobacco consumption. They should also be asked to take counselling and medical help to get rid of this bad habit.

On the basis of the above findings and the suggestions given to the different stakeholders it can be said that though Government and the other concerned agencies are putting their best foot forward to make society a tobacco free place. Various polices including NTCP have been launched to control the tobacco consumption but still we have to go far in this field. The study highlighted the fact that tobacco consumption can be reduced effectively and markedly among the literate people if they could be aware of the ill effects of it. To get success at large every member of the society should take a task to motivate their near and dears to stop consuming tobacco.

Suggestions for the further research:

- (1) Researchers may take up studies for case studies of particular village or city where largest tobacco consumers live.
- (2) Researchers may take up studies on particular type of tobacco consumption viz. Cigarette smokers etc.. .

- (3) Effect of Counselling and Guidance on the tobacco consumption of tobacco consumers can also be studied.
- (4) Use of more sophisticated statistical techniques may be used for more systematic analysis of the data.
- (5) Experimental studies can also be done in this field.
- (6) The research can be done involving a large sample.
- (7) The research can be done on different age groups of tobacco consumers.
- (8) A detailed study for demographic aspect of tobacco consumers and its impact can also be done.

Implications:

- (1) The present study reflects that if educated properly reduction in tobacco consumption be achieved.
- (2) In order to get teenagers must be counselled and guided in emotional and friendly manner.
- (3) Teenagers and other members of society must be give proper guidance so that they may not get attracted towards tobacco products.
- (4) Parental support and elderly guidance can play a vital role.
- (5) There is a need to have a clean and clear policies to provide different agencies an opportunity to explore true effect of different tobacco controlling programmes.
- (6) To ensure reachability of the anti tobacco programmes to every corner of the nation and world , experts will also have to take responsibility.
- (7) If women of the family is motivated and guided effectively she can help in controlling the consumption of tobacco in their family.
- (8) Proper motivation/reward should be given to the tobacco quitters for their good deeds/performance, so that others may also follow the same path..

(9) Government control should be there to manage and control the production of tobacco products.. It is required that it should not be rigid but flexible keeping in view the basic needs and requirements of the society.

In a nutshell it can be said that if tobacco consumption is to be controlled society has to contribute actively. Government is doing its job by introducing various controlling programs. Besides running those programs emphasis should be on effective implementation of the programs. Implementation programs should be planned in such a way so that it must reach to the illiterates and the remote areas. Awareness progamms must include nukkad nataks, volunteers for personal contact programs and other such means which makes it possible to reach to the maximum.

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