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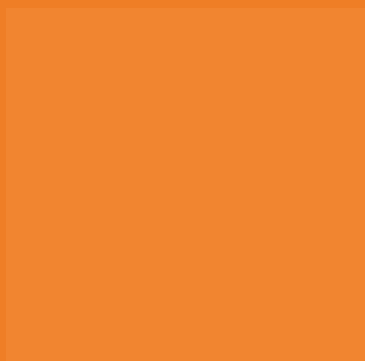
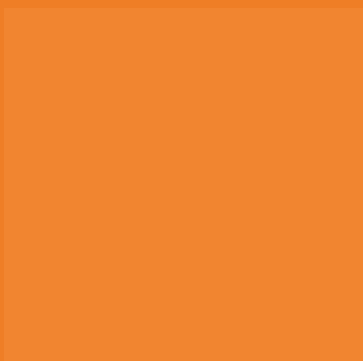
Implementation practices in smokeless tobacco control



F C T C

WHO FRAMEWORK CONVENTION
ON TOBACCO CONTROL

S E C R E T A R I A T



Implementation practices in smokeless tobacco control



FCTC

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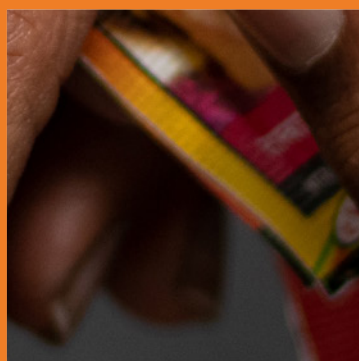
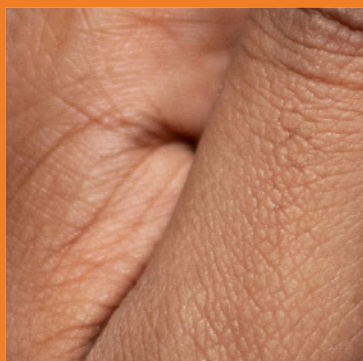
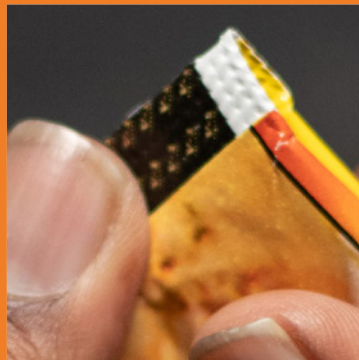
The Implementation Practices in Smokeless Tobacco Control was commissioned by the Secretariat of the WHO Framework Convention on Tobacco Control and finalized under the leadership of Dr Adriana Blanco Marquizo, Head of the Secretariat of the WHO FCTC, and under the guidance of Dr Tibor Szilagyi, Team Leader for Reporting and Knowledge Management in the Secretariat of the WHO FCTC.

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Abbreviations

GATS	Global Adult Tobacco Survey
MoHFW	Ministry of Health and Family Welfare of India
NCD	noncommunicable disease
NGO	nongovernmental organization
SLT	smokeless tobacco
STEPS	WHO STEPwise Approach to NCD Risk Factor Surveillance
TAPS	tobacco advertising, promotion and sponsorship
TB	tuberculosis
VoTV	Voice of Tobacco Victims
WHO FCTC	WHO Framework Convention on Tobacco Control
WHO	World Health Organization



1. Introduction

The use of smokeless tobacco (SLT) is a global concern. The Secretariat of the WHO Framework Convention on Tobacco Control (WHO FCTC) noted in the 2018 *Global Progress Report on Implementation of the WHO Framework Convention on Tobacco Control* that SLT is available in the markets of nearly two thirds of the Parties to the WHO FCTC. Over 350 000 people die each year among the nearly 350 million SLT users worldwide.¹ Earlier studies had indicated that 90% of the burden of SLT use is in low-resource countries. Among them, the majority of users are among the adults in African, South-East Asia and Western Pacific regions, but SLT use is also high among the youth in the South-East Asia Region.

A 2018 study of the data available worldwide on SLT use² showed that nearly 80% of the Parties to the WHO FCTC^{2,3} have data on the prevalence of SLT use for either adults or adolescents at the national and subnational levels. However, there are scanty comparable data available.

The analysis to develop this report covered all the Parties to the Convention as of early 2020.⁴ The study also reviewed implementation of Article 20 of the Convention for other – non-prevalence – indicators. Other key resources containing information on SLT use and policies to control it include the Global Progress Reports^{3,5}, World Health Organization (WHO) reports for 2017 and 2019 on the global tobacco epidemic^{6,7}, and a report of the WHO FCTC Knowledge Hub on Smokeless Tobacco published in 2017.⁸ Additional information sources can be found in the references of the above-mentioned documents.

The 2017 report of the Knowledge Hub on Smokeless Tobacco⁸ included individual examples of best practices from the Parties to the WHO FCTC that have demonstrated some exemplary performance in applying some of the requirements of the WHO FCTC to SLT and, in some cases, have even gone beyond these. Bangladesh, China, Colombia, the Democratic Republic of the Congo, India, Myanmar, Nepal, Pakistan, Sri Lanka and Uzbekistan – all included in this report⁸ – are the top 10 high-burden Parties⁹, which are home to over three quarters of global SLT users.

¹ Sinha DN, Suliankatchi RA, Gupta PC, Thamarangsi T, Agarwal N, Parascandola M et al. Global burden of all-cause and cause-specific mortality due to smokeless tobacco use: systematic review and meta-analysis. *Tob Control*. 2016; 27:35–42. doi:10.1136/tobaccocontrol-2016-053302.

² Sinha DN, Kumar A, Gupta R, Gulati HK, Gupta S, Mehrotra R. Implementation of Article 20 of the World Health Organization Framework Convention on Tobacco Control. *Indian J Med Res*. 2018;148(1):110–5. doi: 10.4103/ijmr.IJMR_288_18.

³ Global progress report on implementation of the WHO Framework Convention on Tobacco Control, 2018. Geneva: World Health Organization; 2018 (https://www.who.int/fctc/reporting/WHO-FCTC-2018_global_progress_report.pdf).

⁴ 180 State Parties; the European Union is represented in the analysis by its Member States.

⁵ Global progress report on implementation of the WHO Framework Convention on Tobacco Control, 2016. Geneva: World Health Organization; 2016 (<https://fctc.who.int/publications/m/item/2016-global-progress-report>).

⁶ WHO report on the global tobacco epidemic 2017. Geneva: World Health Organization; 2017 (<https://apps.who.int/iris/bitstream/handle/10665/255874/9789241512824-eng.pdf>).

⁷ WHO report on the global tobacco epidemic 2019. Geneva: World Health Organization; 2019 <https://apps.who.int/iris/bitstream/handle/10665/326043/9789241516204-eng.pdf>).

⁸ Mehrotra R, Sinha DN, Szilagyi T. Global smokeless tobacco control policies and their implementation. Noida: WHO FCTC Global Knowledge Hub on Smokeless Tobacco, ICMR-National Institute of Cancer Prevention and Research; 2017.

⁹ High-burden Parties are those with over 1 million SLT users or prevalence higher than 10% SLT prevalence, among any gender.

2. Examples of implementation of selected WHO FCTC articles with respect to SLT

Parties to the WHO FCTC were invited in decision FCTC/COP6(8) on SLT products¹⁰ to develop “product specific policies and regulations to protect the health of their citizens, acknowledging the WHO FCTC provisions”, thus promoting implementation of WHO FCTC articles for SLT products.

The examples provided in this paper cover some aspects of the following articles of the WHO FCTC:

- Article 9 (Regulation of the contents of tobacco products)
- Article 10 (Regulation of tobacco product disclosures)
- Article 11 (Packaging and labelling of tobacco products)
- Article 12 (Education, communication and public awareness)
- Article 13 (Tobacco advertising, promotion and sponsorship)
- Article 14 (Demand reduction measures concerning tobacco dependence and cessation)
- Article 20 (Research, surveillance and exchange of information)

There will be an opportunity in the future to look into other policies under the WHO FCTC, such as SLT taxation, different aspects of product regulation and the disclosure of contents, and access to and sales by minors, among others.

2.1. Articles 9 and 10: Regulation of SLT contents and its disclosures

The tobacco-testing laboratory capacity across the globe is limited (Canada, Ethiopia, India, Nigeria, Oman, Pakistan and Sweden are examples of countries where at least one such laboratory has been established), and the focus on SLT in any of the laboratories is minimal.

India has recently scaled up its analytical capacity and, being one of the biggest consumers of SLT products, began regularly analysing SLT products in 2018.

National tobacco testing laboratories, including those for SLTs, have been established in India at the Central Drug Testing Laboratory in Mumbai, at the Regional Drug Testing Laboratory in Guwahati and at the apex laboratory at the National Institute of Cancer Prevention and Research in Noida, which also serves as the WHO FCTC Knowledge Hub on Smokeless Tobacco.¹¹ Recruitment of and training for staff members at the national tobacco testing laboratories were provided during the first phase of the project.¹² A guideline for testing tobacco products has been developed and is being implemented across the laboratories.¹³ Testing of tobacco product samples is initiated by state governments that collect and send samples to the laboratories. Additionally, the WHO Regional Office in the South-East Asia is also supporting laboratory testing at the National Institute of Mental Health and Neurosciences in Bangalore, India.

¹⁰ [https://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6\(8\)-en.pdf](https://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6(8)-en.pdf)

¹¹ WHO FCTC Knowledge Hub on Smokeless Tobacco. Noida: Uttar Pradesh, India (<https://extranet.who.int/fctcapps/fctcapps/fctc/kh/slt>).

¹² Ministry of Health and Family Welfare (Department of Health and Family Welfare). Notification in the Gazette of India, New Delhi, 5 September 2019 (<http://egazette.nic.in/WriteReadData/2019/212116.pdf>).

¹³ Ministry of Health and Family Welfare, Govt. of India. Operational guidelines for National Tobacco Testing Laboratories. <https://ntcp.nhp.gov.in/assets/document/Operational-Guidelines-for-NTTL.pdf>

Nicotine found in 7 pan masala brands

Faraj Rumi

Patna: Seven of the 12 banned pan masala brands in state have tested nicotine positive by National Tobacco Testing Laboratories (NTTL) and National Institute of Cancer Prevention and Research under the Ministry of Health and Family Welfare. The samples of the 15 brands had been sent by the state health department for test after harmful chemical magnesium carbonate was found in 12 of them.

The brands tested nicotine positive were Rajnigandha, Supreme, Kamla Pasand, Rajshree, Roumak, Signature and Madhu. The samples had been collected from Patna, Darbhanga, Gaya, Nawada, Begusarai and Bhujpur.

The order to ban 12 pan masala brands was passed in August after harmful ingredients like magnesium carbonate were found in the samples.

According to the report of NTTL, Rajnigandha, Supreme, Kamla Pasand, Rajshree, Roumak, Signature and Madhu contained 0.042%, 0.186%, 2.26%, 0.103%, 0.200%, 0.046%, 0.151%, and 0.155% nicotine percentage respectively.

It should be noted that the state government banned the sale, distribution and production of nicotine containing products in May 2012, based on the Food Safety and Standards Authority of India (FSSAI) report. As per standards of pan masala laid down by FSSAI, it should not contain either magnesium carbonate or nicotine. However, it was revealed that most brands were adding toxic chemicals in pan masala products.

Experts claimed that pan masala itself is carcinogenic and addition of nicotine makes it more addictive and poisonous.

PMCH superintendent Dr Rajiv Ranjan Prasad told this newspaper on Sunday that oral cancer is common in Bihar because of the use of pan masalas. "It can also lead to cardiac arrest. People, especially youngsters, get influenced to consume such products because of its packaging and the way it is being advertised by the celebrities," he said and added: "Drug testing laboratory in state failed to play an effective role. Earlier, it was defunct. Food inspectors are not trained properly. However, the government has been focusing on such things for the last few years."

Principal secretary (health) Sanjay Kumar told this newspaper that he is yet to receive the formal report from the testing lab. "I received the report on WhatsApp from the experts there. We are waiting for the official reports," he said.

"It is a criminal offence. The pan masala brands are putting something that they are not declaring and above all use of both the chemicals in food items are banned in state. Instead, they wrote on packaging that the product is nicotine-free," Kumar said and added: "Once, the formal reports are received, we will take appropriate legal action against such pan masala brands."



Pan masala being sold in Patna

Some of the reports of these testing laboratories, which explain the results of the tests that were carried out, can support national and state governments in their policy-making and in taking action against the tobacco industry. For instance, the Department of Health of the Government of Bihar, India, sent for testing some samples of pan masala products that were supposed to have a zero level of nicotine, and yet nicotine was found in samples of several of them.¹⁴ The results of the tests helped the Government of Bihar both to strengthen the implementation of policies and to engage in court cases against the tobacco industry.

2.2. Article 11: Packaging and labelling of SLT products

Specific health warnings for SLT packages are mandated in 116 countries worldwide.¹⁵ Graphic health warnings, including on SLT products, are mandated in 47 countries. Timor Leste (93%), Maldives (90%), Nepal (90%), India (85%), Uruguay (80%), Myanmar (75%) and Tajikistan (75%) are top-ranking countries in terms of policy and compliance on the size and coverage of graphic health warnings on SLT packets.

The results of the latest Global Adult Tobacco Survey (GATS) for India in 2017 showed that the graphic warning labels depicting oral cancer¹⁶ (applied to SLT products) are strong tools for discouraging young people from starting tobacco use and have motivated millions of current users to quit.¹⁷

2.3. Article 12: Education, communication, training and public awareness

Parties such as Bangladesh, India, Myanmar, Nepal and Pakistan have implemented some form of national or subnational mass media campaigns that include messages related to SLT products. Parties have also gained media coverage from various events and activities highlighting the hazards of SLT products. Among Parties with a high SLT burden, only India has implemented a national mass media campaign fully dedicated to raising awareness about SLT products (Box 1).

¹⁴ Rumi F. Nicotine found in seven pan masala brands. Times of India, 23 September 2019 (<https://timesofindia.indiatimes.com/city/patna/nicotine-found-in-7-pan-masala-brands/articleshow/71248360.cms>).

¹⁵ WHO report on tobacco epidemic report 2021. (<https://www.who.int/publications/i/item/9789240032095>)

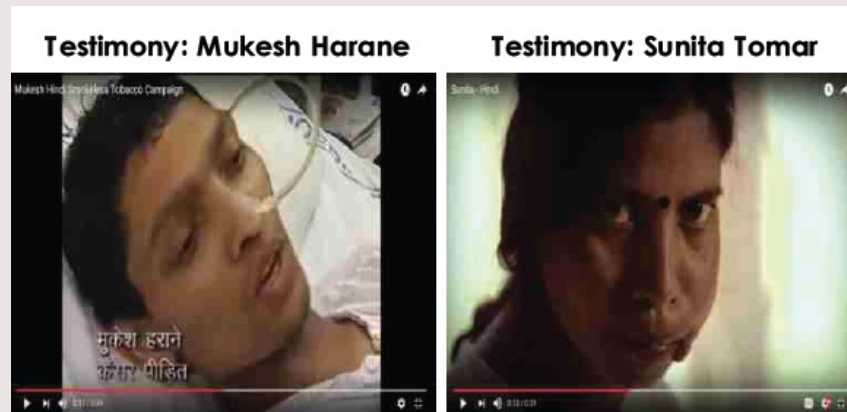
¹⁶ The use of SLT is the primary causative factor for oral cancer. Currently, there is no WHO FCTC Party that is routinely screening the population for oral cancer and SLT use. Chinese Taipei and a few states in India, such as Tamil Nadu have introduced screening for oral cancers.

¹⁷ GATS-2 Global Adult Tobacco Survey India 2016–17: highlights. Fact Sheet. New Delhi: World Health Organization Regional Office for South-East Asia; 2017 (http://www.searo.who.int/india/mediacentre/events/2017/gats2_india.pdf).

Box 1. India: mass media campaign entirely focused on SLT products

India is one of the few countries to have a dedicated budget for mass media campaigns targeted at tobacco use. Since 2008, at least three national campaigns on television and radio and in print media have been conducted in the country each year.

Most campaigns were developed and aired with technical support from the World Lung Foundation, using an evidence-based approach that included vigorous pre-testing. The campaigns were aired in multiple languages across India.



The first national mass media campaign dedicated to the hazards of SLT aired in 2009. The message was targeted at high-priority demographic groups: women, rural residents and low-income groups. A 30-second video message, referred to as *Surgeon*, featured an oral cancer surgeon who presented the serious conditions and disfigurements resulting from SLT-related cancers.

An evaluation of the campaign showed it had a high recall value, with 63% of SLT users who were aware of the campaign admitting that it made them think about – and eventually stop – SLT use as they felt that the message was relevant to their lives and provided new information. The awareness campaign was associated with greater cessation-oriented intention and behaviours among SLT users than in the case of users of smoking products.¹⁸

A further cost–benefit analysis of the campaign found it highly cost-effective. The campaign successfully generated 17 259 148 additional quit attempts and 431 479 permanent quits, and also averted 120 814 deaths. The cost per benefit was US\$ 0.06 per quit attempt, US\$ 2.60 per permanent quit and US\$ 9.20 per death averted.¹⁹

A second campaign was initiated by the Government of India in 2011 and was aired from February to April that year. The campaign was remembered as the “Mukesh story”, the story of a 24-year-old SLT user who died soon after the campaign was aired.

In 2014, the Government supported the production of another campaign featuring Sunita. She narrated her personal testimony while suffering from mouth cancer. The campaign showed Sunita before and after the surgery that removed the cancer and a part of her mouth.

These campaigns were further supported by intense media activities, including the Voice of Tobacco Victims, which highlighted the tragic consequences of SLT use.

¹⁸ Murukutla et al. Results of a national mass media campaign in India to warn against the dangers of smokeless tobacco consumption. *Tob Control*. 2012;21(1):12–7

¹⁹ Murukutla N, Yan H, Wang S, Negi NS, Kotov A, Mullin S et al. Cost-effectiveness of a smokeless tobacco control mass media campaign in India. *Tob Control*. 2018;27(5):547–51. doi:10.1136/tobaccocontrol-2016-053564.

Examples of successful communication efforts fully or partly focused on SLT are discussed below.

Communication efforts by the Voice of Tobacco Victims of India

The Voice of Tobacco Victims (VoTV)²⁰ is a collaborative initiative of the Tata Memorial Hospital, the Government of India, and national and international nongovernmental organizations (NGOs). In VoTV, patients and their families share their heart-wrenching stories about the effects of SLT use. The victims, many of them disfigured by their disease, testify about the impact of tobacco on their lives and warn others about the dangers of tobacco – particularly SLT. VoTV provides the “face of tobacco control”, reminding policy-makers of the need to take effective measures to prevent the disease and suffering caused by tobacco.

This initiative has demonstrated its ability to create an emotional connection with policy-makers – a connection that has repeatedly shown that it is capable of pushing policy-makers to action. VoTV and its supporters have lobbied members of Parliament, ministers and other policy-makers, and have sensitized media and the general public on the consequences of tobacco use on them and their families. These efforts have raised the profile of SLT and have contributed to creating support for various policies, including the more recent ban on *gutka*, which is a popular form of SLT.

Myanmar launches its first-ever mass media anti-tobacco campaign

Myanmar experienced increasing prevalence of SLT use among adults between 2007 and 2014.²¹ To raise awareness of the health risks associated with tobacco use, Myanmar implemented its first mass media campaign focusing on the risks of tobacco use, including betel quid, in September 2017.²² This is a good example of a campaign that involves a broad range of stakeholders and which has had a significant impact. In this campaign, the stakeholders involved had clear roles and responsibilities (Table 1).

Table 1. Organizations and responsibilities in Myanmar’s media campaign on tobacco risks

Organizations involved	Responsibilities
The national NGO People’s Health Foundation, civil authorities, and creative media and research agencies across Myanmar	Designed and implemented the campaign
The Ministry of Health and Sports and the Ministry of Information	Helped in obtaining free and reduced-cost radio and television air time, both in government-owned and private television channels
Vital Strategies (an international NGO)	Provided technical and financial support

The six-week campaign was the first to feature stories on television, radio and posters about actual people harmed by SLT in Myanmar. The public service announcements were based on an evidence-based strategic communication approach and were pre-tested in the population. The post-campaign assessment showed the significant reach of the campaign, covering 48% of the population in 2017 and over 80% during 2018.²²

²⁰ Voice of Tobacco Victims (website). (<https://vovindia.org/>).

²¹ Sinha DN, Bhartiya D, Kumar A, Singh H, Mehrotra R. Men in Myanmar submerged in tobacco: women following. *Nicotine Tob Res.* 2017;19(11):1397–8. doi:10.1093/ntr/ntw314.

²² WHO report on the global tobacco epidemic 2019. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/326043/9789241516204-eng.pdf>).

School-based educational campaigns

Two examples of school-based campaigns are presented below: one anecdotal evidence from Thailand and the other a more recent from India.

In reducing betel quid use through school education, the campaign in Thailand is both interesting and illustrative. In the 1920s, chewing betel quid mixed with tobacco was very common in Thailand, and oral cancer was deemed a major public health problem. Nearly half of all cancer cases seen in hospitals were in oral cavities. Due to the concern of public health officials, schools began to conduct health education focusing on betel quid chewing. This may have contributed to the marked decline in betel quid chewing by 1955, and a decrease in numbers of cancer cases from 1988. Between 1988–1991 and 1999, age-standardized incidence rates for oral cancer in Thailand dropped from 3.6% to 1.2% in males, and from 2.6% to 1.1% in females.²³ Similar trends were seen in both sexes for cancers of the tongue, oropharynx and hypopharynx.

In India, both curricular and extracurricular education on SLT was initiated in schools, particularly schools under the national government and schools using the curriculum of the Central Board of Secondary Education. In a video message dated 30 May 2014, the Board advised all schools under its affiliation not to allow its students to participate in events sponsored by tobacco firms or by any of their subsidiaries. The Central Board of Secondary Education further directed school students not to accept any prize or scholarship that was instituted or offered by the tobacco industry.

In India, most schools in several states are now tobacco-free and tobacco sales are banned within 100 yards of schools in many states. This is at the behest of the national Government and is being implemented by schools run by national and state governments. See Annex 1 for more details about this initiative.

The Government of India had prepared and released *Guidelines for Tobacco Free Schools/Educational Institutions* in 2008 and further revised the Guidelines in 2017.²⁴

2.4. Article 13: Tobacco advertising, promotion and sponsorship

Many Parties to the WHO FCTC have reported that they have implemented a comprehensive ban on tobacco advertising, promotion and sponsorship (TAPS), which is applicable to a variety of tobacco products.

The *Guidelines for Implementation of Article 13 of the WHO FCTC*²⁵ recommend specific measures to limit tobacco use in movies. India's Cigarettes and Other Tobacco Products Act of 2003 includes a comprehensive ban on TAPS (except for display at points of sale). However, as other forms of TAPS were banned, it was observed that tobacco imagery in movies increased significantly. To address this, the implementation rules of the Cigarettes and Other Tobacco Products Act were amended in 2005, resulting in further consultation with the Ministry of Information and Broadcasting, which was responsible for implementing the rules.

²³ Gupta PC, Ray CS, Sinha DN, Singh PK. Smokeless tobacco: A major public health problem in the SEA region: A review. *Indian J Public Health* [serial online] 2011 [cited 2021 Aug 14];55:199-209. (<https://www.ijph.in/text.asp?2011/55/3/199/89948>).

²⁴ Guidelines for Tobacco Free Educational Institution (revised). Ministry of Health and family welfare, Government of India. (<https://ntcp.nhp.gov.in/assets/document/TEFI-Guidelines.pdf>).

²⁵ Guidelines for implementation of Article 13: Guidelines on tobacco advertising, promotion and sponsorship. Adopted by the Conference of the Parties at its third session (decision FCTC/COP3(12)) (<https://fctc.who.int/publications/m/item/tobacco-advertising-promotion-and-sponsorship>).

The Ministry of Health and Family Welfare (MoHFW) issued new rules that became effective on 14 November 2011; these were further amended and notified in September 2012. The revised rules strengthen the implementation of the TAPS ban by putting the onus for implementation on owners or managers of cinemas and broadcasters of television programmes. The Central Board of Film Certification, which operates under the Ministry of Information and Broadcasting, is responsible for enforcing these rules.

The Film Rule under the Cigarettes and Other Tobacco Products Act makes it mandatory to include three forms of warning messages – anti-tobacco health spots of 30 seconds, audiovisual disclaimers and static health warning messages – whenever tobacco products are shown in films and on television programmes. The health spots and disclaimers mandated under the rules have been prepared by the MoHFW and provided to the Central Board of Film Certification for implementation. This is an example of how different sectors within a government can work together for tobacco control.

With regard to implementation of the Film Rule, a study has shown that most cinemas in India are compliant.²⁶ At least 99% of the films surveyed with tobacco scenes were found to have implemented at least one of the three elements of the Film Rule, but only 27% complied with all three elements. This indicates that there is room for further strengthening of implementation of the Film Rule. Compliance in TV was reported as low.

One study noted that contrary to India's Cigarettes and Other Tobacco Products Act, its rules are not being complied with by the over-the-top media services, which are delivered via the Internet, and streaming platforms. In some online series popular among the adolescents the number of tobacco incidents reached more than 100 per hour.^{26,27,28}

2.5. Article 14: SLT dependence and cessation

A literature search of global case control studies shows that only a few Parties (India, Norway, Pakistan, Sweden, and the United Kingdom of Great Britain and Northern Ireland) reported having experience in SLT cessation. Box 2 provides a fuller description of India's SLT cessation programme. Meta-analysis has shown that a behavioural intervention (counselling) alone, as described in the *Guidelines for Implementation of Article 14 of the WHO FCTC*, is associated with a 60% greater chance of quitting the use of SLT than is non-intervention and is the most cost-effective form of intervention for both low- and high-resource settings.²⁹

²⁶ Evaluation of tobacco free film and television policy in India. New York (NY): Vital Strategies; 2017 (https://www.vitalstrategies.org/wp-content/uploads/2017/02/VS_ExecSummary_FilmRuleStudy02.pdf).

²⁷ Arora M, Nazar GP, Chugh A, Rawal T, Shrivastava S, Sinha P, Munish VG, Tullu FT, Schotte K, Polansky JR, Glantz S. Tobacco imagery in on-demand streaming content popular among adolescents and young adults in India: implications for global tobacco control. *Tob Control*. 2021 Jan; 30(1):42-48.

²⁸ Ministry of Electronics and Information Technology of India released a Notification called "Information Technology (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021", published the 25 February 2021, which indicate that media platforms must follow the regulations of Government of India. This implies including tobacco control regulations in India. (<https://egazette.nic.in/WriteReadData/2021/225464.pdf>)

²⁹ Nathan ST, Sinha DN, Sharma S, Mehrotra R. Behavioural interventions for smokeless tobacco cessation. *Nicotine Tob Res*. 2020;22(4):588–93. doi:10.1093/ntr/ntz107.

Box 2. India: programmes combined to promote SLT cessation

The combination of a national quit line, the mCessation programme and the integration of tobacco cessation in various other health programmes makes India a notable example in promoting SLT cessation. The measures put in place include cost-covered cessation services and a national toll-free quit line.

The mCessation programme

In 2015, collaboration between WHO, the International Telecommunication Union's "Be He@lthy, Be Mobile" initiative, and India's MoHFW and Ministry of Communication and Information Technology led to the development of an mCessation project called "Quit Now". The project uses a short messaging service text message that aims to support and encourage tobacco users to quit through a dedicated Internet portal.³⁰

Part of the "Digital India" initiative, the mCessation project uses two-way messaging between the individual seeking to quit and programme specialists, providing dynamic support for the former. A unique feature of the programme allows users to register by giving a missed call to a dedicated national number, or by registering at the website of mCessation. The Government has recently released Version 2 of the mCessation platform that can deliver the content through a short messaging service text message or interactive voice response in 12 languages.

The project's progress is monitored in real time through an online dashboard that disaggregates registrations by gender, geography and type of tobacco use. To date the programme has over 2.1 million self-registered users. An evaluation conducted by MoHFW found an average quit rate of 7% for both smokers and SLT users six months after enrolment. In a study in which 12,000 registered users were asked about their tobacco use, more than 19% said they had abstained over the previous 30 days.

Following the success of the mCessation project, a second national mHealth project was launched focusing on diabetes. Both the mCessation and the mDiabetes projects have been integrated into the national noncommunicable disease (NCD) screening initiative under the national health protection insurance scheme Ayushman Bharat.

Integration of tobacco cessation in national health programmes

Tobacco cessation is part of the National Tobacco Control Programme and has also been integrated in the National NCD Control Programme and, for tuberculosis (TB), into the National Framework for Joint TB-Tobacco Collaborative Activities.³¹

Toll-free national quit line

The first quit line has operated from New Delhi since May 2016 and is available to the public from 08:00 to 20:00 hours every day. The quit line provides counselling services in both Hindi and English. Since the first quit line started, some regional institutions have also begun quit line services. One of the most important centres is in Bangluru (Bangalore) and caters to the people of South India in their own languages. See Annex 2 for details.

Almost 40% of tobacco users who called the quit line and registered for a cessation programme remained abstinent after three to five weeks, with 9% experiencing nicotine withdrawal symptoms for which they were referred to cessation clinics.^{6,32}

³⁰ mCessation project – Quit Tobacco for Life. New Delhi: Ministry of Health and Family Welfare (<https://www.nhp.gov.in/quit-tobacco>).

³¹ <https://tbcindia.gov.in/WriteReadData/TB-Tobacco.pdf>

³² Government's tollfree 'Quitline' helped 40% smokers quit tobacco use. Hindustan Times, New Delhi, 6 January 2017 (<https://www.hindustantimes.com/health-and-fitness/government-s-tollfree-quitline-helped-40-callers-quit-tobacco-use/story-W9hx0LMgz0M5Gw2dld7DaL.html>).

An evaluation by MoHFW at the end of the programme's first year, covering over 12,000 registered users, demonstrated an average quit rate of about 7% among both smokers and SLT users.⁶

On the basis of the initial results, the quit line was further expanded with the addition of several languages used by regional centres.

India's quit line is unique in that nearly three fourths of callers were SLT users (61% only SLT users and 12% dual users). The largest number of calls initially came from New Delhi and nearby states; however, later on calls began coming in from all states across the country. Most quit line users found out about the service from articles and advertisements in newspapers, magazines and pamphlets.³³

Bangladesh: Integration of tobacco cessation into health services

In 2017, WHO supported the National Institute of Preventive and Social Medicine to pilot a tobacco cessation programme and, as part of this, to provide a brief intervention in primary health-care settings. The National Institute of Preventive and Social Medicine set up a capacity-building programme in collaboration with the National Tobacco Control Cell and the Directorate General of Health Services. As part of the programme, 30 master trainers (who could then train others) and 120 primary health-care physicians were trained to provide the brief intervention.

2.6. Article 20: Research, surveillance and exchange of information

The use of SLT is widespread among Parties to the WHO FCTC. Consequently, surveillance and research on SLT products should also be widespread, as required by Article 20 of the Convention. Monitoring the use of SLT products, as well as their related health and economic determinants and consequences, should be promoted in order to support and substantiate policy-making. The data that research and surveillance could provide are fundamental to developing comprehensive tobacco control policies that include SLT products.

Policy-oriented research

Policy research and the dissemination of research data that could stand as the basis for development of SLT control policies have an important role in strengthening WHO FCTC implementation. Several important policy-oriented publications have been developed and launched in recent years, providing the connection between research and policy-making. Some of these publications are presented in Table 2 below.

³³ Kumar R, Jha AK, Munish VG, Pusp A, Sinha P, Gupta P et al. National tobacco quit line: the preliminary Indian experience. New Delhi: University of Delhi Vallabhshai Patel Chest Institute ([http://www.vpci.org.in/uploads/OA%201\(2\).pdf](http://www.vpci.org.in/uploads/OA%201(2).pdf)).

Table 2. Selected publications on policies related to smokeless tobacco use³⁴

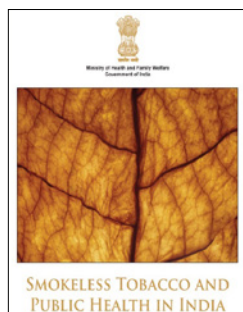
The development of the publication *Global Smokeless Tobacco Control Policies and their Implementation* was a flagship project of the WHO FCTC Global Knowledge Hub on Smokeless Tobacco. The document was published in 2017 and has since been utilized and disseminated through various channels and country assistance projects globally.^{8,35}

This publication is intended to support implementation of decision FCTC/COP6(8) of the Conference of the Parties to the WHO FCTC and in line with the report FCTC/COP/6/9. It provides an overview of the status of SLT control policies and their implementation by the WHO FCTC Parties. The document provides a summary of how all relevant articles of the Convention are applicable to SLT control.

The Knowledge Hub uses the document when assisting Parties to curb the SLT menace. The various analyses used in preparing this publication have also resulted in over 20 SLT-related research articles in peer-reviewed journals.



Subsequently, a series of journal articles was published in the July 2018 issue of the *Indian Journal of Medical Research*.³⁶ Several other papers were published in reputable international journals.



The Ministry of Health and Family Welfare of the Government of India published a monograph on SLT and its implications on public health in 2016 in collaboration with the WHO country office in India, the Public Health Foundation of India, the United States Centers for Disease Control and Prevention, and the United States National Cancer Institute. This monograph has become a reference book for SLT control in India, thus serving as an example for other high-burden countries that wish to publish such country-specific research monographs.³⁷

Epidemiological research and its support for policy-making

Although Parties are requested to establish surveillance programmes on various aspects of tobacco use and control in accordance with Article 20.2, information on the use of SLT is not widely available. From the 2018 data submitted by the Parties as part of their official WHO FCTC implementation reports, only one third (33%) of all Parties reported that they had data on adult SLT use from the previous five years, and

³⁴ In addition to documents submitted to the COP and decisions adopted by the COP.

³⁵ WHO FCTC Knowledge Hub on Smokeless Tobacco. Noida: Uttar Pradesh, India (<https://extranet.who.int/fctcapps/fctcapps/fctc/kh/slt>).

³⁶ *Indian J Med Res.* 2018;148(1):1–122 (<https://www.ijmr.org.in/showBackIssue.asp?issn=0971-5916;year=2018;volume=148;issue=1;month=July>).

³⁷ *Smokeless Tobacco and Public Health in India*. New Delhi: Ministry of Health and Family Welfare; 2016 (<https://untobaccocontrol.org/kh/smokeless-tobacco/wp-content/uploads/sites/6/2018/06/Final-Version-of-SLT-Monograph.pdf>).

mostly from 2014 to 2017. At a higher rate, nearly 58% (105 Parties) had data available on the use of SLT among young people. Most of the youth data were collected with a standardized methodology that made cross-national comparisons possible – mostly as part of the Global Youth Tobacco Survey – responding to the call addressed to Parties to develop and promote national research and to cooperate with WHO on the development of procedures for this purpose.

According to the *WHO Report on the Global Tobacco Epidemic, 2019*, countries with the highest level of achievement on SLT surveillance and monitoring (that means, undertaking surveillance for adults and youth together, using standard methodology) are Bangladesh, Myanmar and Pakistan. India, according to the 2017 GATS and the 2019 Global Youth Tobacco Survey, and Sri Lanka, according to the Global Youth Tobacco Survey 2015 and the 2015 WHO STEPwise Approach to NCD Risk Factor Surveillance (STEPS) survey, now achieve this category as a result of the surveys being published. India is monitoring SLT prevalence among adults and young people chiefly by using its own resources.

Tobacco-related research is essential in defining policy directions and in enacting and monitoring tobacco control legislation. Below, we present examples from Bangladesh, India and Nepal of how data on tobacco use prevalence have supported policy development.

In **Bangladesh**, two rounds of GATS have been conducted, one in 2009 and the other in 2017. Comparing the two survey reports, it is evident that prevalence of SLT use decreased between 2009 (27%) and 2017 (21%) among adults aged 15 years and above.

With regard to the policy landscape, the Tobacco Control Act of 2005 was applicable only to smoking products. In 2009 the Bangladesh GATS found that over one fourth of the adult population was using SLT. To respond to the challenges posed by SLT, the Government of Bangladesh set out to amend the country's tobacco act, resulting in new measures being introduced to control SLT in 2013. The new measures included a ban on advertising and promotion of SLT, adding warning labels on packages of SLT products (50% on the front and 50% on the back area) and raising awareness of the hazards of using SLT.

India has also implemented two rounds of GATS, both funded by MoHFW. It is notable that the prevalence of SLT use among adults aged 15 years and above decreased from 26% in 2009–2010 to 21% in 2016–2017. This reduction is due to adoption of key demand-reduction measures, as required by the WHO FCTC.

India's GATS survey in 2009–2010 revealed that 47% of current smokers and 46% of current users of SLT planned to quit tobacco use eventually, with more than half of these planning or considering doing so within the following 12 months. In view of the high interest in quitting among tobacco users, the Government of India launched a countrywide tobacco cessation programme in January 2016 and a national toll-free quit line in May 2016, also covering SLTs.

GATS in India also made it possible to justify and further promote a number of tobacco control measures adopted between 2009 and 2016, including smoke-free laws and large graphic health warnings on packaging. Without evidence-based data on their expected and real-life impact, it would have been more difficult for the Government to enact and sustain these, especially when faced with vigorous opposition from the tobacco industry.

Nepal used the Tobacco Questions for Surveys module – a subset of GATS questions – in the WHO STEPS survey that was conducted in 2013. The high prevalence of both smoking and SLT use among adult males (27% being current smokers and 31% using SLT products) motivated the Government to enact legislation to increase the size of graphic health warnings to 90% of tobacco packaging surfaces in May 2015 – thus making them the largest health pack warnings on all tobacco products, including SLT products, anywhere in the world. According to the 2019 STEPS, the respective figures declined to 17% of current smokers and 18.3% of current SLT users.³⁸

3. Addressing SLT control in a comprehensive manner: Sri Lanka's approach

A subcommittee on SLTs was established under Sri Lanka's National Authority on Tobacco and Alcohol in August 2015. It aimed to monitor SLT use and formulate mostly preventive policies to protect the health of the population. On the recommendations of the National Authority on Tobacco and Alcohol, in September 2017 the Government of Sri Lanka issued a regulation banning the import, marketing and sale of any type of SLT products in the country. Compliance with these regulations has met some difficulties on account of the historical and cultural context of SLT in Sri Lanka.³⁹

To address this issue in a country where it is customary to present a betel leaf tray with tobacco as a gift to monks, an innovative approach initiated by several tobacco control stakeholders was to present a betel leaf tray without tobacco to monks. This has since become an accepted practice in selected areas of the country.

Once the ban took effect, the Sri Lankan authorities noticed that smuggling of manufactured SLT products intensified. Consequently, in order to confront the problem, the country ratified the Protocol to Eliminate Illicit Trade in Tobacco Products.

The National Cancer Control Programme of Sri Lanka collaborated with the National Authority on Tobacco and Alcohol and cancer treatment units to empower oral cancer survivors to act as change agents for prevention of oral cancer under the Voice of Blue Pea patient group.⁴⁰

³⁸ https://www.who.int/docs/default-source/nepal-documents/ncds/ncd-steps-survey-2019-compressed.pdf?sfvrsn=807bc4c6_2

³⁹ Senaratne R, Mendis S, editors. Prevention and control of noncommunicable diseases: think globally - act locally; lessons from Sri Lanka. Colombo: Ministry of Health, Nutrition and Indigenous Medicine; 2018 (http://www.health.gov.lk/moh_final/english/public/elfinder/files/Downloade/NCDBook2018.pdf).

⁴⁰ Voice of Blue Pea patient group is an oral cancer victim group established in the main cancer treatment centres in Sri Lanka.

4. Going beyond the WHO FCTC: banning SLT products

Australia, Bahrain, Bhutan, the Democratic People's Republic of Korea, the European Union^a, Estonia*, Fiji, Finland*, Gambia, Latvia*, Lithuania*, Malta*, Niue, Oman, Qatar, the Republic of Moldova, Saudi Arabia, Singapore, Sri Lanka, Thailand, Uganda, the United Republic of Tanzania and Vanuatu have gone beyond the basic requirements of the WHO FCTC, in line with Article 2 of the Convention, and have banned the manufacture and sale of SLT products in their jurisdictions.

In India, the banning of the manufacture and sale of *gutka* is a unique example of a result of a multisectoral approach from the executive and judiciary branches of Government, with NGOs contributing to this success in accordance with Article 4.7 of the Convention. In 2010, the Supreme Court of India banned the use of plastics in *gutka* packaging after determining it to be an environmental hazard. This decision, upheld in March 2011, paved the way for banning *gutka* itself since most *gutka* is sold in plastic sachets.

The Government of India and civil society came together to plan an approach for banning *gutka* for health reasons. The Supreme Court also directed the Government of India to undertake an analysis of the contents and harmful effects of SLT. MoHFW, in consultation with experts, prepared a comprehensive report on SLTs and submitted it to the Supreme Court in February 2011. In April 2011, MoHFW and WHO organized a national consultation on SLT which recommended progressive restrictions as well as bans on all SLT – including *gutka*.

A firm basis for banning *gutka* was established when the Supreme Court ruled in 2004 that products such as *gutka* and pan masala are indeed food products. This allowed the Government to enact Regulation 2.3.4 under the 2006 Food Safety and Standards Act. Regulation 2.3.4 mandates that the “product not to contain any substance which may be injurious to health: Tobacco and nicotine shall not be used as ingredients in any food products”, thereby banning the sale of any food product containing tobacco and nicotine, such as *gutka*. To support the implementation of the regulations, MoHFW wrote to state governments requesting them to initiate action.

Civil society groups have played a catalytic role in advocacy to create support for the implementation of the 2006 Food Safety and Standards Act regulations. Advocacy by VoTV (in collaboration with the State Tobacco Control Cells, other partners, and networks from academia and research institutes), which was established by people suffering from the visible effects of tobacco use, provided much-needed impetus. Directors of all regional cancer centres also sent letters to the Prime Minister seeking a *gutka* ban. Political support was garnered through chief ministers of 11 states and hundreds of other leaders who signed pledges to ban *gutka*. Members of legislative assemblies were sensitized by VoTV to the harms of *gutka* and sustained media coverage was generated. As of mid-2021, all Indian states except for Gujarat have banned the manufacture, storage and sale of *gutka*. Two states in India have already banned manufacture, storage and sale of all SLT products.

In relation to other, more targeted policies, there are also some advanced examples of implementation of SLT control policies. For example, Honduras, Kuwait, Samoa, Singapore, Sri Lanka and Uganda have prescribed the minimum legal age for tobacco sales as 21 years. Certain regions of Myanmar, Nepal, Papua New Guinea and the United Arab Emirates have banned the use and spitting of SLT products in public places.

* All these Parties are Member States of the European Union.

^a The first European Union Tobacco Products Directive (2002/37/EC) already prohibited the sale of oral tobacco, that dates prior to the entry into force of the WHO FCTC.

5. Conclusions

SLT use poses implementation challenges to some of the Parties to the WHO FCTC, especially in the South Asia region, where SLT is most widely used. Populations in least-developed countries and low socioeconomic groups tend to bear the highest burden of use of these products, making SLT control a health and development issue. The tobacco industry promotes SLT products as safer alternatives to smoking tobacco.

Understandably, Parties that bear most of the burden and impact of SLT use have been in the forefront of SLT control, putting in place advanced practices such as those presented in this paper. Some of the high-burden Parties have demonstrated very high levels of commitment to curbing the use of SLT by adopting a broad range of measures in accordance with the WHO FCTC and by implementing guidelines adopted by the Conference of the Parties to the WHO FCTC. Some Parties have even gone beyond the requirements of the WHO FCTC and Article 2.1. Nevertheless, there are quite a few challenges to putting the adopted policies into practice, as well as enforcement of those policies.

In the Parties that have still not acted to control SLT use, existing tobacco control legislation and regulations should be updated to include the SLT products in their scope and to apply all WHO FCTC measures, where appropriate, for the prevention and control of their use.

Examples are available on how the implementation of various articles of the Convention has been applied to SLT products. Some of these examples are presented in sections 2 and 3 of this paper. Some of the interventions targeting SLTs are resource intensive, including demand-reduction measures focused on SLT cessation and those related to product regulation. In implementing such measures, low-resource Parties may need targeted assistance through international and multilateral collaboration. However, implementing health warnings, bans on advertising, promotion and sponsorship of SLT products, and banning the sale to minors can be easily managed by low- and middle-income countries, home of 90% of SLT products users.

Most of the best practices described in this paper are the result of multisectoral efforts implemented in the context of political commitment. However, as successive global progress reports on the implementation of the Convention demonstrate, political will and stronger efforts are needed to accelerate implementation – including in relation to SLT products.

As governments progress in their implementation efforts, they will benefit from constant monitoring of the tobacco industry, its developments and its ways of working. In relation to SLT products, this will include monitoring how producers introduce and expand their products in local markets. The industry will employ various tactics to impede policy-making and avoid compliance with regulations on SLT products.

It is hoped that the examples documented in this report will be helpful to other Parties that wish to regulate these products. Additional support and information to control SLT products can be obtained from the WHO FCTC Knowledge Hub on Smokeless Tobacco, based in Noida, India.

Annex 1. Tobacco-free educational institute in India

The Central Board of Secondary Education has made it mandatory for all its affiliated schools to display notice boards with warning messages related to the consumption or sale of tobacco. The Central Board of Secondary Education has formally instructed the schools that “display boards may be put up at the entrance gate outside the boundary wall of schools, in the reception, cafeteria and other prominent places”. Failure to comply will attract a penalty of 100 000 Indian rupees or six months’ imprisonment. The Board has also advised schools not to allow students to participate in any events sponsored by tobacco firms or that promote the use of tobacco in any form.

The compulsory guidelines for ensuring tobacco-free schools are as follows:

1. Display of a “Tobacco-free School” or “Tobacco-free Institution” signboard at a prominent place on the boundary wall outside the main entrance.
2. No sale of tobacco products inside the premises and within a radius of 100 yards from school/educational institutions, and mandatory signage in this regard shall be displayed prominently near the main gate and on the boundary wall of the school/ institution.
3. No smoking or chewing of tobacco inside the premises of the institution by students, teachers, other staff members and visitors.
4. Posters with information about the harmful effects of tobacco should be displayed at prominent places in the school or institution. Students should be encouraged to make their own posters on tobacco control themes.
5. A copy of the Cigarette and Other Tobacco Products Act 2003 needs to be available with the principal or head of the school or institution. (It may be downloaded from the website of the Ministry of Health and Family Welfare)
6. A Tobacco Control Committee needs to be in place. It may be chaired by the school head or principal, with members comprising a science teacher, or any other teachers, school counsellor (if available), at least two National Service Scheme/ National Cadet Corps / Scout students, at least two parents’ representatives, an area Member of Legislative Assembly, an area Station House Officer, municipal councillor, member of Panchayati Raj Institution and any other member. The committee shall monitor the tobacco control initiatives of the school or institution. The committee shall meet quarterly and report to the district administration.
7. Integrate tobacco control activities with the ongoing School Health Programme and Health and Wellness Clubs.
8. Promote writing of anti-tobacco slogans on the school or institution stationery.
9. The principal or head of the school or institution shall recognize tobacco control initiatives by students, teachers and other staff, and certificates of appreciation or awards may be given.

References for Annex 1:

Circular No. 18: No students should participate in any sponsored events promoting any kind of tobacco use. New Delhi: Central Board of Secondary Education;19 June 2009.

Circular No. 14. New Delhi: Central Board of Secondary Education; 30 May, 2014

Further strengthened by letter of MoHFW, India -DO No F No P16102-142017 TC of14 November 2017 and complied by State Government, and now Schools governed by state governments are also compliant to many of the above-mentioned provisions.

<https://ntcp.nhp.gov.in/assets/document/TEFI-Guidelines.pdf>

Annex 2. Regional quit line

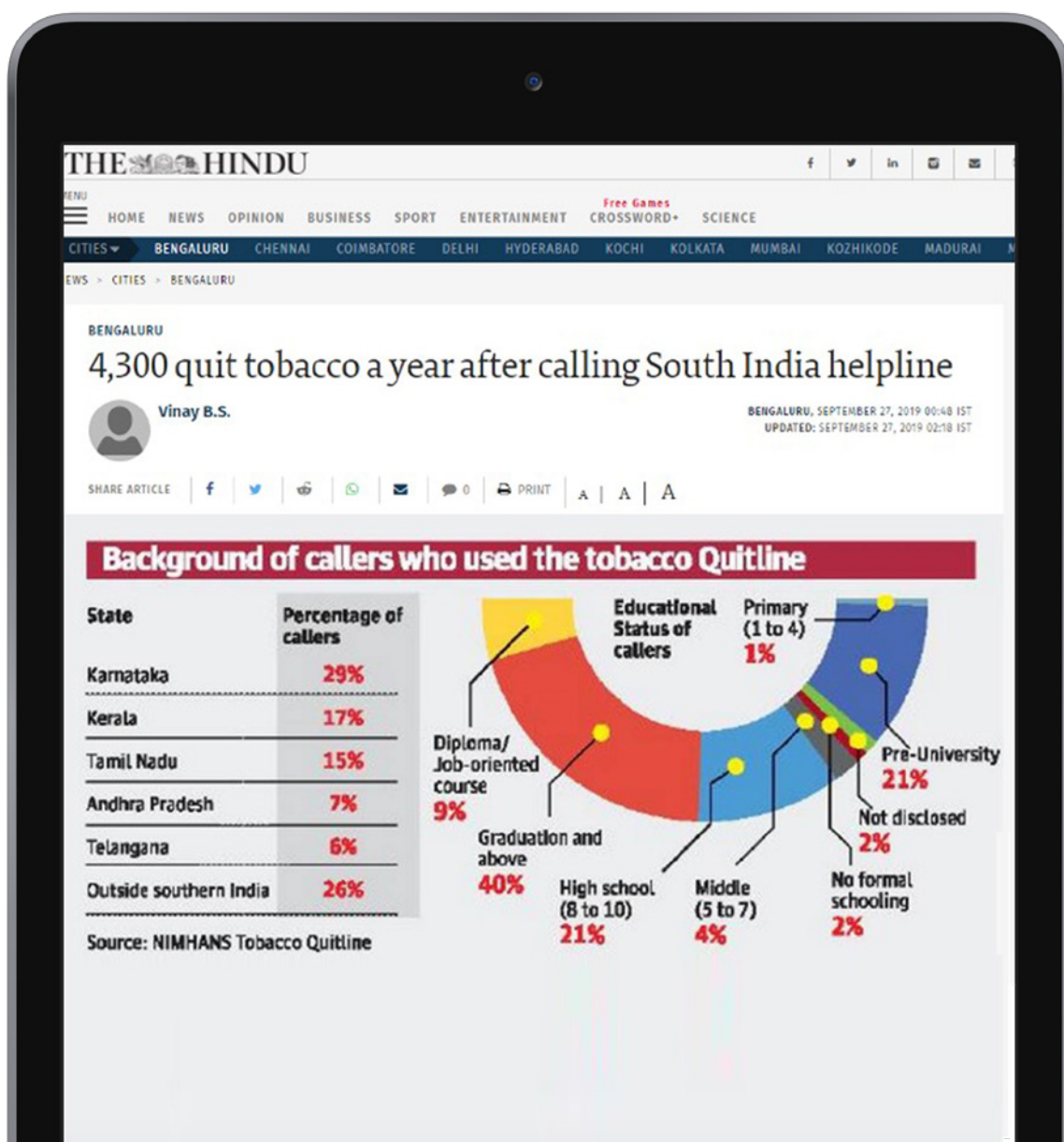
The Indian Government's tobacco quit line for counselling in South Indian languages was established in September 2018 at the National Institute of Mental Health and Neurosciences. At the end of its first year of operation in September 2019, 69 000 callers had been advised, of whom 19 000 registered to quit tobacco within a targeted period. In one year, 4300 of these tobacco users successfully quit using tobacco (Fig. A2.1). Nearly 99% of all callers were males, with an average age of 27.

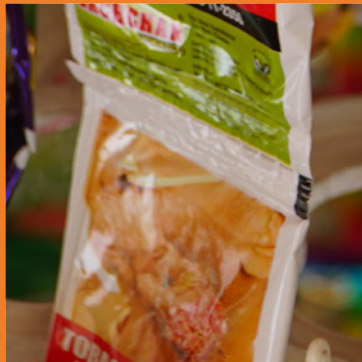
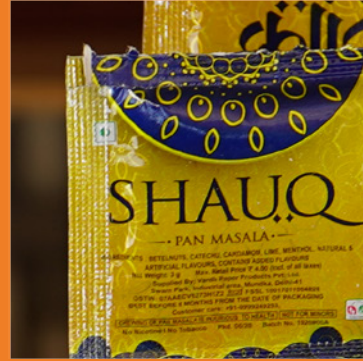
The data suggested that young working adults are more inclined to quit tobacco. Among the callers, 41% were smokers, 47% were SLT users and 12% reported dual use, in other words both smoking and using smokeless forms of tobacco.

References for Annex 2:

4300 quit tobacco a year after calling South India helpline. Bangalore: The Hindu; 27 September 2019 (<https://www.thehindu.com/news/cities/bangalore/4300-quit-tobacco-a-year-after-calling-south-india-helpline/article29523394.ece>).

Fig. A2.1. 4300 quit tobacco a year after calling South India helpline





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