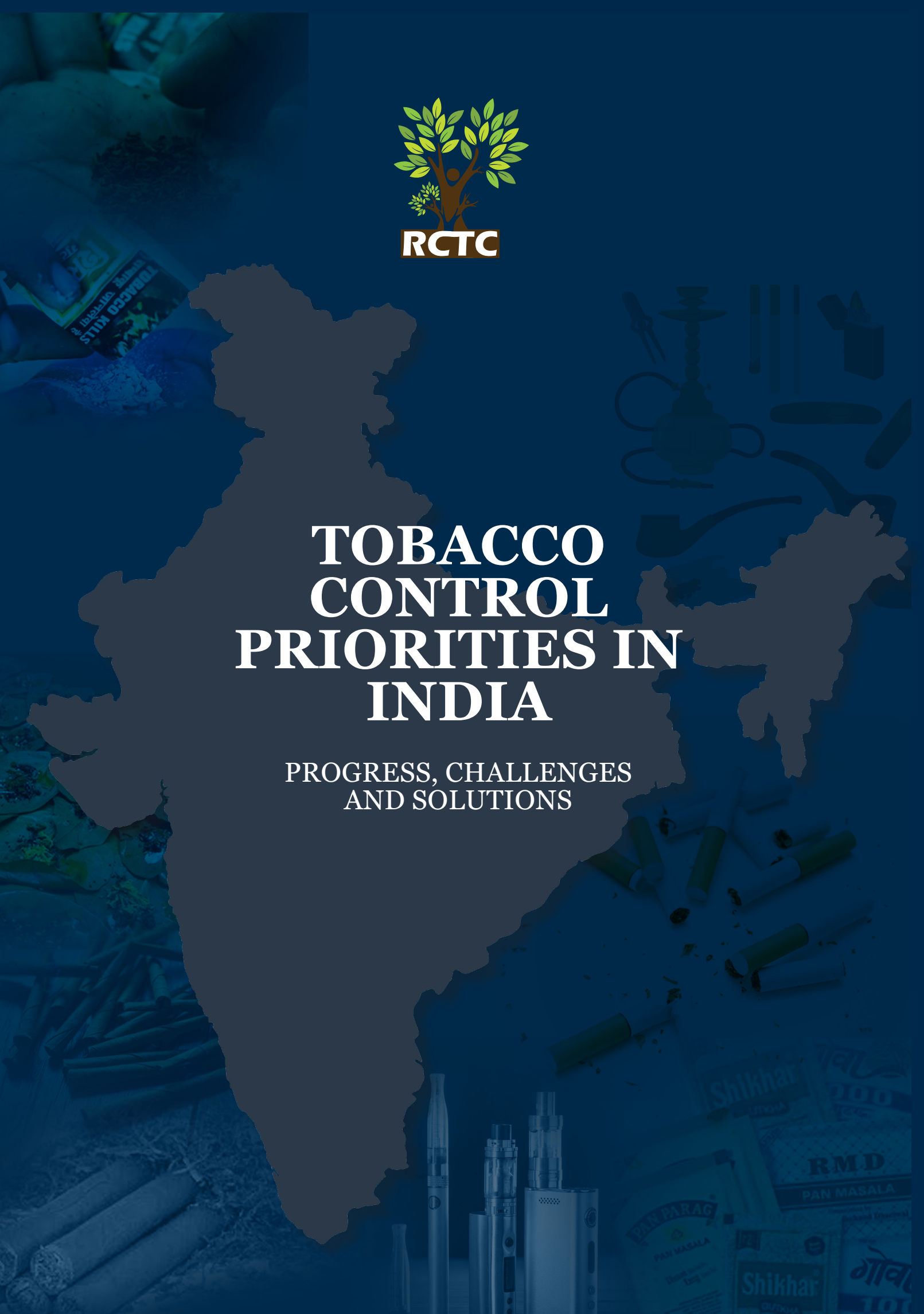
RCTC
TOBACCO CONTROL PRIORITIES IN INDIA
PROGRESS, CHALLENGES AND SOLUTIONS
RMD
PAN MASALA
Shikhar

TOBACCO CONTROL PRIORITIES IN INDIA
Progress, Challenges and Solutions

ISBN Number : 978-81-95-6185-9-6

Publisher
Century Publications
46 Masih Garh
PO : New Friends Colony
New Delhi - 110025, India

Phone : 09868010950
E-mail : centurypublications@hotmail.com
www.centurypublication.co.in

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From Editor Desk

Dr. (Prof.) Sonu Goel
Director, E-RCTC & Professor, DCM & SPH,
PGIMER Chandigarh

This book has come out at a critical juncture, where India is way ahead in tobacco control than many countries, however it still remains a public health problem. Besides, many emerging issues like Tobacco Industry Interference, novel products like ENDS, HNBs and implementation of existing tobacco control policies are a matter of concern.

Tobacco use is a major global public health concern, causing around 8 million deaths each year, with projections indicating that this number will double by 2025. Addressing the significant physical, mental, social and economic burden of tobacco use among young people is a critical priority. Government of India has implemented Cigarette and Other Tobacco Products Act (COTPA) and subsequently National Tobacco Control Program (NTCP) which has led to significant decrease in tobacco use in the society.

In the year 2018, Department of Community Medicine and School of Public Health has established Resource Centre for Tobacco Control (RCTC) which aims to showcases tobacco control initiatives, updates, policies, resource materials etc. from the length and breadth of the country. It has helped in strengthening National Control Tobacco Programme (NTCP) to a great extent. Further, this online hub contains latest notifications and circulars by national and state government's related to effective implementation of NTCP. The portal has helped in increasing the global collaborations between organizations and health care professionals from different corners of the globe who strive to work on diverse tobacco related issues for better enforcement of tobacco control laws in their organizations. It has also enabled researchers to gain knowledge related to the best practices and interventions in tobacco control.

Resource Centre for Tobacco Control's (E-RCTC) has been instrumental in publishing books, compendiums and other educational materials time-to-time. In this series, I am happy to inform you about our latest book, *"Tobacco Control Priorities in India - Progress, Challenges, and Solutions"* which provides comprehensive and valuable material on tobacco control. This book has come out at a critical juncture, where India is way ahead in tobacco control than many countries, however it still remains a public health problem. Besides, many emerging issues like Tobacco Industry Interference, novel products like ENDS, HNBs and implementation of existing tobacco control policies are a matter of concern.

This book not only contains crisp and comprehensive information about 18 emerging topics related to tobacco control, but also the progress made and challenges encountered at national and subnational level. The topics ranged from progress in implementing the WHO MPOWER package, combating tobacco industry interference, creating tobacco-free educational institutions, tackling smokeless tobacco use, and addressing the role of women in tobacco control, among others. The book also suggests various solutions to the challenges along with clear and concrete recommendations.

I hope that this book will be a useful resource to diverse audience including policy makers, implementers; academia and researchers to expand their horizons in tobacco control and re-ignite discussions on important priority areas for driving transformation in policy landscape.

I am immensely thankful to all contributors, reviewers and my team at RCTC who has taken this challenge of compiling this important work in form of a easy-to-read book. I invite you to delve into this comprehensive resource for deepening your understanding which can pave the way to 'Tobacco-Free India' and ensuring the well-being of our communities.

Message

Dr. K Madan Gopal
Advisor- Public Health Division
National Health Systems Resources Center, MOHFW-GOI
Former Senior Consultant, NITI Aayog

With great pleasure and enthusiasm, I extend my warmest congratulations to the E-Resource Centre for Tobacco Control's (E-RCTC) book entitled "Tobacco Control Priorities in India - Progress, Challenges, and Solutions." This comprehensive and insightful work comes at a critical time when the fight against tobacco remains a global priority, and India's efforts in this regard are of particular significance.

I commend the E-RCTC for their dedication to providing a comprehensive reference system for tobacco control in India. Their efforts have undoubtedly contributed to empowering policymakers, implementers, researchers, and advocates in pursuing a tobacco-free nation.

This book serves as a timely reminder of the progress that has been made, the challenges that have been encountered, and the solutions that lie ahead. It explores a broad spectrum of topics, from the implementation of evidence-based policies to the impact on vulnerable populations. The inclusion of key areas such as multi-sectoral convergence, sustainable development goals, and the role of global frameworks like the WHO MPOWER package and the Conference of Parties (COP) and Meeting of Parties (MOP) in tobacco control reflects a comprehensive and holistic approach to tackling this complex issue.

India's commitment to tobacco control is evident through initiatives such as the National Tobacco Control Program (NTCP) and efforts to establish tobacco-free educational institutions. However, as this book illuminates, much work still needs to be done. The challenges posed by tobacco vendor licensing, beedi smoking, tobacco product waste, and the relentless interference of the tobacco industry require concerted efforts and innovative strategies.

This book will inspire readers to deepen their understanding of tobacco control priorities, spark dialogue, and foster partnerships to drive transformative change.

I want to extend my heartfelt appreciation to the authors, researchers, and contributors who have dedicated their expertise and time to this publication. Their invaluable insights, coupled with the dedication and commitment of the E-RCTC, have ensured that this book will serve as an indispensable resource for years to come.

I encourage policymakers, healthcare professionals, researchers, and advocates to embrace the knowledge contained within these pages, drawing inspiration from the progress achieved, reflecting on the challenges faced, and exploring innovative solutions. Together, we can pave the way towards a tobacco-free India, improving the health and well-being of current and future generations.

This book serves as a timely reminder of the progress that has been made, the challenges that have been encountered, and the solutions that lie ahead. It explores a broad spectrum of topics, from the implementation of evidence-based policies to the impact on vulnerable populations.

Message

Dr. Rana J. Singh
Deputy Regional Director (Tobacco and NCD Control),
The Union South-East Asia
International Union Against Tuberculosis and Lung Disease
(The Union)

Approximately one person dies every six seconds due to tobacco consumption and this makes up for one in every ten adult deaths. The burden of tobacco related illnesses is the heaviest among the lower and middle classes. In India, an estimated 267 million people use any kind of tobacco leading to an epidemic driven by diverse products which differs by geographies, populations, gender, age, socio-economic status and educational attainment.

The tobacco use is the single most important preventable cause of morbidity and mortality not just in India but globally too. People around the world want to get rid of this tobacco pandemic and claim their right to health and healthy living in order to protect their future generations.

Therefore, there is dire need to educate and make the people aware of the harmful impact that tobacco has on them and their children's health. Additionally, it is also important to highlight the devastating impact it has on socio-economic status of the people leading to poverty, deforestation, environmental degradation and food insecurity. At the same time, it is important that comprehensive tobacco control policies are strengthened and implemented while also ensuring that strict measures are taken to protect these policies from tobacco industry interference.

In this regard, the tobacco control initiatives undertaken by the Resource Centre for Tobacco Control (RCTC), School of Public Health, PGIMER, Chandigarh in last few years are proving very useful for tobacco control communities including implementers, academicians, CSOs and other stakeholder who have an easy access to relevant knowledge and information at this one-point reference centre.

I am pleased to know that RCTC is coming-up with its another important publication title *"Tobacco Control Priorities in India - Progress, Challenges, and Solutions*. This book aims to shed light on the current state of tobacco control in India and covers a wide range of topics, including tobacco control policies, implementation strategies, challenges faced, and potential solutions. On the occasion of release of this publication, I extend my best wishes to all the staff, experts and volunteers at RCTC and convey my whole hearted support for their work.

I am pleased to know that RCTC is coming-up with its another important publication title *"Tobacco Control Priorities in India - Progress, Challenges, and Solutions*. This book aims to shed light on the current state of tobacco control in India and covers a wide range of topics, including tobacco control policies, implementation strategies, challenges faced, and potential solutions.

Message

Dr. Prakash C. Gupta
Director,
Healis Sekhsaria Institute for
Public Health

Tobacco control is now well-recognized as a priority area for advancing public health. Strategies for tobacco control are well-delineated especially through the WHO Framework Convention on Tobacco Control (FCTC) and MPOWER framework. India is a signatory of WHO FCTC and has enacted COTPA Act 2003.

There is a considerable progress on tobacco control in India during the last two decades but much more is required. We need to remember that the provisions in the FCTC represent the floor, not a ceiling. Therefore countries need to advance further from the FCTC provisions taking into account their special requirements. The progress in tobacco control already attained, needed to be clearly describe along with challenges faced during the progress and how they were addressed. The current book *"Tobacco Control Priorities in India - Progress, Challenges, and Solutions"* exactly address these pertinent issues.

The current volume exactly addresses these issues. This book will be a timely valuable and resource for policymakers, researchers, public health professionals, and anyone interested in tobacco control in India. I congratulate the editors for undertaking this important task.

The progress in tobacco control already attained, needed to be clearly describe along with challenges faced during the progress and how they were addressed. The current book *"Tobacco Control Priorities in India - Progress, Challenges, and Solutions"* exactly address these pertinent issues.

Message

Dr. Mira B Aghi
Behavioral Scientist
Communication Expert,
India

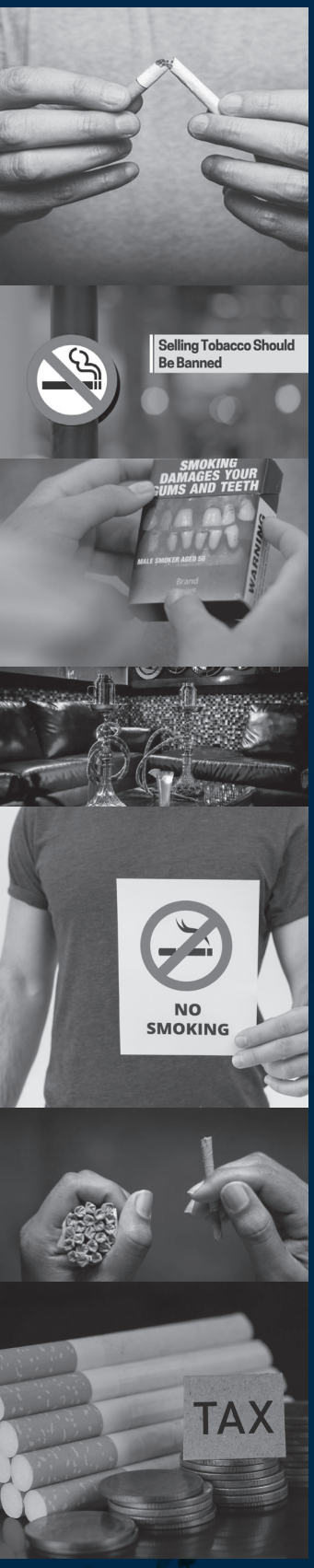
Salute to the E-Resource Centre for Tobacco Control (E-RCTC) on the successful publication of their another book titled "Tobacco Control Priorities in India - Progress, Challenges, and Solutions." This treatise is meant to empower policymakers, implementers, researchers, and advocates in their commitment to creating a tobacco-free nation.

The book covers a wide range of topics, meant to providing valuable insights into the implementation of evidence-based policies and their impact on vulnerable populations. It explores critical areas such as multi-sectoral convergence, sustainable development goals, and the significance of global frameworks like the WHO MPOWER package, Conference of Parties (COP), and Meeting of Parties (MOP) in driving effective tobacco control strategies. By adopting a holistic approach, the book tries to address the complexities surrounding this issue.

India's dedication to tobacco control is evident through initiatives like the National Tobacco Control Program (NTCP) and endeavors to establish tobacco-free educational institutions. However, as emphasized in this book, there is still much work to be done. Overcoming challenges related to tobacco vendor licensing, beedi smoking, tobacco product waste, and the persistent interference of the tobacco industry necessitates unified efforts and innovative strategies.

Hopefully this publication will ignite readers' passion for delving deeper into the crucial priorities of tobacco control, fostering insightful dialogue, and spurring collaborative endeavors to bring about profound and transformative change in this domain.
I would like to express my sincere gratitude to all the contributors who have graciously shared their knowledge and dedicated their time to produce this priceless publication.

Salute to the E-Resource Centre for Tobacco Control (E-RCTC) on the successful publication of their another book titled *"Tobacco Control Priorities in India - Progress, Challenges, and Solutions."* This treatise is meant to empower policymakers, implementers, researchers, and advocates in their commitment to creating a tobacco-free nation.



1 CHAPTER

PROGRESS IN IMPLEMENTING WHO MPOWER PACKAGE IN INDIA

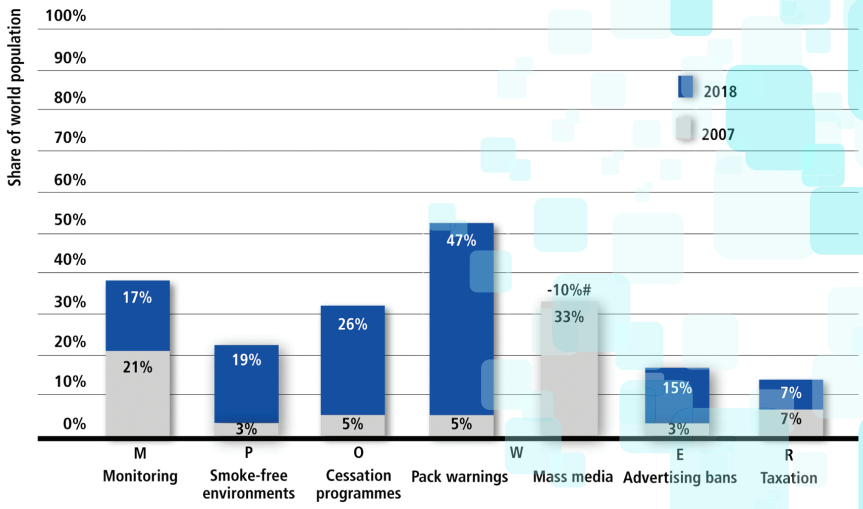
PROGRESS IN IMPLEMENTING
WHO MPOWER PACKAGE IN INDIA

In order to reverse the global tobacco epidemic and enable countries to implement the provisions of the WHO FCTC, the World Health Organization (WHO) introduced the six MPOWER strategies in 2007.

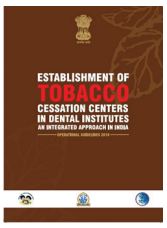
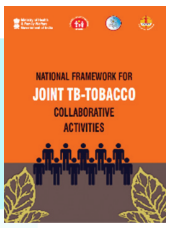
As per latest WHO report (2019), 136 countries covering 5 billion people (65% of the world's population) have implemented at least one of the key policy interventions to reduce tobacco demand. This number has more than quadrupled since 2007 when only 1 billion people – 15% of the world's population – were protected by at least one MPOWER measure (not including Monitoring or mass media campaigns which are assessed separately). Out of 5 billion, 3.9 billion reside in lower middle-income countries. Despite the fact that, the population covered under monitoring tobacco use, cessation programs, and mass media campaigns in terms of best practices decreased by 4%, 1% and 21% respectively, from 2016 till 2018, the other strategies (warning on tobacco packs, adoption of smoke-free environments and TAPS ban) have shown inspiring results. One factor for decrease in population coverage could be due to the fact that 59 countries have yet to adopt single MPOWER measure at highest level of achievement, and this remains a concern to advance tobacco control globally.

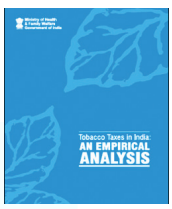
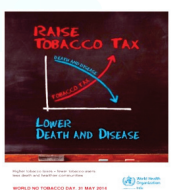
India has made huge strides in implementing WHO MPOWER package through enactment and effective enforcement of a strong Act namely, Cigarettes and Other Tobacco Products Act (COTPA) in the April, 2003 (commenced in May 2004) and smoke free rules in October, 2008. Further, India was amongst the first countries to sign WHO Framework Convention on Tobacco Control (FCTC) treaty in September, 2003 followed by its ratification in February, 2004.

INCREASE IN THE SHARE OF THE WORLD POPULATION COVERED BY SELECTED TOBACCO CONTROL POLICIES, 2007* TO 2018



	Global Progress	India Progress
M Monitor tobacco use and prevention policies   	Monitoring tobacco use in critical to assess & combat tobacco control efforts of the country. WHO encourages the use of standard, scientific and evidence based protocols for tobacco surveys namely Global Adult Tobacco Surveys (GATS) for monitoring tobacco control efforts. The first round of GATS was implemented in 2009-2010 (GATS 1) and the second round in 2016 -17 (GATS -2). The monitoring covering has shown a progress from 2007 (1.6 billion population covered) to 2018 (2.8 billion population covered). The smoking rates declined globally from 22.5% (2007) to 19.2% (2017), a relative reduction of 15% over 10 years.	India conducted GATS in 2009-10 & 2016-17 and the Global Youth Tobacco surveys (GYTS) in 2003, 2006 & 2009 while GYTS 4 is underway. India has a dedicated National Tobacco Control Programme (NTCP) launched in 2007-08 with a tobacco control cell at national/state level (all 35 states/ UTs) along with state and district level coordination committees for monitoring tobacco control activities. A national coordinating mechanism in form of Inter- Ministerial Coordination Committee has also been constituted under the chairmanship of Cabinet Secretary. Besides, committee for monitoring tobacco industry interference also exists in 14 states. For monitoring/ testing tobacco products, three (03) National Tobacco Testing Laboratories (NTTLs) have been established in the campuses of existing Drug Labs- Central Drug Testing Laboratory, Mumbai (CDTL Mumbai), Regional Drug Testing Laboratory, Guwahati (RDTL Guwahati) and at National Institute of Cancer Prevention and Research under ICMR. Due to all round efforts, the prevalence of any form of tobacco use (for persons aged 15 years and above) has decreased significantly by six percentage points from 34.6 percent (GATS-1, 2009-10) to 28.6 percent (GATS-2, 2016-17). The number of tobacco users has reduced by about 81 lakh (8.1 million). Age-standardized prevalence estimates for daily smoking among person aged 15 years and above is currently at 10.5% (7.8-13). The scores of adult daily smoking prevalence and monitoring the prevalence data remained unchanged at highest level [(score of 4 i.e. prevalence less than 15%) and 3 (recent representative data for both adult and youth)] respectively, from year 2011 onwards.

	Global Progress	India Progress
P Protect people from tobacco smoke  	Comprehensive smoke-free legislation is a popular policy measure as they are most easy to implement & enforce. A total of 1.6 billion people living in 62 countries have completely banned (70 countries partially banned) smoking in public/ work places, making it second highest MPOWER measure in terms of country adoption. In 2007 merely 0.2 billion population from 10 countries was covered with comprehensive smoke-free legislation.	Smoking in public places is prohibited as per Section 4 of the Indian Tobacco Control Act. The Act allows for designated smoking areas/zone in hotels with 30 or more rooms, restaurants having a seating capacity of 30 persons or more and airports, however, no service shall be allowed in these smoking area/zone. A dedicated Toll Free help-line (1800110456) has been established to report violations. Due to all round efforts, the exposure to second hand smoke among all adult at various places (past 30 days) has decreased from 52.3% to 38.7% at Home, 6.6% to 5.3% at Govt offices, 11.3% to 7.4% at Restaurants, 17.5% to 13.3% at Public Transportation between GATS-1, and GATS-2. Further, more than 150 jurisdictions (City, Districts & States) achieved high level compliance to smoke-free laws through robust compliance surveys & declared smoke free by government authorities. The score of smoke-free policies increased from 2 (3-5 public places smoke-free) in 2009 to 3 (6-7 public places smoke-free) in 2011 and 2013 to 4 (all public places completely smoke-free) from 2015 onwards.
O Offer help to quit tobacco use    	Offering help to quit tobacco use is a cost-effective population based strategy aimed at increasing chances of tobacco users to successfully quit. There are now 23 coun tries (2.4 billion population) protected by this measure, up from 10 countries in 2007 (0.4 billion population) which makes it second most adopted MPOWER measure in terms of population coverage (primarily due to India & Brazil). Additionally, 148 countries provide some level of cessation support at health care facilities	Tobacco cessation has been a vital component of NTCP. Considering the high intent in quitting among tobacco users, the Govt. of India launched country wide tobacco cessation program in January 2016, national Toll- Free Quitline (1800 11 2356) in May 2016 & a bilingual m-cessation programme (missed call at 011-22901701) in January 2016. A quit rate of 7% after 6 months was noticed among smoker & smokeless tobacco users after the intervention. Since then, Interactive Voice response (IVR) technology is available in many regional languages and is being enrolled by over 2 million tobacco users. MoHFW has developed tobacco dependence treatment guidelines, health worker guide and guidelines for medical officers, while the training module for NTCP officials has also been rolled out. Around 400 tobacco cessation centers were set up in district hospitals. The counselors under the National Programme for Prevention and Control of Cancer, Diabetes, Cardio-vascular diseases and Stroke (NPCDCS) were trained and directed to provide tobacco cessation services at primary health care level (CHC Level) in addition to primary health care providers (health workers) who will provide brief tobacco control interventions at sub-centre level. NRTs are freely available at general stores and fully cost-covered at government health institutes, however it has still not been included in the essential drug list. All dental colleges were instructed to set up cessation facilities. A National Collaborative Framework for TB & Tobacco has also been developed & implemented in few states. Besides it, NTCP has also been integrated with other AYUSH program. Due to multifarious efforts, 'O' along with 'W' component of MPOWER has reached highest level of achievement among all strategies in the country. The quit attempts among smokers and smokeless in past 12 month increased from 33.1% and 21.2% in GATS-1 to 39.8% and 30.1% respectively in GATS-2, whereas those who planned or thinking of quitting increased substantially from 45.3% to 63%. Further, a one year increase in age of initiation of tobacco products (smoke and smokeless) was witnessed between GATS-1 and GATS-2. The cessation program witnessed decreased in scores from 2 (NRT and other services cost covered) in 2009 & 2011 to 1 (data not available) in 2013.
W Warn about the dangers of tobacco	Comprehensive warnings about the dangers of tobacco use are critical to changing its image, especially among adolescents and young adults. Over half of the world's population (3.9 billion) living in 91 countries benefit from large graphic pack warning making it the MPOWER measure with highest population coverage & countries covered. In 2007,	In April 2016, Government of India implemented new regular mandatory large (85% of both front and back panel of tobacco pack as compared to 40% on front panel previously), pictorial, graphic health warnings (separately for smoked and smokeless tobacco products) which shall be rotated after every 12 months. With this, India has 5th largest pack warning label of any country. Further, COTPA requires public service announcement & disclaimers about harm of tobacco use in film or television program whereas tobacco consumption is seen. Under the tobacco free film policy huge free airtime (100 seconds per film/TV program) is generated through films and TV program that display tobacco products or their use.

	Global Progress	India Progress
  	merely 0.4 billion population from 9 countries were covered. 10 countries have also adopted legislation for plain packaging of tobacco products. Additionally, 61 countries have minimal to moderate laws for health warning on packs.	National and sub-national level public awareness/ IEC campaigns along with trainings of different stakeholders are an important activity under NTCP and dedicated funds are made available for same. Due to all round efforts, the quit attempts among smokers in past 12 month increased from 38% in GATS-1 to 61.9% (68.9% among cigarette smokers and 58.6% among bidi smokers in GATS-2) because of warning labels. Further, number increased who noticed health warning labels on packages of cigarette, Bidi and Smokeless Tobacco in GATS 2 (2016-2017) as compared to GATS 1 (2009-2010) Cigarette 70.8 % to 83.0%, Bidi 62.3 % to 78.4% and Smokeless Tobacco 62.9 % to 71.6%. There is a marked increase in scores in health warning on tobacco packs from 1 (small warnings) in 2009 & 2011 to 4 (large warnings with all appropriate characteristics) in 2013 onwards, due to efforts of government, civil society and other stakeholders. Anti-smoking mass media campaign score increased from 0 (data not reported) to 3 (medium sized warning with an appropriate characteristics) from 2019 to 2011 but decreased one point in 2013. It increased to 4 from 2015 onwards.
E Enforce bans on tobacco advertising, promotion and sponsorship 	Marketing and promotion increase tobacco sales and therefore contribute towards killing more people by encouraging current smokers to smoke more and potential users specifically young people to try tobacco and become long-term customers. Around 1.3 billion (18% of global population) from 48 countries have adopted TAPS ban at best practice level in 2018, as compared to 7 countries (0.2 billion population) in 2007. Additionally 103 Countries has adopted partial TAPS ban & 44 not adopted till date.	As per Section 5 of the India's Tobacco Control Act, direct/indirect advertising, promotion and sponsorship of tobacco product is completely prohibited at Point of Sale. This prohibition extends to depiction of tobacco products or their use in films and TV Programs. Steering Committee has been constituted for monitoring the violations under Section – 5 of the Tobacco Control Act at National, State and District level. With all round efforts and active enforcement, the less number of people noticing any type of cigarette, bidi and smokeless tobacco products promotion decreased over time, in case of Cigarette 7.4% to 5.3, Bidi 6.8 % to 5.4% and Smokeless Tobacco 8.8% to 5.7%. Further, the adults noticing information about dangers of smoking (and smokeless tobacco) on television/radio which encouraged them to quit increased from NA (and 30.2%) to 49.2% (and 38.6%). The scores for ban on TAPS remained unchanged at 3 over time (ban on national and some international television, radio and print media but not on all forms of direct and indirect advertisements).
R Raise taxes on tobacco  	Increasing tax is the most cost effective measure to decrease tobacco use. While merely 38 countries levy tax as high as WHO recommended 75% of retail price of cigarette packs, another 62 levy tax between 50-75% of the price and 61 between 25- 50%, which makes this as the fastest growing MPOWER strategy in terms of population coverage since 2016 (despite this, it still has lowest population coverage i.e.14%).	In July 2017, Government of India has implemented the Goods and Services Tax (GST) wherein, all tobacco products have been listed as 'Demerit goods' and placed in the highest tax bracket category of 28%. Over and above GST a cess has been imposed on all demerit goods, except Bidis. Tendu leaves - used for making bidis also attract a GST of 18% (the details of taxation on different tobacco products was mentioned in 3rd Edition of Tobacco Free Times). In the budget for 2019-20 Central Excise has been reintroduced on all tobacco products, however this has made little or no impact on retail price Ministry of Health/WHO has commissioned the following studies as tools for tax advocacy: 1) 'Economic Burden of Tobacco related diseases in India' released in May 2014. 2) Tobacco Taxes in India : An Empirical Analysis Due to all these efforts, the average monthly expenditure on cigarette and bidi (for daily smoker) goes up from GATS-1 to GATS-2 (Cigarette Rs 668/- to 1192.50/- and Bidi Rs 156.3 to Rs 284.1). There was inconsistency in scores on taxation on tobacco products with 3 (51-75% of retail price) in year 2009 and 2015 onwards to 2 (26-50% of retail price) in 2011 and 2013.

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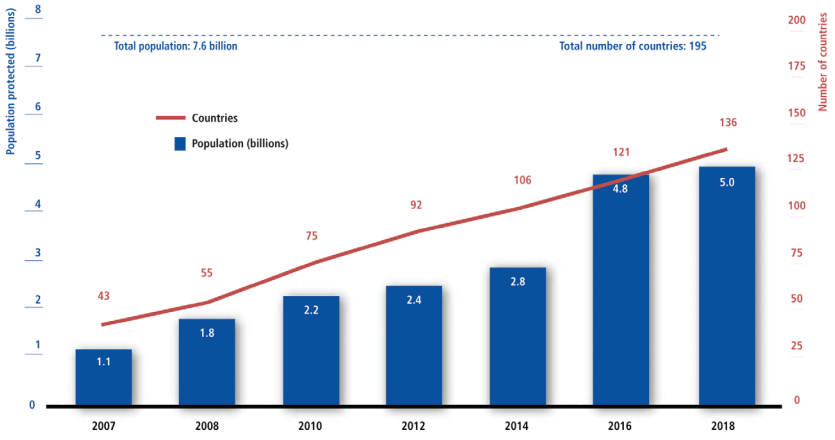
AT LEAST **ONE** MPOWER POLICY AT HIGHEST LEVEL OF ACHIEVEMENT (2007–2018)



EXPERTS SPEAK

The Recently released seventh WHO report on the global tobacco epidemic focusing on the "O" of MPOWER package; "offer help to quit tobacco use" brings back the focus on this largely neglected tobacco control policy measure. There is urgent need to incorporate support for quitting tobacco into any universal health coverage policy. Countries have made progress in establishing tobacco cessation services through various channels. India too expanded quitline to regional level and added more languages for enhanced coverage and outreach. However, there is still a long way to go. The slow progress in other MPOWER measures including mass media campaigns, TAPS ban and raising tobacco taxes need concerted and sustained efforts to reach highest level of achievement.

Dr Jagdish Kaur
Regional Adviser, Tobacco Free Initiative
WHO Regional Office for South-East Asia

In an Indian context, MPOWER to act as a comprehensive evidence-based measure of tobacco control, needs to focus upon monitoring tobacco use and tobacco control policy achievement. This is necessary in the light of achieving non-communicable global voluntary target of 30% relative reduction by 2025 in the prevalence of current tobacco use among persons aged 15 years and above. Though challenging, but proposing a comprehensive ban to all advertising would ensure that potential users are not tapped in the first place. Integrating different cessation activities with National Health Mission framework using information communication technology and facilitating cessation services to a large number of tobacco users (smokers-56% and smokeless 53% as per GATS 2) who are planning to quit is the need of the hour.

Prof Poonam Khattar
Acting Head, Dept. of Communication,
The National Institute of Health and Family Welfare, Munirka, New Delhi, India

India has started to curb the tobacco epidemic; now government must fully implement MPOWER at best practice levels, strengthen state level implementation, and adapt to evolving threats. Vital Strategies is proud to assist this work, particularly through our global expertise in warning people about tobacco's harms and supporting policy change.

Dr Nandita Murukutla
Vice President, Global Policy and Research,
Vital Strategies


Tobacco
causes
cancer

2 CHAPTER

IMPLEMENTATION OF NATIONAL TOBACCO CONTROL PROGRAMME (NTCP) – OVERVIEW

IMPLEMENTATION OF NATIONAL TOBACCO CONTROL PROGRAMME (NTCP) – OVERVIEW

Introduction

Government of India launched the National Tobacco Control Programme (NTCP) in the year 2007-08 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

(v) Facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control

Organizational Structure

NTCP is implemented through a three-tier structure: National, State and District level. The key functions of each tier is provided as under:

NATIONAL

1. Public awareness / mass media campaigns
2. Establishment of tobacco product testing laboratories.
3. Mainstreaming research and trainings with other nodal ministries.
4. Monitoring and evaluation including conduction of GATS/ GYTS
5. Expansion of cessation facilities
6. Establishing National Quit- line [1800-11-2356] and Helpline [1800-11-0456] and m- cessation [011 - 22901701]

STATE

1. Establishment of State Level Coordination Committee and conducting its regular (quarterly) meetings
2. Recruitment and Training for staff appointed at STCC under NTCP.
3. Training / sensitization of relevant stakeholders from various departments including Police, FDA, Health, Judiciary, Media, Academicians, NGO etc.
4. Incorporating tobacco control in state level IEC/ Advocacy Campaigns
5. Establishing tobacco cessation clinics in health care facilities.
6. Enforcement of COTPA
7. Regular reporting to NTCC
8. Use of PIP Flexipool in HR support, travel of staff, IEC etc.
9. Integrating tobacco control with other programmes
10. Monitoring enforcement of tobacco control law

DISTRICT

1. Establishment of District Level Coordination Committee and conducting its regular (quarterly) meetings
2. Recruitment and Training for staff appointed at DTCC under NTCP.
3. Training/ sensitization of key stakeholders: health and social workers, NGOs, school teachers, enforcement officers and nodal persons of different departments.
4. Information, Education and Communication (IEC) activities/ media campaigns
5. Setting-up and strengthening of cessation facilities at district and block levels.
6. Enforcement of COTPA and FSS Act.
7. School awareness programmes
8. Monitoring and enforcement of tobacco control law
9. Co-ordination with Panchayati Raj Institutions for inculcating concept of tobacco control at the grassroots.

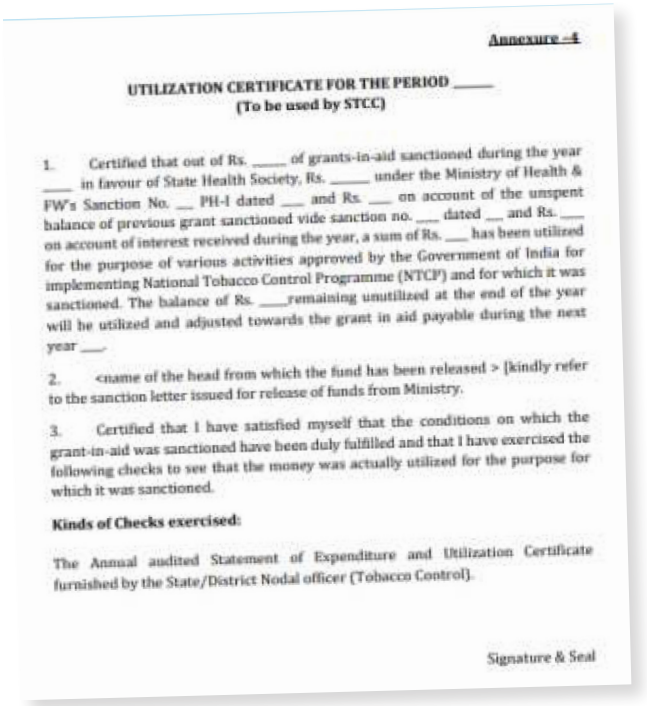
REPORTING FORMATS

Quarterly report:

The State Tobacco Control Cell should report to the National Tobacco Control Cell at the Ministry of Health and Family Welfare and the District Tobacco Control Cell should report to the State Tobacco Control Cell respectively on quarterly basis. It has three parts- A, B and C. The quarterly reports are meant to depict the set up and working of the cell (State and District),staff position, constitution of committees, SOE/ UC submitted, meetings of committee, training workshops/ meetings, TCC and challan details.

Utilization Certificate:

It specifies the details of the grant sanctioned and utilized for the purpose of various activities approved by the Government of India for implementing National Tobacco Control Programme (NTCP).



Annexure –4

UTILIZATION CERTIFICATE FOR THE PERIOD _____
(To be used by STCC)

1. Certified that out of Rs. _____ of grants-in-aid sanctioned during the year ____ in favour of State Health Society, Rs. _____ under the Ministry of Health & FW's Sanction No. __ PH-I dated ___ and Rs. ___ on account of the unspent balance of previous grant sanctioned vide sanction no. ___ dated __ and Rs. ___ on account of interest received during the year, a sum of Rs. ___ has been utilized for the purpose of various activities approved by the Government of India for implementing National Tobacco Control Programme (NTCP) and for which it was sanctioned. The balance of Rs. ____remaining unutilized at the end of the year will be utilized and adjusted towards the grant in aid payable during the next year ___.

2. <name of the head from which the fund has been released > [kindly refer to the sanction letter issued for release of funds from Ministry.

3. Certified that I have satisfied myself that the conditions on which the grant-in-aid was sanctioned have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

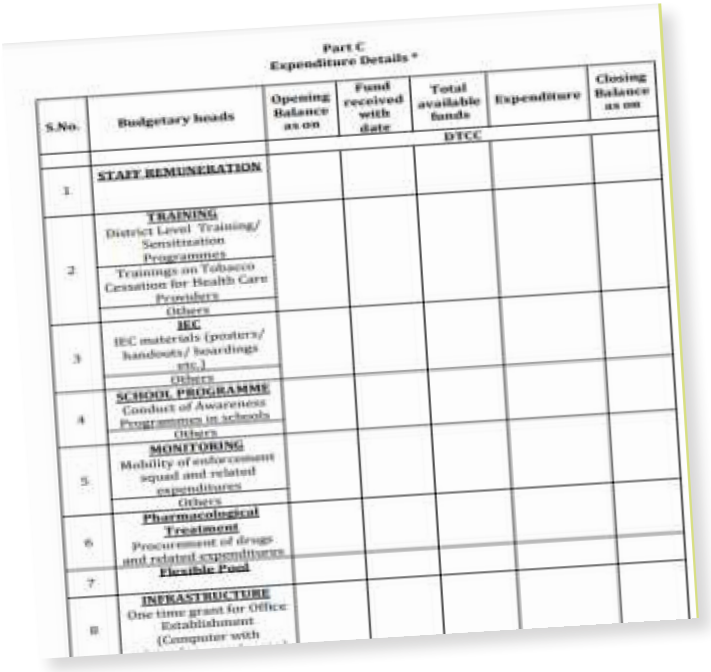
Kinds of Checks exercised:

The Annual audited Statement of Expenditure and Utilization Certificate furnished by the State/District Nodal officer (Tobacco Control).

Signature & Seal

Statement of Expenditure:

The expenditure details is a valuable tool to know whether the cells (National/State/District) are continuously undertaking activities as mentioned in the National Tobacco Control Programme(NTCP) guidelines. It provides a clear information of the fund that has been sanctioned to each cell for carrying out various activities and the details of the expenditure spent on each activity during a particular period of time.



Part C
Expenditure Details *

S.No.	Budgetary heads	Opening Balance as on	Fund received with date	Total available funds	Expenditure	Closing Balance as on
				DTCC		
1	STAFF REMUNERATION					
2	TRAINING District Level Training/ Sensitization Programmes Trainings on Tobacco Cessation for Health Care Providers Others					
3	IEC IEC materials (posters/ handouts/ boardings etc.) Others					
4	SCHOOL PROGRAMME Conduct of Awareness Programmes in schools Others					
5	MONITORING Mobility of enforcement squad and related expenditures Others					
6	Pharmacological Treatment Procurement of drugs and related expenditures					
7	Flexible Pool					
8	INFRASTRUCTURE One time grant for Office Establishment (Computer with					

NGOs under NTCP

One of the main thrust of NTCP is to involve NGOs for various activities, including trainings and capacity building, IEC and awareness generation, school health programs, advocacy, and monitoring/ evaluation. NGO should be registered under the Indian Societies Registration Act / Indian Trust Act /Indian religious and Charitable Act for more than three years. Further, they have working experience in the health / social sector for 3 years and have well-trained staff in health care to organize and carry out various activities under the scheme. The NGO should not have been black listed by any government agency. However, it is up to the respective state governments to decide whether the above stated activities are to be carried out in collaboration with NGOs or by the available state infrastructure.

INDIA'S PROGRESS IN IMPLEMENTATION OF NATIONAL TOBACCO CONTROL PROGRAMME:

2007-2008	National Tobacco Control Programme (NTCP) was launched by the GOI during the 11th Five-Year-Plan.
2007-2008	Training of NTCP programme managers from 21 states and 42 districts by Government of India in collaboration with The Union.
2007-2008	(03) National Tobacco Testing Laboratories (NTTLs) established for monitoring/testing tobacco products.
2007-2008	Operational guidelines developed for effective implementation of NTCP.
2008-	Implementation of FCTC Article 5.3 code of conduct for government employees was created prescribing the standards with which public officials should comply in their dealings with the tobacco industry
2008-2009	Launch of first smoke-free mass media campaign (Dhaun) with support from World Lung Foundation.
2009-10	First Global Adult Tobacco Survey conducted.
2010	A pilot intervention introducing brief advice on tobacco cessation during treatment of TB patients launched in distt. Vadodara.
2011	Food Safety and Standards (Prohibition and Restrictions on Sales) Regulations, issued under the Food Safety and Standards Act, 2006, lays down that tobacco and nicotine shall not be used as ingredients in any food products.
2012	Regulation of the use of cigarettes and other tobacco products in films and TV programme.
2013	Guidelines for implementation of pictorial health warningson cigarette packaging.
2016	Implementation of large pictorial, graphic health warnings (separately for smoked and smokeless tobacco products) launched.
2016	Prohibition on Sale to and by minors and sale around Educational Institution under Section 6 of COTPA.
2016	India hosted the Conference of the Parties at its seventh session (COP7) which focused on implementation of WHO FCTC Article 5.3.
2016	GOI launched a country wide tobacco cessation program and bilingual m-cessation programme (missed call at 011-22901701)
2016	National Toll- Free Quitline (1800 11 2356) launched.
2019	GOI issued a ban on Electronic Nicotine Delivery System (ENDS).

Training resources for NTCP programme managers were developed and trained officials from all 35 states and UT's in collaboration with NIHFW, The Union and WHO

BEST PRACTICES

Mass Media Campaigns

India – "Heartbreak"-Anti Bidi Smoking Campaign

An anti-bidi smoking mass-media campaign was launched by Ministry of Health and Family Welfare under the National Tobacco Control Programme in July 2011. It was launched to raise awareness of general public regarding the risks of heart attacks due to smoking bidis and cigarettes. This was the first government-sponsored mass media campaign in the world that links bidi smoking to heart health.

https://www.who.int/fctc/implementation/ne ws/indianews/en/

Anti Tobacco campaign for youth

An anti-tobacco campaign was started in partnership with Delhi Police and Sambandh Health Foundation, Delhi in May 2016 to save the youth and school children from indulging in tobacco use practices and ensure correct implementation of COTPA for making Delhi into a healthier capital. From health outreach in semi urban areas, to media outreach and strategic partnership with law enforcement agencies, it was one of the major steps to ensure that the voice against tobacco is heard across the country.

http://www.maxindiafoundation.org/project-anti-tobacco.html

National Consultation on Smokeless Tobacco

A National Consultationon Smokeless Tobacco was organized by the Indian Council of Medical Research in April 2011 with an objective to highlight the current pattern and burden of use of smokeless tobacco in India along with a view learning global best practices. It recommended increasing the age of sale of tobacco to beyond 21 years and restricting sale of flavoured smokeless tobacco in less than 50gm pouches/packs.

https://pib.gov.in/newsite/PrintRelease.aspx?relid=7139

Nasha Mukti Abhiyan

The Nasha Mukti Abhiyan was launched in the state of Haryana in 2015 to free people, particulary the youth population from drug addiction. Under this campaign the police department set up "Yuva Clubs" in the villages which helped in sporting youth activities and weaning them away from menance of drugs. In this regard, a helpline number(88140-56100) was also released where anybody could provide information regarding trafficking and misuse of drugs.

https://www.tribuneindia.com/news/archive/feature s/-nasha-mukti-abhiyan-launched-in-sirsa-54051

What Damage will this Cigarette/Bidi Do" cessation campaign

"What Damage Will This Cigarette/Bidi Do," campaign embarked by the Ministry of Health and Family Welfare, Government of India as a national media campaign with technical support from Vital Strategies in June, 2018 at a World Health Organization event. By highlighting tobacco's links to stroke and heart disease, the leading cause of death among tobacco users globally, the campaign amplifies the theme of 2018 year's World No Tobacco Day, which was "Tobacco Breaks Hearts." Smoking cessation was the main highlight of this campaign.

https:// www.adgully.com/ministry-of-health- launches-what-damage-will-this-cigarette-bidi-do- 78550.html

"Spit-free India" movement

Amid Covid-19, "Spit- free India" movement was started by beautiful Bengaluru in June 2020 by starting an online petition on change.org urging the Prime Minister to make spitting a punishable offense. The main objective of this campaign was to ban spitting in public places and to check the spread of the virus.

https://www.thehindu.com/news/cities/chennai/spitt ers-beware/article31771315.ece

A campaign for banning e-cigarette

Voice for Tobacco Free Victims (VoTV) moved a campaign with over 1000 doctors from 24 states of India in April 2019 which appealed to the Prime Minister to enforce a ban on e-cigarettes for protecting youngsters from getting indulged in smoking practices.

The campaign also appealed to ban the sale of loose cigarettes which increases easy accessibility and affordability of tobacco products amongst youngsters. https://economictimes.indiatimes.com/news/politics-and-nation/ban-sale-of-loose-cigarettes-voice-of- tobacco-victims-kerala-to-pm/articleshow/45899571.cms?utm_source=content ofinterest&utm_medium=text&utm_campaign=cppst "Spit-free India" movement. Amid Covid-19.

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https://www.thehindu.com/news/cities/chennai/spitt ers-beware/article31771315.ece

School-Health Programs

Yellow Line Campaign

Yellow Line Campaign began in the state of Punjab from 1st November, 2018 to 7th November, 2018 with a main goal to further tighten the noose around the neck of offenders who are bent on violating the anti tobacco law and to create awareness among the students of the educational institutes against tobacco. The State Government had adopted a stringent policy by the demarcating 100 yard area around an education institution as a place under yellow line and declaring this area as Tobacco Free Zone. Many other states are also conducting such campaigns.

http://diprpunjab.gov.in/?q=content/hm-launches-% E 2 % 80 % 98 yellow- l ine- campaign% E 2 % 80 % 99 - declares-100-yard-area-around-educational-institutes

Tobacco Free Educational Institutions guidelines

The Tobacco-Free Education Guidelines were released by Government of India in 2008 with an objective to provide a fresh m o m e n t u m i n implementation of tobacco control initiatives among adolescents and young adults and to create more awareness about harmful effects and long-term health impact of tobacco use.

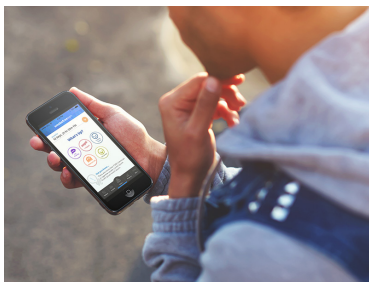
https://ntcp.nhp.gov.in/assets/document/TEFI- Guidelines.pdf

Quit tobacco movement

Salaam Bombay Foundation (SBF), under its leadership program conducts tobacco control awareness campaigns engaging the school children. Launched in 2008, this campaign is implemented every year in the schools having SBF's Super Army Leadership Program to promote freedom from tobacco inspired by the Quit India Movement.

https://www.researchgate.net/publication/323492410_ Engaging youth_i n_anti-tobacco_awareness_campaigns_in_India

"Mobile (m) Cessation"



The Union Health Ministry launched "Mobile (m) Cessation" in 2015, to develop tobacco use abstinence among people interested in quitting. As part of the programme, tobacco users can enroll themselves by giving a missed call to a particular phone number and they will start getting three to four messages daily which will counsel and consistently motivate them to quit tobacco.

https://economictimes.indiatimes.com/industry/cons - products/ tobacco/ government- to- launch- m- c e s s a t i o n - t o - h e l p - k i c k - t o b a c c o - h a b i t / articleshow/49308988.cms?utm_source=contentofin terest&utm_medium=text&utm_campaign=cppst

Mcessation or National Quit Lines

Tobacco cessation clinics (TCCs)

The first formal tobacco cessation clinics were set up as a joint initiative of the Ministry of Health and Family Welfare, Government of India and the World Health Organization's Country Office for India in 2002 to develop simple intervention models for tobacco cessation for smokers and smokeless tobacco users. Thirteen tobacco cessation clinics (TCC) were set up in this regard in different departments viz. psychiatry (3), cancer (5), surgical (2), cardiology (1), chest diseases (1) as well as in a non government organizational setting (1). The TCCs were subsequently expanded to five more Regional Cancer Centres (RCC) in 2005. A network of 19 tobacco cessation clinics (TCCs) was set up over a period of time.

https://apps.who.int/iris/bitstream/handle/10665/329824/whoseajphv1i2p159.pdf?sequence=1&is Allowed=y

WHO-ITU's 'Be Healthy Be Mobile' initiative

The Be Healthy, Be Mobile (BHBM) initiative was set up by the World Health Organization (WHO) and the International Telecommunication union (ITU) supported by Government of India in 2012 with a goal to support tobacco users for successful quitting through constant text messaging on mobile phones. It reaches out to all categories of tobacco users who wanted to quit. As future perspectives, this initiative might help to achieve Goal 3 of the Sustainable Development Goals by 2030 viz. "To ensure healthy lives and promote wellbeing for all at all ages".

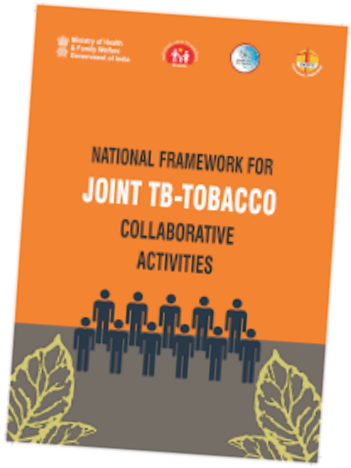
https:// www.who.int/activities/Addressing- mobile-health

Resource Centre for tobacco control

Department of Community Medicine and School of Public health, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh has been conducting various capacity building workshops and programs from last over 5 decades. In this context, Resource Center for Tobacco Control was conceptualized in the year 2018 in collaboration with The Union, SEA, as a platform from where we can fetch all the information related to tobacco control activities of the country. The platform shall not only assimilate and channelize the existing information on tobacco control which are lying scattered, but also a boon for the building aspirants (researchers and academicians) in tobacco control where they can explore opportunities in this area.

Integration with other health programs

TB-Tobacco Collaboration



Tuberculosis (2.8 million incident cases per annum) and tobacco use (nearly 275 million adults) continue to be major public health concerns in India; both of which are mostly preventable. The vast body of evidence suggests that there is a strong association between tobacco use and TB treatment outcomes. Recognizing this the collaboration between RNTCP and NTCP creates an opportunity within the health care system by providing cessation services to every TB patient who is a tobacco user and imparting awareness about consequences of being exposed to secondhand smoke to every TB patient who is not a tobacco user. In this context, The National Framework for Joint TB Tobacco Collaborative Activities was launched in 2017 providing step by step guidelines on the implementation of tobacco cessation services as an integral part of TB case management with support from domain experts, WHO and The Union. India is the first country in WHO South-East Asia Region to implement collaborative framework for TB-Tobacco co morbidities with an expectation of collateral benefits for TB & tobacco control in the country.

Tobacco Cessation Centers in Dental Institutes - An Integrated Approach

The tobacco cessation centers were established in Dental Institutes programmes in accordance with the WHO Oral Health Programme tobacco control policy and WHO policy on tobacco cessation. The operational guidelines for the same were launched in 2018. The initiatives was started to support national oral health programme (NOHP) to routinely identify patients who use tobacco, brief tobacco cessation and providing them with interventions.

Rajasthan High Court banned the sale of gutkha, pan masala in plastic sachets

Rajasthan court prohibited all gutkha manufacturers in the state from using plastic packaging in 2007. The industry challenged the ruling in the apex court, and directed the Centre to ensure that gutkha and paan masala are not sold in plastic pouch. Taking suo moto initiative, the judges asked the central government to conduct a comprehensive study of the ingredients of gutkha and similar products manufactured in the country and their harmful effects on human health.

https://www.downtoearth.org.in/coverage/centre- bans-gutkha-33857

NGO's involvementin enforcement of NTCP

Consultation on Tobacco Vendor Licensing was held in partnership of Tobacco Control Cell, Dept. of Health Punjab and technical support of International Union and Generation Saviour Association in June 2019. In this regard, courtesy notices (Unofficial orders) were issued from time to time against the tobacco vendors if they violate the rules laid down by COTPA(2003)

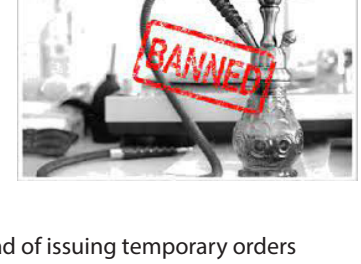
'Rose Campaign'- India's first Campaign on Tobacco Free Educational Institutions

Karnataka has introduced India's first 'Rose Campaign – a Movement for Tobacco Free Educational Institutions led by student and teacher community to sensitize Point of Sale owner on not selling tobacco within 100 yards of any educational institution.

State-Specific Initiatives

Bihar banned the sale of tobacco and nicotine mixed gutkha and pan masala in 2012 for one year. The ban extends every year. Government has banned Pan Masala brands which were found not in conformity with the standards of Pan Masala as specified in Regulation 2.11.5 of the Food Safety and Standards (Food Products and Food Additives) Regulations, 2011

Punjab and Gujarat imposed complete ban on Hookah Bars



The state governments passed a bill on September 18th, 2018, for amendment in the Cigarette and other Tobacco Products Act, 2003 for a complete ban on hookah bars. Punjab and Gujarat government decided to impose a permanent ban on hookah bars in the state instead of issuing temporary orders against them every two months. The move was aimed at reducing the trend of hookah bars, besides use of tobacco in various forms amongst youngsters.

https://www.newindianexpress.com/nation/2018/mar/ 19/ after-gujarat-now-punjab-decides-to-permanently-ban-hookah-bars-189434.html # : ~ : text=CHANDIGARH%3A%20After%20 Gujarat%2C%20Punjab%20Government,against%20them%20 every%20two%20months.&text=The%20amendment%20would%20 result%20in,Hookah%20Bars%20in%20the%20state.

Jharkhand banned 11 brands of Paan Masala

The Jharkhand government has banned 11 premium brands of pan-masala for a year, in May 2020, as products contain magnesium carbonate which can cause acute hyper magnesia and sometimes cardiac arrest, as per the notification issued by the department of health, medical education and family welfare in May 2020. According to the health Minister, Mr. Banna Gupta, the ban would also help contain the spread of Covid-19 in Jharkhand, as people spit after consuming Pan Masala.

Https://www.hindustantimes.com/india-news/jharkhand-bans-1-pan-masala-brands-on health-concerns/story-QXv1MiD7rVHSoAB JOOy60J.html#:~:text=Jharkhand%20health%20minister%20 Banna%20Gupta,premium%20brands%20for%20a%20 year.%E2%80%9

Smoking still a core challenge for child and adolescent health reveals WHO report

The latest Health Behaviour in School-aged Children (HBSC) study focusing on adolescent health and well-being has revealed that levels of cigarette-smoking are worryingly high, particularly among 15-year-olds. In this age group, 15% of adolescents report having smoked a cigarette at least once in the past 30 days and nearly 1 in 3 mentioned having tried smoking (27% of girls and 29% of boys).

Goa bans manufacture, storage, distribution and sale of any article of food containing tobacco

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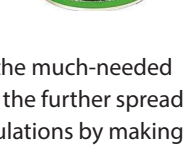
http://timesofindia.indiatimes.com/articleshow/58523 453. cms?utm_source=contentofinterest&utm_medium=text&utm_ campaign=cppst

Karnataka launched 'STOP TOBACCO', a mobile application

Karnataka government has launched 'No Tobacco', a mobile application, to report complaints of any kind of COTPA violation by uploading photographs of the violators . The app 'StopTobacco' is being launched to commemorate the World No Tobacco Day on May 31,2019.

https://www.deccanherald.com/state/app- to-help-report-tobacco-rule-violations- 737554.html

GST Council urged to levy COVID19 cess on tobacco products, to generate Rs 50,000 crore



Public Health Groups along with doctors and economists called out for a complete ban on all smokeless tobacco products and pan masala which results for 90% oral cavity cancer in India. The imposition of COVID cess on all tobacco products will not only help raise the much-needed revenue to fund the stimulus it will also prevent the further spread of the virus, especially amongst vulnerable populations by making tobacco products unaffordable and forcing them to quit.

WTO Reaffirms Australia's Tobacco Plain Packaging Measure

The World Trade Organization (WTO) has reaffirmed its earlier decision that Australia's tobacco plain packaging is a legitimate policy measure that is making a meaningful contribution to public health. "This is a fantastic win not just for Australia, but for governments around the world who want to reduce the terrible toll of sickness and death caused by smoking," Minister Hunt said.

Delhi extends bans on manufacture, storage, distribution and sale of gutka, pan masala for another year

D N Singh, Commissioner (Food Safety), National Capital Territory of Delhi, has prohibited the manufacture, storage, distribution, or sale of tobacco which is either flavored, scented or mixed with any of the said additives, and whether going by the name or form of gutkha, pan masala, flavored/scented tobacco, kharra etc. The decision was taken in the interest of public health for a period of one year in NCT.

Health Ministry notifies new pictorial health warnings for tobacco products

Union Health Ministry on Thursday (July 23) notified new sets of specified health warnings with enhanced pictorial images to be printed on all tobacco products. The new and amended rules will be applicable from December 1, 2020, according to an official statement.

Amid Covid-19, Tobacco ban was to save lives in the country, court told: Africa

The supreme court in Africa presented a judgment to ban the sale of cigarettes. The judgement may present an opportunity for the illicit trade of cigarettes as well as underworld activities and that it had also severely affected the collection of tax in the country.

Plain packaging will accelerate progress towards ending the tobacco epidemic: Singapore

Non-compliance with the plain packaging (or standardized packaging) regulations in Singapore has been implemented from July1 2020, and violations will be an punishable offense with a fine not exceeding $10,000, imprisonment for a term of up to six months, or both for first offenders. Those with a prior qualifying conviction will face heavier penalties.

Pakistan urged to enforce strict taxation for tobacco control

Anti-tobacco campaigners in Pakistan have urged the government to formulate effective measures for tobacco control like increasing the ratio of taxes which will limit the sale and consumption of these products.

UK tobacco sales fell faster after plain packaging rules came into force

The underlying rate of decline in tobacco sales almost doubled after the plain packaging rule was implemented. It has decreased by about 20m a month, researchers have found.

Australia wins tobacco case at the World Trade Organisation

Australia has seen off a final challenge to its "plain packaging" rules for cigarettes, as the tobacco industry's epic campaign against the measures finally runs out of road.

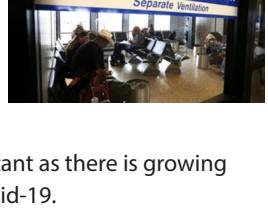
Pass a cigarette puff, get corona virus for free

The World Health Organization in its website, clearly warns that smoking could lead to transmission of COVID-19. Tobacco smokers may be more vulnerable to contracting COVID-19, as the act of smoking involves contact of fingers (and possibly contaminated cigarettes) with the lips, which increases the possibility of transmission of viruses from hand to mouth.

27.1% of India's all cancer cases in 2020 will be tobacco-related, ICMR report estimates

The National Cancer Registry Programme Report 2020, released by the Indian Council of Medical Research (ICMR), estimates there will be 13.9 lakh cases of cancer in India in 2020, and that this number is likely to rise to 15.7 lakh by 2025. The estimates are based on data retrieved from 28 Population-Based Cancer Registries (PBCRs) and 58 Hospital-Based Cancer Registries (HBCRs) from across India, between 2012 and 2016.

Smoking rooms at airports should be permanently closed: Experts



According to public health group member and Chairman of Max Institute of Cancer Care, Harit Chaturvedi, there is imperative need to close smoking room at the airports permanently to minimize the risk of virus spread as well as to reduce the health harm from second hand smoke. This is important as there is growing evidence of smoking being a risk of Covid-19.

Tobacco Related cancer is higher among men in Nagaland :NCPR

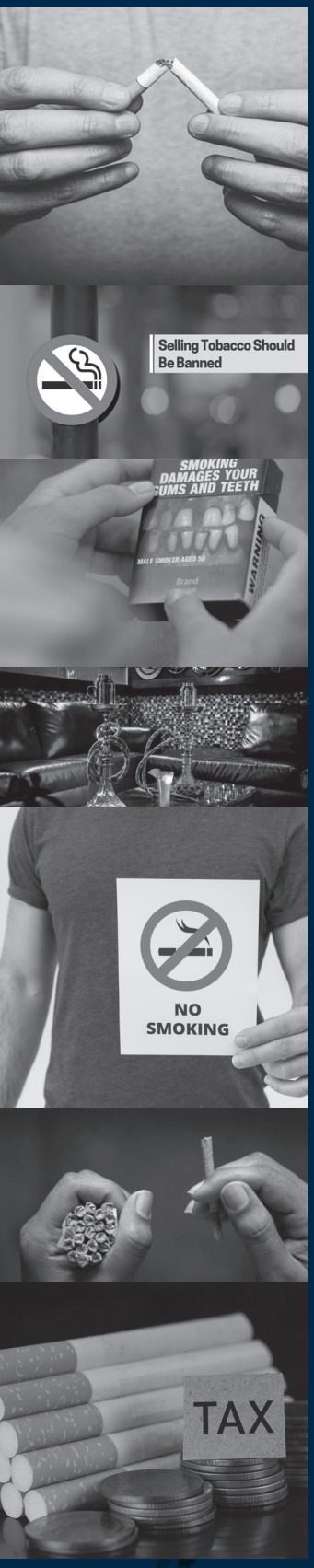
The relative proportion of cancers associated with the use of tobacco i n Nagaland was 39.3% and 11.5% in males and females respectively, according to the recent National Cancer Registry Programme Report (NCRP) 2020.

Follow START to quit tobacco and lead a healthy life

As Indian Council of Medical Research (ICMR) has projected that 27.1 per cent of India's all cancer cases in 2020 will be tobacco-related, a highly experienced surgical oncologist has urged people to quit all tobacco products for a healthy and cancer-free life. He has urged people who are addicted to smoking and tobacco products to follow 'START.' Dr Vedant Kabra, Head, Department of Surgical Oncology, HCMCT Manipal Hospitals, New Delhi, said that quitting all tobacco-related products is the first step one can take towards improving their overall health.

Maharashtra: Spit, tobacco, smoke to fetch fine and jail

Municipal commissioner Tukaram Mundhe issued a notification regarding spitting, smoking (including e-cigarettes) and chewing tobacco and related products in public places and on premises of private establishments will attract fine as well as imprisonment for both consumer and sellers.



3 CHAPTER

COMMIT TO QUIT

COMMIT TO QUIT

Tobacco quit status GLOBALLY:

Studies have revealed that most of the tobacco users are well aware of the ill effects of tobacco use and brief advice from health professionals can increase quitting success rates by up to 30%, while intensive advice increases the chance of quitting by 84%. Without cessation support only 4% of attempts to quit tobacco will succeed. Despite the existence of substantial evidence on the need for tobacco cessation services worldwide, only 23 countries provide comprehensive cessation services with full or partial cost-coverage to assist tobacco users to quit. Currently, over 70% of the 1.3 billion tobacco users globally lack access to the tools they need to quit successfully. (WHOreport)

In accordance with WHO's **Framework Convention on Tobacco Control (FCTC)**, countries are required to treat tobacco use and dependence. WHO provides capacity building and training packages to help governments establish or strengthen their national tobacco cessation systems including integrating brief tobacco interventions into their primary care systems, developing national toll-free quit lines and mCessation projects. "Offering help to quit" is also one of the six key interventions in the MPOWER package of technical measures and resources which was introduced by WHO in 2007.

Why Quitting is beneficial?

IMPROVES health and **INCREASES** life expectancy.

LOWERS risk of 12 types of cancers.

LOWERS risk of chronic obstructive pulmonary disease (COPD).

LOWERS risk of some poor reproductive health outcomes.

BENEFITS people who have already been diagnosed with coronary heart disease or COPD.

BENEFITS people at any age-even people who have smoked for years or have smoked heavily will benefit from quitting.

IN INDIA:

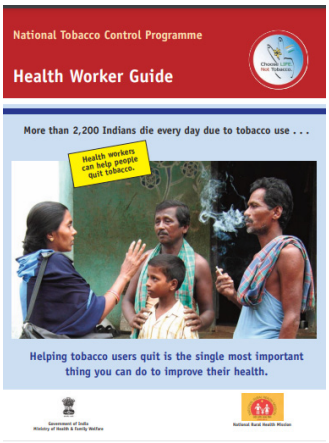
The proportion of current tobacco smokers planning to quit tobacco use has seen a rise from 46.6% in GATS 1 to 55.4% in GATS 2 survey. However, this increase in the intention to quit was lower, 38.5 to 33.2% (4.4%) among the current users of smokeless tobacco. Further, about 38.5% smokers and 33.2% users of smokeless tobacco have made a quit attempt in the last one year in our country. Furthermore, 48.8% of smokers and 31.7% smokeless tobacco users were advised to quit tobacco use by a health care provider in the last 12 months. Several cessation methods have been offered under the National Tobacco Control Program by Government of India viz. pharmacotherapy in the form of nicotine replacement therapy or other prescription medications; counseling; support through helpline call centers (1800 112 356) or through mobile—the latter is known as m-Cessation(011-22901701). However, a modest (4.1%) users took the support of pharmaco-therapy while almost twice as many (8.6%) took counselling support.

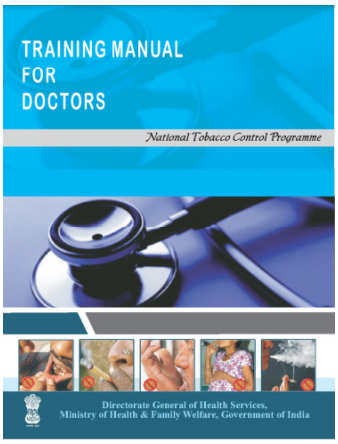
In 2002, acknowledging the importance of tobacco cessation services for the tobacco users who intend to quit, Ministry of Health and Family Welfare, Government of India set up 13 tobacco cessation clinics (TCCs) with the support of the World Health Organization India Country office. Subsequently, six more TCCs were established to provide tobacco cessation interventions. Currently, Tobacco Cessation Centres are active in more than 487 districts in the country.

Provisions for quitting tobacco-Global and India

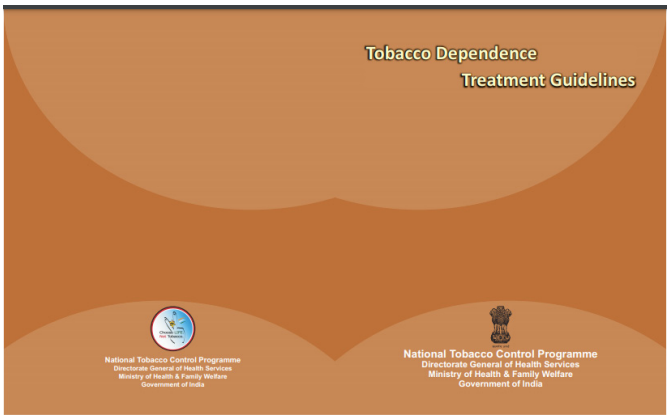
Article 14 of WHO-FCTC	Each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.
"O"- (Offer help to quit) component of MPOWER strategy	Strengthen health systems so they can make tobacco cessation advice available as part of primary health care. Support quit lines and other community initiatives in conjunction with easily accessible, low cost pharmacological treatment where appropriate.
National Tobacco Control Programme (NTCP), India	A district level tobacco cessation centre (TCC) is being established in each district hospital and shall be provided with staff, equipment, training and outreach services

National Tobacco Control Programme Quit Provisions





Dedicated State Tobacco Control Cells and District Tobacco Control Cells are established at State and District level for effective implementation and monitoring of tobacco control initiatives including Training; IEC activities; School awareness programme and Setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at the district level. Tobacco Cessation Centres (TCCs) exist almost in every State/Union Territory apart from the hospitals providing cessation facilities. One who wants to quit tobacco may visit these centers for counseling and/or pharmacological therapy. Any health care professional with some training can provide tobacco cessation services that include Doctors, Psychologists, Social Workers, Nurses, and Dentists.



SOME MILESTONES IN TOBACCO CONTROL IN INDIA

The journey began in 2001. It can be categorized into following heads:

A. Tobacco Cessation Clinics-

i. These are the outpatient-based services in various health facilities under their clinical settings. Tobacco cessation clinics (TCCs) project by the Ministry of Health and Family Welfare, Government of India (MoHFW) in collaboration with World Health Organization, SEARO and India Offices- It was launched in January 2001 through TCCs established in 13 Tertiary Care Centers countrywide; another 6 centers were added in next phase. Reporting on the feasibility of tobacco cessation services in India through a report it published in 2012, it opined that "integration of TCCs into the healthcare system remains a challenge" as managing 34,741 patients in first 5 years, over follow-up over six weeks, only 14% (3255 patients) had quitted.

ii. Establishing TCCs in every district of India "to help people to quit" has been the fourth of the five objectives of the National Tobacco Control Program of India (NTCP) that was launched in year 2007-08 under 11th 5-year plan. Its objectives at the State and District levels are to (1) train the healthcare providers and (2) set up and strengthen the cessation facilities including provision of pharmacological treatment facilities respectively. Till date, it has established these in over 500 districts. This objective is also getting fulfilled through the convergence under National Health Mission of other national health programs along with NTCP, such as NPCDCS, RNTCP, NOHP, NMHP, etc. wherein their clinics also assist in quitting tobacco. Their results, either collectively or under each head are yet to be known.

iii. Tobacco cessation is also delivered through the deaddiction services provided by the psychiatry departments/units of the medical colleges and apex national mental health institutes such as NIMHANS, IBHAS, etc., ~1120 clinics run by the dentists trained under the TII of the IDA and the specific TCCs run by a few private and corporate health facilities.

iv. In the preceding twelve years, the country also had publication of some tobacco cessation specific studies. These have reported a quit rate which varied from a low of 12.5% at 2 months follow-up to the highest of 42% at 42 months

B. Quitlines- These services counsel tobacco users to quit telephonically on calling at a specified telephone number post-registration. After an initial "intensive intervention" through the trained counselors, further assistance is provided, usually proactively by the follow-up calls that are prescheduled. Globally, this service with an average quit rate around 30% is mostly provided at "no fee".

i. American Cancer Society (ACS) under its India Cancer Initiative between October 2006 to December 2010 launched the ACS Quitline for its Indian workplace partners in December 2008. It was established in collaboration with Wipro India at New Delhi. Winding up its operation, its offer to MoHFW to take over did not materialize. But MoHFW coordinated for the intent of ACS with some agencies interested to provide quitline service in India.

ii. Johnson and Johnson, India Office at Mumbailaunched its "national tobacco cessation toll-free quitline on World No Tobacco Day (WNTD) 2012. Its status stays unreported.

iii. Population Services International (PSI) India with its expertise in social marketing, established its quitline in Chennai, Tamil Nadu "Wish to Quit" in September 2011. It intended to serve the workplaces in Tamil Nadu and Karnataka as well as the State of Tamil Nadu. As the internal funding exhausted, it winded up in August 2013 as neither of the proposed collaborative partners could be engaged optimally.

iv. Rajasthan Cancer Foundation, Jaipur has worked informally, as a volunteer with the State Medical Helpline (Toll-free no. 104) through its private partners, Piramal Swasthya and GVK EMRI from April 2013 onwards. In September 2014, it reported an overall quit rate of 19.93% for total abstinence in 1525 callers; for those who could be followed-up for 6 months to 1 year, the self-reported quit rate was 58.01%.

v. The MoHFW launched the toll-free National Tobacco Quitline Service (NTQLS) at 1800-11-2356 on WNTD 2016. It is established at Patel Chest Institute, New Delhi. For the 5179 callers registered out of 16,548 inbound calls and 60,222 IVR hits, it reported a quit rate of 38.81% at the end of the fourth proactive call made between 4- 8 weeks.

vi. The strengthen the NTQLS delivery, the MoHFW extended it regionally through 3 regional quitlines (all serving through the toll-free calls at 1800-11-2356) based out of BB Cancer Institute, Guwahati, Assam, Tata Memorial Center, Mumbai and NIMHANS, Bengaluru in September 2018. At the end of 1-year, the NIMHANS- based regional quitline reported that out of over 5 lac calls received, ~75% from Southern India, it could attend 69,000 calls and assist 19,000 callers for a quit success of around 40%.

vii. All the NTQLS services, both nationally and regionally, have observed a need for upscaling the resource to be able to serve all their callers promptly and effectively.

C. mCessation- This short text-message based mobile health program, India mCessation program to help tobacco users quit through 011-22901701 is a collaborative outcome between WHO and International Telecommunication Union (ITU) with the MoHFW and the Ministry of Telecommunications. Launched in 2015, at the end of 1-year, it reported a quit rate of 19% for total abstinence in last 30 days among 12,502 subscribers out of nearly 2 million registered for the service delivery.

Why should you quit?

1. 180 million tobacco-related deaths averted if the adult tobacco consumption reduces by half.
2. Quitting before 50 years of age reduce the risk of dying in the next 15 years to half.
3. Smoking cessation causes an immediate decline in the blood carbon monoxide levels, normalization of pulse rate, blood pressure, and restoration of sense of taste and smell.
4. In the long run quitting reduces the risk for lung cancer, coronary heart disease and chronic obstructive pulmonary disease.
5. Even among pregnant women who quit smoking later in pregnancy, infant birth weights are higher than among women who continue to smoke.
6. Smoking cessation also promotes favorable changes in the lipid profile and body fat deposition.
7. It also prevents the diseases due to inhalation of secondhand smoke among non-users of tobacco.
8. Cessation of smokeless tobacco use is associated with reduced risks of oral cancer and precancerous lesions, cardiovascular diseases, and dental problems.
9. In addition to all the health benefits, quitting tobacco use saves a huge sum of money.
10. Some immediate to long term benefits have been recorded by quitting smoking:
    - **20 minutes:** heart rate, blood pressure drop
    - **12 hours:** carbon monoxide in the bloodstream drops to normal
    - **2 weeks–3 months:** circulation, lung function improves; heart attack risk begins to drop
    - **1–9 months:** cough less, breathe easier
    - **1 year:** risk of coronary heart disease cut in half
    - **2–5 years:** risk of cancer of mouth, throat, esophagus, bladder cut in half; stroke risk is reduced to that of a nonsmoker
    - **10 years:** half as likely to die from lung cancer; risk of kidney or pancreatic cancer decreases
    - **15 years:** risk of coronary heart disease same as non-smoker's risk.

ROADMAP FOR CESSATION IN INDIA

These are proposed in view of the currently unsatisfactory status of the tobacco cessation and the existing challenges and barriers that are being observed and discussed among the tobacco control community during its academic interactions online or through the various national meets held prior to the COVID pandemic:

i. **People:** All current tobacco users and their family should be made aware of the benefits of quitting through government-run mass communication campaigns for motivating them to quit through the existing toll-free services (NTQLS and/or mCessation) or the TCCs that are easily accessible, preferably at "no fee" or supported duly by whichever health insurance plan they have bought for all consultations as well the complete course of the primary cessation medications (Nicotine Replacement Therapy[NRT] with or without Varenicline or Bupropion) prescribed by their doctor or even bought over-the-counter as admissible for the NRT.

ii. **Healthcare Workers:** Every healthcare worker should be empowered suitably as per their role in their assigned patient care; and ,should also be made accountable to deliver tobacco cessation to all tobacco using patients s/he is encountering at each and every clinical encounter. Their biannual accreditation should be mandated through the respective State Medical or Nursing Councils and/or their parent medical or nursing associations.

iii. **Health Facilities:** All health facilities at all levels of healthcare countrywide, both in the government, private and any other health sector such as missionary, civil society, etc. should be encouraged, empowered, and enabled to provide the cessation services optimally and in a sustainable manner through a Systems Approach and by coding the tobacco using patients as per the latest International Classification of Diseases (ICD- 11). Further, these should be regulated both at the national and the State levels respectively, to observe a regularity in reporting and with an absolute transparency, preferably through a national real-time grid or an App accessible easily and for free.

iv. **Workplaces:** Quitting all forms of tobacco use should be made compulsory at all workplaces within a timeline; and, through a policy and workplan concurred in-house after thorough communication among all their functional cadres at all levels. Those quitting successfully should be monitored for their maintaining the quit status and recognized and rewarded socially to establish quitting as "the Norm". Those who fail to quit, or relapse should be supported suitable to be "A Former User". Those who fail despite these efforts should be penalized as per the existing disciplinary guidelines of the respective workplace.

v. **Women and Youth Specific Measures:** Both groups need specific as well as priority attention: ***(1) Women*** because of their additional suffering during the reproductive phase of life and when elderly; and, also, because of (a) their obvious need to preserve the confidentiality and (b) inability afford and/or access the cessation portals due to their multi-factorial limitations in the male-dominated communities; ***(2) Youth*** because of their highest degree of susceptibility to experiment with tobacco products including ENDS and get addicted; and, also because of (a) different messages and (b) solutions they prefer vs. adults to quit and stay quit. Making access free and easy to both groups and raising age of tobacco purchase to 25 years along with a decision at an earliest on the cut-off date for tobacco-free generation in India appear most useful.

vi. **Communities:** The time has come now that an Inter-Ministerial body under the joint leadership of Social Welfare Ministry and MoHFW generates a policy that will effectively denormalizes tobacco use in any community countrywide by empowering them for integrating "Saying NO to tobacco" or "Quit Now" in their daily lives; proposing the use of mass communication appears a doable action to clear myths, stigmas and beliefs as well eliminate comraderies in tobacco use.

vii. **Governance:** Ensuring adequate resources for an optimal delivery of tobacco cessation and monitoring, evaluating, and reporting it on a regular basis should be prioritized under the continuum of NTCP. Besides, the governance also have an onus to facilitate, supervise and regulate all other stakeholders to benefit and strengthen the quality as well as growth of tobacco cessation delivery overall everywhere in the country. The smooth and timely coordination of the MoHFW and the State Medical and Health department needs no emphasis.

viii. **Strengthen Tobacco Control Measures (MPOWER):** The strategies being used to implement WHO MPOWER measures optimally needs no emphasis in view of their evidence-based efficacy. Specifically, the measures related to raising the tobacco tax until the unaffordability of tobacco products is obvious, introducing a wider spectrum of pictorial warnings along with one benefit of quitting with each of these and efficient and easy-to-implement enforcement of COTPA can be prioritized.

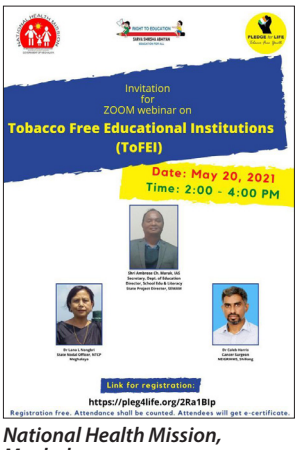
Lastly, it is important to remember that "O" in MPOWER is "Not an Orphan" but an "Opportunity" for both health system and tobacco users and, also, an "Onus" and "Obligation" on health managers to deliver "optimal" tobacco cessation services.

World No Tobacco Day 2021
Activities across the Country

The International Union Against Tuberculosis and Lung Diseases organized a TweetChat in which Dr. Omara Dogar led the discussion on "Smoking cessation prioritization and Dr. Sonu Goel led the discussion on "Tobacco Endgame"

Webinars Conducted By:

1. The **Assam** Care Foundation and the district tobacco control cell in support of Inspector of Schools, department of education, Kokrajhar
2. National Health Mission, **Meghalaya**; Sarva Shikhsha Abhiyan and Pledge for life (tobacco free youth)on tobacco free educational institutions.
3. All India Institute of Medical Sciences, **Rishikesh** with the theme of this year "Commit to Quit".
4. Uttaranchal University, **Dehradun**, on dangers of tobacco among the students.
5. Indira Gandhi Institute of Dental Sciences in association with NSS unit and National Tobacco control program, **Pondicherry** state health mission on ill effects of tobacco.
6. SRM University, **Andhra Pradesh** on ill effects of tobacco.
7. **Nehru Yuva Kendra Sangathan** on Tobacco Free Young Generation
8. Life First, **Salaam Bombay Foundation and Narotam Sekhsaria Foundation** on Tobacco Cessation in India: Policies, Practices and Challenges.
9. **The International Union against Tuberculosis and Lung Diseases, Rajasthan Cancer Foundation, Jaipur and Shikshit Rojgar Kendra Prabandhak Samiti** on Tobacco Cessation.
10. Maulana Azad Institute of Dental Sciences, **New Delhi** on Technological Interventions in Tobacco Cessation in India: Evidence to Practice and Road Ahead
11. Manipal College of Dental Sciences, **Karnataka**, on Adolescent and young adult sensitization on risks at Hookah Café.
12. State Tobacco Control Cell, Department of Health, Government of **Gujarat** on Commit to quit: Cessation a Vital Component of Tobacco Control
13. Bareilly International University, **Uttar Pradesh** on Dentists brief Tobacco Cessation Intervention: A call to Action.
14. National Health Mission, **Maharashtra**; Atoms in the Service of Nation and Vital Strategies on Commit to Quit.
15. Cancer Aid Society, **Delhi** on Commit to Quit
16. Strategic Institute of Public Health Education and Research, **Chandigarh**; Indian Medical Association, Chandigarh and Resource Center for Tobacco Control Chandigarh on Commit to Quit.



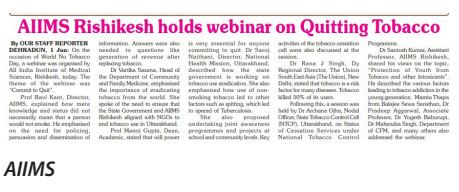
National Health Mission, Meghalaya

Life First, Salaam Bombay Foundation

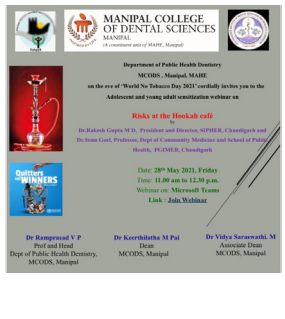
Jaipur

Maulana Azad Institute of Dental Sciences

Bareilly



AIIMS



Manipal College of Dental Sciences

Gujarat

Cancer Aid Society, Delhi

www.rctcpgi.org | 30

Oath Taking Ceremony conducted by:

1. Various medical institutions in Rewari, Haryana
2. Manipur University, Canchipur.
3. National Institute of Technology (NIT) Srinagar
4. Maulana Azad Institute of Dental Sciences, Karnataka took 360 Degree Commit To Quit Pledge.
5. Chandigarh administration Health Department

Campaigns conducted by:

6. Goacan, NGO launched a fortnight long drive campaign to curb tobacco use by asking people to take a No Tobacco Pledge.
7. Department of Mental Health Education in collaboration with the National Tobacco Quitline, CAM, Department of Psychiatry, and Department of Psychiatric Social Work, Bengaluru organized a campaign" Own your Power" to share "quit tobacco" stories to inspire other tobacco users to quit.
8. Tobacco free generation conducted a week long (24th to 31st May 2021) creative content creation to make people aware of the benefits they can experience in their life by "Quitting Tobacco".
9. The tobacco control committee and Girls College, Kurukshetra in support of N.S.S. has organized an online awareness campaign in which the teaching staff of the college sensitized the participants on the varied components of tobacco and its harms amid covid 19.

Poster Competitions Conducted By:

1. The Haryana state college in collaboration with youth redcross unit had successfully organized an online poster making competition to aware the participants about the ill effects of tobacco especially in youth.
2. MDSD girls college Ambala, Haryana and Association of Haryanavi Australia organized an international poster making competition.
3. Manipal Academy of Higher Education conducted E poster competition.
4. Tobacco Free Generation and Generation Saviour Association, Punjab

Sports stars pledge to protect youth from tobacco addiction

"On World No Tobacco Day, let's pledge to spread awareness on the risks of tobacco consumption and protect our younger generation from the menace of tobacco products"

V.V.S Laxman, Former Cricketer

"Tobacco Use not only harms our health but it is also a threat to the health of our friends and family. Additionally, tobacco users also have a greater risk of developing severe cases of Covid 19. I want all of you to break free from dependence on tobacco and stay healthy.

P.V. Sindhu, Ace Shuttler

National Consultations

A National Consultation on Tobacco Cessation: A pillar of Tobacco Free Generation was organized by Generation Savior Association, Punjab and The International Union Against Tuberculosis and Lung Diseases in which the components of tobacco free generation and tobacco cessation were discussed.

Others

6. DAV college Pundiri, Ambala, Haryana had organized an inter college debate competition virtually on zoom platform and students debated on various emerging topics of tobacco. Besides, all the students took "No Tobacco Pledge" during the event.
7. A World No Tobacco Day Contest was organized by Mary Anne Charity Trust, The Union, Cancer care India and Indian Dental Association, Madras
8. Tobacco Monitor organized a 10 day long online contest to mark the World No Tobacco day 2021.
9. Manav Rachna Dental College, Chandigarh, Department of Public Health Dentistry and Research and Innovation Catalyst organized a CDE program on Tobacco Cessation
10. Assam care foundation organized a online art competition for school students.
11. Indira Gandhi Mahila MAhavidalya, Kaithal, Haryana organized a National level online competition.
12. Inauguration of "World's First Virtual Cessation Clinic" by IcanCare.
13. Health Department, Bihar placed tobacco awareness signages across the state.
14. IEC material on "World No Tobacco Day 2021" theme was developed by Strategic Institute for Public Health Education and Research (SIPHER), Voice of Tobacco Victims, Ministry of Health and Family Welfare, Government of India
15. Cancer Foundation of India and HCL Foundation organized an E Discussion on "Role of Behavioral Management in Quitting Tobacco"
16. The Rajasthan Cancer Foundation, Jaipur has developed and shared 10 short duration videos on various aspects on tobacco cessation and specific focus on women, youth and environment to mark World No Tobacco Day in collaboration with different organizations viz. Rajasthan Patrika, the biggest inter-state media house, facilitated by SRKPS, Jhunjhunu; Mahatma Gandhi Medical Institute and its Sri Ram Cancer Center; Bharat Vikas Parishad, South Rajasthan;Cancer Aid Society, Lucknow, U.P.; Medical Practitioners Society, Udaipur, Rajasthan; and, SRKPS, Jhunjhunu and The Union.

4 CHAPTER

"TACKLING TOBACCO INDUSTRY INTERFERENCE"

“Tackling Tobacco Industry Interference”

Background

Tobacco use is a major global public health concern, leading to more than 8 million deaths annually worldwide. India is a hub of diverse tobacco products and second largest consumer in the world. This has led to the growth of the tobacco industry in the country, which has in turn contributed to India having one of the highest rates of oral cancer in the world, particularly among men(1). Despite the fact that tobacco kills half of its users, it is still consumed by 1.3 billion people globally, thanks in part to the strategies and tactics employed by the multibillion-dollar tobacco industry to attract new users and retain existing ones(2). To safeguard public health interests, it is crucial for all key stakeholders and government officials to develop strategies to combat tobacco industry interference.

What is the “tobacco industry”?

The “tobacco industry” refers to the entire industry involved in the development, production, marketing, and sale of tobacco products, including cigarettes, cigars, smokeless tobacco, and others. This industry includes tobacco growers, manufacturers, wholesalers, distributors, and retailers, among others.

Despite the well-known health risks associated with tobacco use, the industry has continued to promote and sell tobacco products, often using deceptive tactics to downplay the harm caused by these products. The tobacco industry has a long history of prioritizing profits over public health, and its actions have contributed to the ongoing global tobacco epidemic. Despite efforts to regulate the industry, tobacco remains a major source of revenue for governments worldwide, due to taxes and excise duties on tobacco products.

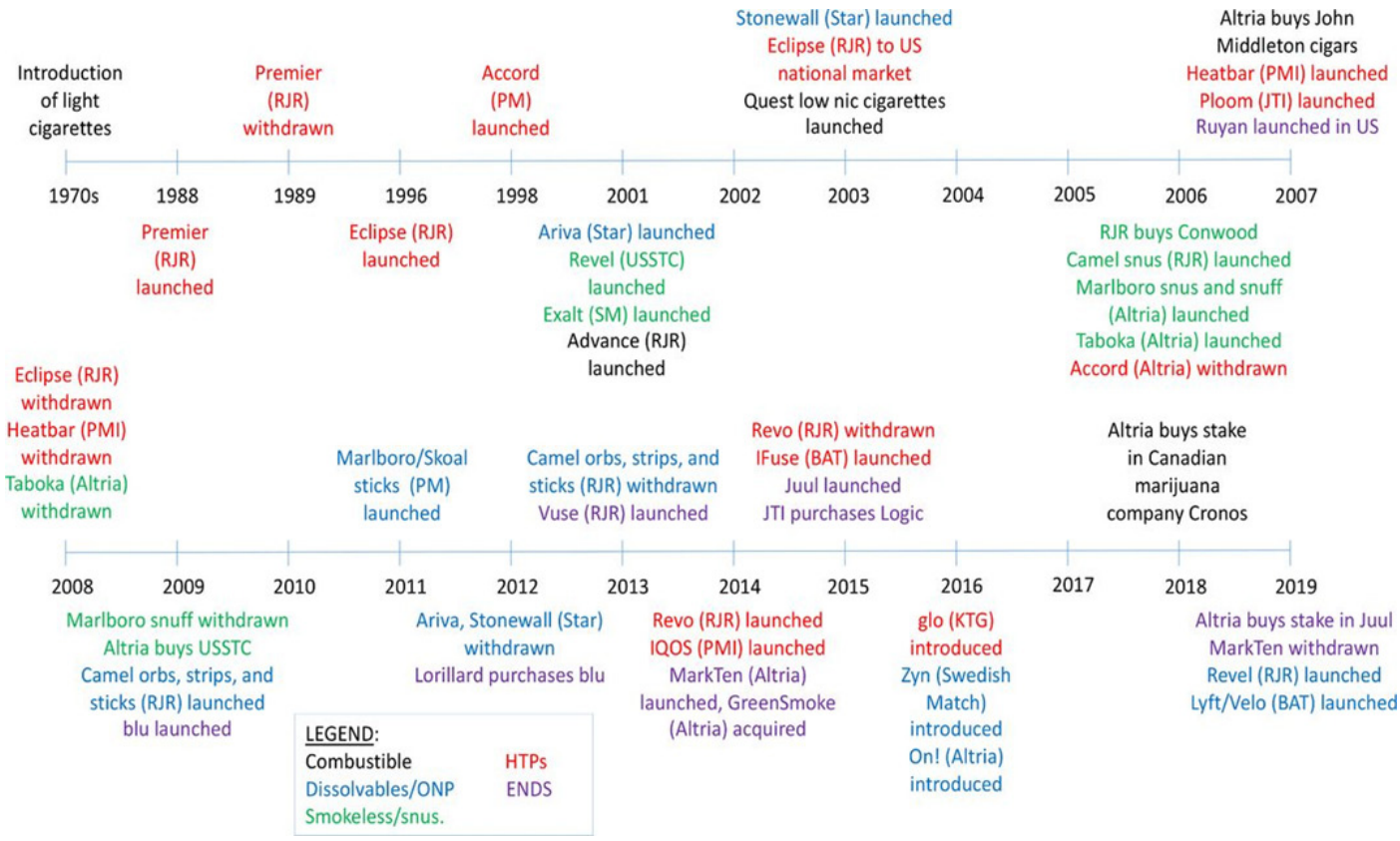
Evolution of Tobacco consumption

Year	Event
6,000 BC	Native Americans first start cultivating the tobacco plant.
Circa 1 BC	Indigenous American tribes start smoking tobacco in religious ceremonies and for medicinal purposes.
1492	Christopher Columbus first encounters dried tobacco leaves. They were given to him as a gift by the American Indians.
1492	Tobacco plant and smoking introduced to Europeans.
1531	Europeans start cultivation of the tobacco plant in Central America.
1558	First attempt at tobacco cultivation in Europe fail.
1571	European doctors start publishing works on healthy properties of the tobacco plant.
1600	Tobacco used as cash-crop – a monetary standard that lasts twice as long as the gold standard.
1602	King James I condemns tobacco in his treatise A Counterblast to Tobacco.
1614	Tobacco shops open across Britain, selling the Virginia blend tobacco.
1624	Popes ban use of tobacco in holy places.
1633	Turkey introduces a death penalty for smoking.
1650	Tobacco arrives in Africa – European settlers grow it and use it as a currency.
1700	African slaves are first forced to work on tobacco plantations.
1730	First American tobacco companies open their doors in Virginia.
1753	Tobacco genus named by a Swedish botanist Carolus Linnaeus – nicotiana rustica and nicotiana tabacum named for the first time.
1791	British doctors find that snuff leads to increased risk of nose cancer.

1794	First American tobacco tax.
1826	Nicotine isolated for the first time.
1847	Philip Morris opens their first shop in Great Britain, selling hand-rolled Turkish cigarettes.
1880	Bonsack develops the first cigarette-rolling machine.
1890	American Tobacco Company opens its doors.
1902	Philip Morris starts selling cigarettes in the US – one of the brands offered is Marlboro.
1912	First reported connection between smoking and lung cancer.
1918	An entire generation of young men returns from war addicted to cigarettes.
1924	Over 70 billion of cigarettes are sold in the US.
1925	Philip Morris starts marketing to women.
1947	Lorillard chemist admits that there is enough evidence that smoking can cause cancer.
1950	50% of a cigarette now consists of the cigarette filter tip.
1961	First American cigarette factory produces 20 million cigarettes.
1967	Surgeon General definitively links smoking to lung cancer and heart problems.
1970	Tobacco manufacturers legally obliged to print a warning on the labels that smoking is a health hazard.
1970-1990	Tobacco companies faced with a series of lawsuits. Courts limit their advertising and marketing.
1990	4 billion cigarettes are sold this year and manufacture is on the rise.
1992	Nicotine patch is introduced.
1996	Researchers find conclusive evidence that tobacco damages a cancer-suppressor gene.
1997	Liggett Tobacco Company issues a statement acknowledging that tobacco causes cancer and carries a considerable health risk.
1997	Tobacco companies slammed with major lawsuits.
1997	For the first time in history a tobacco company CEO admits on trial that cigarettes and related tobacco products cause cancer.
1990	Bans on public smoking come into effect in most states in America, as well as in other countries in the world.

(Source:https://tobaccofreelife.org/tobacco/tobaccohistory/#:~:text=Circa%201%20BC%20%E2%80%93%20Indigenous%20American,and%20smoking%20introduced%20to%20Europeans.)

Timeline of new product introductions by the tobacco industry, 1970–2019. BAT, British American Tobacco; ENDS, electronic nicotine delivery systems; HTP, heated tobacco product; JTI, Japan Tobacco International; ONP, oral nicotine product; PM, Philip Morris; PMI, Philip Morris International; RJR, RJ Reynolds; SM, Swedish Match; USSTC, US Smokeless Tobacco Company.



How tobacco industry works?

Three factors contribute significantly to tobacco use and addiction which are manipulated by the tobacco industry. The first is the addictiveness of tobacco products, particularly nicotine, the second is their attractiveness, and the third is their toxicity. Tobacco companies use design elements, sweeteners, flavors, and toxicity to increase societal addiction and consumption. The tobacco industry manipulates tobacco products and misleads the public by claiming that nicotine is not carcinogenic and that the products are less harmful. (4)

The tobacco industry has a long history of interfering with public health policies aimed at reducing tobacco use. Here are some common forms of tobacco industry interference:

1. **Lobbying:** The tobacco industry spends vast sums of money on lobbying government officials to shape policies that favour their interests. This includes advocating for weaker regulations and introducing lesser tax on tobacco products.
2. **Political donations:** Tobacco companies donate large sums of money to political candidates and parties that support their agenda. This creates a conflict of interest for politicians and makes it more difficult for them to take action against the tobacco industry.
3. **Advertising and promotion:** Tobacco companies use aggressive marketing tactics to promote their products, especially in countries with weak tobacco control regulations. They sponsor events and concerts, advertise in magazines and on billboards, and use social media to target young people.
4. **Industry-funded research:** Tobacco companies fund research studies to generate scientific evidence that supports their interests. They often use this research to cast doubt on the harmful effects of tobacco use and to argue against stronger tobacco control policies.
5. **Litigation:** Tobacco companies use the legal system to challenge tobacco control policies and regulations. They file lawsuits against governments and public health organizations to delay or block policies that would harm their profits.
6. **Corporate social responsibility:** Tobacco companies engage in corporate social responsibility (CSR) activities to improve their public image and gain legitimacy. These activities often involve supporting education or health initiatives, but they are also used to influence policy makers and promote their products.
7. **Influence on international treaties:** Tobacco companies exert pressure on international organizations and governments to weaken tobacco control treaties and agreements. This includes opposing measures such as tax increases, graphic warning labels, and advertising restrictions.
8. **Strategic alliances:** Tobacco companies form alliances with other industries, such as the hospitality industry or the media, to create a united front against tobacco control policies. This allows them to use their combined power to influence policy makers and public opinion.
9. **Funding front groups:** Tobacco companies fund front groups that appear to be independent but are actually working on their behalf. These groups often promote industry-friendly policies and create confusion about the health risks of tobacco use.
10. **Influence on scientific research:** Tobacco companies have been known to influence scientific research by funding studies that promote their interests and suppressing studies that show the harmful effects of tobacco use.

The tobacco industry prioritises revenue over people health

The tobacco industry prioritizes profits over public health by misrepresenting scientific findings, donating to politicians who oppose regulation, and funding biased research. These conflicts with the goals of governments and public health professionals who seek to improve health and discourage tobacco use. The industry is aware of the negative impact of policies on its sales and actively works to stop them. (5, 6)

Tobacco industry and research

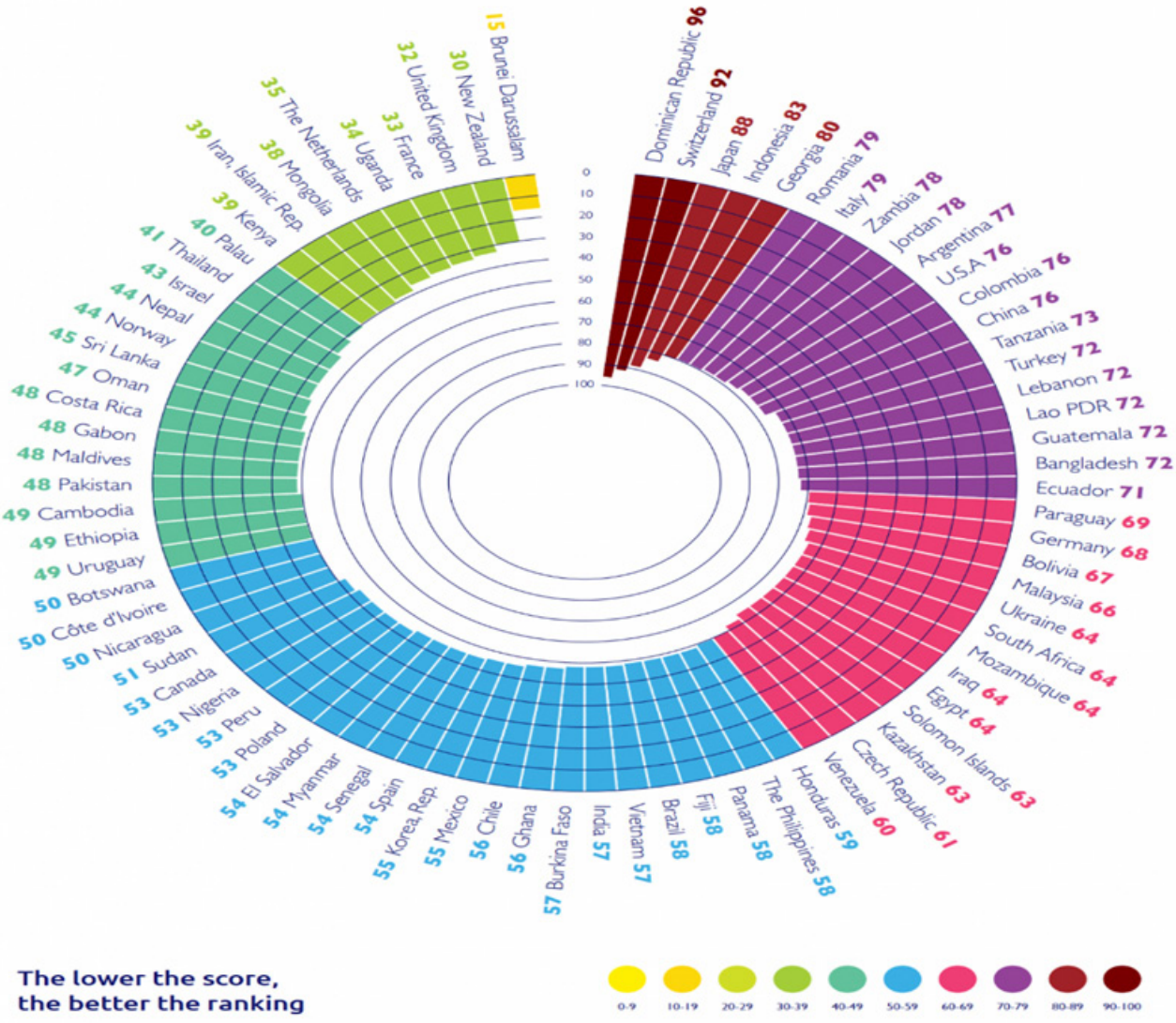
The tobacco industry tries to manipulate young researchers and promote biased research to cover up the harmful effects of tobacco. Accepting industry-sponsored research in scientific journals and conferences gives the industry credibility and allows them to use scientific forums to confront policy initiatives. This legitimizes their findings and allows them to present them to regulators. (5)

Tobacco industry interference in low and middle income coubtries

"The enemy, the tobacco industry, has changed its face and its tactics. The wolf is no longer in sheep's clothing and its teeth are bared." - Dr. Margaret Chan's (Director General of WHO) keynote speech at 15th world conference on Tobacco or health, Singapore 20th march 2012.

The tobacco industry hides behind deceptive tactics while making huge profits from a product that kills half its users each year. They market their products in low- and middle-income countries where regulation is lacking, targeting children and youth with appealing flavours, celebrity endorsements, and social media influencers. They position tobacco products prominently at points of sale frequented by young people, making them easily accessible and attractive.

The Global Tobacco Industry Interference Index (Global Tobacco Index)



The Global Tobacco Industry Interference Index (Global Tobacco Index) evaluates how governments are protecting public health policies from tobacco industry interference, despite the industry's harmful impact. Governments have succumbed to the industry's demands and lobbying, including accepting its charity, contributing to 8 million deaths and $1.4 trillion in annual health and productivity losses

The Tobacco Industry and Corporate Social Responsibility

The tobacco industry uses CSR to create a positive image of their company and products, even to youth, by highlighting "positive" business practices and making contributions to community, health, and environmental organizations. However, this should be prohibited as it indirectly promotes tobacco use. The WHO sees tobacco industry and CSR as inherently contradictory, as they conflict with public health goals.(9-10).

COVID-19 and Tobacco Industry CSR activities in India

Table 1 CSR activities by tobacco industry in India during COVID-19

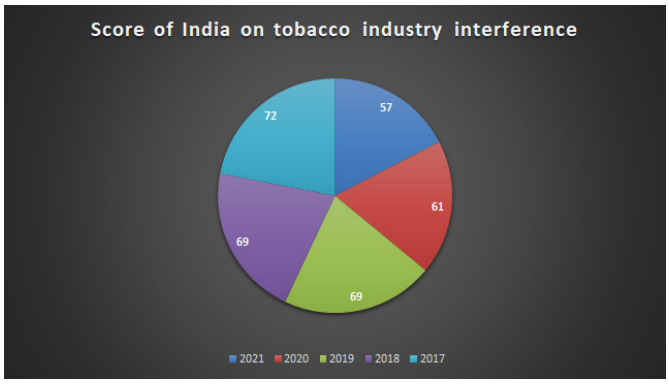
Name of company	Amount (US$, in 000)	Type of support	Partners
Donation to PM CARES Fund			
ITC	13212	PM CARES Fund	Government of India
Dharampal Satyapal	2642	PM CARES Fund and other organisation fighting against coronavirus	Government of India; Gurudwara Prabandhak Samiti
Donation to Chief Minister's Relief Fund			
Deccan Tobacco Company	33	Andhra Pradesh Chief Minister's Relief Fund	Government of Andhra Pradesh
ITC	264	Karnataka Chief Minister's Relief Fund	Government of Karnataka
ITC	264	Tamil Nadu Chief Minister's Relief Fund	Government of Tamil Nadu
ITC	264	Maharashtra Chief Minister's Relief Fund	Government of Maharashtra
VST Industries	132	Telangana Chief Minister's Relief Fund	Government of Telangana
Donation to health and hospital administration			
Gujarat Tobacco Merchants Association	24	Portable ventilator machines	Kheda Government Civil Hospital, Gujarat
ITC	In kind	Support Bharat Heavy Electricals (BHEL) to operationalise a 30-bed temporary centre for COVID-19 in Haridwar, Uttarakhand	BHEL is a public sector undertaking
Donation to administration			
Godfrey Phillips India	In kind	Masks for front-line COVID-19 workers in Srinagar	Srinagar District Administration
Godfrey Phillips India	In kind	Personal protective equipment to Inspector General of Police Kashmir for use among the police staff	Jammu and Kashmir Police Department
Awareness targeting kids and women			
ITC	In kind	Awareness among kids about the five steps to prevent the spread of COVID-19 brings out the 'Do the 5' song	Green Gold Animations, the creator of cartoon series *Chhota Bheem*
ITC	In kind	Awareness on handwashing with the state government of Kerala to help 'Break the Chain'	Government of Kerala
ITC	In kind	Salutes mothers with 'Stay Strong Moms' campaign through virtual music concert	Leading singers of the Indian film industry
Essential commodities and food items			
ITC	In kind	Food and hygiene essentials across 17 states of India	State, district, local administration, 'Child Rights and You (CRY), SOS Children's Village India and other NGOs
ITC	In kind	Distribution of milk for children in Kolkata	Save the Children India, The Hope Foundation India and SOS Children's Villages of India
ITC	In kind	Distribution of free meals and groceries	Government of Telangana
ITC	In kind	Help customers order grocery essentials	Domino's, Zomato, Dunzo, Swiggy, Apna Complex, MyGate, NoBroker and Azgo
ITC	In kind	Juices and soaps for the police department in Srinagar	Jammu and Kashmir Police Department
ITC	In kind	17000 refreshment kits containing fruit juice, milkshake and chocolates for corona warriors in Bengaluru	Municipal Corporation of Greater Bengaluru
Self-administered contingency fund			
ITC	19817	COVID-19 contingency fund for vulnerable sections of society	State, district and local administration besides NGOs

CSR, corporate social responsibility; NGOs, non-governmental organisations; PM CARES Fund, Prime Minister's Citizen Assistance and Relief in Emergency Situations Fund.

India's score on tobacco industry interference

India's score on the 2021 Tobacco Industry Interference Index is 57 out of 100, slightly better than the 2020 score of 61. This indicates an improvement in implementing FCTC Article 5.3 compared to previous years.

India's score on Tobacco Industry Interference form 2017-2021



Barrier between the tobacco industry and the government

India has implemented a new code of conduct to prevent interactions between the government and the tobacco industry. The code applies to all officials in the Union Health Ministry and its related entities, and it requires termination of any existing partnerships with tobacco companies. The code outlines guidelines for interactions with the tobacco industry, including avoiding conflicts of interest and reporting violations. This code is in compliance with the FCTC treaty ratified by India and 181 other countries in 2004.

How to beat tobacco industry interference

WHO FCTC Article 5.3

WHO FCTC Article 5.3 is designed to safeguard robust tobacco control policies from the detrimental influence of the tobacco industry. Specifically, Article 5.3 legally compels treaty parties "to protect public health policies related to tobacco control from commercial and other vested interests of the tobacco industry." The article aims to prevent the tobacco industry from diluting and undermining effective and life-saving tobacco control legislation. It advocates for the enactment and implementation of laws and policies that prevent tobacco industry interference with tobacco control advocates and governments, ensuring that public health takes precedence over increasing tobacco industry profits.
As per Article 5.3 of the global tobacco treaty, countries that have ratified the treaty should avoid:

- Treating tobacco companies as "stakeholders" in public health policy
- Investing in the tobacco industry
- Partnering with tobacco companies for health or any other purposes
- Accepting the tobacco industry's corporate social responsibility schemes, which are often used as a tactic to divert attention from the harms caused by their products.

Act Globally & Act Locally

Now is the time for advocates and public officials to slam the door on tobacco industry tactics, and focus on implementing the treaty's lifesaving measures. The article 5.3 guidelines are the backbone of the treaty- they can and should prevent tobacco industry interference in everything from bans on advertising, promotion and sponsorship to smoke free public places to graphic warning labels. There should be establishment of a government agency or committee, to oversee implementation of Article 5.3 at state and national level. This government body will be responsible for the following actions;

- Carry out a formal assessment of the state's compliance with Article 5.3 of the FCTC.
- Implement guidelines for meetings and other interactions with the tobacco industry deemed necessary, including a requirement that they be made public.
- Develop enforcement mechanism for public agencies' engagement with the tobacco industry, conduct of officials in dealings with industry, and management of conflict of interest.
- Establish a formal mechanism for monitoring and responding to the tobacco industry's activities.
- Seek support from Civil society and build partnerships with NGOs to utilize their expertise and experience in monitoring and responding to tobacco industry interference.

How can NGOs Help?

- Non-governmental organizations can help governments by supporting them with information and promotion of good policy.

NGOs can

- Find out what their government's policy is on engaging with the tobacco industry and whether they have carried out an assessment of Article 5.3 compliance.
- Ask the department/ministry of health in their country what it intends to do to encourage the implementation of Article 5.3 and its guidelines.
- Establish a coalition of civil society organization to educate the public about the tobacco industry's behavior and to recommend the government about strong tobacco control actions, including legislation and increasing tobacco taxation
- Encourage governments and hold TI accountable for their actions.

Transparency Measures under Article 5.3

- Transparency in government relationships with the tobacco industry, including disclosure of records, public notice of dealings, and public records.
- Disclosure of tobacco industry activities, which includes: production, manufacture, market share, revenues, marketing expenditures, philanthropy – with penalties on tobacco industry for providing false or misleading information.
- Disclosure or registration of tobacco industry affiliated entities, including lobbyists
- Candidates for government positions with responsibility for health policy must disclose any current or past employment with the tobacco industry, as well as future intentions to do so.

(Source: - Framework Convention on Tobacco Control (Article 5.3) Protecting Against Tobacco Industry Interference, Generation Saviour Association and The Union)

Conclusion

Tobacco industry interference continues to be a significant threat to public health policies in India and around the world. It is crucial to strengthen existing coalitions and identify activities of TI to develop an accurate plan of action to combat tobacco industry interference. Academic institutions can play a critical role in monitoring and capacity building of key stakeholders in industry interference activities. Additionally, civil society can play an active role in mitigating tobacco industry interference, by raising awareness about the harmful effects of tobacco use and advocating for stronger tobacco control policies. Only by working together can we overcome the challenges posed by the tobacco industry and create a healthier future for all.

Recommendations

Here are some recommendations for tackling tobacco industry interference in India:

1. Strengthen implementation of the WHO Framework Convention on Tobacco Control (FCTC), which provides a comprehensive framework for tobacco control policies and addresses industry interference.
2. Develop and implement strong regulations to prevent tobacco industry interference in public policies, including the prohibition of all forms of contributions, sponsorships, and partnerships with the tobacco industry.
3. Increase awareness among policymakers, civil society, and the general public about the tactics and strategies employed by the tobacco industry to interfere in public health policies.
4. Establish a centralized system for reporting and monitoring tobacco industry interference and implementing effective measures to prevent and combat it.

5. Engage with academic institutions, public health organizations, and civil society to develop evidence-based policies and strategies for addressing tobacco industry interference.
6. Create a code of conduct that applies to all government officials and departments to prevent any interaction with the tobacco industry that could influence public policies.
7. Strengthen and expand existing coalitions and partnerships to build a united front against tobacco industry interference.

By implementing these recommendations, India can take significant steps towards reducing the harmful impact of tobacco and protecting public health policies from industry interference.

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EXPERTS COMMENTS

"There are three significant elements that contribute to tobacco use and addiction: the addictiveness of tobacco products, particularly nicotine; the attractiveness of tobacco products; and the toxicity of tobacco products. The tobacco industry manipulates these elements to increase addiction and consumption in society. They use design elements, sweeteners, flavors, and toxicity to make their products more attractive and addictive. The tobacco industry also dupes the public by claiming that nicotine is not carcinogenic and that their products are less harmful than they actually are. This manipulation of tobacco products by the industry is a significant obstacle to effective tobacco control policies and efforts.

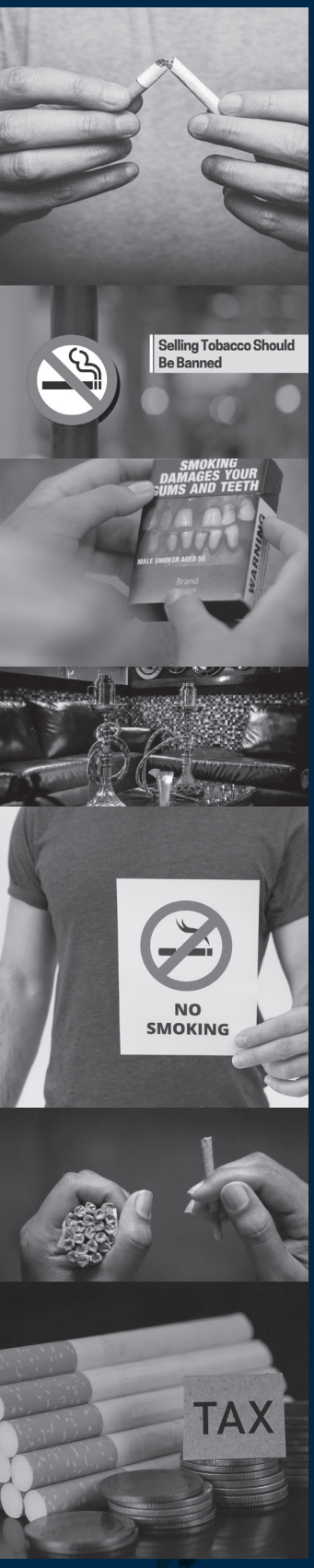
- Dr. Leimapokpam Swasticharan,
Additional Deputy Director General of Health Services
-Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of India

"The tobacco industry has a tendency to manipulate public perception in order to maintain a facade of respectability and responsibility. Even during the COVID-19 pandemic, when there were shortages of essential resources in the healthcare and other sectors, the tobacco industry managed to benefit from the situation. Despite overwhelming evidence that smoking increases the risk of respiratory illnesses and can have serious negative impacts on health, the tobacco industry continued to promote their products. Shockingly, the Indian tobacco industry donated a staggering $36.7 million to various government funds, including the "Prime Minister's Citizen Assistance and Relief in Emergency Situations Fund" (PM CARES Fund) and the Chief Minister's Relief Funds in multiple state governments across the country. In fact, ITC was the largest contributor of cash and in-kind donations during the COVID-19 crisis.

- Dr. Rana J Singh,
Deputy Regional Director, The Union (South-East Asia), New Delhi

"Tobacco is the leading preventable cause of adult mortality in India and across the globe, and the tobacco industry bears primary responsibility for this public health crisis. The industry's singular focus is profit generation and distribution to its stakeholders and it will resort to any means necessary to achieve this objective. While policymakers and advocates strive to lessen the burden of tobacco use and implement effective control measures, the tobacco industry actively works to counter these efforts. Despite mounting evidence of the harmful impacts of tobacco use, the industry continues to push its products and maintain a grip on the market through aggressive marketing tactics and political influence.

- Dr. Prakash C Gupta,
Director, Healis - Sekhsaria Institute of Public Health, Navi Mumbai



5 CHAPTER

TOBACCO-FREE EDUCATIONAL INSTITUTIONS A WAY FORWARD

TOBACCO-FREE EDUCATIONAL INSTITUTIONS A WAY FORWARD

Background:

The tobacco epidemic is one of the biggest public health threats and single largest cause of preventable deaths and illness the world has ever faced, killing more than 8 million people as year around the world. Over 80% of the 1.3 billion tobacco users worldwide live in low- and middle-income countries, It kills half of its users prematurely, mostly in their most productive age and is a major risk factor for cancer, cardiovascular diseases (CVD), diabetes, chronic lung disease, stroke, infertility, blindness, tuberculosis (TB), oral cavities etc. In India, over 13.00 lac people die from tobacco use every year, i.e. about 3500 people die per day. As per the Global Youth Tobacco Survey (GYTS), 2009, 14.6% of students in India aged between 13 to 15 years use tobacco with the rate for boys (19.0%) being significantly higher than that for girls (8.3%). Among them, 8.1% of students smoked tobacco for boys (11.2%) being three times higher girls (3.7%.) Also, boys (11.1%) had significantly higher use of SLT than girls (6.0%). Between 2003 and 2009, cigarette smoking had not changed but bidi smoking increased from 2.2% to 5.3 % . Both boys and girls had a significant increase in bidi smoking between 2003 and 2006 with boys (5.8%) were 3.3 times as likely to smoke bidi (7.3% versus 2.2%) as compared to girls.

In 2008, Ministry of Health and Family Welfare, Government of India had launched the "Guidelines for Tobacco Free Schools/ Educational Institutions" and "Step by Step Guidelines for implementation of Section 6 (b) of the Act and Rules" in 2017. These guidelines provide a fresh momentum to implementation of tobacco control initiatives among adolescents and young adults.

Need of Tobacco Free Educational Institutions

- More awareness about harmful effects of tobacco use amongst the students, teachers, workers and officials.
- Awareness about various avenues available for tobacco cessation.
- A healthy and tobacco free environment in educational institutions.
- Better implementation of legal provisions regarding sale and use of tobacco products.
- Youth being future of the nation should be safeguarded
- Tobacco litter desecrating the campus.
- Aggressive marketing of tobacco companies, which are particularly targeting youth.
- Prevent exposure to second-hand smoke (SHS).

Guidelines of Tobacco Free Educational Institutions

Display of "Tobacco Free Educational Institution" and "Tobacco Free Area" signage on the boundary wall, the main entrance, the official notice boards within the premises of educational institution and outside. The signage could be in the form of boards or wall paints. The educational institutions are encouraged to innovate or adapt the signage according to their capacity and context.

Designate Tobacco Monitor(s) whose name, designation and phone number should also be mentioned on the signages.

No tobacco products are sold inside the premises and in an area within a 100 yards from the premises. Any violation should be reported to the National Quitline at 1800-11-2356.

The EI management must not permit consumption of tobacco products in the premises of the institution .

Must not participate in any event sponsored by any firm or a subsidiary of a firm or a seller, which promotes the use of or manufactures or sells tobacco products in any form. EIs/ Students should also not accept any prize or scholarship instituted by such firms Prohibit use of tobacco substitutes like electronic and nicotine delivery systems(ENDs) which are usually marketed as safer alternatives for conventional cigarettes.

Use the Self-Evaluation Scorecard to assess the status of implementation of the ToEFI Guidelines in their institution and get a certificate to this effect to those EIs who score 90% and above marks.

The prescribed formats of the signage:

Self-Evaluation Scorecard for Tobacco Free Educational Institution

Name of the Educational Institution:-

Name and Designation of Evaluator:-

Date of Evaluation:-

Final Score of the Educational Institute: .....

Sl. No.	Criteria	Weightage Points	Scored points by the Institute
1	Display of 'Tobacco Free Area' Signage inside the premise of Educational Institute at all prominent place(s).	Mandatory (10)	
	The name/designation/contact number are mentioned / updated in the signage	Mandatory (10)	
2	Display of "Tobacco Free Education Institution" signage at entrance/ boundary wall of Educational Institute.	Mandatory (10)	
	The name/designation/contact number are mentioned / updated in the signage	Mandatory (10)	
3	No evidence of use of tobacco products inside the premise i.e. cigarette/beedi butts or discarded gutka/tobacco pouches, spitting spots.	Mandatory (10)	
4	Poster or other awareness materials on harms of tobacco displayed in the premise.	9	
5	Organisation of at least one tobacco control activity during last 6 months.	9	
6	Designation of Tobacco Monitors and their names, designations, and contact number are mentioned on the signages	9	
7	Inclusion of "No Tobacco Use" norm in the EI's code of conduct guidelines	9	
8	Marking of 100 yards area from the outer limit of boundary wall / fence of the EI.	7	
9	No shops selling tobacco products within 100 yards of the Educational Institute.	7	

The prescribed format of Self-Evaluation Scoreboard FOR TFI is:

TOBACCO FREE EDUCATIONAL INSTITUTION

Sale of cigarettes and other tobacco products in an area within radius of one hundred yards of this educational institution is strictly prohibited and is a punishable offence.

If you see any violation, please report to –

Name _____

Designation _____

Contact Person _____

OR

Call at Quitline Number – 1800-112-356 (Toll free)

By Order

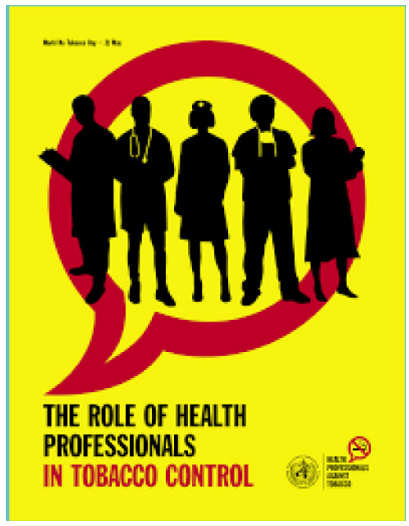
Legal Provisions of Tobacco Free Institutions (TFI)

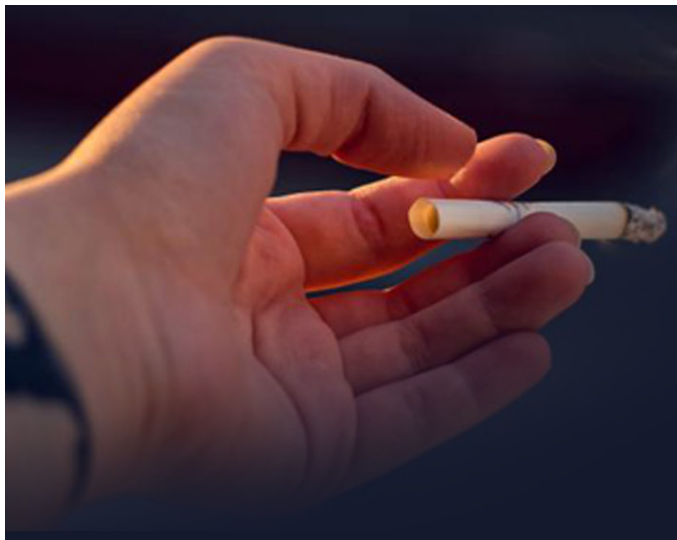
ACT	Section	Offence	Penalties	
COTPA	Section 4*	Smoking in Public Places	Fine upto Rs.200 under section 21	
	Section 6a*	Sale of tobacco products to or by minors	Fine upto Rs.200 under section 24	
	Section 6b*	Sale of tobacco products within 100 yards of any Educational Institute	Fine upto Rs.200 under section 24	
	Section 5	Direct/indirect advertisement of tobacco products and scholarship/ sponsorship of any event by tobacco companies	Under Section 22- **First Offence:** Fine up to Rs. 1000/- or imprisonment up to two years or both **Subsequent offence:** Fine up to Rs. 5000/- or imprisonment up to five years or both	
	Section 7	Mandatory display of specified health warnings on all tobacco product packs	Under Section 20 - **First Offence for Producer or Manufacturer:** Fine up to Rs 5,000/- or imprisonment up to two years or both. **Subsequent Offence:** Fine up to Rs 10,000/- and imprisonment up to five years	Under Section 20 - **First Offence for Seller or distributor:** Fine up to Rs 1,000/- or imprisonment up to one year or both. **Subsequent Offence:** Fine up to Rs 3,000/- and imprisonment up to two years
Juvenile Justice Act	Section 77	Giving or causing to give any addictive substance including tobacco to minors	Upto 1 lakh fine and 7 years imprisonment	
Indian Penal Code	Section 268	Creating Public nuisance which causes any common injury, danger or annoyance to the public	Fine upto Rs. 200/-	
	Section 269	Negligent act likely to spread infection of disease dangerous to life	Imprisonment upto 6 Months or Fine or both	
	Section 278	Making atmosphere noxious to health	Fine upto Rs. 500/-	
Food Safety and Standards Act, 2006 (FSSA, 2006)	Regulation 2.3.4 of Food Safety and Standards (Prohibition and Restrictions on sales) Regulations, 2011	Use of Tobacco and nicotine as ingredients in any food products.	Penalty not exceeding Rs. 10.00 lakh under Section 57 (1) (ii) of FSSA, 2006	

Roles & Responsibilities of Various Stakeholders

Ministry of Health & Family Welfare – Tobacco Control Division (National Tobacco Control Cell)

- Ensure that communications/advisories are sent to State Tobacco Control Cell for monitoring these guidelines at regular intervals.
- Dissemination of IEC materials / prototypes like posters, flip charts, brochures to States and uploaded on the NTCP website www.ntcp.nhp.gov.in
- Collaborate with Ministry of Human Resource Development (Department of School Education and Department of Higher Education) for inclusion of a chapter on the harmful effects of tobacco use in curricula.
- Develop a monitoring mechanism for evaluation and assessment of implementation of Guidelines for ToFEI through internal review mechanism.
- Implement a mechanism for certification of EIs and for providing a Certificate to an EI that successfully reaches the benchmark score of 90/100 and above.





State / District Tobacco Control Cell

- Coordinate with state education departments (School/ Higher/Technical/Medical Education) to institutionalize tobacco control by incorporating tobacco control activities in their academic calendar.
- Coordinate with state education departments for sending circular to all heads of institutions to comply with the guidelines and permitting them to utilize the funds available under the untied grants.
- Encourage district authorities and local bodies to set up institutional mechanisms to facilitate implementation and monitoring mechanism of these guidelines .
- Disseminate guidelines in all educational institutions in coordination with education departments. Funds under National Tobacco Control Programme can be utilized for this.
- Make efforts to get questions related to 'Tobacco Free Educational Institution' included in existing monitoring/ inspection mechanism of Education Departments.
- Engage with department of rural development/urban administration for setting up institutional mechanism for supervision and monitoring of these guidelines through Village Health, Sanitation & Nutrition Committees in rural areas and Mahila Arogya Samitis and Mohalla Samitis\Ward Sabhas in urban areas.
- Co-opt representatives of the state education departments (School/Higher/Technical/ Medical Education) in the state and district level coordination committees.

Civil Society Organizations

Civil Society Organizations (CSO) can play a pivotal role in implementation of guidelines, specially in its dissemination and in building capacities of managements and teams in educational institutions. CSO can also support the STCCs, DTCCs and EIs by providing inputs such as technical assistance for IEC. The CSOs can also undertake assessment of implementation status of these guidelines in an EI and assist the institution in removing gaps in implementation or mobilize support from the local institutions.

Role of teachers in achieving tobacco free school status

Micro-level Intervention

- Check the level of knowledge of students on various forms of tobacco and their harmful effects
- Increase the knowledge of students on the harmful effects of tobacco and second-hand smoke exposure.
- Acquaint the students on the occasions were they might be offered tobacco and teach them how to say "NO"

Macro-level Intervention

- Keep a check on smoking in public places near schools.
- Report the sale of tobacco products to or by minors at point of sale.
- Deny permission for any sport/cultural events sponsored by tobacco company in your school.
- Report the sale of cigarette and other tobacco products within a radius of 100 yards of your institution to the Head of the Institution.

Best Practices

Global

The Truth Initiative Tobacco-free College Program

The Truth Initiative Tobacco-Free College Program was started in 2015, which offers grant upto $ 20,000s to minority-serving academic institutions to engage their campus community in addressing smoking and tobacco use. It targets to reduce tobacco use among young adults, create opportunities to educate students about tobacco and help the economy and environment. Since 2015, Truth Initiative has provided grants to 135 historically colleges and universities to advocate for, adopt and implement a 100 percent smoke-or tobacco-free policy.

Tobacco-Free Generation Campus Initiative (TFGCI)

Since its inception in 2016, with generous support from the CVS Health Foundation, American Cancer Society has provided grants of up to $20,000 to 106, post-secondary institutions across the U.S, to adopt 100% smoke and tobacco-free campus policies. Its current grantee institutions range from small, private colleges, to large, research universities; and who, together, have the opportunity to positively affect the lives of over 1.7 million students and all of the faculty, staff and visitors on those campuses.

Ohio Campus Tobacco Ban

In 2012, the Ohio Board of Regents voted unanimously to issue a strong recommendation to Ohio's college and university trustees that each campus should consider implementing a policy to become tobacco-free.

Tobacco-free college campuses

The CVS Health Foundation, in partnership with the American Cancer Society and Truth Initiative, have provided grants to the U.S. col leges and universities who are committed to developing 100% smoke- and tobacco-free campus policies to help them advocate for, adopt and implement policies since 2016.

Red Ribbon Week

Red Ribbon Week is by far the largest and oldest drug revention campaign launched in1985 in Mexico City and was started by the National Family Partnership which includes displaying red ribbons as a symbol of intolerance toward the use of drugs. It takes place on the same dates every year, October 23 through 31st and raises awareness about drugs, including tobacco, inhalants, heroin and more. This national US health observance actively celebrated in nearly all US middle schools and high schools, which have their own locally based campaigns for Red Ribbon Week every year. Red Ribbon Week empowers communities and individuals across the US, especially youth, to take a stand for drug prevention and education.

Tobacco-Free Initiative

Tobacco-free initiative of Bloomberg School of Public Health community was launched in August 2014 to encourage the school community to strive for the health benefits quitting tobacco can bring: more money, a longer life, a cleaner environment and a healthy body.

Under this initiative, school prohibits the use of any tobacco product—including cigars, cigarillos, hookah-smoked products, any oral or chewed tobacco and e-cigarettes—in all buildings, facilities and vehicles. The initiative also forbids the use of tobacco products on all outdoor campus grounds and discourages its use on city property adjacent to campus grounds.

Tobacco-free Generation Campus Initiative for school community

Since its inception in 2016, with generous support from the CVS Health Foundation, American Cancer Society has provided grants of up to $20,000 to 106, post-secondary institutions across the U.S, to adopt 100% smoke and tobacco-free campus policies. Its current grantee institutions range from small, private colleges, to large, research universities; and who, together, have the opportunity to positively affect the lives of over 1.7 million students and all of the faculty, staff and visitors on those campuses.

SMS campaign to make educational institutions tobacco free

The Assam government had started a campaign to make educational institutions tobacco free in collaboration with Healis Sekhsaria Institute for Public Health and Tata Trusts in June, 2016. Following this, the Assam Education Department has instructed the principal/heads of education institutions and the district education officers to implement the TFEI campaign across the state.

Pledge for life: School children join campaign, say 'no' to tobacco

Say "No" to tobacco campaign was launched by Sambandh Health Foundation (SHF), Tata Trusts, Caring Friends and Voice of Tobacco Victims (VoTV) campaign in collaboration with the Maharashtra Government in October, 2018. The campaign has been initiated as there has been a rise in tobacco consumption among school children and to make schools tobacco-free and make teachers and students say 'No to Tobacco'.

UP government bans tobacco near universities, colleges

The Uttar Pradesh government has banned the sale of tobacco near universities and colleges in the state in April 2018. According to this order, a ban on the use of pan and tobacco in universities and colleges was enforced. Officials have been asked to put up sign boards against tobacco use in campus. No student, teacher, or any employee should be seen consuming tobacco products inside the premises. Educational institutions should also organize various activities to spread awareness on the ill-effects of tobacco, the letter states.

Health ministry calls for 'tobacco monitors' in schools among revised guidelines for Tobacco-free Educational Institutions

The Union Health Ministry has asked educational institutions, especially secondary schools, to designate 'tobacco monitors' from among students and staff in a bid to boost the implementation of tobacco control initiatives among adolescents. The revised guidelines for Tobacco-free Educational Institutions, which were released on the World No Tobacco Day on May 31, 2019, provides a series of activities that schools and educational institutes can undertake to make their institutes free from tobacco.

Complete ban on sale of tobacco in medical, educational institutions of Haryana

The Haryana government constituted steering committees at district-level to ensure complete ban on smoking and sale of tobacco in the periphery of medical and educational institutions in the state in July 2018. The religious institutions, NGOs and social organizations were also invited to participate in this campaign.

Punjab bans tobacco near schools, colleges

The Punjab government has imposed a complete ban on tobacco and tobacco products around educational and religious institutions in February 2015. The officers concerned were asked to keep a close vigil near educational institutions, colleges, coaching institutes and schools and ensure complete ban on sale of single stick cigarettes and all kinds of tobacco products within 100 yards of these institutions.

Educational institutes took part in drives for a tobacco-free Thane

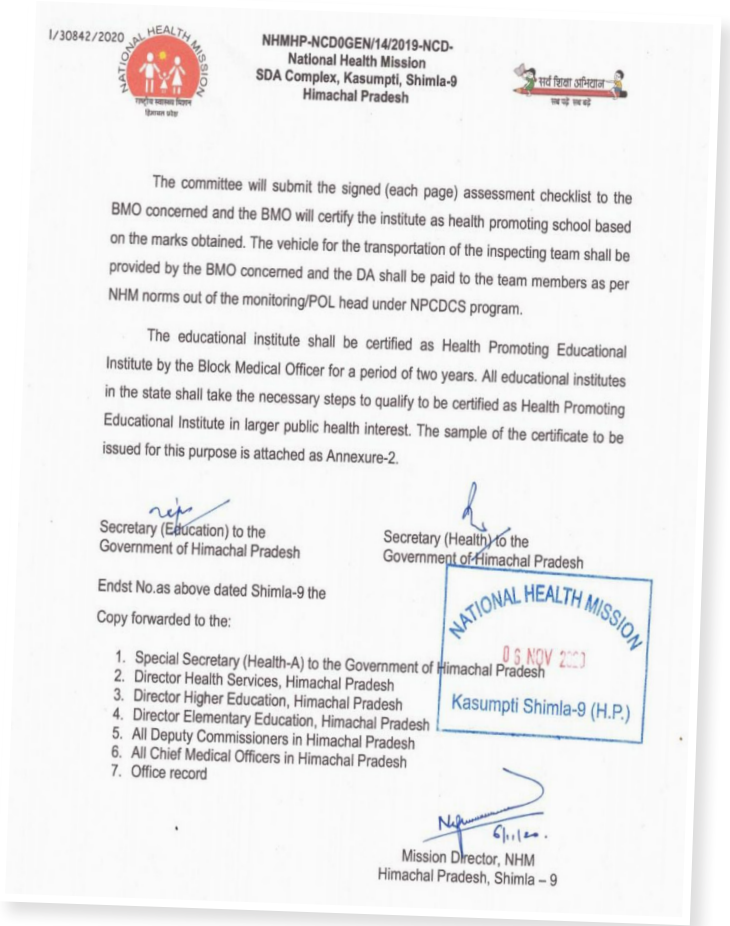
Educational institutes across Thane district took part in initiatives to raise awareness against tobacco in 2016. As part of awareness drives, the institutes organized anti-tobacco rallies and pledge to go tobacco-free. A number of schools also created a symbolic holi by burning tobacco wrappers. More than 20,000 students across Thane took a pledge to work towards making their schools and surrounding areas tobacco-free and also placed posters around the school and its premises to draw the attention of students and parents.

Sale of tobacco to be banned near schools in Kerala

The government of Kerala has banned the sale of pan masala and other addictive products within the radius of 400 meters from an educational institution in the year 2011-2012.

Educational Institutes to follow Tobacco free educational guidelines: Himachal Pradesh

The Mission Director, National Health Mission, Shimla, has passed an order in the state that all the educational institutions have to follow tobacco free educational institutions guidelines to get certified as health promoting educational institute.



I/30842/2020

NHMHP-NCD0GEN/14/2019-NCD-
National Health Mission
SDA Complex, Kasumpti, Shimla-9
Himachal Pradesh

The committee will submit the signed (each page) assessment checklist to the BMO concerned and the BMO will certify the institute as health promoting school based on the marks obtained. The vehicle for the transportation of the inspecting team shall be provided by the BMO concerned and the DA shall be paid to the team members as per NHM norms out of the monitoring/POL head under NPCDCS program.

The educational institute shall be certified as Health Promoting Educational Institute by the Block Medical Officer for a period of two years. All educational institutes in the state shall take the necessary steps to qualify to be certified as Health Promoting Educational Institute in larger public health interest. The sample of the certificate to be issued for this purpose is attached as Annexure-2.

Secretary (Education) to the
Government of Himachal Pradesh

Secretary (Health) to the
Government of Himachal Pradesh

Endst No.as above dated Shimla-9 the

Copy forwarded to the:

1. Special Secretary (Health-A) to the Government of Himachal Pradesh
2. Director Health Services, Himachal Pradesh
3. Director Higher Education, Himachal Pradesh
4. Director Elementary Education, Himachal Pradesh
5. All Deputy Commissioners in Himachal Pradesh
6. All Chief Medical Officers in Himachal Pradesh
7. Office record

NATIONAL HEALTH MISSION
Kasumpti Shimla-9 (H.P.)

Mission Director, NHM
Himachal Pradesh, Shimla – 9

6 CHAPTER

SMOKELESS TOBACCO (SLT) USE IN INDIA - A JOURNEY TOWARDS TOBACCO ENDGAME

SMOKELESS TOBACCO (SLT) USE IN INDIA - A JOURNEY TOWARDS TOBACCO ENDGAME

Smokeless tobacco (SLT), also known as spit tobacco, chewing tobacco, chew, and dip, is a non-combustible tobacco product that is used by means other than smoking. More than 40 forms of SLT are available and consumed globally. In India particularly, it is taken in the various forms and commonly as chewing, snuffing, dipping, and application to teeth and gums. Smokeless tobacco users place snuff or chewing tobacco between their inner cheek and gums on the lower part of their jaw and suck on the tobacco juices. Users chew and spit often because the saliva builds up (due to irritation of mucosa by tobacco or other products). This sucking and chewing allows nicotine to get into the bloodstream through the gums, without the need to swallow the tobacco juices.

India is the second largest producer and the third largest consumer of tobacco. According to the Global Adult Tobacco

Survey India Report (2009–2010), there are more than twice as many users of smokeless tobacco (26%) as cigarette smokers. The SLT is available in India as paan with tobacco, paan masala, khaini, zarda, gutka, mawa, snus, mishri, and gul etc. All SLT contains nicotine, and are therefore addictive. Like other tobacco products, there is no safe level of SLT. More than 28 known carcinogens (nitrosamine being most important) have been identified, which are responsible for cancers of the oral cavity, esophagus, pharynx, cervix, and penis alongwith cardiovascular diseases, low birth weight and mental illness. The use of chewing tobacco increases the relative risk of death by 15–30%.

What are common types of SLT?

Dipping Tobacco (or naswar) is the most common type where tobacco is placed between lip (upper or lower) and gums, and is being spit regularly.

Chewing tobacco is larger-grain tobacco leaves that are twisted or shredded which is later chewed. They come loose in paper packets or small cans.

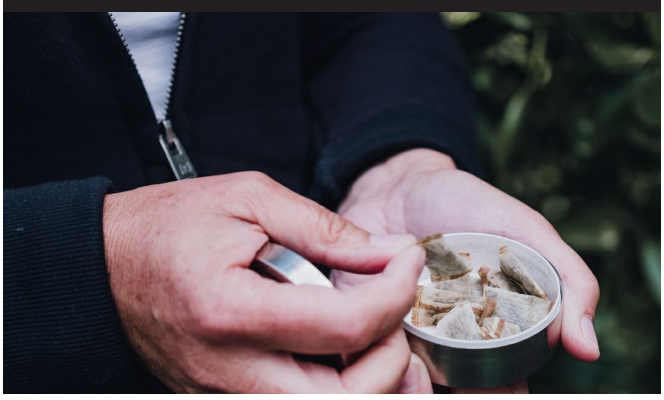
Snuff is finer-grain tobacco that is inhaled or 'snuffed' into nasal cavity.

Snus is similar to dipping tobacco, where tobacco is placed under upper lip, with no spitting.

Gutka is a mixture of tobacco, areca nut, slaked lime and various flavouring agents.

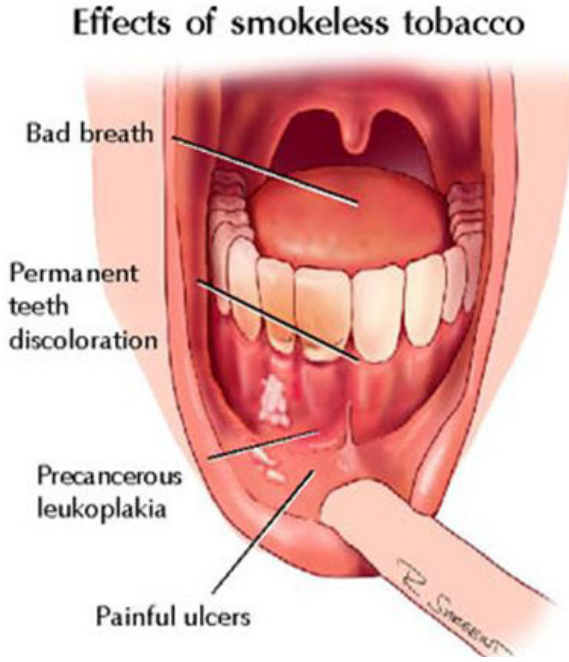
Khaini is sun-dried coarse tobacco leaves which are mixed with slaked lime paste.

Zarda is chewing tobacco mixed with colouring/spice essence lqmiq, creamy snuff, dissolvable tobacco, toombak, tobacco paste are other forms of SLT.



Why Is Smokeless Tobacco Dangerous?

At least 28 harmful chemicals and carcinogen have been found in smokeless tobacco products. The most harmful chemicals are tobacco-specific nitrosamines, which are formed during the growing, curing, fermenting, and aging of tobacco. The level of tobacco-specific nitrosamines varies by product. Scientists have found that the nitrosamine level is directly related to the risk of cancer. In addition to a variety of nitrosamines, other cancer-causing substances in smokeless tobacco include polonium–210 (a radioactive element found in tobacco fertilizer) and polynuclear aromatic hydrocarbons (also known as polycyclic aromatic hydrocarbons.



Why Do People Use Smokeless Tobacco?

Smokeless tobacco has been around for hundreds of years. It became more popular in the U.S. when baseball players in the 1970s began using it, thinking it was a safer alternative to smoking (which is not true). Even today, people believe that it is as dangerous as smoking cigarettes. Moreover, it is more affordable and easily available at Point of Sale.

What can be serious health risks of Smokeless Tobacco?

- cracked/bleeding lips and gums
- Receding gums, which can eventually make teeth fall out
- Increased heart rate, high blood pressure, and irregular heartbeat
- higher chances of heart attacks and strokes
- Cancer
- Oral cancer (cancer of the mouth) is the cancer most often linked to smokeless tobacco use. But users also can get cancer in the stomach, the throat, and the bladder because the chemicals from the tobacco get into their digestive systems through their spit.

In the most severe cases, problems caused by smokeless tobacco can lead to permanent disfigurement, such as the loss of teeth and even bones in the face. Smokeless tobacco also causes bad breath, yellowish-brown stains on the teeth, and mouth sores in most users.

Bihar Pan Masala Ban - A Gateway to SLT Free Nation (An Experience of Bihar)

According to the Global Adult Tobacco S u r v e y R e p o r t 2 0 1 7 (G AT S 2) approximately 27 crore adults use tobacco products in India, out of which 20 crore adults use Smokeless Tobacco (SLT) products including Pan Masala. According to experts, almost 90% of oral cancers are caused by SLT use and India is the oral cancer capital of the world.

GATS-2 reveals that 25.9% adults in the State of Bihar use tobacco products, of which 23.5% adults use SLT including Pan Masala. Nearly 14.6% of children (13-15 years) use tobacco in any form in Bihar. Given this, the tobacco epidemic persists in Bihar.

Why Pan Masala ban?

Pan Masala is standardized product and defined by the FSSAI to be sold with the warning, "Chewing of Pan Masala is injurious to health". As per the Food Safety and Standards (Prohibition and Restrictions on Sales) Regulation, 2011, clause 2.3.4:

"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." The use of magnesium carbonate, nicotine or any other additives is prohibited in any food product including pan masala. Based on findings from State Food Testing laboratory reports, Bihar Government banned the manufacture, storage, transportation and sale of 15 prominent brands of Pan Masala (these include: Rajnigandha, Rajniwas, Supreme, Pan Parag, Bahar, Bahubali, Rajshree, Raunak, Siggnature, Sir Gold, Shikhar, Vimal, Kamala Pasand, Pashan and Madhu). Subsequently the samples of pan masala were sent to National Tobacco Testing Laboratory, Noida for further testing. On testing 7 different brands of pan masala were found to contain " NICOTINE" though their package mentioned "No Nicotine". Bihar Government has banned only those Pan Masala brands which were found not in conformity with the standards of Pan Masala as specified in Regulation 2.11.5 of the Food Safety and Standards (Food Products and Food Additives) Regulations, 2011.

Outcomes of Pan Masala ban

I. Prevalence of Smoke Less Tobacco (SLT) use has reduced in the state from GATS-1 (2009-10) to GATS-2 (2015-16). Therefore, the Oral Cancer incidence will also decline.

ii. Due to regular enforcement drives, all major brands of Pan Masala including SLT (Twin Pack) have vanished from the market.
iii. Greater Awareness among the SLT users about the use of toxic chemical like NICOTINE in Pan Masala through larger media coverage.

iv. Point of sale (PoS) have become free from SLT, so the compliance of section 5 will be better in the state.

v. Outdoor advertisement of Pan Masala through hoardings have been removed by Tobacco industries (TI), which will be resulted in reduction of surrogate advertisement.

Journey of Smokeless Tobacco in India

Prevalence of Smoke Less Tobacco (SLT) use has reduced in the states from GATS-1 (2009-10) to GATS-2 (2015-16)

1986
Statutory warning on chewing tobacco products, 'chewing of tobacco is injurious to health' noticed under the Prevention of Food and Adulteration Rules, 1955.

1992
Ban on manufacture and sale of toothpastes and toothpowders containing tobacco under the Drugs and Cosmetics Act of 1940. Supreme Court in Laxmikant vs UOI & Ors., 1997(4) SCC 739, upheld the ban with the observations that imposition of total ban is in the public interest.

1996-2003
Implementation of prohibition of smoking and spitting laws by several States e.g. Gujarat, Goa, West Bengal, Tamil Nadu etc. [Not seen Gujarat`s the others are The Goa Prohibition of Smoking and Spitting Act, 1997/The Tamil Nadu Prohibition of Smoking and Spitting Act, 2003/The West Bengal Prohibition of Smoking and Spitting and Protection of Health of Non-Smokers and Minor Act, 2001 etc.

2001
Ministry of Railways imposed ban on sale of gutka on railway station premises, concourses and reservation centers and in trains.

2001-2003
Ban on manufacture, storage, distribution and sale of pan masala, gutkha, and chewing tobacco by state of Maharashtra, Goa, Tamil Nadu, Andhra Pradesh, under Section 7(iv) of the Prevention of Food & Adulteration Act 1954.

2003
The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act 2003 (COTPA) enacted to prohibit advertisements and regulate the trade and commerce, production, supply and distribution of tobacco products.

2004
Supreme Court of India quashed the ban by states saying it could only be done by the Central Government (Godawat Pan Masala Vs. Union of India)

2005
State of Goa bans manufacture, storage, distribution and sale of any article of food containing tobacco (as it was considered injurious to health) under the Goa Public Health Amendment Act, 2005 resulting in ban in gutkha and other favoured SLT in the state

2006
The Food Safety and Standards Act, 2006 (FSSA), enacted with the objective to fix food standards and regulate/monitor the manufacturing, import, processing, distribution and sale of food so as to ensure safe and wholesome food to the people. Regulation under the Act eventually restricted use of tobacco and nicotine as ingredients in food items, resulting in ban on Gutkha and other flavoured SLT in the country.[The objective of the Act was to provide safe and wholesome food for human consumption was to provide safe food/unsafe food, hence injurious SLT products which were considered as food became unsafe for human consumption]

2007
Rajasthan High Court banned the sale of gutkha, pan masala in plastic sachets for being major toxic pollutants and further directed payment of fine by the manufacturers of gutkha, tobacco and pan masala and other forms of chewing tobacco on the basis of 'Polluter Pays Principle'. (Indian Asthma Care Society Vs State of Rajasthan and Others)

2010
Supreme Court of India directs Government to undertake a comprehensive analysis and study of the contents of gutkha, tobacco, pan masala and similar articles manufactured in the country and harmful effects of consumption of such articles. (AnkurGutkha Vs Indian Asthma Care Society & Ors) and to notify and implement the Plastics (Manufacture, Usage and Waste Management) Rules, for banning use of plastic material in the sachets of gutkha, tobacco and pan masala. NIHFW conducted a comprehensive review of literature on the contents and health effects of smokeless tobacco and areca-nut, which concludes that SLT, Arecanut causes many cancers and other diseases.

2011
An Expert Committee constituted by MoHFW submited a voluminous report on the hazards of using SLT products including gutkha, tobacco, pan masala and similar articles. Committee reports that, there are 3095 chemical components in SLT products (including gutkha), among them 28 are proven carcinogen.

2011

National Consultation on Smokeless Tobacco Control organized by MoHFW, WHO and Public Health Foundation of India, which taking into account the Supreme Court's observations and the Expert Committee report recommended a ban on SLT under the Food Safety and Standards Act, 2006.

Food Safety and Standards Authority of India notices Regulations 2.3.4 of the Food Safety and Standards (Prohibition and Restrictions on Sales), prohibiting use of tobacco and nicotine as ingredient in food items thereby banning manufacture and sale of gutka (i.e. pan masala with tobacco) and other favoured tobacco products as these contain food items.[In lay terms gutka is pan masala with tobacco, where Pan Masala is a standardized food product]

2012

State of Madhya Pradesh becomes the first State to ban the sale of Gutkha and Pan Masala (containing tobacco and nicotine) in compliance with Regulation 2.3.4

2013

Supreme Court of India directs all states to implement the FSSAI Regulation 2.3.4 and ban manufacture and sale of gutkha and pan masala (with tobacco and nicotine)

2013-14

Almost all states and union territories ban manufacture and sale of gutkha and pan masala (with tobacco and nicotine) in the country.

2014

Assam becomes the first state to enact a specific law for banning consumption and manufacture of all forms of smokeless tobacco by passing the Assam Health (Prohibition of Manufacturing, Trade, Advertisement, Storage, Distribution, Sale and Consumption of Zarda, Gutkha, Pan Masala Containing Tobacco) Bill, 2013. Subsequently by order dated 27.10.2017, Guwahati High Court struck down the law as unconstitutional.

2015

Expert group consultation on smokeless tobacco and public health organized by the WHO-SEAR adopted the 'Mumbai Call for Action 2015' for prevention control of SLT in the SEAR region. Which inter alia called governments to raise the priority on SLT control and include SLT as an integral part of the national and local tobacco control frameworks, as well as other health and development agenda.

2016

Establishment of the WHO FCTC Global Knowledge Hub on Smokeless Tobacco at the ICMR-National Institute of Cancer Prevention and Research, Noida, Uttar Pradesh with a mandate to generate and share expertise, information, knowledge and provide training, regionally and globally on SLT, as appropriate.

2016

To circumvent the ban on gutka, manufacturers were selling gutka in twin packs(pan masala and chewing tobacco in separate packs but conjoint and sold together) Supreme Court of India, taking note of the same, directed the statutory authorities to implement the ban strictly, in terms of Regulation 2.3.4 of the FSS Act. Taking congnigence, the state of Bihar strictly implemented regulations under FSS Act by testing samples of pan masala and those brands which were found non-compliant with the regulation were banned. This led to disappearance of twin packs.

2017

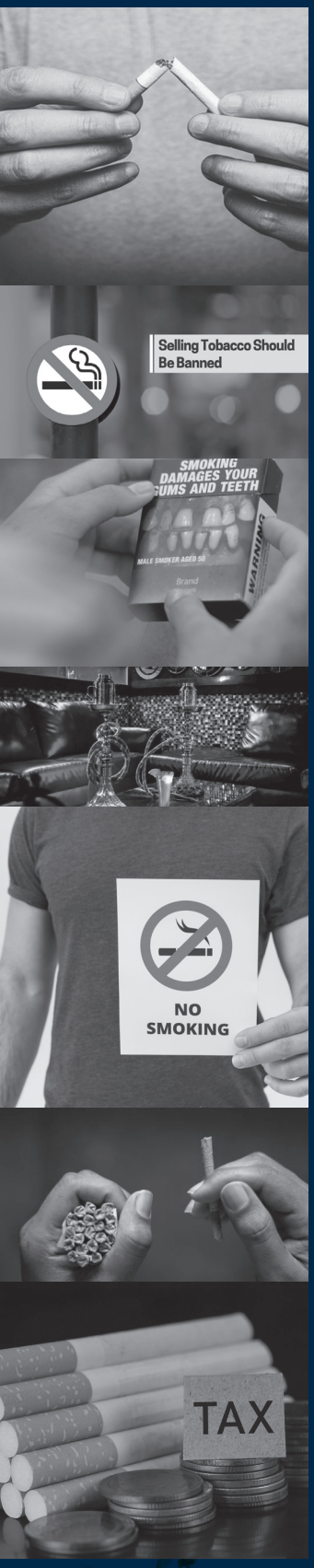
National workshop on the 'Priorities in Smokeless Tobacco Control – Research & Training Needs' organized by ICMR-National Institute of Cancer Prevention and Research, Noida, Uttar Pradesh recommends several actionable measures to curb SLT and areca nut use in the country.

2018

National Consultation on Smokeless Tobacco organized by the Indian Council of Medical Research recommended increasing the age of sale to beyond 21 years, standardization of sale by restricting sale of SLT in less than 50gm pouches/packs and ban on sale of flavoured SLT products.

2018-19

State governments of Maharasthra, Himachal Pradesh and Bihar banned sale of pan masala and flavoured/scented supari and 12 states [Mizoram, Manipur, Maharashtra, Himachal Pradesh, Jammu & Kashmir, Andhra Pradesh, West Bengal, Dadar Nagar Haveli, Bihar, Delhi, Himachal Pradesh and Haryana] also ban all form of processed, favored, scented chewing tobacco, under Section 30(2)(a) of the FSSA, that empowers the Commissioner of Food Safety to prohibit in the interest of public health, the manufacture, storage, distribution or sale of any article of food.



7 CHAPTER

INDIA'S E-CIGARETTE STORY...ENDS TO 'END OF THE ROAD'

INDIA'S E-CIGARETTE STORY...ENDS TO 'END OF THE ROAD'

E-cigarettes (also known as "e-cigs," "e- hookahs," "mods," "vape pens," "tank systems" or "electronic nicotine delivery systems (ENDS)) are electronic devices, which look like regular cigarettes, cigars, or other everyday household items viz. USB flash drives, pens etc. Using an e-cigarette is sometimes called "vaping" or "JUULing." JUUL is a popular brand of e-cigarette that is shaped like a USB flash drive. It has a high level of nicotine (a single JUUL pod contains as much nicotine as a pack of 20 regular cigarettes).

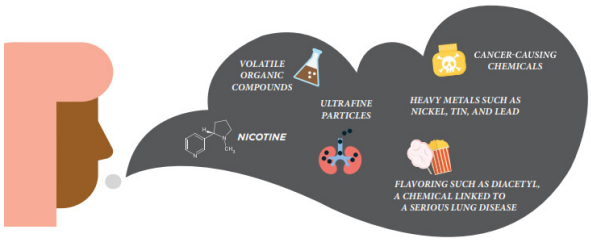
How Do E-cigarettes Work?

Most have a battery, a heating element, and a place to hold a liquid (called "e-juice or "vape juice," containing nicotine and flavorings). The liquid is heated to produce an aerosol (mix of small particles in the air) which is inhaled into the lungs of smoker (vaper) and by-stander (second-hand vaping). E-cigarette devices can be used to deliver marijuana and other drugs.

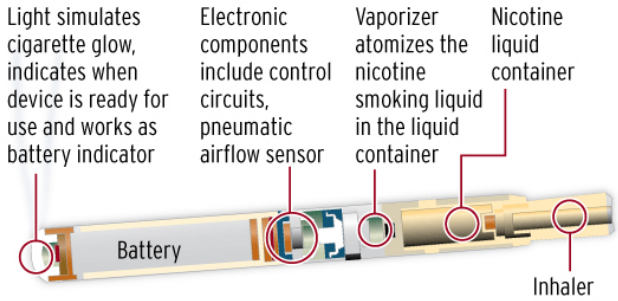
E-Cigarettes aerosols:

It contains very harmful substances including:

1. Nicotine
2. Ultrafine particles that can be inhaled deep into the lungs
3. Volatile organic compounds
4. Flavorings such as diacetyl, a chemical linked to a serious lung disease
5. Cancer-causing chemicals
6. Heavy metals such as nickel, tin, and lead1



How e-cigarettes work



Nicotine levels compared

Electronic		Traditional
One e-cigarette	**Equivalent**	6-7 cigarettes
100	**Puffs per cigarette**	15
6-24 mg.	**Nicotine level**	0.6-2.4 mg.
E-cigarette with 24 mg of nicotine **0.16 mg/puff**	**Nicotine per puff**	Cigarette with 1.8 mg of nicotine **0.16 mg/puff**

Sources: E-Cig, Winston-Salem Journal

McCLATCHY TRIBUNE

WHAT ARE THE RISKS OF E-CIGARETTES?

- E-cigarettes do not have any proven substantial benefits in terms of 'harm reduction' or 'quitting alternatives'
- E-cigarettes are not safe for youth, young adults, pregnant women, or adults. Most e-cigarettes contain nicotine (besides many other harmful substances) which is highly addictive and can harm adolescent brain development that control attention, learning, mood, and impulse control.
- Young people who use e-cigarettes may be more likely to smoke cigarettes in the future along potential for other addictions.
- Some of the ingredients in e-cigarette aerosol could be really harmful to the lungs in the long-term
- Children and adults have been poisoned by swallowing, breathing, or absorbing e-cigarette liquid through their skin or eyes.
- Defective e-cigarette batteries have caused some fires and explosions, a few of which have resulted in serious injuries.
- It is available in over 500 flavours, which masks the pungent taste of nicotine and it becomes difficult for consumers to know what e-cigarette products contain. For example, many e-cigarettes marketed as containing zero percent nicotine have been found to contain nicotine
- Widespread advertising for these products has contributed to the increase in e-cigarette use among youth.

The Decision

The Union Government recently issued an ordinance to ban the sale, storage and manufacture of e- cigarettes/ ENDS. The ordinance came into effect on Sep 18, 2019. With this, consumption, production, manufacturing, import, export, transport, sale, distribution, storage and advertisement of e-cigarettes would become illegal in India. The penalties for violations of the law include one-year imprisonment or fine of up to Rs. 1 lakh (US$1400) or both for first offence and three years' imprisonment and fine up to Rs. 5 lakh (US$7000) for a subsequent offence. The law also makes it punishable to store electronic- cigarettes with six-month imprisonment or fine up to Rs 50,000 (US$700) or both. "E-cigarettes were promoted as a way to get people out of their smoking habits but reports have shown that many people are not using it as a weaning mechanism but are rather addicted to it," Union Finance Minister Nirmala Sitharaman had said while justifying the ban on e-cigarettes.

Global Perspective

Overall, more than 30 countries have banned these e- cigarettes/ENDS and other countries are planning to ban them. Tobacco growing countries like Thailand, Nepal, Brazil, Mexico, Sri Lanka have also banned ENDS to save the livelihoods of their farmers

India's E-Cigarette Story- From Boom to Bust

2012-

- Anecdotal evidence suggests that e-cigarette entered the Indian market in the year 2012.
- A couple of Indian public health professionals trained in UCSF under Prof. Stan Glantz came to know about the deadly menace of ENDS- June 2012

2013-

- Consultation on ENDS under Joint Secretary, Ministry of Health & Family Welfare (MOHFW) -July, 2013
- Punjab was the first state in India to declare ENDS as an unapproved drug under Drugs and Cosmetics Act-July 2013

2014-

- Enforcement and regularly monitoring of sale of ENDS by highest officials at State and District level in Punjab. Seizure of these products in few districts and court cases launched against seven violators contravening Drugs and Cosmetics Act. First violator was imposed fine of 1 Lakh INR (1500 USD) and 3 years imprisonment-April 2014
- MOHFW and The Union follow up Consultation under Chairmanship of Additional Secretary. Three sub-groups were created-Legal, Health and Advocacy & Public Opinion - July 2014
- Union Health minister proposed ban on ENDS in World Lung Conference, Barcelona- November 2014

2016-

- Punjab Government issued a Demi-Official letter to Cyber Crime cell to curb the ENDS sale on the E commerce site- August 2016
- Cyber Crime Cell identified (and issued notice to) 26 E-commerce sites selling the E cigarettes- August 2016.

2017-

- Vape-Expo organised in Noida-UP got cancelled by UP Govt. by intervention of Anti- Tobacco Activists-September 2017
- Various states (Punjab, Maharashtra, Karnataka, Kerala, Bihar, Uttar Pradesh, Jammu & Kashmir, Mizoram, Tamil Nadu, HP, Puducherry, Jharkhand, Haryana, UT Chandigarh, Rajasthan, Meghalaya, Odisha, Nagaland) banned ENDS gradually under Drug and Cosmetic Act or Poisons Act.

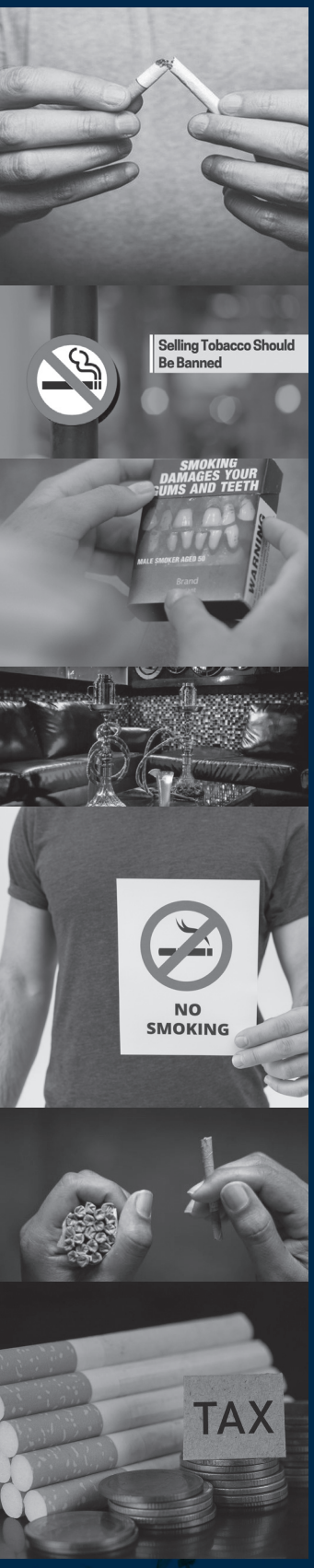
2018-

- MOHFW issues an advisory to states/UTs to act against ENDS and like products under Drugs and Cosmetics Act- August 2018

2019-

- DO letters written by Commissioner-FDA to Govt. of India/ C-FDAs of all states after being sensitized in a consultation on ENDS conducted by SIPHER in collaboration with School of Public Health, PGIMER, Chandigarh. The 'Chandigarh Declaration on ENDS' was further endorsed in National Conference on Tobacco or Health, Mumbai- February 2019
- Three Ministries advance regulations to control the epidemic of e-cigarettes. Further, Central Drug Regulator directed all drug controllers to disallow manufacture, sale , import and advertisement of ENDS – March 2019
- MOHFW block entry to JUUL in India- March 2019
- Voice for Tobacco Free Victims (VoTV) launched a campaign where over 1000 doctors from 24 states of India appeal to Prime Minister to enforce ban on e-cigarettes– April 2019
- White paper on e-cigarette by Indian Council of Medical Research- May 2019
- Government of India (GOI) completely banned e-cigarettes and like products approving Prohibition of Electronic Cigarettes Ordinance 2019, following recommendations of a Group of Ministers (GoM)- September 2019
- A survey conducted to assess the impact of ordinance of GOI by SIPHER, a public health organization, observed 23 e-commerce websites and found that none was selling ENDS- October 2019


SUSTAINABLE DEVELOPMENT GOALS
1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL-BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS
SUSTAINABLE DEVELOPMENT GOALS



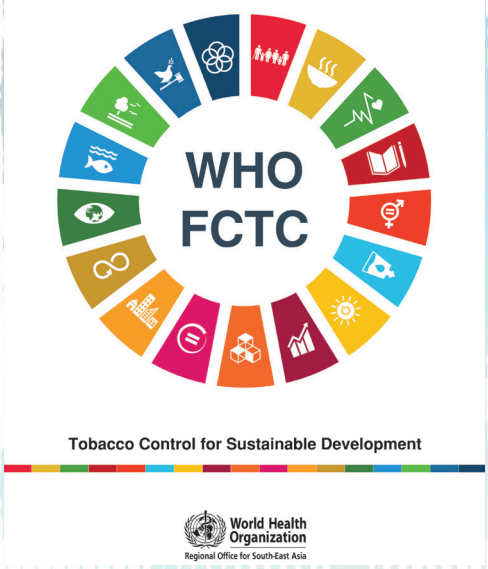
8 CHAPTER

TOBACCO CONTROL AND SUSTAINABLE DEVELOPMENT GOALS

Tobacco Control and Sustainable Development Goals

"Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs"

-Brundtland Report 1987



Background and Introduction:

Tobacco costs lives, causes economic loss, contributes to environmental degradation, and poses significant threats to sustainable development. Tobacco use and production is linked to negatively impacting all 17 United Nation (UN)'s Sustainable Development Goals (SDGs).

The governments across globe face tough task in resourcing and implementation of decisions to achieve the ambitious SDG agenda (17 goals and 169 targets). Despite inclusion of a specific target for implementation of the WHO Framework Convention on Tobacco Control (FCTC; target 3.a), there is a risk that tobacco control will remain a focus for the health community only. Reducing tobacco use plays a major role in global efforts to achieve the SDG target of reducing premature deaths from non-communicable diseases (NCDs) by one third by 2030. All the 17 Goals have a direct or indirect relationship to tobacco control.

What are the SDGs?

The Sustainable Development Goals (SDGs) are a United Nations initiative, formally adopted by the United Nations General Assembly on 25 September 2015 in a resolution entitled Transforming our world: the 2030 Agenda for Sustainable Development. The SDGs build on and succeed the Millennium Development Goals. They include 17 goals and 169 targets to be achieved over the next 15 years, with the aim to "end poverty, protect the planet, and ensure prosperity for all as part of a new sustainable development agenda". Alongside the SDGs are governmental commitments to action that will enable progress towards the targets. The SDGs apply to all countries, rich and poor, and recognize the crucial interrelationship of health, poverty, education, gender, and many other issues.

How tobacco impedes sustainable development?

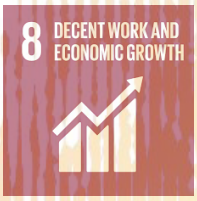
More than 17 million people work in tobacco cultivation worldwide, mainly in low- and middle-income countries with low labour standards, where more than 90% of the global tobacco harvest is produced. Smallholder farmers find it difficult to earn a living from tobacco cultivation (irreconcilable with SDGs 1 and 2) and need the help of their children as contribution to their livelihood, even at the expense of their education (irreconcilable with SDGs 8.7 and 4). Dangerous chemicals are intensively used in the fields, and due to the lack of protective clothing, occupational accidents such as poisonings are widespread (irreconcilable with SDGs 3.9 and 8). In addition, nicotine is absorbed through the skin when workers get into contact with tobacco leaves, eventually causing acute nicotine poisoning, the so-called 'green tobacco sickness' (irreconcilable with SDG 8.8). Thus, the widespread use of child labor is particularly worrying. On top of it, tobacco cultivation damages the environment: tobacco depletes the soil of nutrients and, consequently, forests are cleared to develop new fertile fields as well as to obtain firewood for curing the green tobacco leaves. The curing process requires globally around 8 million tonnes of fuelwood every year (irreconcilable with SDGs 12.2, 13 and 15.2). Furthermore, the chemicals used in tobacco growing enter water bodies and adversely affect aquatic life biodiversity (irreconcilable with SDGs 6.3 and 6.6). (Eichborn, 2020).

A recent report published by National Cancer Institute (NCI)of USA and WHO entitled "The Economics of Tobacco and Tobacco Control" concludes the following:

- **Tobacco control reduces the disproportionate burden that tobacco use imposes on the poor.**
- **Tobacco (Smoking and smokeless) use is concentrated among the poor and other vulnerable groups such as children ad women and tobacco use accounts for a significant share of the health disparities between rich and poor.**

What is the role of tobacco control in attaining sustainable development goals?

SDG	Problem Caused by Tobacco Use	How Tobacco Control Help in achieving Sustainable Development Goals
	Tobacco use leads to • Chronic diseases that are costly to treat. • Premature deaths that cause financial burden. • Keep farmers in a debt cycle	Tobacco Control can lead to poverty alleviation efforts by • Banning on advertising • More smoke free places • Higher tobacco taxes, etc. These efforts will allow income to be redirected towards necessities like food, education, and other investments that could lift the poor out of poverty.
	• Spending on tobacco products often represent more than 10% of household expenditure, taking away income for necessities like food. • Tobacco cultivation eats up large areas of land which could otherwise be used for food production. • Tobacco is one of the major causes of soil and land degradation, stripping the nutrients of soil faster than other crops, contributing further to food insecurity as the land becomes unsuitable or less productive for purposes of growing food crops.	Reducing tobacco use can: • Redirect spending to ease hunger (food and nutrition), from tobacco products and health costs for tobacco-related illnesses. • Sift land used for tobacco production to the growing of food crops with support from the government as mandated under the World health Organization (WHO) Framework Convention on Tobacco Control (WHO FCTC)
	Tobacco use causes: • Death, disability and disease. Kills over 8 million people every year • Costs the world economy nearly 2% of its gross domestic product. • Strips land and soil of their viability.	One of the SDG targets is strengthening the implementation of WHO FCTC, a treaty which sets forth measures proven to be effective in reducing tobacco consumption. If nothing is done, 1 billion people could die from tobacco-related diseases in this century.

	Tobacco use results in: • Children being forced to drop out of school to take care of a sick relative or to find work to make up for lost wages. • Children (14 and under) work in tobacco fields depriving them of education. • Smoking among adolescents and exposure to second-hand smoke leads to learning problems/ cognitive impairment.	• Money can be used for the education of children, rather than on tobacco addiction or tobacco-related diseases. • Without tobacco, families can better afford to keep kids in school. • Reduced tobacco production means that more children kept in from schools rather than working tobacco fields. • Reducing adolescent smoking reduces the risks of learning disabilities and of cognitive impairment later in life
	• Tobacco use has been rising among women, as women have been specifically targeted by the tobacco industry. • Women face gender-specific health risks from tobacco, such as the disproportionate burden in exposure to second-hand smoke and use during pregnancy.	Tobacco control measures can stop the rise in tobacco use among women and girls, and also reduce problems associated with second-hand smoke exposure.
	Both tobacco consumption and production cause: • Water pollution. • Cigarette butts are the most widely littered product globally, often dumped into oceans, lakes and other water sources, which causes toxicity due to arsenic, lead, nicotine and ethyl phenol are leached into aquatic environments • Tobacco growing is water-intensive and disperses chemicals into nearby waterways, contaminating even deep groundwater.	Tobacco control provides a comprehensive approach in achieving the goal of having clean water and sanitation. The reduction in tobacco use will result in less littered cigarette butts, and less chemical contamination of waterways
	The tobacco consumption: • Unable the common people to buy sustainable source of energy e.g. L.P.G. etc. • Like factories effect our environment, same way tobacco smoking does.	Tobacco Control will help in: • Energy efficiency and increase use of renewables. • Maintaining and protecting ecosystems allow using and further developing hydropower sources of electricity and bioenergy.
	• Tobacco farmers are often trapped in a cycle of indebtedness towards the tobacco industry, as they are exploited and forced to sell tobacco leaves at fixed low prices. • Tobacco farming uses child labor, taking children away from school. • Tobacco growers are moreover exposed to the health risk posed by "green tobacco illness" due to nicotine toxicity in handling tobacco leaves	Tobacco control can: • Avoid losses to productivity and GDP which result from "premature mortality, sick leave and unwell workers who remain on the job but perform below capacity. • Also advance better and safer working conditions, as workplaces become smoke-free spaces. • Supports families to shift from tobacco growing, and the "debt-bonded and child labor it often entails," to alternative economic activities which can be more lucrative and do not harm growers' health.
	The manufacturing, distribution and/or sale of tobacco or tobacco-related products; entities working to specifically further the interests of the tobacco industry through: • lobbying, advertising, legal advice or similar activities; • Entities being funded, supported or influenced in their governance by tobacco-related entities; • Entities having tobacco industry or their representatives among their members.	Effective tobacco control measures require quality and up-to-date research, and the ability to harness innovations in technology, by adapting to new platforms (e.g. social media) and disciplines (e.g. behavioral science) in order • To raise awareness. • Support cessation and unmask tobacco industry tactics.

	Tobacco use is highest among: • The poor. • Those with low literacy rates • Those with a mental health condition. Those already facing social disadvantage, living in neighbourhoods that are unsafe or with limited recreation or with limited access to health services.	Tobacco control can close gaps in inequality by: • Increasing Tobacco taxes which will reduce consumption most among the poor, especially when revenues from taxes are reinvested into disadvantaged communities. • Reducing tobacco use through effective tobacco control measures as provided in the WHO FCTC will improve health and increase opportunities in education and labor, among others, which can further reduce inequalities
	Tobacco smoke causes: • Lowering and degrading air quality • Compromising the safety of housing, workplaces, transport systems and public spaces. Globally, 570,000 children under five die each year from respiratory infections, such as pneumonia, that are attributable to indoor and outdoor air pollution and second-hand smoke.	Tobacco control helps to produce safe and sustainable cities and communities by: • Reducing pollution from second-hand smoke and disposed cigarette butts. • Implementing tobacco taxes as mandated by the WHO FCTC can provide additional, sustainable sources of funding for health care and other social causes.
	Tobacco consumption generates: • Tons of waste and releases thousands of chemicals into the planet's air, water and soil. • Cigarette butts that are the most discarded waste item worldwide, amounting to 1.69 billion pounds of toxic trash each year. • Indoor Particulate Matter (PM) Smokers are at higher risk of dying from cardiovascular disease and lung cancer, because air pollution "combines synergistically with cigarette smoking for mortality.	Tobacco control can enhance responsible consumption and production by: • Reducing tobacco use and its resultant waste. • Farmers shifting from tobacco production toward activities that are friendlier to people and planet. • Supporting tobacco users to quit or reduce consumption and non-users to never start.
	Tobacco production, including growing and curing, causes: • Aggressive deforestation. • Increased greenhouse gas emissions (e.g. carbon dioxide and methane), global warming and changes in rainfall • Irreversible biodiversity loss.	The implementation of tobacco control and climate action can help: • In raising awareness and provide solutions to climate change, as measures like the support for alternative economic livelihoods for tobacco growers. • Tobacco cessation can help tackle the problem of climate change.
	•Tobacco is a major cause of marine pollution and toxicity, causing harm to aquatic life. • Cigarette butts is the most common single debris item collected representing 15% of the total debris which are harmful to beaches and oceans, and harm aquatic life, including marine and freshwater fish. Pesticides and agrochemical residues from tobacco growing pollute nearby waterways, jeopardizing not only clean water for human use but also the welfare of aquatic organisms.	Tobacco control can reduce water pollution and improve aquatic life. The WHO FCTC provides a means by which to reduce tobacco production and use, which will help reduce water pollution and protect life under water.
	Tobacco is one of the major causes of: • Deforestation • Soil and land degradation. • Stripping off the soil nutrients Destructive forest fires. • Changing of local streams from permanent to seasonal.	Tobacco control can improve life on land by • Reducing and preventing further environmental damage • Supporting economic alternatives to tobacco growing under Article 17 of the WHO FCTC • Contribute to the reduction of tobacco production and use, which will in turn, contribute to the protection of land resources and help restore biodiversity, and thereby, improve life on land.

	Tobacco industry interference weakens institutions and the rule of law by interfering with: • Policy making • By aggressive lobbying • Hijacking the legislative process	Tobacco control promotes good governance and strong institutions. The implementation of the WHO FCTC can thus promote: • Enhancing capacities for intersectoral engagement. • Conflict of interest management Promoting greater transparency and accountability • Reducing corruption. • Placing stronger protection against undue interference in policy making, and progress in combating organized crime (with respect to illicit trade of tobacco products). • Strengthening the legislative and oversight capacities of lawmakers and parliamentarians
	Tobacco industry partnerships with government and other institutions form part of its public relations strategy, designed to: • Enhance their image, by lending them credibility and legitimacy, and thereby sending a deceptive message that their products are safe and benign. • Corporate social responsibility (CSR) contributions and activities, to gain access to high-level officials, which allows them to help in crafting policies that are in line with their commercial interests.	• Parties must protect public health policies from the commercial and vested interests of the tobacco industry. • The implementation of Article 5.3 will ensure compliance with the foregoing obligation, including the rejection of partnerships and other agreements with the tobacco industry. • Full compliance with Article 5.3 of the WHO FCTC ensures transparency and that policies adopted and implemented are in line with the standards provided in the treaty.

How WHO Global Conference on NCDs Pursuing Policy Coherence to achieve SDG Target 3.4 On NCDs (Montevideo, Uruguay, 18-20 October 2017)?

MONTEVIDEO ROADMAP 2018-2030 ON NCDs AS A SUSTAINABLE DEVELOPMENT PRIORITY

WHO Global Conference on Noncommunicable Diseases

Pursuing policy coherence to achieve SDG target 3.4 on NCDs

(Montevideo, 18-20 October 2017)

The draft Outcome Document "Montevideo Roadmap 2018-2030 on NCDs as a Sustainable Development Priority" outlines the commitment of the Heads of State and Government, Ministers and representatives of State and Government, in the following:

- Reinvigorating political action.
- Enabling health systems to respond more effectively to NCDs
- Increasing significantly the financing of national NCD responses and international cooperation
- Increasing efforts to engage sectors beyond health
- Seeking measures to address the negative impact of products and environmental factors harmful for health and strengthen the contribution and accountability of the private sector
- Reinforcing the role of non-state actors.

What is the multi-sectoral action [MSA] led by multiple stakeholders for tobacco control?

- Tobacco control provides a good example for the need and the potential impact of multi sectoral action in NCD prevention and control.
- Effective tobacco control involves not only addressing it at the individual level (preventing use by individuals, helping users to quit) but also leveraging MSAs to address production, trade, taxation, and implementation of tobacco control laws.

What was the Baseline measurement of SDGs in 188 countries in 2015?

Name of the Country	SDG Index
Iceland-1	85
Singapore -2	85
Sweden -3	85
UK -5	82
Japan-27	76
USA -28	75
India -143	42
Central African Republic- 188	20

What integrations have been done with developmental agenda?

1. **International Labour Organization (ILO) –** ILO is an observer to WHO FCTC. In 2019, endorsed its new integrated strategy for tobacco sector.
   - It aimed to end ILO's involvement in tobacco industry CSR schemes.
   - ILO tried to cut the financial ties with tobacco companies because this industry exploits labour and leaves the farmers in poverty trap. ILO also ended its PPP with ECLT and JTI.
2. **WTO (World Trade Organizations)-** There was a legal challenge posed by tobacco industry to oppose plain packaging of tobacco products in Australia. But in 2018, the WTO panel decided that Australia's policy for plain packaging was consistent with WTO Laws. It was accepted on the grounds that Australia aimed to improve public health by reducing tobacco consumption.
3. **Role of Environmental Health Agencies :** Conduct variety of activities to control Tobacco exposure through enforcement of local codes, ordinances and statues restricting tobacco use.
   - Providing educational resources and creating awareness on tobacco cessation.

What are the initiatives undertaken by Ministry of Health and Family Welfare for attaining Tobacco related SDG's?

1. **Strengthening National Tobacco Control Policy**
   Although, many activities have been going on for tobacco control viz. a dedicated tobacco control program with many components, NCD program and other related program but now there is a need to focus and strengthen the tobacco control policy with which we can not only attain sustainable development goals but also a total endgame of tobacco.
2. **Revisiting National Tobacco Control Programme and revision of operational guidelines**
   - Mapping of all the activities in ministry and different state governments
   - Accelerating agendas of NTCP in the states and districts and covering all its components
   - Focussing on 2003 amendment.
   - Access the monitoring of SLCC and DLCC through Health Management Information System.
   -

What can be done to achieve SDG's by focusing on tobacco control?

- Strengthening national tobacco control and NCD policies, in addition to reorienting health systems to address prevention of NCDs, most notably through tobacco control.
- Implementing WHO Best Buys- Tobacco taxation is the subject of FCTC Article 6 and best practice guidelines on implementation were approved by all Parties to the treaty in 2014.
- Research that cuts across disciplinary boundaries and is embedded within the implementation of cross-cutting policies is critical in ensuring that efforts to achieve SDG targets in one sector are optimized to support achievement of targets in another – recognizing that the inherent contradictions within some of the SDGs (notably those related to economic growth and environmental sustainability) will need to be acknowledged and addressed.
- Systems approaches for localizing the SDGs: co-production of place-based case studies, in accordance with MSAP.

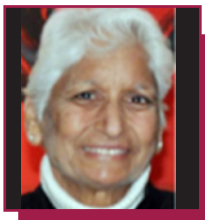
What can people working in tobacco control do to increase awareness of the SDG's and ensure further action?

For the SDG's goals to be achieved, everyone needs to do their part: "Governments, the private sector, civil society and people like you."

1. The governments have the primary responsibility for follow-up and review, at the national, regional and global levels, in relation to the progress made in implementing the Goals and targets so far and plan for next activity.
2. The essential role of national parliaments is through their enactment of legislation and adoption of budgets and their role in ensuring accountability for the effective implementation of commitments towards SDG's.
3. Governments and public institutions should work closely on implementation with regional and local authorities, sub-regional institutions, international institutions, academia, philanthropic organizations, volunteer groups and others.
4. Vital roles for civil society include:

- Increasing public awareness of the SDGs and governments' commitment to their implementation; developing appropriate national or international coalitions to ensure support for the SDGs [(these may be subject-specific, for example, on tobacco control (as with the Framework Convention Alliance) or more broadly based, for example, on reducing NCDs)];
- Ascertaining what governments are doing about the SDGs both in specific sectors and across government;
- Monitoring and reviewing progress; and, when appropriate, reminding governments of their obligations and the need for plans, programmes and reports;
- Drawing continuing attention to the potential to address not only tobacco and NCDs but also many other SDGs and targets through increase in tobacco taxes, which remain the single most effective means of reducing tobacco use.
- Further promoting awareness that tobacco taxation can play an important role in financing action on the SDGs; and maintaining pressure for strong action on tobacco and comprehensive approaches to tobacco control, consistent with the commitments from governments set out in both the SDGs and the WHO FCTC.

EXPERTS COMMENTS



There is a direct and indirect link between all the 17 SDG goals and tobacco control and the governmental commitment is integral to achieve tobacco control. There is an urgent need to adhere with WHO Framework Convention on Tobacco Control(WHO-FCTC). Most importantly, the demand for political courage to progress further on the END game is needed.

Dr Mira B Aghi,
Behavioral Scientist Communication Expert

It depends upon the tobacco control professionals on how they project the advancement in tobacco control and take this as an advantage in attaining a sustainable development goals in every area. In this way, we will definitely succeed in achieving the targets of sustainable development goals that will go a great way in multi sectoral and real advancement in tobacco control.

Dr P C Gupta, Director of Healis - Sekhsaria Institute of Public Health, Navi Mumbai

Tobacco itself is a biggest risk for non-communicable diseases as it accounts for 70-80% mortality everywhere. Tobacco control is related to almost all the SDG's. There's a need that countries focus on tobacco control and then they might achieve the SDG's targets. There is need to enhance the collaborations with tobacco control organizations. All the departments and health sectors needs to come together and work for a common goal. Sdg's concern everybody and the entire global and not only health economy but a lot of other things depend upon this.

Dr Jagdish Kaur, Regional Adviser (Tobacco Free Initiative), WHO SEARO office

In 2015, the United Nations has formally adopted implementation of FCTC as an important goal to achieve sustainable development goals which is a plan to eradicate global poverty. United Nations made it very clear that SDG's formally recognize the negative impact of tobacco consumption on health, wealth and development. UN wanted all the member countries to commit to combat the ongoing tobacco epidemic especially through the implementation of WHO FCTC.

Dr Rana J Singh, Deputy Regional Director, NCD & Tobacco Control, The UNION SEA Office, New Delhi

9 CHAPTER

MULTI-SECTORAL CONVERGENCE IN TOBACCO CONTROL

Multi-Sectoral Convergence in Tobacco Control

Problem Statement

Tobacco use is a global problem and the World Health organization has advised the member states to take appropriate measures to protect the vulnerable populations from tobacco use in the 14th plenary meeting in 1986. Government of India enacted the Tobacco Control Law (COTPA) in the year 2003 and ratified the Framework Convention on Tobacco Control (FCTC) in 2004 as a commitment toward tobacco control. Subsequently the National Tobacco Control Program (NTCP) was started in 2006-07 to implement COTPA in letter and spirit. However, multiple issues infringe people implemention of the tobacco control policies and programs. In order to ensure effective implementation of the tobacco control policies Multi-Sectoral convergence is required. Let us explore the scope of Multi-Sectoral convergence for tobacco control in Indian context in this edition of Tobacco Free Times (TFT).

Tobacco use is one of the most complex issues of public health importance, with a profound impact on resources especially among poor, low-income and middle-income countries such as India, where tobacco use is high and the health inequalities are rampant. The complexity of this issue is attributed to the inter-relationship between the tobacco growers, processors, product manufacturers, transporters, traders, advertising agencies, users and the regulatory authorities like agriculture experts, governments, etc. While health sector attempts various modalities for tobacco control, tobacco industry people continue to adopt various measures for promotion of tobacco use, often with active support of sectors other than health. The lobbying by tobacco industry has resulted in conflict between objectives of different sectors connected with tobacco. Although, the argument of health sector regarding tobacco's role in increased morbidity and mortality is quietly accepted by all, but agricultural experts continue to advocate for improving the yield of tobacco and provide facilities to growers; commerce and trade sector continuously harps on the economic contribution by tobacco to the nation mass media does not wish to lose its earnings by banning tobacco advertisements; and educational institutions often express inability to provide wider coverage on tobacco education on account of already heavy curriculum. Clearly, the priority of different sectors is limited to the boundaries of their respective expertise. This highlights the need for action by engaging various sectors, which is even more important today when we are discussing "Tobaco Endgame" in the country. We cant achieve this ambitious goal without convergene of various setors within and outside health.

The potential of convergence as innovation in tobacco control

Convergence is the transformation and escalation of interactions among different disciplines, technologies, communities, and domains to achieve mutual compatibility and common goals. Most often, convergence is driven by societal values and needs for progress or improvement at community level. Tobacco control is a societal issue as it improve each one in the society.

Convergence in tobacco control arena requires branching out in unconventional and unexpected ways to add value to meet shared goals in a mutually serving tobacco control agenda. Here, we define convergence as, the bringing together of academic, public and private sectors, local and regional health authorities, and citizens to develop and implement massive innovative tobacco control initiatives within this ambit of their scope.

The overarching goal is to achieve economic productivity at individual and societal level, societal equity and sustainability, and empowerment of individuals and communities through tobacco control. Convergent approaches can bridge the disconnect that exists sometimes between various sections or departments by strategically disrupting existing conventional processes of working alone to joint investments and distribution of resources. Convergence can also stimulate methods to bypass the lack of a public health infrastructure and resoures in one sector from other sectors by pooling of resources for acting community organizations with interests in the community. Further, effective implementation of the FCTC requires multi-sectoral efforts through integration of tobacco control into broader health and development agendas such as food and water security, environment, the right to education and human rights. With limited resources, the convergence of different sectors alongside communities may be our best bet to hareness the tobacco control initiatives undertaken till date for achieving health and adopt sustainable development goals. Moreover, it involves multiple sectors and encourages participation and inclusiveness of various stakeholders. The global tobacco control community needs to explore innovative partnerships beyond its traditional confines and build a global coalition that supports tobacco control by partnering with others having convergent concerns on common determinants. A firm political commitment and inter-sectoral coordination between government and non-government agencies is paramount in order to implement effective tobacco control programs.

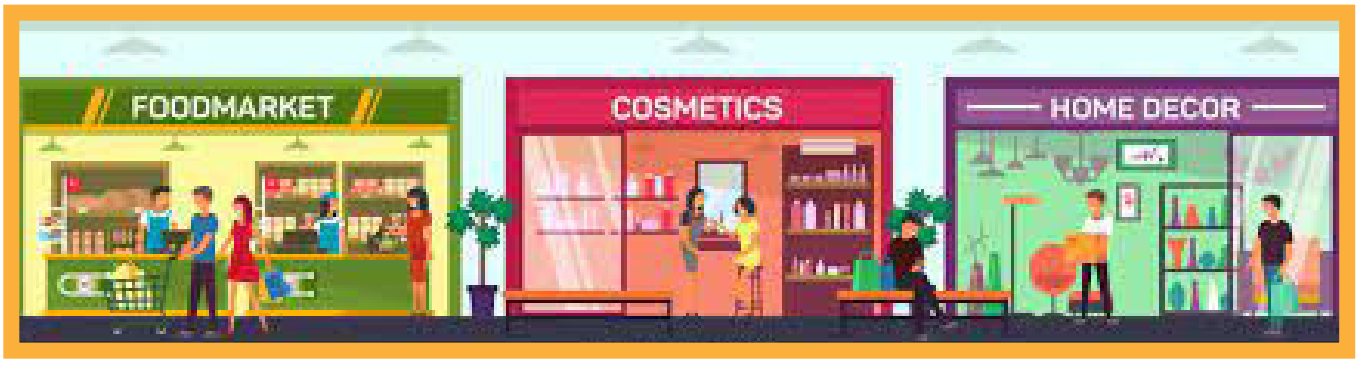
Multi-Sectoral Connections in Tobacco Control




Tobacco Industry





Tobacco Trade


Other Connected Industries

Role of Engagement of Health and various sectors to address the issue

The roles envisaged from various sectors in tobacco control are described below:

Engagement of Non-Health Stakeholders for effective Tobacco Control

Stakeholder	Rationale
Tax and Revenue	Raising taxes on tobacco products increases tax revenue while reducing the burden of tobacco. Raising tobacco taxes are the most effective and cost-effective measure for reducing tobacco use
Environment	Tobacco consumption and production cause severe and often irreversible damage to our national resources. One must consider the entire 'environmental life cycle' of tobacco production, which releases tons of waste and chemical into water, air and soil. Tobacco control limits environmental harm, while preserving our natural resources.
Agriculture	Tobacco growing is resource-intensive (and damaging). It harms the health of tobacco farmers while earning them low (or even no) profit. Supporting farmers in shifting to higher value crops or alternative economic activities improves health, increases farmer incomes, and contributes to the sustainability of national resources.
Employment (Labour market: public, private, incl. unions)	Tobacco products cause immense losses in productivity each year, incurred by workers and employers due to premature mortality, sick leave, smoke breaks, and low performance. Smoke-free workplaces and services to help smokers reduce and quit improve both health and productivity.
Communication (incl. private media, public service)	The tobacco industry employs predatory tactics, targeting vulnerable populations and distorting the facts in its marketing. The 'empowered' lifestyle tobacco proclaims to represent instead leads to death and disability. More communication tools should be made available to both counter the industry's tactics and to help tobacco-users quit.
Tourism, Food and Catering (incl. wholesale, retail, food and beverage industries)	Smoke-free restaurants and other areas accessible by the public are becoming the norm and it is a myth that implementing smoke-free laws reduces business and income from tourism.
Local Governments, Urban Planning (incl. transport)	Tobacco smoke pollutes air quality, reducing the safety of housing, workplaces, and public spaces. Local governments have an extremely impactful role to play: Smoke-free cities and increasing taxes are both effective and revenue-generating.
Education, Sports and Youth Affairs	Education is the top priority in protecting our children from the predatory marketing strategies of the tobacco industry. Tobacco use impairs learning and leads to early death in half of its users. Tobacco dependence is also the cause of many children not attending school. Educating children and families leads to better learning and health outcomes.
Social and Economic Development	Expenditures on tobacco products and tobacco-related diseases exacerbate poverty all over the world. Expenditure due to tobacco-use causes children to drop out of school and prevents productive employment, trapping many in a vicious cycle of poverty. Tobacco control measures, including access to cessation services, can mitigate the tobacco-poverty dynamic.
Gender and Family Welfare	The tobacco industry explicitly targets women, youth and LGBT and tobacco use is rising rapidly among women and girls. Women are disproportionately exposed to second-hand smoke which not only causes death and disability but can lead to pregnancy complications. Strengthened tobacco control can help close gaps in gender-related policies, programs and research.
Executive and Legislative Branches	The government is legally obligated to implement all WHO-FCTC provisions (if a Party to the treaty). Comprehensive implementation of tobacco control measures is effective in reducing the tobacco burden, but doing so requires strong support from the executive and legislative branches. Reducing tobacco-use increases productivity and saves tremendous costs.
Investment, Trade and Industry	Trade liberalization, foreign direct investment, and transnational tobacco advertising, marketing and promotion are spreading the tobacco epidemic.

Integrating Tobacco Control With Primary and Secondary Healthcare Programmes

As tobacco is a major risk factor all common Non communicable diseases (NCDs), integration of tobacco control with other national health programs will ensure optimal use of limited human and financial resources in the health systems of LMICs and provide frequent opportunities for intervention at the primary and secondary care levels, thus helping reduce the addiction, illness and death caused by tobacco use. Though a separate tobacco control programs at national level now exist in several countries, they are frequently isolated from other health service functions. Cessation services could have a greater reach into the community if they were incorporated into the country's primary healthcare services. When patients attend clinics for tuberculosis, reproductive and child health problems, NCDs, or even a dental check-up, for example, an enquiry about active or passive tobacco exposure by a doctor and brief advice to quit can increase the rates of tobacco cessation. However, until tobacco cessation advice is recognized as an important component of such services, these opportunities will be missed.

Conclusion: An Integrated Approach to Tobacco Control: A Mix of Challenges and Opportunities

An integrated comprehensive approach to tobacco control is need of the hour. However, it is a mixture of challenges and opportunities. Some of them are as under:

Cooperation from other sector NGOs and government departments, through raising concerns around deforestation, food security, water security etc caused by tobacco is necessary for bringing the focus of government in to the issue.

There is a need to engage professionals and volunteers alike from sectors other than health to intellectually engage with and operationally accommodate tobacco control in this propotions.

The tobacco control community and its philanthropic supporters must connect with the development community to exchange information and resources for winning war against tobacco industry.

Social activists across the globe can help with issues related to poverty alleviation and bridging inequity from tobacco and deal with various human rights violations in tobacco cultivation, manufacturing and use. Besides healthcare costs, productivity loss due to tobacco use is an area to be dealt in collaboration with developmental economists.

Inter-ministerial coordination is of paramount importance in effective implementation of various regulatory and fiscal measures. For example, taxation of tobacco products, which is an effective tobacco control policy, requires advocacy with and cooperation of the finance and commerce ministries.

Education ministries must recognize the important role of education in reducing tobacco use.

10 CHAPTER

TOBACCO FREE GENERATION

Tobacco Free Generation

What is tobacco free generation?

The Tobacco-Free Generation (TFG) proposal advocates a legislation which precludes the sale and supply of tobacco to individuals born after a certain year. The measure is aimed at substantiating existing tobacco control Act and overcoming defects with current youth access laws. TFG is designed to end the vicious cycle of experimentation, addiction, disease and death by phasing out sales of tobacco products to youth.

What is the need for tobacco free generation?

As per recently conducted GYTS-India 2019-2020, nearly one-fifth of students aged 13-15 years used any form of tobacco products in their life and almost 8.5% use tobacco currently. Further, median age of the initiation of cigarrete, bidi and smokeless tobacco was 11.5 years, 10.5 years and 9.9 years respectively. More than three fourth of tobacco users bought it from store/paan shop/ street vendors and half of them were not refused because of their age. This is despite the fact that four-fifth of schools were aware of tobacco control act and policy regarding display of "tobacco free schools" board. In United States, 9 out of 10 adults who smoke cigarette daily first try smoking by the age of 18 years and virtually everyday by 26 years. Therefore, preventing youth initiation is a key to end tobacco epidemic. Various studies have shown that the reduction in retail sales induced only by instrumental measures (such as from FCTC Article 16) reduces cigarette consumption but not initiation, because peer sharing of cigarettes continues despite packets being purchased less frequently. In recognizing both the difficulty of forcing tobacco addicts to quit along with importance of preventing initiation among teenagers, many jurisdictions have introduced restrictions on supply (including sale) of tobacco to those under a certain age. Although people in many countries adhere to these laws, evidence supporting their effectiveness is very limited. Furthermore, tobacco being a legal product is always available in the market encouraging youth access to it. There are two important drawbacks to an 'underage' restriction (i.e. 15-17 year olds) if done alone. First, it creates a "rite-of-passage" effect. The underage may proudly feel that by smoking they appear 18, which shall incite them to smoke at early age. Secondly, it has an adverse signaling effect which is why they might feel that if the government says that smoking is acceptable for an 18-year-old, then can it really be dangerous for a 16- or 17-year-old? Under the above typology, laws for underage restrictions of smoking attempt to rely upon the legal aspects of compliance, but overlook personal, social and environmental influences.

What is tobacco free generation proposal?

To avoid expecting existing smokers to quit and denying that smoking is acceptable from a particular age, the tobacco-free generation propose a future date/year (eg 1.1.2024) after which there are to be no new recipients of tobacco products to the person born on/ after certain date (eg. 1.1.2006).

For e.g. in a country with an existing under-18 law, a suitable effective date can be 1/1/2024. So, the people born on/after 1/1/2006 may not be able to purchase tobacco products. People born before the birth date are still able to be supplied with tobacco. For them, existing laws apply.

With the implementation of TFG, the age gap between teenagers and the visible tobacco users steadily widens over a period of time, which shall facilitate a favorable 'norm cascade' of gradually reduction of tobacco use prevalence among teenage cohorts. In this way, enforcement of existing laws becomes progressively easier and self enforcing as it shapes upon the norms of society. Thus, we shall gradually reduce the supply of all tobacco products to the individuals by the end of the century and it becomes a 'last century' phenomena.

What are the limitations of TFG?

Although, TFG is a widely accepted concept, there are few concerns for its effective implementation.

Retailer compliance: Retailers may feel threatened by the proposal as it may restrict their supplies and profits. Because retailers can be important enablers of the proposal's success, supporting policies should recognise their motivations like the retailers may be benefitted with some kind of compensation or making available emerging teenage products(clothing, IT, entertainment et) for not loosing their current customers. They should be provided with an adequate window to shift to the alternative livelihood for better adjustment and thus decreasing the sale of tobacco products.

Alternative Supply: One of the concern of TFG is regarding alternative supply of tobacco products to youth i.e. either parents, older siblings or older friends introduce tobacco consumption to the children. For this, these alternative suppliers should be educated and made aware about the tobacco addiction among children and keep the tobacco products out of reach from them.

We need to clarify the role of a "good parent" or a "good friend/ sibling' to them, similar to mandatory car seats for infant/young children.

Avoiding addiction from other sources: There is a concern about children who were denied tobacco products may take nicotine/tobacco from other sources like opium smoking etc. Thus government need to make stringent law for other alternatives like opium, herione (supply control, licensing control program) where it will become very difficult for young children to obtain it in the market.

Denial of Choice: The addictiveness of tobacco is important in relation to the issue of choice. The "free to choose" approach is unconvincing with a drug as highly addictive as tobacco and even more dubious when it is known that most smokers take this habit as teenagers and later want to quit which is very different. The change of choices in the children is the key towards tobacco free generation which can be achieved by making them aware about the ill and irreversible effects of tobacco consumption.

What is the status of tobacco free generation in the world?

1.Tobacco Free Generation Campaign: Balanga City, 2015

The Balanga city government initiated a "Tobacco-Free Generation" (TFG) campaign in 2015 with an aim to eliminate tobacco smoking among those born after the year 2000. Various programs were conducted under this campaign viz a programme to promote healthy lifestyles during adolescence, "Say no to Cigarettes" program to involve youth in promoting smoke-free homes by writing letters to relatives to encourage them to pledge to quit smoking. Also, the city council expanded the coverage of the smoking ban in the University Town to cover a further 3 km radius in 2016.

2. Tobacco-free generation proposal: Singapore, 2010

Singapore published the tobacco free generation proposal in 2010, suggesting that tobacco sales must be denied to a person below the age of 18 years or a citizen born on or after 1 January 2000. Since then, advocacy movements in Singapore have been working on the promotion of a positive social movement towards a tobacco-free generation, engaging children in the initiative and gaining public support.

3. Tobacco-Free Generation Bill: Tasmania,2014

The Public Health Amendment (Tobacco free Generation) Bill 2014 was tabled in the Tasmanian Parliament in November 2014. The Bill proposed to phase out the sale of tobacco products to any person born after the year 2000 and progressively reducing the availability of tobacco products in Tasmania.

4. Denmark Tobacco Free Generation: Action Plan, 2022

To achieve tobacco free generation, the Denmark government planned for a ban that prevents young people born in and after 2010 from buying cigarettes and other nicotine products. The government assured that they are ready to ban sale of these products to this generation by progressively raising the age limit. To do so, it will also promote the operations of smoking cessation centres and courses to help over 70% of smokers who want to adopt healthier lifestyles.

5. Tobacco Free Generation: WHO European Region

Various member states in WHO European region are moving towards becoming tobacco free, a smoking prevalence of 5% or less. Ireland and NewZealand aim to be tobacco free by 2025, UK (Scotland) by 2034 and Finland by 2040.

Tobacco denormalization in Ireland: 2019

Tobacco denormalizationin Ireland was started in 2019 with a aim to imply that smoking is not – and should not be – a normal activity in society. It is an important aspect of many tobacco-free initiatives, including those in Finland, Ireland and United Kingdom (Scotland). Making smoking less attractive to children and young people and increasing its social unacceptabilityare key elements in the denormalization of tobacco.

Scotland's tobacco-free generation: 2013

An ambitious target to achieve TFG by 2034 was proposed by Scotland in the year 2013. The aim of this plan is to protect children born since 2013 from indulging in tobacco practices so that when they start to turn 21 (from 2034), they will truly be tobacco-free and will come of age in a Scotland that will remain tobacco-free for generations. It means by 2034 less than 5% of adults will smoke.

Tobacco Free Generation: Finland, 2014

Finland was the first country to move from talking about tobacco control to using legislation to try to put an end to tobacco use. Its vision is for children and adolescents to grow up in a society where smoking is not part of the norm. The current goal is for 2% or less of the adult population to be smokers by 2040.

6. Tobacco Free Generation Plan: New Zealand, 2022

New Zealand has announced a suite of proposals aimed at outlawing smoking for the next generation and moving the country closer to its goal of being smoke-free by 2025. The plans include the gradual increase of the legal smoking age, which could extend to a ban on the sale of cigarettes and tobacco products to anyone born after 2004, making smoking effectively illegal for that generation.

7. Tobacco free generation strategy: Canada,2021

To achieve its stated goal of under five per cent prevalence by 2035, Canada has been a laggard with respect to raising age of purchase. Also, the national polls have consistently shown 70 to 80 per cent support for raising it. In addition to this, the government of Canada announced two important and potentially life-saving measures that would help protect young people from the harms of vaping in 2021 viz. the regulations of decreasing nicotine content and a ban on flavours with an exemption of mint, menthol and tobacco flavours which remains one of the most powerful marketing tools to attract young users.

Conclusions:

Tobacco smoking is and remains an important issue that affects children as a vast majority of children are also exposed to tobacco industry marketing. The existing underage restraints on tobacco access could partly achieve their objectives because of the rite-of-passage effect and adverse health signalling effect. These problems can be overcomed by the tobacco-free generation measure by ending the legal provision of tobacco products to the generations that have not yet commenced consumption. A better investment in children's health, which includes as an essential component for their complete protection from tobacco, is therefore key to a healthy, productive population. It is a surer path to the ultimate eradication of tobacco from the society as it laid on personal, social and environmental aspects(rather than merely on legal aspects) pertaining to future generations. So, it is the time to step up efforts to protect children from tobacco in view of a healthy, tobacco-free younger generation.

Check out some articles related to tobacco free generartion

Assessing how a tobacco-free campus leads to attitude change and support among students, faculty, and staff. ***Glasgow TE, Miller CA, Barsell DJ, Do EK, Fuemmeler BF. 2021. 2021.***

European progress in working towards a tobacco-free generation. ***Been JV, Laverty AA, Tsampi A, Filippidis FT. 2021. 2021, PubMed.***

The tobacco-free generation proposal. ***AJ., Berrick. 2013. 2013.***

Tobacco-free homes for tobacco-free generations: establishing positive smoke-free role models for youth. ***MS., Cattaruzza. 2015. 2015.***

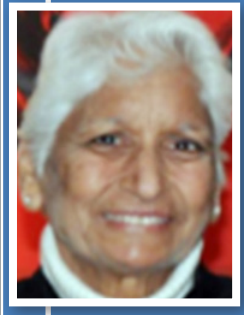
EXPERTS COMMENTS

In order to achieve tobacco free generation, we need to fix tobacco endgame timelines and targets. The roles and responsibilities of different stakeholders should also be defined. Working in collaborations and partnerships could help in achieving this target.

Dr Rana J Singh,
Deputy Regional Director, The Union SEA

There is a need to intervene for reduction in the pace of tobacco industry interference, which is, in fact, multiplying its efforts in luring the younger audience for tobacco use. The already existing policies viz. demand reduction, tobacco free youth, cessation services and supply side should be strengthened which will surely pave a road towards tobacco endgame.

Dr. P.C. Gupta,
Director, Healis Sekhsaria Institute for Public Health, Navi Mumbai



The approach towards tobacco control in the country should be changed. There is a need to involve and communicate with the young people while planning strategies and framing policies for tobacco control and thus determining the next course of action.

Dr. Mira B Aghi,
Behavioural Scientist and Communication Expert

Tobacco control professionals are going deeper in the area of tobacco control and "Tobacco Free Generation" is one of the steps to achieve it. Govt. of India is taking various initiatives to make India tobacco free by 2047. We should strategize and list the objectives for tobacco endgame, for which a collaborative work can be done.

Dr. L Swasticharan,
Addl DDG, Ministry of Health and Family Welfare, GOI

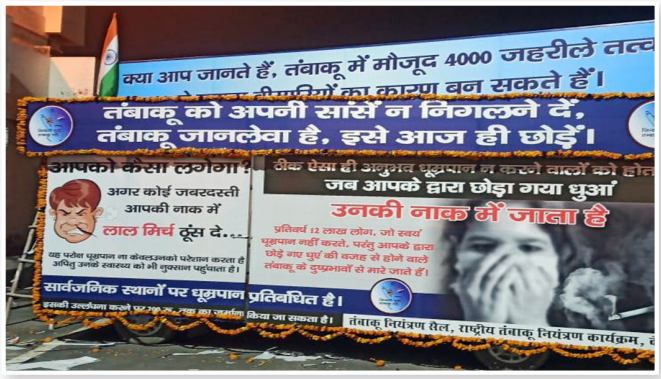
Glimpses of the state-wise activities

Covid vaccination camp was organised by the volunteers of Uttrakhand Tobacco free Coalition (UTFC) and BSS

NTCP IEC Hoardings in public and private schools: Kaithal

Signage campaign in Katni: Madhya Pradesh

Orientation of DSPs on Indian Tobacco Control Act-COTPA 2003: Madhya Pradesh



Anti-tobacco awareness on Republic Day Jhanki, Chattisgarh on 26th January,2022

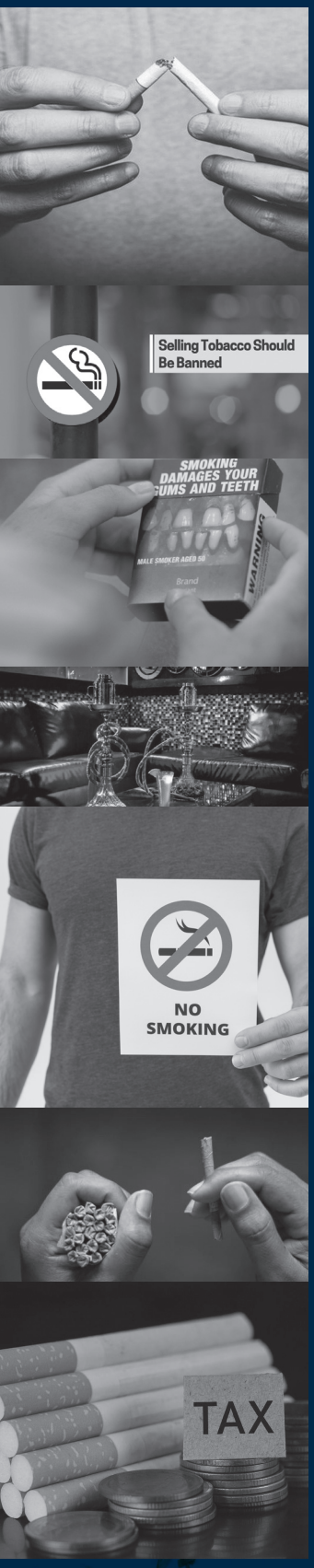
Signage campaign in Jabalpur: Madhya Pradesh

Reformation of policy on generating awareness on tobacco use. (amendment in COTPA, Chattisgarh

Tobacco Control Awareness Rath :Indore

Enforcement drive of the violations of COTPA: Maharashtra

DLCC meeting organized to implement 100 days plan for Tobacco Free Rajasthan Abhiyan: Ajmer



11 CHAPTER

TOBACCO FREE TIME – **PRICING AND TAXATION ON TOBACCO PRODUCTS IN INDIA**

Tobacco Free Time –Pricing and Taxation on Tobacco Products in India

Background

Tobacco taxation and pricing are important tools in reducing tobacco consumption and promoting public health. By increasing the cost of tobacco products, governments can discourage individuals from starting to smoke and encourage current smokers to quit. Studies have shown that higher tobacco taxes are associated with decreased smoking rates and improved health outcomes (1). Adam Smith, in his work "An Inquiry into the Nature and Causes of the Wealth of Nations" in 1776 argues that certain luxury goods, such as sugar, rum, and tobacco, are not necessary for survival and are consumed by a large portion of the population. Therefore, they are well-suited for higher taxation.

The reasoning behind this is that these goods do not contribute to the overall well-being and productivity of society, and instead impose negative externalities on society, such as increased healthcare costs due to tobacco-related illnesses. By taxing these goods, governments can raise revenue to fund public goods and services, and also discourage the consumption of these harmful goods. Additionally, by taxing tobacco, governments can reduce the number of deaths caused by smoking and the health care costs associated with it (2).

In addition to reducing consumption, tobacco taxation can also generate revenue for governments. This revenue can be used to fund public health programs, such as smoking cessation services and anti-smoking education campaigns. Additionally, by making tobacco products more expensive, governments can also decrease the financial burden on society caused by smoking-related illnesses. Overall, implementing effective tobacco taxation and pricing policies is a crucial step in creating a tobacco-free future.

Global experiences

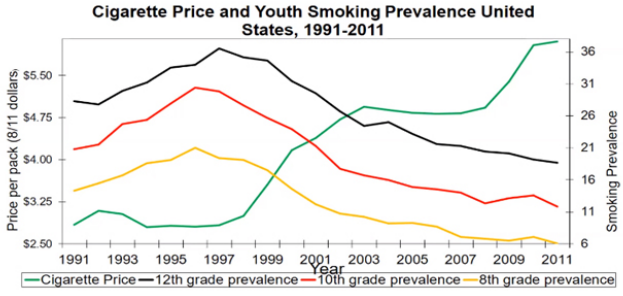
Tobacco taxation is a widely used policy tool for reducing tobacco consumption and promoting public health globally. Many countries around the world have implemented various forms of tobacco taxation, including excise taxes, value-added taxes, and specific taxes. Excise taxes are taxes imposed on a specific good, such as cigarettes, and are typically calculated as a percentage of the retail price. Value-added taxes (VATs) are taxes imposed on the value added to a good at each stage of production or distribution. Specific taxes are fixed amounts of tax imposed per unit of a good, such as per pack of cigarettes.

Retail price and tax incidence can vary significantly for smokeless tobacco products across different countries. In some countries, taxes on smokeless tobacco may be low or non-existent, which can result in lower retail prices for these products. In other countries, taxes on smokeless tobacco may be high, which can lead to higher retail prices for these products. In the European Union, for example, member states have the freedom to set their own excise tax rates on tobacco products, but there is a minimum excise tax rate set by EU law. This has resulted in significant price differences between member states, with some having much higher taxes than others. Spain has implemented various cigarette tax increases throughout the years, which have been associated with changes in the illegal cigarette market. From 1991 to 2008, the government of Spain increased cigarette taxes several times, which led to a significant increase in the retail price of cigarettes.

In Australia, the government has implemented a comprehensive tobacco control strategy, which includes high excise taxes and plain packaging requirements. As a result, Australia now has some of the highest cigarette prices in the world and one of the lowest smoking rates.

In Africa, the tobacco industry is one of the largest employers, making it difficult for governments to implement high taxes. Thus, many countries have relatively low taxes on tobacco products, making them more affordable and accessible to the population.
In the United States, cigarette prices have increased significantly due to various federal and state-level tax increases from 1991 to 2011. This led to a corresponding decrease in youth smoking prevalence.
In the United States, federal and state taxes on cigarettes vary widely, with some states having very low taxes while others have much higher taxes. The federal tax on cigarettes is currently $1.01 per pack.

Cigarette Price and Youth Smoking Prevalence United State, 1991-2011



Source: PowerPoint presentation from Dr. Rana J Singh, during National webinar on Pricing and taxation on tobacco products in India.

Overall, while tobacco taxation is a powerful tool for reducing consumption and promoting public health, its implementation and effectiveness can vary widely across countries depending on political, economic, and social contexts.

History of tobacco taxation in India

The history of tobacco taxation in India can be traced back to as early as 20th century when the British colonial government first imposed taxes on tobacco products as a source of revenue. These taxes were initially low and were primarily used to generate revenue for the government. In the post-independence era, the Indian government continued to impose taxes on tobacco products as a way to generate revenue. However, over time, the government began to recognize the negative health effects of tobacco use and the financial burden it placed on society. As a result, the government gradually increased taxes on tobacco products in order to discourage consumption.

In the 1990s, India began implementing more comprehensive tobacco control measures, including higher taxes on tobacco

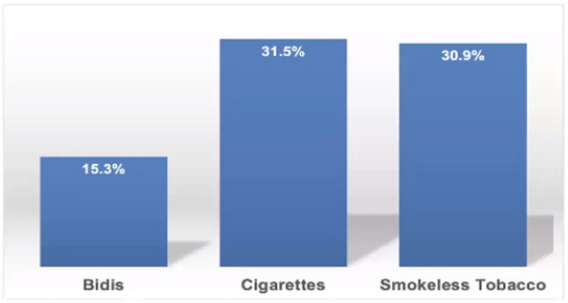
products. The government increased excise taxes on cigarettes and other tobacco products several times in the following decades.

The history of tax on bidis in India can be traced back to the early 20th century when bidis were first taxed at the state level. The taxes on bidis have traditionally been lower due to the fact that it is considered as poor men enjoyment. Also, taxing of it might affect the larger cottage industry in the country.

The scenario of tobacco taxation in India prior to the implementation of the Goods and Services Tax (GST) in 2017 was characterized by multiple taxes at both the central and state levels leading to variation in price of tobacco products across states.

Some of the key taxes included Excise Duty, Value Added Tax (VAT), and Additional Excise Duty (6). After the implementation of GST, the taxation of tobacco products in India has undergone significant changes. Under the GST regime, tobacco products fall under the highest tax bracket of 28% along with an additional cess. The cess on

Average VAT on Tobacco (FY 2015-16)



Source: John, RM et al. Estimated impact of the GST on tobacco products in India. Tobacco Control Vol. 28, 506–512 (2019)

tobacco products was introduced to compensate for any revenue loss to the states as a result of the implementation of GST. As of January 2023, the current GST rate on tobacco products in India is 28% + Rs. 5 per 1000 sticks of cigarettes (for cigarettes not exceeding 65 mm), and 28% + Rs. 1,591 per 1000 sticks of cigarettes (for cigarettes exceeding 65 mm) (7.8).

The taxation on smokeless tobacco (SLT) products follows a compounded levy system, also known as presumptive taxation. This system requires manufacturers to pay a fixed amount of duty per packing machine used in the production of SLT products such as chewing tobacco, pan masala, and gutkha. The amount of duty is determined based on the retail price of the pouches produced by the packing machine (9).

Three types of duties are imposed on SLT, including the Basic Excise Duty (BED), the Additional Duty of Excise, and the National Calamity Contingent Duty (NCCD). The NCCD was introduced in 2001 to provide financial resources for natural disasters and was set at a rate of 10% for chewing tobacco, pan masala, and snuff tobacco, without any changes from 2001 to 2013 (9). In 2005, the Government of India (GoI) also imposed a new duty called the health cess on pan masala and other tobacco products to provide financial resources for the National Rural Health Mission (9).

Tobacco taxes are relatively low, particularly for bidis. The average cost of a pack of bidis is just Rs 4, and taxes on bidis only account for 9% of the retail price. In contrast, taxes on cigarettes make up around 38% of the retail price, which is significantly lower than the

Central Excise Taxes on Tobacco Products

Products	2015-16	2016-17	Growth	2017-18	Growth
Cigarettes (per 100 Sticks)					
Non-filter ≤ 65 mm	1440	1585	10%	1681	6%
Non-filter 65 to 70 mm	2590	2850	10%	3021	6%
Filter ≤ 65 mm	1440	1585	10%	1681	6%
Filter 65 to 70 mm	1900	2090	10%	2216	6%
Filter 70 to 75 mm	2590	2850	10%	3021	6%
Other	3790	3790	10%	4421	6%
Bidis (Hand-made) (per 1000)	**16**	**16**	**0%**	**16**	**0%**
Chewing Tobacco/Zarda/Gutka	**86%**	**97%**	**12.8%**	**103%**	**6%**

*Constitute Basic excise duty, National Calamity Contingent Duty (NCCD), Health Cess, Bidi Welfare Cess.

Source: Union Budget Documents, various years

recommended rate of 65-80% suggested by the World Bank for countries with effective tobacco control policies. Additionally, taxes in India are complex and vary depending on the type of tobacco product. For example, cigarettes are taxed based on their length, and there are differential taxes on hand-rolled versus machine-rolled bidis, which contributes to the availability of cheap tobacco products. Furthermore, tobacco taxes in India are not regularly

Taxation of tobacco products in India- pre GST and post-GST (FY 2017-2018)

	Pre-GST structure		Post-GST Structure			
Tobacco Item	**Excise**	**VAT**	**GST**	**NCCD**	**Compensation cess**	
	INR/1000 sticks			INR/1000 sticks	Specific INR/1000 sticks	*Ad valorem*
Cigarettes (weighted average)	2504.1	31.54%	28%	116.2	2882.1	10.1%
Non-filter <65 mm	1681	31.54%	28%	90	2076	5%
Non-filter 65–70 mm	3021	31.54%	28%	145	3668	5%
Filter <65 mm	1681	31.54%	28%	90	2076	5%
Filter 65–70 mm	2216	31.54%	28%	90	2747	5%
Filter 70–75 mm	3021	31.54%	28%	145	3668	5%
Other	4421	31.54%	28%	235	4170	36%
Bidi (weighted average)	16.38	15.25%	28%	1.02	0	0
Machine-made	35	15.25%	28%	2	0	0
Hand-made	16	15.25%	28%	1	0	0
	103%	30.94%	28%	10%	0	104%

Excise duty pre-GST also includes the NCCD. Specific taxes (excise, compensation cess and NCCD) on cigarettes and *bidi* are per 1000 sticks. Average excise duties for cigarettes and *bidi* are weighted based on market share for different tiers while average VAT rates on all products are weighted based on states' consumption shares. The compensation cess on SLT is a simple average of the cesses for all chewing tobacco varieties under tariff item 2403 listed by the Central Board of Excise and Customs. VAT, GST and *ad-valorem* cesses are applied on pretax value added at each stage of the supply chain. US$1≈INR 68.
GST, goods and services tax; INR, Indian rupee; NCCD, National Calamity Contingent Duty; SLT, smokeless tobacco; VAT, value-added tax.

adjusted for inflation, which means that over time tobacco products are becoming increasingly affordable.

As of 2021, the excise tax on cigarettes ranges from Rs.2875 to Rs.4209 per thousand sticks. Value-added taxes (VAT) on tobacco products vary from state to state, with some states imposing higher rates than others. In addition, specific taxes are also imposed on certain tobacco products, such as gutkha and pan masala.

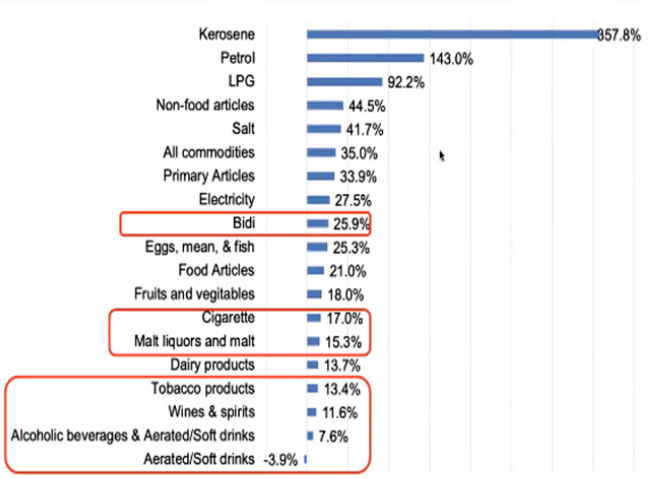
Current Tax Structure (FY 2021-22)

	GST	NCCD	Compensation Cess		Excise Tax (2019-20)
Cigarettes (length in mm)			Specific	*Ad Valorem*	
Non-Filter <65	28%	200	2076	5%	5
Non-Filter 65-70	28%	250	3668	5%	5
Filter <65	28%	440	2076	5%	5
Filter 65-70	28%	440	2747	5%	5
Filter 70-75	28%	545	3668	5%	5
Filter 75-85	28%	735	4170	36%	10
Other	28%	735	4170	36%	10
Bidis	28%	1.02	0	0	0.05
Smokeless Tobacco	28%	25%	0	104%	0.5%

Note: Values not in % are INR/1000 sticks of bidis/cigarettes.

Source: PowerPoint presentation from Dr. Rijo M John during National webinar on Pricing and taxation on tobacco products in India.

Inflation from the time of GST



Note: What is shown is the wholesale price inflation from the month of Jul 2017 to Jul 2022.
Source: Estimated using data from the Ministry of Commerce and Industry, GoI.

Impact of GST on Cigarettes across Indian states

	Pre-GST baseline (estimated): 2017–2018					Post-GST: 2017–2018	
States	VAT	Retail price (INR per pack of 25)	Tax burden	Quantity (million sticks)	VAT revenue (INR million)	% change in quantity	Change in SGST revenue compared with VAT (%)
All India	15.3%	15.00	16.0%	260000	20643	–10.1%	–
Rajasthan	65.0%	22.60	41.2%	16572	5902	25.3%	–74.9%
Jammu & Kashmir	40.0%	18.70	30.8%	1401	299	11.6%	–62.7%
Madhya Pradesh	37.0%	18.24	29.3%	9257	1824	9.6%	–60.3%
Assam	30.0%	17.18	25.5%	25271	4008	4.6%	–52.9%
Mizoram	30.0%	17.18	25.5%	18	3	4.6%	–52.9%
Meghalaya	27.0%	16.73	23.7%	977	139	2.3%	–48.7%
Gujarat	25.0%	16.44	22.5%	10982	1444	0.7%	–45.4%
Nagaland	25.0%	16.44	22.5%	231	30	0.7%	–45.4%
Goa	25.0%	16.44	22.5%	58	8	0.7%	–45.4%
Himachal Pradesh	22.0%	15.99	20.6%	2050	236	–1.8%	–39.3%
Arunachal Pradesh	20.0%	15.70	19.3%	358	37	–3.6%	–34.2%
Chandigarh	20.0%	15.70	19.3%	97	10	–3.6%	–34.2%
Delhi	20.0%	15.70	19.3%	3332	349	–3.6%	–34.2%
Tripura	14.5%	14.89	15.4%	2119	160	–8.7%	–13.6%
Kerala	14.5%	14.89	15.4%	3462	261	–8.7%	–13.6%
Tamil Nadu	14.5%	14.89	15.4%	13137	991	–8.7%	–13.6%
Punjab	14.3%	14.86	15.3%	2481	185	–8.9%	–12.6%
Manipur	13.5%	14.74	14.7%	212	15	–9.7%	–8.1%
Uttar Pradesh	13.5%	14.74	14.7%	51296	3599	–9.7%	–8.1%
Bihar	13.5%	14.74	14.7%	5329	374	–9.7%	–8.1%
Haryana	13.1%	14.69	14.4%	7174	489	–10.1%	–5.8%
Maharashtra	12.5%	14.60	13.9%	4313	280	–10.7%	–1.8%
Odisha	10.0%	14.24	12.0%	3053	158	–13.3%	19.6%
Uttarakhand	8.0%	13.95	10.3%	3562	147	–15.4%	46.0%
Chhattisgarh	5.0%	13.52	7.8%	1917	49	–18.8%	125.0%
Jharkhand	5.0%	13.52	7.8%	2165	56	–18.8%	125.0%
Andhra Pradesh	0.0%	12.81	3.2%	5010	0	–24.9%	–
Karnataka	0.0%	12.81	3.2%	8148	0	–24.9%	–
Sikkim	0.0%	12.81	3.2%	34	0	–24.9%	–
West Bengal	0.0%	12.81	3.2%	72725	0	–24.9%	–
Telangana	0.0%	12.81	3.2%	3257	0	–24.9%	–

States are sorted in decreasing order of percentage change in revenue of *bidi* under the GST. Aggregates for India are weighted averages based on states consumption shares.

Impact of GST on Bidi across Indian states

	Pre-GST baseline (estimated): 2017–2018					Post-GST: 2017–2018	
States	VAT	Retail price (INR per pack of 25)	Tax burden	Quantity (million sticks)	VAT revenue (INR million)	% change in quantity	Change in SGST revenue compared with VAT (%)
All India	15.3%	15.00	16.0%	260000	20643	–10.1%	–
Rajasthan	65.0%	22.60	41.2%	16572	5902	25.3%	–74.9%
Jammu & Kashmir	40.0%	18.70	30.8%	1401	299	11.6%	–62.7%
Madhya Pradesh	37.0%	18.24	29.3%	9257	1824	9.6%	–60.3%
Assam	30.0%	17.18	25.5%	25271	4008	4.6%	–52.9%
Mizoram	30.0%	17.18	25.5%	18	3	4.6%	–52.9%
Meghalaya	27.0%	16.73	23.7%	977	139	2.3%	–48.7%
Gujarat	25.0%	16.44	22.5%	10982	1444	0.7%	–45.4%
Nagaland	25.0%	16.44	22.5%	231	30	0.7%	–45.4%
Goa	25.0%	16.44	22.5%	58	8	0.7%	–45.4%
Himachal Pradesh	22.0%	15.99	20.6%	2050	236	–1.8%	–39.3%
Arunachal Pradesh	20.0%	15.70	19.3%	358	37	–3.6%	–34.2%
Chandigarh	20.0%	15.70	19.3%	97	10	–3.6%	–34.2%
Delhi	20.0%	15.70	19.3%	3332	349	–3.6%	–34.2%
Tripura	14.5%	14.89	15.4%	2119	160	–8.7%	–13.6%
Kerala	14.5%	14.89	15.4%	3462	261	–8.7%	–13.6%
Tamil Nadu	14.5%	14.89	15.4%	13137	991	–8.7%	–13.6%
Punjab	14.3%	14.86	15.3%	2481	185	–8.9%	–12.6%
Manipur	13.5%	14.74	14.7%	212	15	–9.7%	–8.1%
Uttar Pradesh	13.5%	14.74	14.7%	51296	3599	–9.7%	–8.1%
Bihar	13.5%	14.74	14.7%	5329	374	–9.7%	–8.1%
Haryana	13.1%	14.69	14.4%	7174	489	–10.1%	–5.8%
Maharashtra	12.5%	14.60	13.9%	4313	280	–10.7%	–1.8%
Odisha	10.0%	14.24	12.0%	3053	158	–13.3%	19.6%
Uttarakhand	8.0%	13.95	10.3%	3562	147	–15.4%	46.0%
Chhattisgarh	5.0%	13.52	7.8%	1917	49	–18.8%	125.0%
Jharkhand	5.0%	13.52	7.8%	2165	56	–18.8%	125.0%
Andhra Pradesh	0.0%	12.81	3.2%	5010	0	–24.9%	–
Karnataka	0.0%	12.81	3.2%	8148	0	–24.9%	–
Sikkim	0.0%	12.81	3.2%	34	0	–24.9%	–
West Bengal	0.0%	12.81	3.2%	72725	0	–24.9%	–
Telangana	0.0%	12.81	3.2%	3257	0	–24.9%	–

States are sorted in decreasing order of percentage change in revenue of *bidi* under the GST. Aggregates for India are weighted averages based on states consumption shares.

Source: PowerPoint presentation from Dr. Rijo M John during National webinar on Pricing and taxation on tobacco products in India.

Impact of GST on Smokeless Tobacco across Indian states

	Pre-GST baseline (estimated): 2017–2018					Post-GST: 2017–2018	
States	VAT	Retail price (INR per pouch of 10 g)	Tax burden	Quantity (million 10 g pouch)	VAT revenue (INR million)	Change in quantity (%)	Change in SGST revenue compared with VAT (%)
All India	30.9%	11.50	57.1%	11440	31086	–6.0%	–
Madhya Pradesh	52.0%	13.64	62.4%	879	4102	9.3%	–82.8%
Rajasthan	45.0%	12.92	60.8%	415	1663	4.9%	–80.7%
Uttar Pradesh	41.0%	12.51	59.9%	2469	8982	2.2%	–79.3%
Jammu & Kashmir	40.0%	12.41	59.6%	23	82	1.5%	–78.9%
Himachal Pradesh	36.0%	12.01	58.5%	10	31	–1.4%	–77.2%
West Bengal	35.0%	11.91	58.3%	837	2585	–2.2%	–76.7%
Jharkhand	32.0%	11.61	57.4%	492	1383	–4.5%	–75.0%
Mizoram	30.0%	11.41	56.8%	16	42	–6.1%	–73.7%
Tamil Nadu	30.0%	11.41	56.8%	355	934	–6.1%	–73.7%
Gujarat	25.0%	10.91	55.3%	527	1150	–10.4%	–69.8%
Maharashtra	25.0%	10.91	55.3%	1273	2778	–10.4%	–69.8%
Nagaland	25.0%	10.91	55.3%	34	74	–10.4%	–69.8%
Odisha	25.0%	10.91	55.3%	801	1748	–10.4%	–69.8%
Tripura	25.0%	10.91	55.3%	81	176	–10.4%	–69.8%
Kerala	22.5%	10.66	54.5%	84	164	–12.7%	–67.2%
Sikkim	22.0%	10.62	54.3%	3	5	–13.1%	–66.6%
Chhattisgarh	21.5%	10.57	54.1%	399	745	–13.6%	–66.0%
Haryana	21.0%	10.52	54.0%	73	133	–14.1%	–65.3%
Arunachal Pradesh	20.0%	10.42	53.6%	24	41	–15.0%	–64.0%
Delhi	20.0%	10.42	53.6%	75	130	–15.0%	–64.0%
Telangana	20.0%	10.42	53.6%	162	282	–15.0%	–64.0%
Andhra Pradesh	20.0%	10.42	53.6%	162	281	–15.0%	–64.0%
Assam	20.0%	10.42	53.6%	560	973	–15.0%	–64.0%
Bihar	20.0%	10.42	53.6%	981	1703	–15.0%	–64.0%
Chandigarh	20.0%	10.42	53.6%	3	6	–15.0%	–64.0%
Meghalaya	20.0%	10.42	53.6%	25	43	–15.0%	–64.0%
Uttarakhand	20.0%	10.42	53.6%	56	96	–15.0%	–64.0%
Karnataka	17.0%	10.13	52.6%	456	670	–18.0%	–59.0%
Punjab	14.3%	9.87	51.5%	103	128	–20.8%	–52.8%
Manipur	13.5%	9.79	51.2%	61	71	–21.7%	–50.5%

States are sorted in decreasing order of percentage change in revenue of SLT under the GST. Aggregates for India are weighted averages based on states SLT prevalence shares.

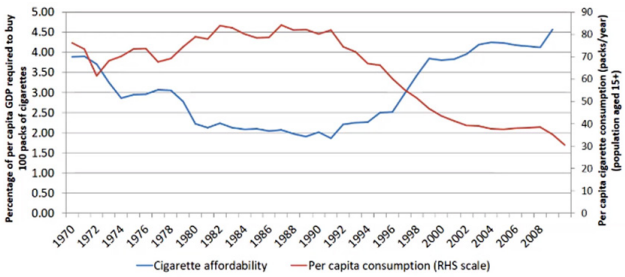
In recent years, the Indian government has been facing pressure from public health advocates to increase taxes on tobacco products in order to reduce consumption and improve public health.

However, the government has been hesitant to do so due to concerns about the impact on revenue and employment.

Roadmap of Tobacco Taxation in India - Challenges, Gaps, and Recommendations for the achievement of Tobacco Endgame

The roadmap for tobacco taxation in India to achieve the tobacco endgame (a world with minimal or no harm caused by tobacco) would need to address several challenges and gaps in the current system. One major challenge is easy affordability of tobacco products, which makes them accessible to a large population, despite the taxes imposed on them. To address this, the government would need to significantly increase taxes on tobacco products to make them less affordable and reduce consumption.

A very close relationship between cigarette consumption and affordability (r=0.98)



Source: PowerPoint presentation from Dr. Rijo M John during National webinar on Pricing and taxation on tobacco products in India.

Another challenge is the strong lobbying efforts of the tobacco industry, which often opposes higher taxes on their products. The government would need to take a strong stance against these efforts and put the health of the population first. Another gap in the current system is the lack of effective enforcement of existing laws and regulations on tobacco taxes. To address this, the government would need to improve its enforcement mechanisms and ensure that all tobacco products are properly taxed and labeled.

The operational recommendations for having taxation on Tobacco products and strengthening tobacco control activities in India are:

- Implementation of uniform taxation rate across all tobacco products, regardless of their length or type (Filtered or Non-Filtered, etc).
- Tax rate on tobacco products should be linked to inflation. (It should be at least some percentage higher than inflation to decrease affordability).
- The tax rate on all tobacco products should be increased as per the recommendation of WHO (at least, 75% of the retail price of tobacco products) since it has not changed in the last five years.
- Compensation tax should be introduced on tobacco products in addition to Natural Calamity Contingent Duty (NCCD), which should also be increased.
- Implementing taxation at every stage of the tobacco supply chain, from manufacture to sale.
- Sufficient evidence should be generated on the taxation of tobacco products and linking it with diverse areas of public health.
- Exemption, subsidy, or incentives should not be provided to small companies or cottage industries.

Conclusion

Tobacco taxation is a powerful tool for reducing tobacco consumption and promoting public health. In India, the history of tobacco taxation has been marked by a gradual shift from using taxes primarily as a source of revenue to using them as a tool for promoting public health. However, the current scenario of tobacco taxation in India is challenging, with tobacco products remaining relatively affordable and accessible to a large population.

To achieve the tobacco endgame in India, the government would need to address several challenges and gaps in the current system, such as reducing the affordability of tobacco products to the general population, counter-lobbying efforts of the tobacco industry, improving enforcement mechanisms, and strengthening public education by improving increasing taxes on tobacco products in line with the World Health Organization (WHO) guidelines.

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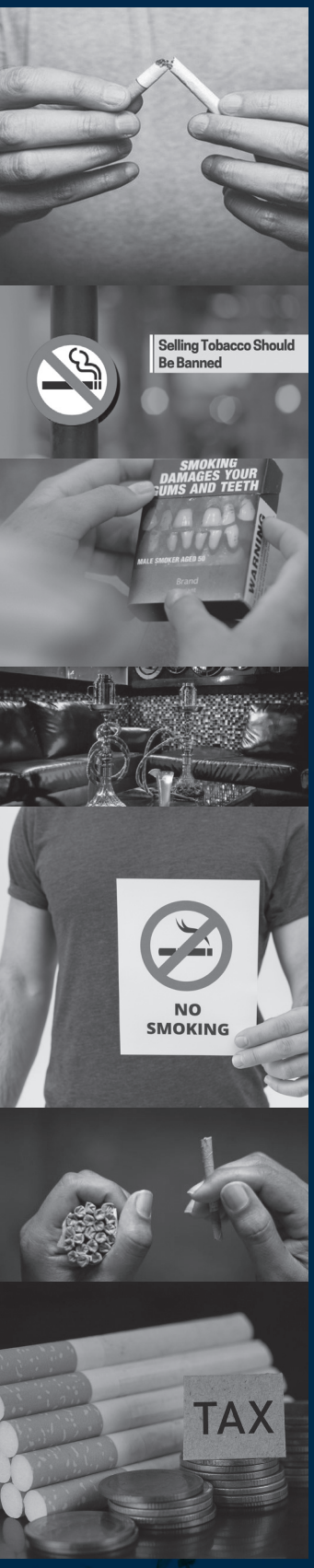


12 CHAPTER

TOBACCO PRODUCT WASTE (TPW)

TOBACCO PRODUCT WASTE (TPW)

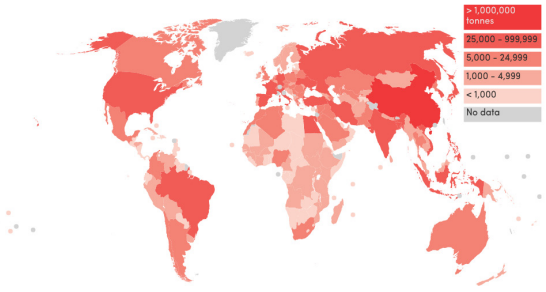
Q1. What is tobacco product waste (TPW)?

The waste generated during tobacco production (pesticides, fungicides,growth regulators), tobacco products manufacturing (nicotine and harmful chemicals), packaging (paper, ink, cellophane, foil and glue) and after consumption constitutes tobacco product waste (TPW). Cigarette butts (30-40%) is the most common form of litter with non-biodegradable cellulose acetate filter attached to most manufactured cigarettes as the main component of cigarette butt waste (arsenic, lead, nicotine and ethyl phenol).In addition, batteries, chemicals, packaging and other non-biodegradable materials of electronic cigarettes also constitutes to TPW resulting extensive consequences for the environment, climate, and human population.[1–3] Besides, polythene pouches used for smokeless tobacco products also constitutes TPW.

Q2. What is the burden of TPW?

As many as 5.6 trillion cigarettes are discarded as litter each year, comprising up to 770,000 metric tons of waste.98 percent of cigarette filters are made of plastic fibers (cellulose acetate) that are tightly packed together, which leads to an estimated 1.69 billion pounds of cigarette butts winding up as toxic trash each year.Besides cigarettes, other tobacco products make significant contributions to the prevalence of tobacco-associated litter. Plastic cigar tips, which are most commonly used with cigarillos and small cigars, are one of the most abundant items of plastic marine debris on beaches around the world, sometimes second in quantity only to cigarette butts.[4,5]In India, 15,000 tonnes of plastic waste is generated daily from smokeless tobacco products of which only 9,000 tonnes is collected and processed.[6]

Cigarette Butt and Packaging Waste By Tonne



Q3. How long does it take for cigarettes to decompose?

Although cigarettes don't break down naturally, they can gradually decompose depending on environmental conditions like the rain and sun. Estimates on the time it takes vary, but a recent study found that a cigarette butt was only about 38 percent decomposed after two years.[7] Littered plastic pouches of smokeless tobacco pose an environmental threat and take up about 1000 years to decompose in the landfills.

Q4. What are the various constituents of TPW?

There are 7000 chemicals contained in cigarettes TPW, and many of them, such as ethyl phenol, heavy metals and nicotine, are themselves toxic. At least 50 are known human carcinogens.Some polyaromatic hydrocarbons in roadside cigarette butt waste and roadside soil are:[8]

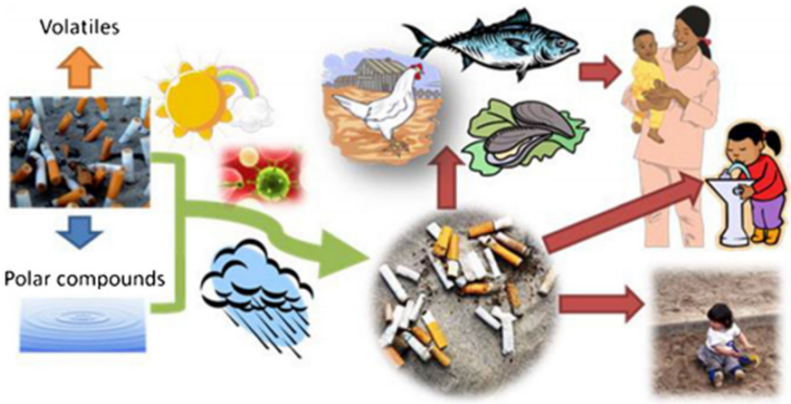
PAHs	Concentration (mg/kg wet)		Load potential (mg/km/month)[1]
	Cigarette butts	Roadside soil	
Fluorene	0.028	0.01	0.0023
Phenanthrene	0.078	0.14	0.0063
Anthracene	0.071	0.0058	0.00057
Pyrene	0.091	0.36	0.0074
Benzo(*a*)anthracene	0.026	0.084	0.0021
Chrysene	0.044	0.11	0.0035
Benzo(*b*)fluoranthene	0.031	0.088	0.0025
Benzo(*k*)fluoranthene	0.015	0.055	0.0012
Benzo(*a*)pyrene	0.031	0.12	0.0025
Dibenzo(*a,h*)anthracene	0.0065	0.016	0.00053
Benzo(*g,h,i*)perylene	0.031	0.093	0.0025
Total	0.39	1.1	0.032

Dangerous pesticides that are used during agricultural production of tobacco have devastating effects too. Some of them are:[6]

Pesticides	Effects
Aldicarb	Affects brain, immune and reproductive system in animals and humans, highly toxic even in low doses.
Chlorpyrifos	Affects brain and respiratory system at high doses; found widely in soil,water, air and food.
1,3-Dichloropropene	Highly toxic effects on skin,eye,respiratory and reproductive system; probable cancer causing agent in humans.
Imidacloprid	Affects brain and respiratory system; highly toxic to bees.
Chloropicrin	Lung-damaging agent, high-level exposures cause vomiting, toxic to fish and other organisms.
Methyl Bromide	Affects skin, eye, brain and respiratory system, may cause fluid in lungs, headaches, tremors, paralysis and convulsions.

Q5. What is the possible pathway for human health risks due to TPW?

The pollutant from TPW is transferred by deposition on land and water bodies followed by runoff to surface water that provides drinking water. It could also be transferred by deposition to vegetation that feeds humans or to vegetation that feeds the animals that supply meat and milk to troops.Toxic chemicals are leached from discarded tobacco products and may then contaminate our streams, rivers, beaches, and urban environments. Each of these scenarios also defines a pathway through the air emission of TPW.[2]



Q6. What is the Indian scenario of tobacco product waste?

More than 100 billion cigarette butts are being dumped in India every year. The public discourse in India on the health impacts of tobacco use along with the discussions on its effect on environment has been scanty. Fortunately, India has taken up the legislative strategy of refraining smokeless tobacco manufacturers from using plastic materials in the sachets of gutkha and pan masala under the Plastic Waste Management Rules, 2016. However, until recently cigarette butts escaped any such regulations. Moreover, cigarette/bidi butts has been termed 'biodegradable' by Ministry of Environment and Forests Recognizing the health hazard posed by non-biodegradable cigarette/bidi butts, the environmental experts in the country contended for the stricter implementation of laws on public smoking and an appropriate system in place for the management of TPW. In addition, Swachh Bharat Abhiyan or Clean India Mission was launched on 2nd October 2019 which follows '3R's i.e. Reduce waste (by refusing unnecessary packaging), Reuse and Recycle is a viable option for the management of tobacco product waste. Besides, some legislations have been passed in our country so far to tackle tobacco product waste to an extent. Some of these are:

- The Rajasthan High Court applied 'polluter pays' principle on the gutka manufacturer being responsible for creating plastic waste and imposed exemplary damages while restrained the manufacturers of gutkaand and pan masala from selling their products in plastic sachets. The direction from the Apex Court in this matter resulted in changing of the plastic waste management and handling regulation which banned the storing, packing or selling of gutka, tobacco and pan masala in plastic sachets which resulted in restriction on the use of plastics for packaging of gutka, tobacco and pan masala.
- The following laws/legislations bans the use of plastic for the packaging of tobacco products:
  - Rules 2(2) and 4(f) and (i) of the Plastic Waste Management Rules, 2016
  - Sections 6, 8 and 25 of the Environment (Protection) Act, 1986
- The following laws/legislations bans the spitting and littering of tobacco products in public places:
  - Section 133 of the CrPC
  - Sections 268 and 269 of IPC,
  - Swachh Bharat Abhiyan (Clean India Mission)

Q7.What is the global scenario of tobacco product waste?

Cigarette butts are dropped on sidewalks in urban neighborhoods, in parks, beaches, and flicked from movingcars. Cigarette butts are the most common debris item collected from beaches and waterways during the annual International Coastal Cleanups, a status that has been maintained since 1986 (Novotny, 2009). In the United States, an estimated 326.6 billion cigarettes were sold in 2011 (CDC, 2012), and in California, approximately 2 billion cigarettes were sold in that year. It is estimated that 1 in every 3 smoked cigarette are discarded as environmental waste. Discarded cigarette butts have been linked to wildfires, which result in the destruction of wildlife, vegetation and structures (National Fire Protection Agency, 2010).[9]

Q8.What are the harmful effects of tobacco product waste?

Cigarette butts contain all the carcinogens, heavy metals, pesticides, and nicotine that make tobacco use the leading cause of preventable death worldwide (Moerman, 2011, Sheets, 1991, Hoffman, 1997).

Some of the harmful effects of TPW are summarized as under

Agricultural Chemicals	The harmful chemicals in tobacco leaf are transferred to cigarette smoke, they are retained by the cigarette filters and tobacco remnants in cigarette butts which have the tendency to bio-accumulate in the human food chain.
Effect on marine/ aquatic life	Numerous chemicals from tobacco leaf such as heavy metals, nicotine and ethylphenol get into water and contaminate aquatic environments. The toxic exposure can poison fish, as well as animals who eat cigarette butts.
Effect on animals	Animals indiscriminate eaters, and ingested plastic trash, including cigarette butts, can choke an animal or poison it with toxins and leads subsequent under-nutrition.
Effect due to nicotine presence	These may represent a wide variety of symptoms including nausea, vomiting, salivation and diaphoresis; with severe poisoning, there may be convulsions, bradycardia with hypotension, cardiac arrhythmias and respiratory depression.
Effect on children	Children often explore their environment through oral contact or through mimicry of adult behaviours. It causes nausea and vomiting in low doses, and more extensive neurological symptoms with higher doses.
Effect on birds	Curious birds ingests cigarette butts left in household ashtrays and this ingestion can cause excessive salivation, excitement, tremors, vomiting, lack of coordination, weakness, convulsions, respiratory failure and even death

Q9. What are the environmental principles applicable to TPW management?

Extended Producer Responsibility Principle (EPR) and Product stewardship (PS): Thomas Lindhqvist, Senior Lecturer, The International Institute for Industrial Environment Economics, defined EPR as an environmental policy protection strategy to reach an environmental objective of a decreased total environmental impact from a product, by making the manufacturer of the product responsible for the entire life-cycle of the product and especially for take-back, recycling and final disposal of the product. PS contrasts with EPR in that PS may involve other actors along the supply and retail chain, whereas EPR focuses all the responsibility for waste management onto manufacturers.

Polluter Pays Principle (PPP): Asframed, the PPP meant that the polluter should bear the expenses of carrying out pollution prevention and control measures decided by public authorities to ensure that the environment is in an acceptable state.

Precautionary Principle: The Precautionary Principle is based on the caution that governs many aspects of daily life, and responds to the complexity of environmental risks to health and the often indeterminate nature of cause-and-effect relationships between potentially hazardous waste products and health effects. This principle calls for preventive, anticipatory measures to be taken when an activity raises threats of harm to the environment, wildlife, or human health, even if cause-and-effect relationships are not fully established.[8]

Q10. What are the initiatives (best practices) taken by various stakeholders to curb TPW?

Several initiatives have been set forth to fight the crusade against TPW in various parts of the world.

1. Swachh Association

Swachh Association, an NGO in Nagpur, India started in December 2019, as an innovative project of collecting and recycling the cigarette butts. About 150 kg of cigarette butts have in been collected per month in the past three months as a part of this campaign

2. CODE- A recycling company

A company named 'CODE' was started by two entrepreneurs Naman Gupta and Vishal Kanet in Noida, India which offers a one-time recycling solution to TPW. The company provides user collection units called VBins to the customers in which the cigarette waste is segregated. After every 15 days the company's garbage collector collects the waste from the generator's location. The company pays Rs. 700 for every kilogram and Rs. 80 for every 100 grams of cigarette waste collected.

3. Anti-Littering Campaign

To mark World Cleanup Day 2019, over 3,900 people from 31 countries took part and picked up 83 tons of waste, including 827,000 cigarette butts. These cleanups had a powerful impact on the communities where they took place, and that is why it has been included as a part of the "Reduce Litter from the Ground" anti-littering strategy

4. 'The only butt' campaign

The 'only butt campaign' has been successfully used by businesses, government departments and since 2004 in Australia to educate smokers about the problem of cigarette butt litter – with sensational results.

When combined with an appropriate photo, 'the only butt' campaign encourages smokers to consider their cigarette butt litter in the context of the organisation's specific situation. To aximize their smokers interest in their organisation's efforts to reduce cigarette butt litter many of our clients actually run intra-corporate competitions amongst their staff and employees for them to submit their own 'butt' photos.

5. Let's Do It India (LDII) Campaign

'Let's Do It India', a Delhi based NGO is working towards educating people on this kind of waste and also encourages people to collect and donate their cigarette butts to the organization for recycle purposes The NGO targets to collect about 1 crore cigarette-butts (3 tonnesapprox) until the end of 2021. The campaign aims to stir awareness around the severe environmental impact of cigarette butts while shifting behaviours to regulate butt litter

6. Fill the Bottle Campaign

'Fill the Bottle Campaign'launched in August 2019 by a group of French teenagers to clean the cigarette butts flicked into drains, mashed under foot or dropped in parks .The campaign has inspired thousands to clean up what is thought to be the most common form of litter around the globe.

7. Bin The Butt Campaign

The 'Bin The Butt' campaignis being developed in UK for local authorities, to help stamp out the smoking related litter issue and aims to raise awareness amongst smokers and highlight the link between the cigarette butt they drop on the street or down the drain and the impact it has on the marine environment.

Q11. What are the various models proposed by the stakeholders on TPW ?

The imperishable nature of TPW renders it a potential hazard for the environment and therefore requires appropriate policy interventions.

Following models have been proposed by the stakeholders for possible action on TPW:

Labeling: There is enough evidence stating the effectiveness of package warning on tobacco products. Additional labels on the toxicity of the cigarette butts on the environment should be considered.

Deposit/Return: Several US states have implemented deposit-return schemes on glass and metal beverage containers wherein a consumer-paid monetary deposit is imposed, which is reimbursed on return of these items. This system has proven effective in reducing the litter and increasing the recycle of goods. A similar system could be put into place for the management of TPW.

Litigations: Litigations can be filed by the state or local authorities against the tobacco industry; holding them responsiblefor cleanup and nuisance costs associated with tobaccoproducts.

Fines: Fines can be levied against the tobacco users and the manufacturers by the government authorities for public littering of TPW.

Product changes: States could consider banningthe sale of filtered cigarettes if these were to be consideredan environmental hazard and nuisance burden.All tobacco product packaging should be environment friendly and made of bio-degradable materialse.g. paper, other natural fibres or metals such as tin.

Consumer education and responsibility: It is an accepted notion in health behavior science that human behavior changes only if there are costs, benefits, and social norms to support these changes. Tobacco control enthusiasts and environmentalists should join hands for educating the public on the hazardous impact of TPW on the environment.

Cost recovery/Waste tax: Tobacco litter abatement costs to cities are substantial. One solution to reducing toxic waste from computers, telephones, and televisions is a consumer-funded Advanced Recycling Fee (ARF) which is assessed at the time of purchase for these products and it is meant to pay for the costs of recycling and disposingproperly of any non-recyclable material. San Francisco has implemented this intervention by raising the price by approximately $0.20–$0.40 per pack. Such a price hike would also result in reduced consumption.

Mitigation Fees: Some governments impose mitigation fees to offset costs they incur to deal with improperly disposedcigarettebutts.These costs cover services such as litter collection and disposal, public education, signage, and administration of the self-funding program. A mitigation fee is also likely to result indirectly in an increase in cigarette prices.

Deposit and Refund Programs: A deposit and refund program requires that consumers pay an extra fee when purchasing cigarettes. Consumers then recoup the fee by returning used filters to the manufacturer or place of purchase. Unreimbursed deposits can be used to fund cigarette butt waste cleanups, public education programs about the negative consequences of smoking and butt flicking.

Biodegradable Filters or Unfiltered Cigarettes: Some companies have developed biodegradable and compostable cigarette filters using natural fibers like hemp, cotton, and food-grade starch. These alternative filters are intended to help reduce environmental pollution from cigarette butts, since they decompose more quickly in the environment, as well as in smokers' lungs.

Product Stewardship: The product stewardship approach requires that a manufacturing industry assume responsibility for the entire lifecycle of its products.

Filter Recycling: Several programs and processes have been developed to recycle used filters into useful materials, such as sealants or adhesives, with the goal of keeping cigarette butts out of landfills and off streets and beaches.

NATIONAL CONSULTATION (VIRTUAL) ON TOBACCO PRODUCT WASTE AND ITS HEALTH AND ENVIRONMENTAL IMPACT

A national consultation on tobacco product waste (TPW) & its health and environmental impact was virtually organized by E-Resource Centre for Tobacco Control (E-RCTC), Department of Community Medicine & School of Public Health, PGIMER Chandigarh In collaboration with Strategic Institute of Public Health Education and Research (SIPHER) and The International Union Against Tuberculosis and Lung Disease (The Union) South-East Asia Office, New Delhi on 1st November 2020.

Mr. C. D. Singh, IFS, Addl. Principal Conservator of Forests (C), Ministry of Environment, Forest and Climate Change, Regional Office (NZ) Chandigarh was the Guest of Honour at the consultation that was attended by experts from The Union South East Asia, International Forum for Environment Sustainability and Technology (iFOREST), WHO Regional Office for South-East Asia, Tata Memorial Hospital, Mumbai, Healis Sekhsaria Institute of Public Health, Mumbai, Rajasthan Cancer Foundation, Jaipur, Department of Community Medicine & School of Public Health, PGIMER, Chandigarh and Strategic Institute of Public Health Education & Research (SIPHER), Chandigarh. In addition, more than 50 other experts and participants joined the consultation and gave their inputs through various online platforms.

EXPERTS COMMENTS

"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 and more than 1.25 million per year in India."

- Dr. Rakesh Gupta
President & Director of Public Health, SIPHER

"Cigarette filters are made of cellulose acetate, which is a nearly non-biodegradable plastic that collects chemicals that are produced by smoking. This plastic component of filtered cigarettes may not degrade in the environment for many years."

- Dr. Rana J Singh
Deputy Regional Director, The Union - South East Asia

"The Government is in process to develop guidelines for cigarette butt disposal by December. The country has done tremendous work on the health aspect of tobacco; however, the environmental aspect is yet to be worked on."

- Chandra Bhushan
Environmentalist and CEO iFORESTS

"Tobacco product waste (TPW) has received little attention despite post-consumption litter produced by the approximately 6.3 trillion cigarettes smoked globally every year."

- Dr. Sonu Goel
Director E-RCTC & Professor, PGIMER Chandigarh

"Tobacco not only kills 13.5 lac Indians who consume it but also kills many more millions by adversely impact our environment. Tobacco users should be conscious that they are patronizing an Industry that will not only kill them but also causing humongous damage to our nature endangering all living species and polluting air/water/soil. One tree is cut for every 300 cigarette sticks."

- Prof. Dr. Pankaj Chaturvedi
Deputy Director, Center for Cancer Epidemiology, Tata Memorial Center, Mumbai

The Consultation ended with following recommendations:

RELATED TO MINISTRY OF ENVIRONMENT AND FORESTS
TO BE IMPLEMENTED BY CPCB:

Appropriate amends may be made in rules for implementation of Pollution Control Act

1. Cigarette butts, which primarily contain cellulose acetate (95%), a redundant addition to cigarettes should be banned to be used in manufacturing of cigarettes.
2. All tobacco product packaging should be environment friendly and made of bio-degradable materials e.g. paper, other natural fibres or metals such as tin.
3. The central pollution control board should classify tobacco product wastes including spitting induced from tobacco use as toxic waste and issue regulations for its proper collection, management and disposal.
4. The CPCB should ensure proper disposal of TPW and impose hefty penalty for littering of TPW.
5. Regulations should also require that all tobacco products pack should be labeled that they comply with and have paid for waste collection, management and disposal.
6. Extended Producer Responsibility should be imposed on the manufacturers of all tobacco products who shall be responsible for collection, transport, processing and safe disposal of their TPW i.e. for the entire lifecycle of the products they produce.

NATIONAL PROGRAMME ON CLEANLINESS
National missions on cleanliness like Swacch Bharat Mission and the Swachh-Nirmal Tat Mission should

RELATED TO MINISTRY OF HEALTH & FAMILY WELFARE

1. Regulation under the COTPA, 2003:
All the provisions of COTPA should be implemented strictly by all stakeholders departments including those related to TPW in compliance to WHO FCTC treaty signed by Govt. of India.

2. National Tobacco Control Programme (NTCP)
State level coordination committee under NTCP, should include a member from the state pollution control board to guide about the collection, management and disposal of TPW.

RELATED TO DEPT. OF LOCAL GOVERNMENT (REGULATION BY MUNICIPAL, PANCHAYAT AND LOCAL BODIES)

1. Onus of compliance with the provision should be placed equally on the manufacturers, distributors, retailers and the users. They should be required by the municipal authorities to pay for the cleaning, recycling and tobacco litter abatement keeping with the 'polluter pays' principle.
2. Local authorities should ban use and spitting of tobacco in all public places as a preventive measure to control TPW induced communicable and infectious diseases.
3. Limit the number of tobacco product retailers within a jurisdiction by licensing of tobacco shops, wherein the retailers should be held responsible for collection and disposal of the TPW from their customers.

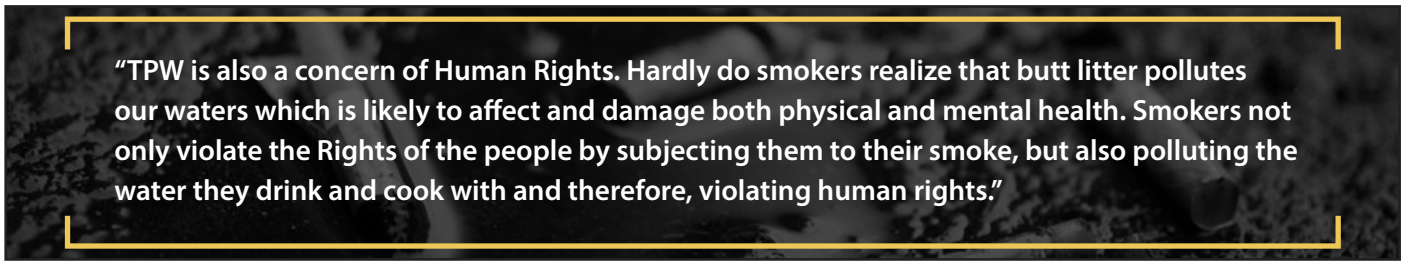
RELATED TO MINISTRY OF CONSUMER AFFAIRS, FOOD & PUBLIC DISTRIBUTION

Legal Metrology Act:

1. To reduce TPW, tobacco products should be sold in a standardized packaging of no less than 20 cigarettes and Bidis and no less than 100 grams for other tobacco products. Regulation to this effect should be issued under COTPA.
2. Regulations should also require that all tobacco products pack should be labelled that they comply with and have paid for waste collection, management and disposal.

MASS AWARENESS INITIATIVES BY MOEF, MOH&FW AND MINISTRY OF CONSUMER AFFAIRS, FOOD & PUBLIC DISTRIBUTION

1. Central, State and District pollution control boards and tobacco control cells should inform the public about the toxicity and environmental hazards of TPW and discourage tobacco use inthe interest of their own health, others health and the health of the environment.
2. Awareness of public through advisories in Print/ electronic / Social media regarding health and environmental impact of TPW should be prioritized through targeted IEC campaigns
3. Such awareness material should also target all manufacturers, distributors and retailers of tobacco products who should be directed to comply with existing provisions and regulations under various legislationse.g. Food Safety and Standards Act, Drugs and Cosmetics Act, Poisons Act, Indian Penal Code, Juvenile Justice Act, Prohibition on ENDS Act, Environment Protection Act etc.



Way forward

Tobacco product manufacturing is extremely resource-intensive and releases millions of tons of hazardous waste and emissions, while tobacco-associated deforestation alone is a substantial contributor to climate change. Further, there is enough evidence pointing towards the ubiquitous nature of TPW and its toxic impact on environment to make a strong case on the need for our Government to address the issue as a matter of priority. Several models have been recommended for effective management of TPW but addressing the elephant in the room, strategy for imposing absolute liability of the TPW on the manufacturers of tobacco products is still in question. A strong partnership between environmental groups and tobacco control advocates is the need of the hour to layout the roadmap for effective TPW management.

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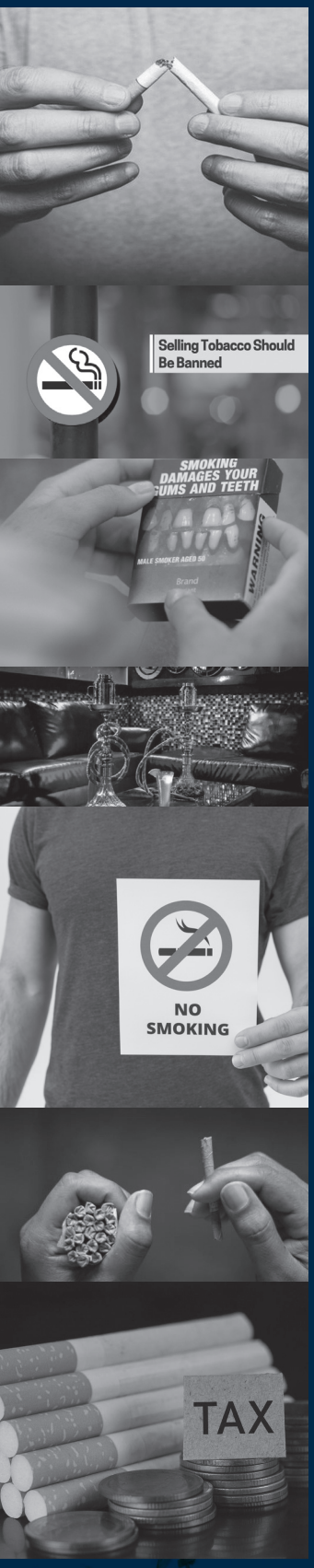
We are thankful to Dr Garima Bhatt and Dr Neema Joseph for their valuable contributions.



13 CHAPTER

WOMEN AND TOBACCO

WOMEN AND TOBACCO

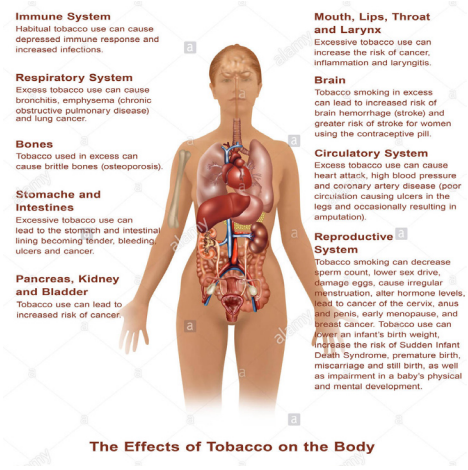
Why focus on women?

"The true strength of women is seen when she is in hot water and now it is the time to make them realize they are actually in it."

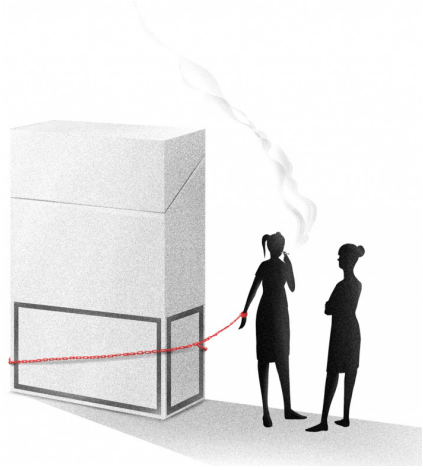
The women is the key focus for tobacco as the rise in the number of women smokers around the world have enormous adverse effects on households' financial status and family health. The health effects of tobacco on women are substantially more than men. Women suffer additional hazards during the time of pregnancy, female cancers and also face the additional hazards in terms of passive smoking. Previously, we had social and cultural constraints which prevented women in involving in tobacco practices, but now over a period of time these constraints are weakening and as a result rising trends of tobacco use among women is seen. Besides this, the tobacco industries also targeting women by marketing light, slim, flavored and many others like tobacco products. However, in India and in some other countries, women also use different forms of tobacco products. It is predicted to have a rise in the number of female users of tobacco over the next several decades as a result of increased prevalence, as well as population growth unless sustained and innovative initiatives are undertaken.

What is the worldwide burden of tobacco use among women?

Globally, the prevalence of smoking is higher for men (40% as of 2006) than for women (nearly 9% as of 2006). However, there is a wide regional variation in smoking prevalence among both males and females. For e.g. in the Americas and Europe the prevalence of female smoking is high, around 17% and 22% respectively. In South-east Asia and Western Pacific region the prevalence of smoking among males and females (37 % in and 57% respectively) is 4-5%. Nonetheless, in half the countries surveyed by the Global Youth Tobacco Survey (GYTS), there is no sex difference in rates of youth smoking, indicating a rise in tobacco use among girls.

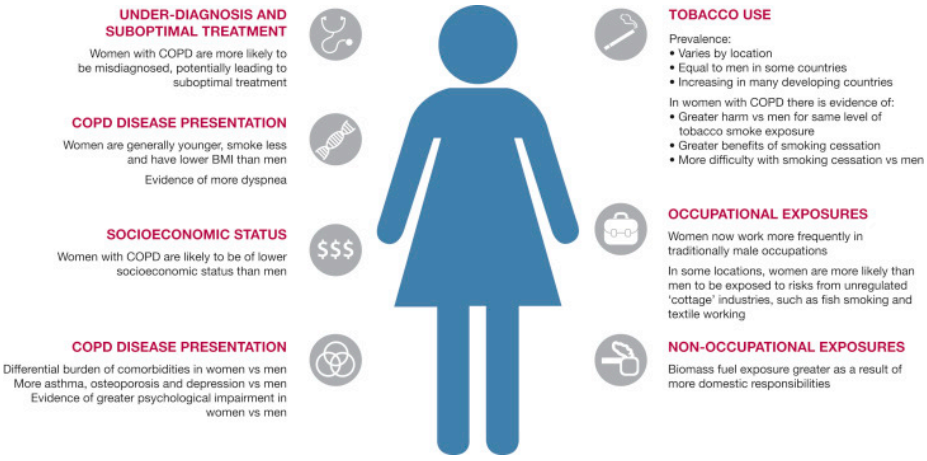


The Effects of Tobacco on the Body



What is the burden of tobacco use among women in India?

According to the GATS 1 (2009-2010) 47.9% of males and 20.3% of females in India use tobacco. In the same year the GYTS survey established that 19% of the boys and 8.3% of the girls used tobacco. A 27.6% difference in tobacco use between genders among adults whereas a meager 10.7% difference among youth may be indicative of rising tobacco use among girls. Nearly 58.2 million women consume any form of SLT in India. The SLT use among women was over 10% in 16 States of India (GATS 2). Although SLT use has declined from 18.4 per cent (GATS 2009-2010) to 12.8 per cent (GATS 2016-2017) among women, a relative increase in SLT use was evident in nine States of India.



What are the roots of tobacco uptake among women?

Factors underpinning the initiation of tobacco use among women are different from that of men. The roots of tobacco uptake among girls and women often include cultural, psychosocial and socioeconomic factors. In Asian and Pacific countries where smoking has become a symbol of women empowerment, many young females are turning to tobacco use as a sign of freedom. Others take up the habit believing that smoking helps them to achieve one of the so called 'societal standards' of beauty- being slim. Quite contradictory to the actual facts some Indian women believe that chewing tobacco can cure toothaches and can be useful during childbirth. Several studies have revealed that there is lower self-esteem among girls than boys which is likely to be associated with smoking. Girls also tend to overestimate smoking prevalence in their environment, are less knowledgeable about nicotine and addiction, and usually have parents or friends who smoke which in turn augment the initiation of smoking among them. In developing countries like India, the lack of health education programs and unequal access to health education and information by females results in girls having little or no knowledge on the harmful effects of tobacco use.

What is the level of exposure to Secondhand Smoke (SHS) among women?

In 2004, of the 430000 adult deaths due to SHS exposure, about 64% were women. Although by 2008, an additional 154 million people worldwide had been covered by comprehensive smoke-free laws, nearly 90% of the world's population is not protected. The exixting laws do not limit exposure to SHS in homes where women and children are exposed through the smoking of the male family members. SHS compromises women's health, especially in cultures and countries where women do not have the power to negotiate smoke free spaces, even in their homes. A 2002 national survey reported that in China, less than 3% of the women smoked, even so more than half of the women of reproductive age were regularly exposed to tobacco smoke.

Ruminate……

Men being the majority of world's smokers and largely responsible for women's involuntary exposure to SHS at home; have a duty to join in the gender equality movement and support women's human rights which is a cornerstone for a comprehensive tobacco control.

Why the negative impact of tobacco more severe among women?

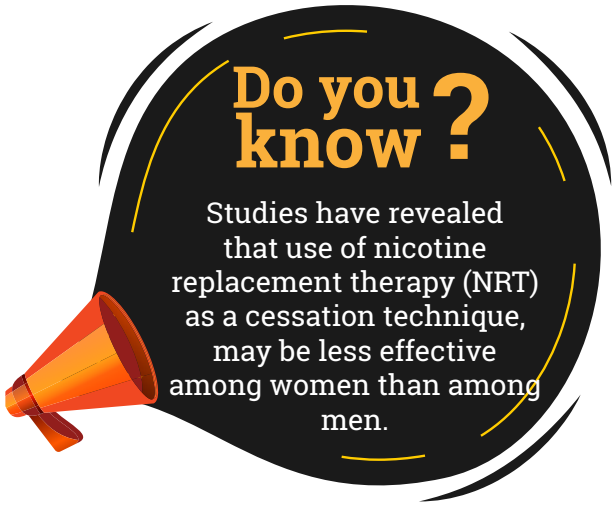
Although women and men who smoke share excess risks for many diseases, women experience additional risks that are unique to them. Women who smoke are at increased risk of developing potentially fatal chronic obstructive pulmonary disease (COPD). In industrialized countries, the prevalence of COPD is now almost as high in women as it is in men. Lung cancer mortality rates among women have increased by 800% in United States. Lung cancer even surpassed breast cancer as the leading cause of death due to cancer in the country. In addition smoking also affects reproductive health. Female smokers are at a higher risk to experience infertility and delays in conceiving. Maternal smoking during pregnancy increases risk of prematurity, stillbirth, neonatal death and may cause reduction in secretion of breast milk. Smoking is also a cause of coronary heart disease (CHD) in women; this risk being higher among smoker women using oral contraceptives. Among postmenopausal women, current smokers have lower bone density than non-smokers and an increased risk of hip fracture.

Why the tobacco addiction is stronger among women?

The nicotine content of tobacco products varies widely according to the brand and form of tobacco. More women than men smoke "light" or "ultra-light" cigarettes which is often construed as the safer alternative. In reality, "light" cigarette smokers engage in compensatory smoking. They inhale more deeply and more often, in an effort to achieve the desired amount of nicotine. Women have higher sensitivity to nicotine as compared to men and therefore affects women's physiology and mood differently from that of men. For example, the rates of nicotine metabolism are significantly higher in women smokers who use oral contraceptives and those who are pregnant.

Why the cessation services are less effective among women?

A report by US Department of Health and Human Services concluded that "across all treatments, women have more difficulty giving up smoking than men, both at the end of treatment and at long-term points of measurement". Women have also reported having more withdrawal symptoms as compared to men. Because women are more prone to depression there is an increased risk of relapse among female smokers as compared to males. Menopause, with its attendant hormonal changes (leading to behavioral events such as fluctuations in affect or difficulty with weight control) and changes in social roles, provides a barrier to cessation among women. The poverty and lack of social support are the other key barriers making quitting more difficult for them as compared to men.



How the tobacco industry influence women and girls?

One of the powerful influences driving the uptake of tobacco among women is the advertising tactics of tobacco industry. The tobacco industry portrays its product as a symbol of liberation for women by associating cigarette smoking with fashion, freedom and "modern" styles and values. There is enough evidence stating that the tobacco industry considers female consumers as a profitable market. "Female brands", "light" cigarettes, low prices, easy availability and free samples are few of the strategies employed by tobacco industry and sadly, has succeeded in creating a huge market for the product among young women. In India, where it is deemed culturally incorrect for women to buy cigarettes openly, companies have set up a home-delivery system. Massive advertisement combined with changing gender roles and increased earning capacity among women has created a lucrative market for the product among women globally.

How the employment of women in tobacco industries effects them?

Beedi industry in India is among the biggest unorganized sector employing a large number of women and children. It earns huge profits at a low cost risk and liabilities. It is one of the most exploited industry where the employment of women exceeds that of men. The beedi industry comprises women and girls working for a male dominated industry where the manufacturer, contractor and the consumer are all males. Working for 14-15 hrs. a day they continuously inhale, swallow and expose their skin and mucous surface to tobacco dust predisposing them to development of several ailments.

What is the way forward?

Vigilance in tobacco control: Framing gender related tobacco control policy

A tobacco epidemic among women and girls will not only contribute to rise in health-care costs but also curtail any possibility of improving maternal health and reducing poverty. Application of gender equity framework to tobacco control is integral to effective implementation of WHO-FCTC, especially the articles concerning with SHS, packaging and labelling, health warnings, and ban on TAPS. *A gender equity framework suggests that comprehensive tobacco control requires gender analysis to many sectors outside health- including finance, trade and agriculture- all of which influence tobacco use among women.*

Ruminate……
The design of tobacco control policies may be gender neutral, yet the policies affect men and women very differently.

Following table proposes WHO-FCTC articles from the lens of gender equity framework.

Gender equity perspective on WHO-FCTC

Article	Content	Interpretation through gender equality framework
Article 11.1a	• The packaging and labelling of tobacco products should not promote the product by any means that are "false, misleading, deceptive or likely to create an erroneous impression aboutits characteristics, health effects, hazards or emissions" • Use of terms like "low tar", "light", "ultra-light", and "mild" is prohibited.	Such misleading terms have traditionally been targeted at women, beginning in 1927 with a Philip Morris cigarette that was advertised as being "mild as May".
Article 11.1b	• Place health warnings on tobacco product packaging, with optional use of pictures or pictograms.	Since the majority of illiterate adults are women, picture-based health warnings are an important component of gender specific tobacco control strategies.
Article 11.3	• The warnings must appear in the principal language(s) of the country.	Health warnings should beplaced on the packaging of all tobacco products, not only cigarettes, because women in some countries (eg. India) use tobacco in other forms
Article 8.2	• Adopt and implement, at the national level, effective measures that provide for "protection from exposure to tobacco smoke in indoorworkplaces, public transport, indoor public places and, as appropriate, other public places"	Majority of the women are exposed to secondhand tobacco smoke which in addition to other pollutants damage the lungs and thus further harms women's health.
Article 13	• Implementation ofcomprehensive ban of tobacco advertising, promotion, and sponsorship in accordance with its constitution or constitutional principles.	Tobacco industry has long incorporated a gender analysis into its marketing strategies, and thus an effective tobacco control response must also take gender into account.Legislation and policies should specifically address marketing strategies that target women and girls
Article 20	• Develop and promote national research and tocoordinate research programmes at the regional andinternational levels in the field of tobacco control	To address gender-specific issues, research should investigate differences in the determinants and consequences of tobacco consumption and exposure to tobacco smoke for girls and women, as well as boys and men, at all ages throughout the life-course.
Article 12	• Promote and strengthen public awareness of tobacco control issues. • Provide public access to information on the tobacco industry that is relevant to the objectives of the WHOFCTC	Tobacco control enthusiasts should establish reciprocal relationships with women's organizations to increase the prominence of tobacco control on women's health and women's rights agendas.Counter advertising debunking the false claims linking tobacco use to women's empowerment in of utmost importance.

Curiosity corner.....

Organizations/treaties addressing gender issues in tobacco control:

1. Framework Convention Alliance
2. International Network of Women Against Tobacco (INWAT)
3. US National Organization of Women.
4. Women's Environment and Development Organization
5. Brazil: REDEH/CEMINA
6. Latin American Women's Health Network
7. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

Recommendations (from the consultation):

1. Use of tobacco based dentifrices especially among women needs to be addressed.
2. Establish self-help groups for women: e.g. 'Stree Shakti groups' at village levels.
3. The smoking cessation services should be available at obstetrics clinics used as women during childbirth are highly motivated to quit for protecting their babies.
4. There is a need for a gender specific tobacco control policy.
5. The IEC materials used for cessation should be women centric.
6. There should be opportunistic screening among women at various sites.
7. Pack warning should focus on the negative impacts of tobacco use on the reproductive health of women.

EXPERT COMMENTS

"There is a need for specific action plan for focusing issues of women in tobacco control. Joint efforts by Ministry of Labour, Ministry of Health and Family Welfare & Ministry of Women and Child Development is essential in addressing these issues"

- Ms. Preeti Sudan,
Ex- IAS Officer, Secretary, Ministry of Health & Family Welfare, Government of India.

"Need for a focused research on gender specific tobacco related issues and a gender segregated analysis on who are using the tobacco quit line is the need of hour"

- Dr. Monika Arora,
Director, Public Health Foundation of India.

"Equal participation of women in forums to keep a track of the industry activities focusing women is a pressing priority. I salute the RCTC team for highlighting the women centric aspect of tobacco control"

- Dr. Nidhi Sejpal Pouranik,
Senior Technical Advisor, The Union

"Scaling up of research on the addiction patterns among women and how it is different from men is of paramount importance"

- Dr. Shalini Singh,
Director, National Institute of Cancer Prevention and Research

"Despite the studies presenting evidence on the negative effects of tobacco use on the mother and fetus; SLT use among women is the most common problem especially among pregnant women"

- Dr. Prakash C Gupta,
Director of Healis – Sekhsaria Institute for Public Health, Navi Mumbai

14 CHAPTER

COP AND MOP

COP AND MOP

Global progress in implementation of the WHO FCTC (special emphasis on the progress made by India since last COP)

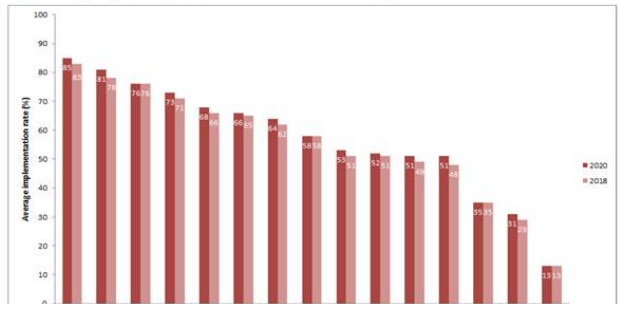
- Mr Ashish Kumar Pandey, Deputy Director, The Union, New York, USA

Tobacco control has always struggled to find its place in the priorities list of many parties to FCTC. During the worldwide pandemic, its progress has further slowed down. As of 2020, over 5.3 billion people – 69% of the world's population are covered by at least one MPOWER measure adopted at the highest level. Between 2018-20, MPOWER measures coverage extended to only seven more countries. Nevertheless, an even greater concern is implementing the FCTC articles that vary across regions and countries. The FCTC secretariat reported good progress in the implementation of Article 8 (Smoke free), Article 11 (Packaging and labelling), Article 12 (Communication, training and awareness) and Article 16 (sale to and by minors). Whereas, Article 17 (alternative livelihood), Article 18 (Environment protection) and Article 13 (TAPS) implementation are lagging far behind. The report calls for urgent actions for the Global Strategy indicators under Articles 5 and 6, the time-bound Articles 8, 11 and 13, and Articles 17 and 18.

India has taken exemplary steps in developing tobacco control policies and programmes, i.e. the Cigarette and Other Tobacco Control Act (COTPA), Prohibition of E-Cigarette Act, and National Tobacco Control Programme. Despite that DSRs, tobacco advertising allowance at the point of sales, and a few contradicting departmental policies undermine its intended protection. Tobacco Industry exploits these gaps to normalise and promote tobacco use. Therefore, India needs to prioritise removing DSR and TAPS exceptions, banning characterising flavours/additives and prohibiting indirect advertisements along with other progressive measures like track and trace system to limit illicit trade.

It is also essential, especially for the parties like India, to adopt the Whole-of-Government Approach aligned with FCTC Article 5.3 policy to protect its tobacco control progress from the tobacco industry and its allies.

Fig. 1. Average implementation rates of substantive articles among all 181 Parties in 2018–2020*

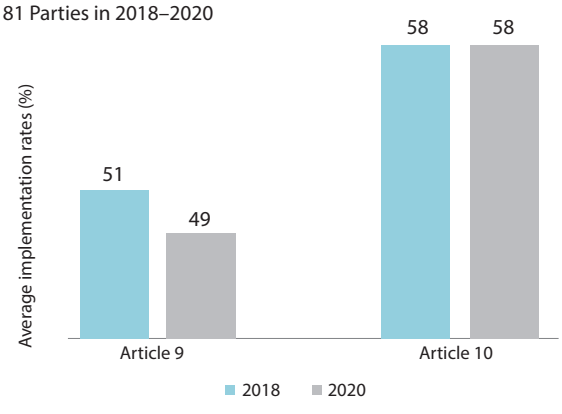


The global progress and developments in India on the implementation of Articles 9 and 10 of the WHO FCTC

Prof Sonu Goel, Professor of Health Management, School of Public Health, Post Graduate Institute of Medical Education and Research, Chandigarh-160012, India| Adjunct Associate Clinical Professor in the School of Medicine, Faculty of Education & Health Sciences, University of Limerick I Vice-Chair Tobacco Control, The Union I Director, e-Resource Centre for Tobacco Control

Articles 9 and 10 of FCTC– which calls for the regulation of contents and disclosures of tobacco products, including water-pipe, smokeless tobacco and heated tobacco products (HTPs) –is a valuable tool that complements other tried and tested tobacco control measures to drive down the demand for tobacco. WHO "No Tobacco Unit" works on the implementation of Article 9 &10 of FCTC with support from other technical teams comprising of the WHO Study Group on Tobacco Product Regulation (TobReg); the WHO Tobacco Laboratory Network (TobLabNet); WHO collaborating centres; and independent experts. The primary work includes identifying the existing standardized methods for the determination of contents and emissions of electronic nicotine delivery systems (ENDS) and/or electronic non-nicotine delivery systems (ENNDS) and gather evidence from WHO TobLabNet member laboratories on the methods being used in their laboratories to determine the contents and emissions of ENDS and ENNDS. Following it, TobReg proposed a priority list of toxic contents and emissions of tobacco products. Despite the WHO initiatives in recent years, only around half of all 181

Fig. 1. Average implementation rates of Article 9 &10 among all 181 Parties in 2018–2020



Parties regulate, test or measure the contents and the emissions of tobacco products. However, banning characterizing flavors or additives in tobacco products have been supported by majority and over two thirds of Parties require the disclosure of information on the contents of tobacco products to government authorities, but fewer Parties (61%) require the same for the emissions of products. Public disclosure, especially in relation to emissions, remains uncommon.

Keeping pace with the aforementioned global developments, Government of India in September, 2019 granted recognition to three testing laboratories for the purposes of testing the nicotine and tar contents in cigarettes and any other tobacco product. These laboratories are the National Tobacco Testing Laboratory at National Institute of Cancer Prevention and Research, Noida, Uttar Pradesh; the National Tobacco Testing Laboratory at Central Drugs Testing Laboratory, Mumbai and the National Tobacco Testing Laboratory at Regional Drugs Testing Laboratory, Guwahati, Assam. Apart from testing tobacco samples for nicotine, these laboratories also aims to undertake relevant research and generate scientific data on products' constituents and explore ways of safe disposal of tobacco related wastes.

Research and evidence on novel and emerging tobacco products

Dr Shivam Kapoor, Technical Adviser (STOP), The Union South East Asia Office, New Delhi, India

According to the 2021 WHO report on the Global Tobacco Epidemic, which covered the year ending 31 December 2020, 32 countries had banned the sale of ENDS, while 79 adopted one or more legislative measures. Whereas 11 countries had banned the sale of HTPs, while 48 specifically regulated HTPs in one form or another.

On 18 September 2019, India addressed the rapidly changing nature of novel tobacco products and promulgated a nationwide Ordinance (Prohibition of E-cigarettes Ordinance 2019) that prohibits the production, manufacture, import, export, transport, sale, distribution, storage and advertisement of all forms of ENDS/ENNDS, consisting e-cigarettes, heated tobacco products, e-hookah and similar devices. On 5 December 2019, both houses of Parliament of India passed the Prohibition of E-cigarettes Act 2019 (PECA-2019), replacing and, thus, repealing the Ordinance. The law punishes first-time violation with a maximum of one-year imprisonment or fine of Rs. 100000/- (about 1300 US$) or with both.

Despite a nationwide ban, multi state-level survey showed that ENDS/ENNDS was still available at retailer storefronts within major cities in India. Research has also highlighted that these novel and emerging products are highly available and accessible through online sales.

On 16 June, 2021, a National Consultation on Enforcement of ENDS ban in India called for stricter compliance with PECA-2019 by all stakeholders at all levels, especially indirect and deceitful violation of the law e.g. advertising, sale and promotion, especially through internet and social media.

The Implementation Review Mechanism – Processes and way forward

Dr Rana J Singh, Deputy Regional Director, The Union, South East Asia Office, New Delhi, India

Based on the recommendations of the Expert Group on reporting mechanism an Implementation Review Mechanism (IRM) under the WHO FCTC was considered important to improve implementation of the Convention. At the 8th Session of the Conference of the Parties (COP) held in Geneva in 2018, decision was taken to conduct a pilot project exercise for the IRM with voluntary participation of 12 Parties. In the last two years the Convention Secretariat conducted the review following a process outlined by the Expert Group and the Implementation Review Committee. Two Parties from the six WHO Regions participated in the pilot project for IRM.

Implementation reviews suggest that there is wide variation of implementation among Parties. Key provisions of the Treaty that were time-bound were accomplished the most.

Several Parties fully implemented Articles 8, 11 and 13, Articles 14, 15 and 16 were also reported to be full or almost full compliance. However, gaps in implementing Article 5.3 was most common while none of the Parties in the pilot exercise fully implemented Article 6.

Desk review for IRM was highly useful, however, it was observed that obtaining even the regular implementation reports could be a challenge. Like all other things, IRM process was highly impacted by the COVID-19 pandemic. It was suggested that IRM should be renamed as "Implementation Review and Support Mechanism" (IRSM) with the key aim to "promote and facilitate mutual assistance and cooperation among the Parties that is intended to be objective, transparent and cost-effective." The report from the pilot exercise provides consistent process and a template structure for review of the Treaty implementation by individual Parties (Fig-1).

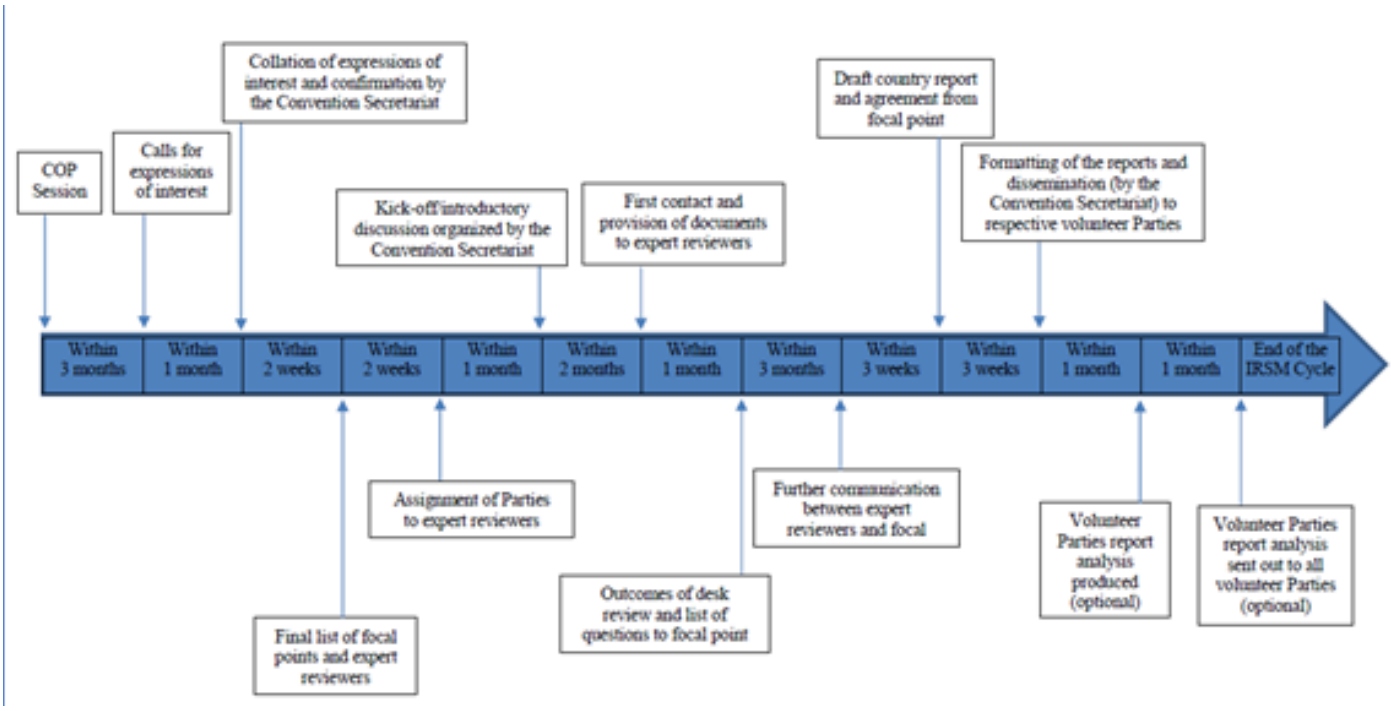


Fig-1: Model schedule for IRSM and guidelines

All Parties should support, adopt and undertake IRSM to not only measure the progress in Treaty implementation but also meeting their reporting requirements under the Treaty.

National and Global priorities for tobacco control in the next two years

Dr Prashant Kumar Singh, Scientist 'D', Division of Preventive Oncology & Population Health and Nodal Officer, WHO Global Knowledge Hub on Smokeless Tobacco, ICMR – National Institute of Cancer Prevention & Research (NICPR), Noida, India

The forthcoming meeting for the Ninth Session of COP of the WHO FCTC and the Second Session of the Meeting of the Parties (MOP) of the Protocol to Eliminate Illicit Trade in Tobacco Products (ITP) creates a global opportunity to provide valuable insights on the varied crucial issues related to tobacco control globally and in India. Some of the priorities proposed for next two years for us include providing technical assistance to parties, role of knowledge hubs providing assistance to parties in implementing COP decisions and identification of research gaps and tobacco industry monitoring.

We, at WHO FCTC Global Knowledge Hub on Smokeless Tobacco (KH-SLT), ICMR-National Institute of Cancer Prevention and Research, Noida underscore the necessity to provide technical assistance to the Parties with high prevalence of SLT in terms of sensitization of the government officials and public health experts on tobacco use and its adverse health effects. We envision development of comprehensive tobacco control measures applicable and acceptable in the socio-cultural and local context with focus on the region and in particular India which hosts nearly 70% of the global SLT users. In order to achieve the proposed work plan for 2022-23, awareness regarding the COP decisions is crucial wherein all the Knowledge hubs shall coordinate in terms of training and technological support for various tobacco control measures.

The 'Health for All' goal could not be achieved until the high risk population groups such as pregnant and/or lactating women, migrants and displace population remains at the risk of tobacco use and related NCDs. Thus, the identification of global strategic research gaps in tobacco epidemiology, prevention and cessation remains a key priority for us. One of the important aspects of tobacco control is to address the influence of tobacco industries across multiple sectors and work towards meeting the mandates of Article 5.3 of the Convention. A dedicated National Multiagency Monitoring Group could be formed to assess the tobacco industry interferences in public policies including public health and reverse brand stretching and related surrogate advertising. One of the means to address this collectively should include national and regional workshops for building capacity and influence decision making of various stakeholders including research institutions, health professional bodies and various government departments.

Investment proposal for implementation of the WHO FCTC and the Protocol to Eliminate Illicit Trade in Tobacco Products

Mr Pranay Lal, Senior Technical Adviser, The Union South East Asia Office, New Delhi, India

To govern illicit trade protocol, raise normative and operational conflicts across licensure of manufacturing unit, cross-border and domestic intellectual property protection, and coordinated activity to combat legal and illicit trade, as well as transnational organized crime.

Globally WHO FCTC need to learn lessons from WHO's experience from counterfeit medicines governance without adopting its inefficiencies. Closing the resource gap will require action on multiple fronts. Domestic resource mobilization will have an important role to play. Increasing tobacco taxes presents a 'win-win' opportunity, raising revenue for health spending while reducing consumption. In India, 2% CSR taxation from tobacco sector can be used to advance tobacco control and specifically ensure compliance to provisions of the Protocol. Globally, WHO can adopt advanced market commitment models or levy from luxury goods (like those developed from UNITAID for HIV/AIDS). For innovative financing to take off requires leadership at global and national level.

India's progress towards implementing the Protocol to Eliminate Illicit Trade in Tobacco Products

India assumed a leadership position towards the adoption of ITP in 2018. The Government of India has conducted several ministerial discussions to find current gaps and steps need to comply with FCTC prescribed good practices and ITP commitments and guidelines. The Government of India has identified y Central Board of Indirect taxes and Customs (CBIC) as the lead agency in the current discussions on ITP. CBIC and the Directorate General of Revenue Intelligence (DGRI) are mandated to keep a constant vigil on the illicit trade of tobacco, especially across borders. CBIC and the Ministry of Health and Family Welfare has will work closely to comply with provisions of Article 15 WHO FCTC and Section 7 of the Cigarettes and Other Tobacco Products Act, 2003. In addition, there are several corrections that are required internally before India can accede towards compliance to ITP and FCTC provisions. Among these is strict licensure and registration of manufacturing units, and ensuring stadardization of tobacco packages. Some challenges are being addressed in states like banning prohibiting sale of loose cigarettes, which has been done in 17 states.

MOHFW has also requested for guidelines from Central Pollution Control Board (CPCB) for safe disposal of tobacco products ahead of its compliance towards the protocol. In addition, two Government of India delegations have visited Uganda and Kenya, and the EU states to understand experience on T&T. The learnings from the experience from LMICs and EU suggests it is possible to maintain high prices while lowering illicit trade using approaches like prominent tax stamps, local-language warnings on cigarette packs, as well as enforcing penalties. India however must remain cautious of adopting the EU model as there are concerns of tobacco industry influence and manipulation.

Greater participation of NGOs key to COP and MOP functioning

Ms Opinder Preet Kaur Gill and Dr Aastha Bagga

Opinder Preet Kaur Gill

Dr Aastha Bagga

Non-Government Organisations play a pivotal role in tobacco control. Through their capacity building efforts, they not only sensitise stakeholders promoting better understanding of tobacco control issues and practices but also accelerate the implementation of tobacco control laws and policies. They have been instrumental in supporting the government in advancing tobacco control. NGOs have been working relentlessly on the ground and providing critical services for tobacco cessation and helping tobacco users to quit.

Realizing the gravitas of the situation, they were the first to reconfigure themselves and pushed for new initiatives like tobacco smoke free cities, tobacco free educational institutes, tobacco free villages and other tobacco free jurisdictions. Combating tobacco industry interference, engaging youth in tobacco control activities, issuing courtesy notices to violating tobacco vendors are some of the key initiatives undertaken by NGOs that were later substantiated and institutionalised by governments.

Besides this NGOs have played an important role in developing national and international cooperation which has stimulated tobacco control globally, regionally and locally. Undoubtedly, greater participation of NGOs is definitely a key to further strengthen the COP and MOP functioning and in advancing tobacco control while contributing in the compliance with the Treaty and Protocol obligations.

Track and Trace mechanism through lens of Tobacco Vendor Licensing

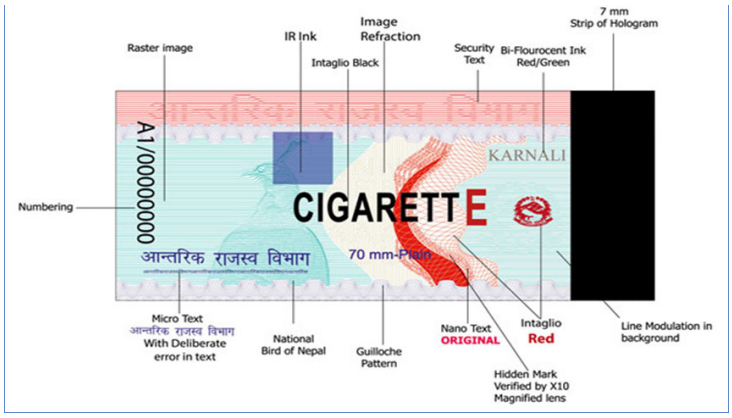
Dr Nidhi Sejpal Pouranik, Senior Technical Adviser, The Union South East Asia Office, New Delhi, India

Illicit tobacco makes cigarettes cheaper, or more accessible, resulting in more people smoking, which in turn has negative health consequences and associated higher healthcare costs. A tracking and tracing system for tobacco products is a system which enables monitoring in real time, the movement of tobacco products throughout all stages of the supply chain — from production or import sites to retail outlets — and for identifying where illicit activity has occurred.

Experts agree that the single most effective solution to countering illicit tobacco is to better control the supply chain. Through measures like Tobacco Vendor Licensing (national advisory by MoHFW on 21st Sept 2017 urging states to adopt Tobacco Vendor Licensing through local municipal authorities), local governments can maintain an inventory of all the businesses that are selling tobacco, including the different kinds of businesses that sell tobacco and where they are located relative to schools, youth-populated areas, and each other.

Through specific terms and conditions, tobacco licensed vendors can be mandated to sell only those tobacco products that are marked with a unique identifier (e.g. tax stamp that are unique, secure and non-removable with an array of features such as holograms, florescent ink, and ultra violet fibres, etc. as in fig below), so they can be monitored at each step of the process from the point of production up to the point of sale, creating a time and location history for every step. More so, wholesalers and retailers can be mandated by the government to provide detailed information on their products, including source and destination. Stamps including a serial number that provides information on the duty paid, producer, importer, product details, and volume, can be linked to a data management system located at the government local/municipal offices. The local government/municipal officers can check the authenticity of cigarettes/tobacco products sold in licensed retail shops during enforcement drives. Failure to comply, can be subjected to a high and prohibitive penalty.

Therefore, in summary, while the introduction of a track and trace regime for tobacco products through tobacco vendor licensing is a critical component to secure the supply chain, it also an apt measure by the government to take necessary measures to prevent diversion of tobacco into illicit channels.



Assistance and Cooperation to strengthen implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products

Dr Upendra Bhojani, Director, Institute of Public Health, Bengaluru, Karnataka, India.

I recently had a call with a friend from Bangladesh working in tobacco control. Soon, we ended up discussing how it is important to study certain aspects of financing and supply chains of tobacco companies in the region to better understand potential tax avoidance strategies by some companies. And, how this would require close cooperation among tobacco control researchers/advocates across the countries in the region.

This relates to an agenda item called "Assistance and Cooperation" that the MOP to the Protocol to Eliminate Illicit Trade in Tobacco Products aims to discuss in its second session happening from 15-18 November 2021. The MOP had established a Working Group to make suggestions on how some of the Articles (21; 23; 24; 28; 29) of the Protocol that deals with sharing of information and achieving administrative and legal assistance across countries could be optimally implemented. The Group was also tasked to document and suggest good practices concerning the prevention of illicit trade of tobacco in/through free zones and international transit (Article 12).

The Group tabled a report highlighting the need to detail various aspects of these Articles to guide their implementation. The report emphasizes the importance of regional approach while highlighting (i) several existing platforms that can be used for sharing enforcement-related information across countries; (ii) list of organizations and agreements that can be optimized to enhance mutual legal assistance across countries; and (iii) issues that require detailing by parties to enhance administrative and legal assistance across countries in preventing the illicit trade in tobacco. There is a DARFT decision for MOP to consider wherein parties are requested to designate contact points and national authorities/agencies for mutual administrative and legal assistance and consider (or build upon) suggestions in the working group report for enhancing measures for free zones and international transit. The draft decision requests the Convention Secretariate to act as a facilitator of cooperation and exchange of good practices/assistance across parties, and as a reservoir for needed information (on designated agencies, etc.). It also suggests the Secretariat engage with and invite important international agencies (like World Customs Organization; International Criminal Police Organization) to become observers and engage with the Protocol implementation processes.

Preventing Tobacco Industry Interference is a Must – Declaration of interest for Members of the Bureau and Regional Coordinators for the Meeting of the Parties

The importance of preventing tobacco industry interference in public policymaking and implementation as a crucial measure for effective tobacco control is widely acknowledged. Article 5.3 and the relevant guidelines of the WHO FCTC provide measures to do so.

It is keeping with this logic that the MOP in its very first session, adopted the Code of Conduct and the Declaration of Interest form for the members of the Bureau and Regional Coordinators, people who play a crucial role during intersession period supporting the MOP processes. The Code of Conduct, apart from providing guiding principles and duties of the Bureau members and Regional Coordinators, defines what constitutes conflicts of interest and requires them to sign a Declaration of Interest form ensuring there is no conflict of interests. This Code of Conduct requires members not to participate in/support/endorse any partnership/policy proposals by the tobacco industry and not to demand/accept any contributions from the tobacco industry. It also demands members to not engage in any relationship with the tobacco industry after the end of their tenure with the Bureau and certainly not so within 24 months of the end of their tenure with the Bureau.

This time the Convention Secretariat (on request of the Bureau) has proposed certain amendments to the Declaration of Interest form (i) adding the word "exportation" while defining tobacco industry to include entities engaged in the exportation of tobacco products; and (ii) removing the word "health" to now make it "public policies with respect to tobacco control" ensuring that the Protocol requires the implementation of public policies beyond those that are purely related to health. The DRAFT decision requests parties to adopt these amendments and continue to remain vigilant while nominating Bureau members keeping in consideration Article 5.3 of the WHO FCTC. This issue of preventing Conflict of Interest and tobacco industry interference is crucial to our region given many countries in the region are engaged in tobacco production and trade. India has supported similar actions in past at the WHO FCTC COP and MOP and has recently put in place a Code of Conduct for officials of the Ministry of Health and Family Welfare. So, it is desired and very likely that India will support this decision while enhancing Article 5.3 measures at the national level.

Financial resources and mechanisms of assistance to support implementation of the ITP

Dr Amit Yadav, Senior Technical Adviser, The Union South East Asia Office, New Delhi, India

The MOP2 will consider this report that describes the proposed Strategy for Mechanisms of Assistance and Mobilization of Financial Resources to Support Implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products. This report looked at the technical and financial support, capacity-building and technical resources needed by the Parties to implement the ITP. The report on the subject by the Convention Secretariat outlines that the Parties identified the need for assistance in understanding the Protocol, specialised technical assistance to build domestic capacities, assistance in generating initial start-up resources and match needs with the priorities. It further, impresses upon conducting joint needs assessment, offering investment cases, developing toolkits and facilitating South–South and Triangular cooperation.

A comprehensive Strategy for Mechanisms of Assistance and Mobilization of Financial Resources to Support Implementation of the ITP has been presented for consideration of the Parties at MOP2 with following key components.

It will be important for both developed and developing countries to adopt the suggested strategies and undertake the recommended needs assessment as the first step moving forward in the similar manner in implementing the WHO FCTC. Moving forward, India should not only take stock of its preparedness to implement the ITP but also support other countries in the region to Ratify and thereafter implement the Protocol.

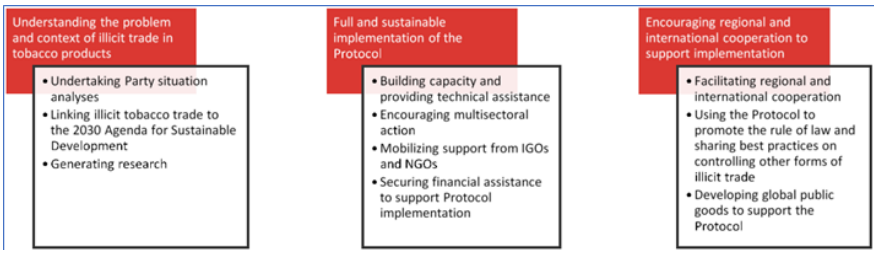


Fig-1: Components of the Strategy

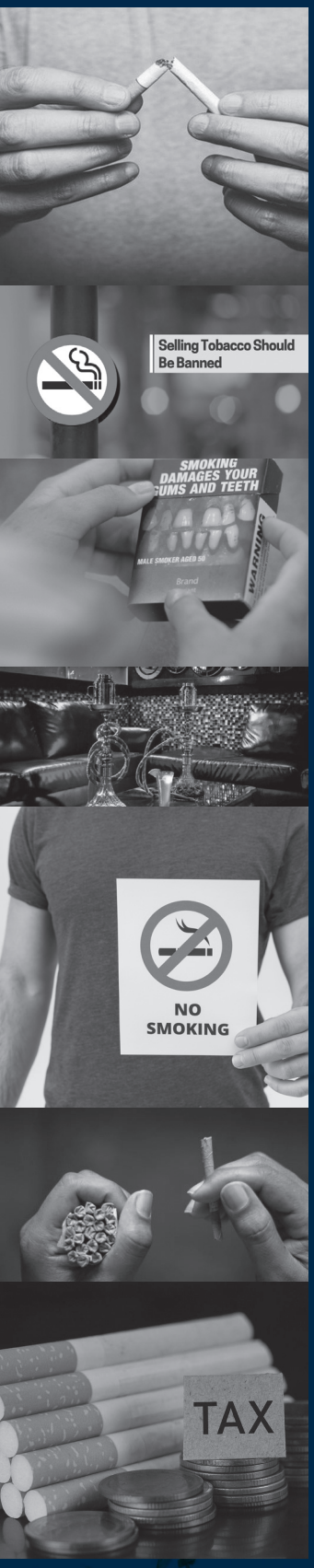
Priorities for the implementation of the ITP

While governments and non-government stakeholders prepare for the MOP2, they must look at the priorities for further advancing and implementing the ITP that will decide where the Parties intend to spend their funds available for tobacco control. Given that Parties have already indicated need for technical resources and capacity building, it is important to prioritise the needs assessment exercise and development of focused action plans for early adoption and implementation of the ITP. For the same, regional or sub regional training workshops needs to be prioritised as suggested in the workplan for next two years.

Other priorities that focus on advancing and implementing the Protocol inter alia include:

- Interim solution of the Global Information-sharing Focal Point
- Establish and operate an online platform to facilitate the dissemination and exchange of information
- Develop and disseminate technical publications on ITP
- Organize multi-sectoral workshops to address challenges in the implementation of the Protocol
- High level meetings to garner political support for the ratification and implementation of the Protocol
- Implementation of national/regional tracking and tracing systems in LMICs and LDCs
- Develop social communication materials on the importance of the Protocol
- Engage and encourage participation of relevant IGOs and NGOs by inviting them to become observers to the MOP
- Impact of implementation of the Protocol to the achievement of the Sustainable Development Goals (SDGs)

Parties must, therefore, at the global, national and local level work towards meeting the objectives of the ITP and prevent all avenues of illicit trade in tobacco products while prioritising the above action areas.



15 CHAPTER

REGULATING INDIGENOUS TOBACCO PRODUCTS

Regulating Indigenous Tobacco Products

Indigenous Tobacco Products

Tobacco is the most widely produced non-food crop in the world [3]. The term 'Indigenous' refers to something being originated or occurs naturally at a particular place. In terms of its definition, tobacco is not indigenous to India. Tobacco cultivation was introduced in India by the Portuguese in the year 1605 [1]. About 15 states in the country grow tobacco, significantly influencing the economy and prosperity of the farming community. Bidi, Hookah, Chewing, Cigar-wrapper, Cheroot, Burley, Oriental, Lanka, Pikka, Natu, Motihari, Jati etc. are the different types of tobacco products grown in the country [2]. Nicotiana tabacum and Nicotiana rustica are commercially cultivated plants for tobacco. Indian tobacco is referred to as Lobelia inflata. It belongs to the Solanaceae family.

Historical Aspects of Indigenous Tobacco Products

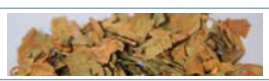
Smoked Tobacco

There is a lack of historical evidence regarding the exact period during which the practice of tobacco smoking began in India. Some studies report that the use of hookah for tobacco smoking originated in the court of Emperor Akbar in the late 16th century, suggested by royal physicians. Tobacco was an unknown substance at that time. In a small bowl at the top, tobacco, (flavoured with molasses) was kept smouldering with burning charcoal. It was used by both men and women [4]. Bidis were developed soon after, in all possibilities around the Kheda and Panchamahal districts of Gujarat, where cultivation of tobacco was higher. Labourers would roll leftover tobacco in leaves of the Astra tree (Bauhinia variegata) and smoke for leisure. Communities across India also experimented using leaves of mango (Mangifera spp.), jackfruit (Artocarpus spp.), banana, sal (Shorea robusta), pandanus (Pandanus odoratissimus, kewda) and palash (Butea monosperma) [5]. Initially, bidis were made only for self-consumption, but their increasing popularity led to their becoming a home-grown business. Soon the popularity of bidis outpaced that of hookahs by overcoming the impediment of its 'sharing characteristic'. Chutta is a coarsely prepared cheroot varying from 5 to 9 cm in size. Reverse chutta smoking is widespread in certain coastal districts of Andhra Pradesh, particularly Vishakhapatnam and Srikakulam. Men smoke chuttas either conventionally or in a reverse fashion. However, women smoke chuttas in reverse fashion [6]. But there is a lack of historical evidence regarding this product.

Smokeless Tobacco

There is a great variety of smokeless tobacco consumption in India. Many of the products are manufactured as cottage and small-scale industries using varying mixtures and their process of manufacturing differs widely [7]. There is a wide range of smokeless tobacco products which are predominantly used in the Indian subcontinent and particularly in India. The main products are pan, khaini, chewing tobacco leaf, gutkha, zarda, tamak pata, gul, kharra, kiwam, mishri, kawa, dhora, gudakhu, dry snuff, creamy snuff, taibur, lal dantmanjan etc. In addition to these, there are various non-marketed products as well. The usage of smokeless tobacco among Indians can be traced back to 1499. Amerigo Vespucci found Indians on Margarita Island, off the coast of Venezuela, who chewed a green herb known as tobacco in order to quench their thirst since it produced an increase in salivation. It was also reported that the Indians chewed tobacco leaves to whiten their teeth and to alleviate hunger [8, 9, 10]. However, references to pan and betel nut appear in ancient Pali and Sanskrit literature as late as 400 BC, in Buddhist Jataka tales and Dharamsutras [11, 12].

Profiling of Indigenous tobacco products

Indigenous Product	Image	Description	State
Smoked Tobacco			
Hukkah		The smoke is filtered through water kept in a bottle connected to a special receptacle containing a small amount of tobacco, seasoned with molasses and topped with pieces of burning charcoal.	Uttarakhand, Jammu & Kashmir, Haryana and in some North Eastern states like Arunachal Pradesh, Mizoram, Meghalaya and Tripura.
Bidi		A cheap, unfiltered cigarette made of tobacco flakes wrapped in a tendu or leaf.	West Bengal, North Eastern States, Uttar Pradesh, Uttarakhand, Rajasthan, Haryana and Madhya Pradesh.
Chutta		It is is a homemade cigar varying from 5 to 9 cm. Reverse chutta smoking is widespread in certain coastal districts of Andhra Pradesh, particularly Vishakhapatnam and Srikakulam.	Rajasthan and North-Eastern states and few districts of Andhra Pradesh, particularly Vishakhapatnam and Srikakulam.
Smokeless Tobacco			
Paan		It is a combination of betel leaf, slaked lime (calcium hydroxide) and pieces of areca nuts, with sweetening added.	Across all states
Khaini		It is sun-dried or fermented coarsely cut tobacco leave mixed with slaked lime. It is placed in the mouth between the gums and cheeks and sucked slowly for 10-15 minutes.	Delhi, Jharkhand, Bihar, Chhattisgarh, Nagaland, Mizoram, Manipur, Maharashtra, Madhya Pradesh, Uttar Pradesh, Arunachal Pradesh, Sikkim and Assam
Tambakoo		It is finely or coarsely shredded tobacco leaves. It is used for chewing or sucking.	Across all states
Gutkha		It is a mixture of areca nut, slaked lime, catechu and sun-dried, roasted, finely chopped tobacco with flavourings and sweeteners. It is held in the mouth, sucked and chewed.	Mizoram, Arunachal Pradesh and Nagaland
Zarda		It is flavoured chewing tobacco flakes mixed with aromatic spices, menthol, herbs, fragrances, saffron, raw kiwam, silver flakes and sandalwood oil.	Across all states
Gul		Gul is a pyrolysed powdered tobacco product with the ash of tendu leaves, marketed in small tin cans or sachets as a dental care product.	Uttar Pradesh, Uttaranchal, Jharkhand, Bihar and Orissa
Sada Pata		Air cured loose tobacco leaf used for chewing as well as for smoking.	All over India
Kharra		Combination of tobacco, areca nut, lime, catechu with additional ingredients.	Wardha district and Maharashtra
Qiwam		Thick paste prepared from tobacco leaf extract, spices (e.g., saffron, cardamom, aniseed) and additives such as musk.	All states of India

Mishri		It is roasted and powdered tobacco. It is applied to the gums using a finger, used as a dentifrice.	Gujarat and adjoining areas of Maharashtra
Mawa		It is a mixture of thin shavings of areca nut with some tobacco flakes and slaked lime. It is placed in the mouth and chewed for 10 – 20 minutes.	Gujarat and Maharashtra
Dhora		Wet mixture of tobacco, slaked lime, areca nut and other ingredients like catechu (Kattha), peppermint and cardamom. It is chewed and sucked.	Allahbad, Janupur, Uttar Pradesh
Gudakhu		Paste like tobacco preparation made using fine tobacco leaf dust, sheera (molasses), lime and gerumati (red soil). It is rubbed over the teeth and gums with fingertip	Bihar, chattisgarh, Odisha, West Bengal, Uttar Pradesh, Uttrakhand
Dry Snuff		Dry powdered tobacco available as unscented plain, mentholised and scented varieties. Used orally and in nasals.	Gujarat, Maharashtra, Goa and Eastern part of India
Creamy Snuff		Commercially manufactured tobacco based paste consisting of finely grounded tobacco mixed with clove oil, glycerin, spearmint, menthol, camphor, salts, water and other hydrating agents. It is rubbed in gums and teeth.	Gujarat, Maharashtra, Goa and Eastern part of India
Lal Dantmanjan		Fine red tobacco powder, herbs, and flavorings. Additionally ginger, pepper and camphor may be used. It is used for cleaning teeth.	Bihar, Uttar Pradesh, Uttranchal, Orrisa, Mizoram, Nagaland, Arunachal Pradesh, Assam, Meghalaya, Tripura, Goa, Maharahtra, Manipur and Sikkim
Mainpuri		Mixture of finely cut betel nut and small pieces of tobacco leaves treated in slaked lime and flavouring agents such as powdered cloves, cardamom, Kewara (extract from the fragrant flower of Pandanus odoratissimus) and sandalwood powder. Catechu is sometimes used.	Mainpuri district of Uttar Pradesh

Source: WHO, ICMR [13]

Historical Aspects of Indigenous Tobacco Products

The use of indigenous tobacco products is associated with significant health risks and causes of death and disease in India similar to non-indigenous tobacco products. Tobacco users in any form are 4-6 times more likely to develop oral cancer compared to non-users and these cancers can form within 5 years of regular use. It is also considered a gateway drug which leads not only to cigarette smoking but also use of other drugs such as alcohol, marijuana, cocaine, and inhalants [14]. Its usage is associated with both short-term effects in the form of gingivitis, dizziness, ulcers, high blood pressure, mouth ulcers etc. and long-term effects like cancer, heart diseases, chronic respiratory diseases, adverse reproductive effects and tooth and bone loss [15].

Regular use of Areca nut can lead to various diseases of the nervous system (Euphoria, increased skin temperatures, salivation, palpitation, and neurotoxicity), cardiovascular (Tachycardia and increased systolic blood pressure, increased coronary artery spasm and increased atherogenesis), gastrointestinal system (hyperlipidemia, hepatotoxicity, decrease growth in weight and BMI), Type II Diabetes, Endocrine System and Reproductive Health (Thyroid, Prostate Hyperplasia, Infertility, Vitamin D Deficiency), blood-related disorders (increased fibrogenesis, decreased production of IL-2 and IFN- γ, Cytotxic to RBCs), problems of Leukotrienes and arachidonic pathways (Analgesics at high doses, Anti-inflammatory, Carcinogenic and mutagenic) and respiratory disorders (aggravation of asthma, decreased FEV, Dyspnea, Tachycardia, palpitations, vertigo, vomiting etc. [16].

Pan Masala, another smokeless tobacco, form has also been found to be a leading cause of oral submucous fibrosis that often progresses to oral cancer. It is also associated with the hepatotoxic- increased level of enzymes, deranged carbohydrate and lipid metabolism. It is also found that it is harmful to kidneys and testes leading to increased creatinine and sperm deformities [17]. Some studies have also revealed various side effects of khaini on pulmonary functions which includes pulmonary dysfunctioning and fibrosis [18]. Further, kharra chewing has been found to be associated with severe periodontal health in patients with oral submucous fibrosis (OSMF) [19]. Qiwam/Kiwam consumption is found to be associated with potentially malignant disorders, oral cancer and decreased sperm count [20]. The incidence of micronuclei (MN) was found to have increased in the mucosa cells of gudakhu users, and the increase was significant in those who had used it for more than 5 year [21, 22].

Studies have found bidi smoking to be associated with severe baseline respiratory impairment, all-cause mortality and cardiorespiratory outcomes [23]. Waterpipe smoking is positively associated with lung cancer and there is some evidence that waterpipe smoking is also positively associated with overall cancer mortality. It is also found to be associated with adverse respiratory and cardiovascular outcomes [24, 25].

Economic effects of Indigenous Tobacco Products

Some recent studies have shown that the economic costs (accounting for direct cost and indirect cost) attributable to tobacco use related diseases and deaths in India are INR 1773.4 billion. The study finds that the economic burden from tobacco accounts for more than 1% of India's GDP while direct health expenditures on tobacco-related diseases account for 5.3% of total private and public health expenditure [26]. Approximately more than 85% of this total burden of diseases is associated with indigenous tobacco product usage because more than 85% of tobacco consumption in India is in the form of indigenous products [27].

The total expenditure on indigenous tobacco products was found to be 0.36% of GDP in 2011. This is more than the public health expenditure of each of the Indian states in the same time period. Therefore, through proper awareness strategies and programmes, this huge expenditure can be redirected towards more productive activities.

Challenges and Recommendations

Reducing tobacco use plays a major role in global efforts to achieve the Sustainable Development Goals (SDG) target to reduce 1/3rd of premature deaths from non-communicable diseases (NCDs) by one third by 2030. Most of the 17 SDG's have a direct or indirect relation to tobacco control. Thus, tobacco control strategies will have an important bearing on tobacco endgame and SDG commitments.

Key Recommendations:

1. Mapping of various tobacco products (including indigenous tobacco products) should be done at the state and regional level.
2. Evidence-based research should be done especially on indigenous tobacco products.
3. There is a need to conduct more webinars/discussions on the indigenous tobacco products which will help in the sensitization of tobacco control workforce to achieve the target.
4. A bottom-up approach should be adopted for the strict implementation of tobacco control related policies and programmes, especially pertaining to indigenous tobacco products.
5. There is a need to strengthen evidence-based advocacy on the regulation of indigenous tobacco products.
6. There is a need of strong partnerships and collaborations with the academic institutions, tobacco control experts, civil society organizations (CSOs) and various stakeholders.
7. There should be mention of indigenous tobacco products in existing tobacco control policies and act (COTPA).

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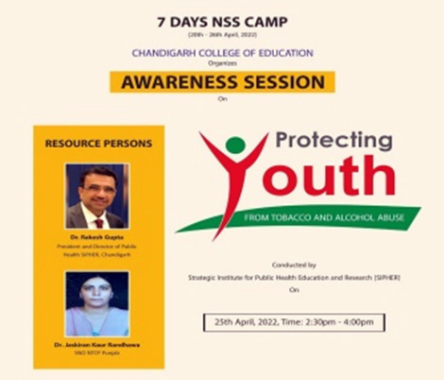
Acknowledgement:

The content was jointly written by Dr Nirmalya Mukherjee, Director, MANT and Dr Paramita Bhattacharya, Assistant Director, MANT. And in doing so support was received from Dr Ravi Kaushik, Professor, Department of Physiology, MAMC, New Delhi; Dr Arpit Gupta, Associate Professor, OHSC, PGIMER, Chandigarh; Dr Gopal Chouhan,SPO, NTCP, Himachal Pradesh.

Glimpses of State-Wise Activities

An awareness camp on "Protecting Youth from Tobacco and Alcohol Abuse" was conducted at Chandigarh Group of Colleges on 25th April,2022



Block Health Mela was organized by NTCP and Sanghai Youth Tobacco Free & Education Organization at Imphal East

Tobacco Cessation Centers giving services to the patients in District Hospital, Tonk, Rajasthan

Discussion on 31 days plan for the month of May with WNTD and tobacco free panchayat in Uttrakhand

A fruitful discussion regarding activities of Generation Saviour Association and the future plans for uplifting the status of Tobacco Control in the State with Dr Vijay Kumar Singla, Hon'ble Health Minister, Punjab.

Regional Consultation Workshop organized for effective implementation of tobacco control policies in Raipur

Display of 'Tobacco Free Board' in Bhojpur, Bihar

Tobacco free Village - Tobacco free Uttarakhand Campaign

Tobacco cessation training drive: Chattisgarh

Tobacco free signages campaing with DTC team vill syalidgar, Almora

704 schools conducted 2,769 on-ground anti-tobacco activities: Gujarat


SMOKING CAUSES MOUTH CANCER
TONGUE CANCER
SMOKING CAUSES BLINDNESS
JPS
Blue
20

16 CHAPTER

PLAIN PACKAGING

Plain Packaging

What is Plain Packaging?

Plain packaging of tobacco products—also known as "generic packaging" or "standardized packaging"—means that tobacco products should be sold in standard (shape and size) packaging with an unappealing color; and the printing of tobacco company logos, brand imagery, colors, or promotional text on the packaging and on individual tobacco products is prohibited.

Plain packaging includes standardisation of pack colour and removal of all branding from packaging, with the exception of brand name which appears in a standardised font, typeface and position on the package. Standard packaging also mandates the standardisation of pack shape, size and method of opening. In all definitions, however, relevant legal markings, such as health warnings and tax stamps, are retained.

Source: David, H. "Plain packaging" regulations for tobacco products: The impact of standardizing the color and design of cigarette packs. 2010, Salud pública de México. 52 (2). S226-32. 10.1590/S0036-36342010000800018.

Why Plain Packaging?

- It eliminates scope of promotion and advertisement of the tobacco product which will contribute highly to tobacco control by enhancing visibility of health warnings and content of the product.
- Standardized size/quantity of the tobacco product will help in eliminating convenience to access the product, affordability to buy due to low price, availability, tax evasion by tobacco companies and littering of one-time use sachets.
- It is associated with fewer false health beliefs, it is less attractive and less appealing, it discourages non-smoker to use tobacco and therefore demand and it prompts quitting.

WHO FCTC on Plain Packaging

The WHO FCTC Guidelines for Implementation of Article 11 recommends as under:

Para 45: Parties should consider adopting measures to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style (plain packaging). This may increase the noticeability and effectiveness of health warnings and messages, prevent the package from detracting attention from them, and address industry package design techniques that may suggest that some products are less harmful than others.

Source: World Health Organization. WHO Framework convention on tobacco control. Geneva, Switzerland: World Health Organization, 2003.

Global Status of Plain Packaging

On 31 May 2016, on World No Tobacco Day , the WHO called on governments to get ready for plain packaging of tobacco products in which plain packaging was included in guidelines of World Health Organization Framework Convention on Tobacco Control (WHO FCTC).

Australia

Australia was the first country in the world to introduce plain packaging, with all packets sold from 1 December 2012 being sold in logo-free, drab dark brown packaging. There has been opposition from tobacco companies to plain packaging laws, some of which have sued the Australian government in Australian and international courts. Since the Australian government won the court cases, several other countries replicated the enactment of plain packaging laws.

Under the legislation, companies have had to sell their cigarettes in a logo-free, drab dark brown packaging from 1 December 2012. Government research found that a specific olive green colour, Pantone 448 C, was the least attractive colour, particularly for young people. With the plain packaging and increase in tax the Australian government brought down smoking rates from 16.6% in 2007 to less than 10% by 2018.

The Evidence from Australia

Australia's official Post-Implementation Review also shows that changes to packaging have reduced the prevalence of smoking in the country. It quantifies the combined impact of plain packaging and new and enlarged health warnings on the prevalence of smoking. It was concluded that the changes to packaging reduced average smoking prevalence by 0.55 percentage points between December 2012 and September 2015. This decrease is entirely due to changes in combined packaging, and the impact of plain packaging on prevalence is expected to grow over time as the initiation of tobacco use declines in Australia.

Countries/Jurisdictions where Plain Packaging is mandatory

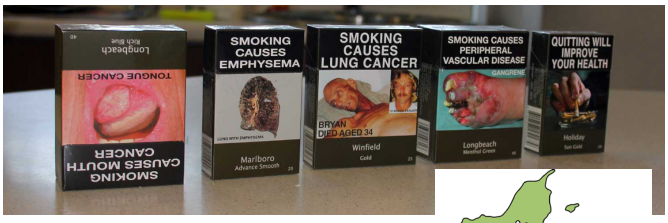
Canada

The Government of Canada introduced the Tobacco Products Regulations (Plain and Standardized Appearance), which were published to the Canada Gazette on 24 April 2019: The phase-in began on 9 November 2019, and completed on 7 February 2020. The new Tobacco Products Regulations (Plain and Standardized Appearance) aims to drive down tobacco use to 5% among the Canadian population by 2035. Canada was the tenth country to require plain packaging since Australia in 2012. But Canada is the first country which standardized cigarettes length and width.

Belgium

Belgium introduced the plain packaging for tobacco products on 1st January 2020. It provides that the packaging of all tobacco products must have a standard colour, Pantone 448 C, a drab dark brown considered to be the ugliest colour in the world. The brand name, for its part, is demoted to a mere trade name and may not appear more than once on the packaging. In practice, all packaging that does not meet the requirements of the royal decree on plain packaing were supposed to be removed from circulation by 1st January 2020, with the exception of items held in stock by retailers. The latter were allowed to sell these products until 31 December 2020.

Denmark

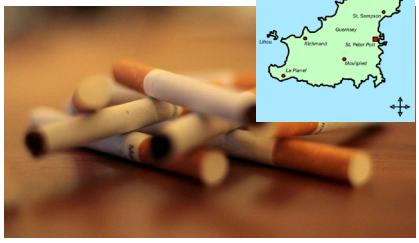


On 21st December 2020, the Danish Parliament adopted an amendment to the Tobacco Act establishing a requirement to ensure that "each unit pack and any outer packaging [of tobacco products] has a standardized design," according to the Framework Convention for Tobacco Control. This requirement does not apply to cigars and pipe tobacco. It states that only plain packs can be sold by retailers in Denmark as of 1 April 2022. Subsequently, the minister of health issued Executive Order 572 of March 2021 detailing the standardized design and packaging requirements applicable to individual packets, outer and inner packaging and packaging material of tobacco products and herbal smoking products. These include standardized design requirements regarding surfaces, text, wrapping material and markings. Executive Order 699 of April 2021 further extends the applicability of plain packaging provisions to electronic cigarettes and refill containers with and without nicotine.

France

The plain packaging law in France was enforced in May, 2016. According to the law, the cigarettes manufactured after 20 May 2016 or sold after 1 January 2017 in France (including overseas departments and regions of France) are placed in the neutral packaging of uniform size and colour. In pursuit of this law, the brand name will appear but in a small, uniform typeface and packets will be shorn of logos.

Guernsey



Plain packaging was introduced in Guernsey on 31 July 2021. A one-year transition period allowed the retailers to sell off their stock. No branding was allowed on cigarette and loose tobacco packaging in Guernsey from 31st July 2022 onwards. The regulations align to those being proposed to the States Assembly in Jersey. Product names will be presented in a standard font, size and colour and trademarks, logos, colour schemes and graphics will not be permitted by law.

Hungary

The Decree of 16 August 2016 requires that new cigarette and tobacco brands that will be introduced on the Hungarian market after 20 August 2016 has to be in a uniform plain packaging, void of brand logos. As of July 2017, the first cigarettes with unified plain packaging hit the Hungarian market. One new cigarette brand of Von Eicken GmbH have been launched with such unified package. Eventually, all cigarette and tobacco products are to be sold in uniform packs from 20 May 2019.

Ireland

The plain packaging law was taken into effect on 30 September 2017, with the sale of previously-manufactured cigarettes allowed until 30 September 2018. Plain packaging is required for all tobacco products. The law requires that one of 14 combined (text/picture) health warnings occupy 65% of the front and back surface of tobacco product packaging, and be located at the top edge of the package.

Israel

January 8, 2019 the Knesset passed a bill on the restriction on Advertising and Marketing of Tobacco Products that includes provisions for the introduction of plain packaging in the country w.e.f. January 8, 2020 for both manufacturers and retailers.

Jersey

The Government of Jersey has ordered branding be removed from packaging from 1st August, 2022. Packaging on cigarettes will be standardised in local shops in Jersey to try to reduce the number of smokers. New, bigger picture warnings will be added along with information on the Help2Quit service.

Mauritius

On 31 May 2020, to mark the World No Tobacco Day, the Minister of Health and Wellness Mr Kailesh Jagutpal reiterated the decision of the country to introduce plain packaging.

Myanmar

In October 2021, the Ministry of Health of Myanmar issued a regulation for introducing tobacco plain packaging. After this regulation, Retailers are allowed to sell non-compliant products for 90 days from 1 January 2023.

The Netherlands

Plain packaging for cigarettes and rolling tobacco is mandated since 1st October 2020 at the production level and 1 October 2021 at the retail level, as well as for cigars and electronic cigarettes by 2022.

New Zealand

The New Zealand Parliament passed plain packaging legislation on September 8, 2016, and released final regulations in June 2017. Plain packaging regulations came into force at the manufacturer level on March 14, 2018. Retailers were given 12 weeks to transition to standardised (plain) packaging.

As of June 6, 2018, all tobacco products in New Zealand were required to be sold in dark brown/green coloured packaging, with no company logos/imagery and the same font for all brands. The packages have new, larger warnings that cover at least 75% of the front of the package, and 100% of the back.

Norway

Law on Standardized cigarette packages and smokeless tobacco boxes is into force since 1st July 2018 in Norway. Plain tobacco packaging regulations were announced on March 31, 2017, and came into force in Norway on July 1, 2017. Retailers were given 1 year (until July 1, 2018) to transition to the new standardized cigarette packages and smokeless tobacco boxes.

Saudi Arabia

In August 2019, the plain packaging policy took effect in the Saudi Arabia to restrict the use and sale of cigarette tobacco products. As such, the country became the first to do so in the Middle East and North Africa (MENA) region. Aligned with its 2030 vision for public health promotion, Saudi Arabia is determined to reduce the burden of tobacco consumption after the national prevalence of cigarette smoking increased from 12.2% in 2013 to 21.4% in 2018. In addition to other tobacco treatment and prevention services, the adoption of plain packaging is expected to discourage youth from smoking and help smokers to quit. Retailers were allowed to sell their stock of non-compliant packs until the end of December 2019.

Singapore

Singapore adopted plain packaging of tobacco products, which was implemented with immediate effect on 1st July 2020. The new measure restricted the use of logos, colours, images or other promotional information associated with the tobacco brand on all types of tobacco products sold in Singapore. Product and brand names were allowed in a standardised font style and colour.

Slovenia

Plain packaging is required for all packaging of cigarettes and roll-your-own tobacco beginning January 1, 2020. Combined picture and textual health warnings are required to appear on 65 percent of the front and back of smoked tobacco product packaging. Rotation is required every 12 months. The Parliament of Slovenia passed a law for the introduction of plain packaging from 2020.

Thailand

Regulation on plain cigarette packaging in Thailand was officially gazetted on 14 December 2018. The law permitted a 90-day phase-out period for old cigarette stocks, i.e. by 12 December 2019, all cigarettes in Thailand must be sold in brown-coloured packs with cigarette brand names printed in a standardised font type, size, colour, and location, without brand colours or logos. The law entered into force on 10 September 2019. Retailers could sell their stock of non-compliant cigarettes until 8 December 2019.

Turkey

Turkey introduced plain packaging on tobacco products from Jan 1, 2020 and required the health warnings to cover 85% of the packs. According to the amendment, tobacco products shall be marketed in plain and standard packaging with warning messages and other mandatory texts, phrases and images. The brand name will be written only on one side of the pack, covering no more than 5% of the side. No brand logo or symbol will be allowed in the new designs.

United Kingdom

Standardised packaging, was fully implemented in the UK on 21st May 2017 for factory-made cigarettes and roll-your-own/ hand-rolling tobacco. The policy stipulates the removal of all brand images, colours and promotions from tobacco product packaging.

Status of plain packaging in India

Section 7 of the Cigarettes and Other Tobacco Products Act, 2003 specifies the requirements for pictorial health warnings. It says

7. Restrictions on trade and commerce in, and production, supply and distribution of cigarettes and other tobacco products. –(1) No person shall, directly or indirectly, produce, supply or distribute cigarettes or any other tobacco products unless every package of cigarettes or any other tobacco products produced, supplied or distributed by him bears thereon, or on its label such specified warning including a pictorial warning as may be prescribed.

The law also prohibits import of tobacco products unless and until the product packages have the specified pictorial warnings on them.

First set of pictorial health warnings were notified in 2008 and came into force from May 31, 2009.

Packaging and labelling rules were further amended and the new rules prescribed larger and stronger pictorial health warnings that covered 85% of the front and back of the tobacco products packs. These warning came into force from 1st April 2016.

From July 2019 the regulation also requires display of quit line along with the pictorial health warnings.

Notified in July 2019

New Health warnings 2022

New Health warnings 2023

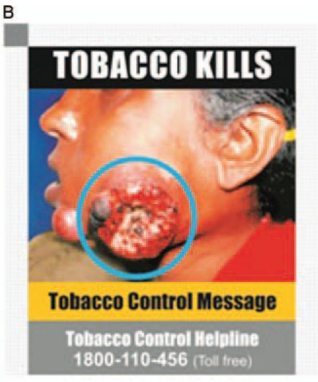
High Courts of Rajasthan and Allahabad direct Governments to invest on Plain Packaging

Rajasthan High Court: Plain packaging is an improved and effective strategy for tobacco control, and therefore, it should be given a serious thought by legislature.

Allahabad High Court: Directed the Centre and the State Governments to consider implementation of plain packaging of tobacco products and observed that, 'tobacco plain packaging measure would be a long-term investment to safeguard the health of the Indian youth'

A

B



EXPERTS COMMENTS

"The cigarette pack is itself a mobile billboard and it is very important for youth and children as it attracts them. Tobacco industries also take advantage and continue to evolve their tactics to continue with their current customers and attract new. In this regard, WHO FCTC advices the countries to work on the concept of plain packaging.

Dr. Rana J Singh,
Deputy Regional Director, International Union Against Tuberculosis and Lung Disease, South East Asia

"The tobacco companies are continuously exploiting the tobacco control laws with an objective to promote their products and increasingly focus on filter innovations.The power of packaging as a sales tool may diminish in markets with plain packaging.

Dr. Rakesh Gupta,
President and Director, Strategic Institute of Public Health Education and Research, Chandigarh

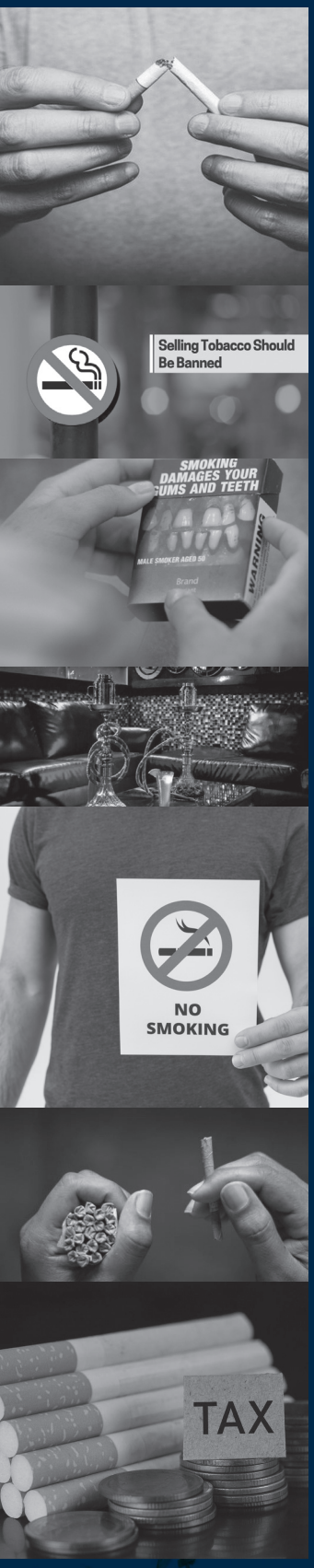
"Plain packaging is now well-recognised as an important effective strategy in tobacco control. Australia was the first country to implement it in 2012 even though the opposition by the tobacco industry was intense and prolonged. Until 2015, Australia remained the only country requiring plain packaging but by now, 21 countries/ jurisdictions mandate plain packaging. In addition, 14 countries are well on the way to implementing plain packaging as the evidence for its effectiveness is continuing to accumulate. India, with its huge spectrum of smoking and smokeless tobacco products, ought to move fast towards plain packaging of all tobacco products in the country.

Dr. Prakash C. Gupta,
Director,
Healis-Sekhsaria Institute for Public Health, Mumbai

Consultation on Standardized Packaging of Tobacco Products in India

A national consultation was organised by The Union, South East Asia Office, in Indore from 27-30 September, 2022 to inter alia deliberate on the status of standard packaging globally and to explore the possibilities for standard packaging of tobacco products in India. Experts agreed that currently majority of the tobacco products are available in market with many violations like blur, cropped image, changed colour, absence of quit line numbers etc. have a very low compliance with the statutory pictorial health warnings and a move to standardised the packs will help improve the compliance, especially the clarity of pictorial health warnings on the packs.


CHECK POINT



17 CHAPTER

TOBACCO VENDOR LICENSING

Tobacco Vendor Licensing

What is Tobacco Vendor Licensing?

Tobacco Vendor Licensing (TVL) can be defined as a health-promoting policy that requires all Point-of-Sale (POS) locations that sell tobacco to obtain a special license in order to sell tobacco products to consumers. In its broader sense, TVL encompasses a range of policies or regulations that aim to decrease the number of POS/tobacco retailers in a certain city, neighborhood, or community, help defeat tobacco's social acceptability and make access to such products less convenient. TVL also helps ensure better compliance with other tobacco control interventions, such as increasing tobacco taxes or banning tobacco advertisement, promotion, and sponsorship at the point of sale.

Common features of TVL policies:

Application Restrictions: Vendors must pay an application fee to get a license. The optimal charge would at least cover the costs of executing the licensing statute. Additionally, some regulations forbid retailers from selling tobacco products alongside certain other goods, such as pharmacies that also sell medications or prescriptions or retailers that stock kid-friendly goods. Retailers may also be forbidden from offering free cigarettes or selling them loose.

License Revocation: This enables regulators to revoke vendors' licenses and stop them from selling tobacco goods if they are found to have broken any pertinent tobacco control laws, including those relating to illegal advertising, sales to minors, or incomplete tax compliance.

Location Restrictions: A policy can specify that vendors must be a specific distance away from residential areas, schools, or other places that cater to young people. The TVL policy could also limit the types of vendors that can apply for licenses and forbid the sale of goods from roadside stands or kiosks.

Density Restrictions: A policy can limit the number of points of sale in specific areas such as schools, parks, playgrounds, or other places that youth frequent. It can also allow an opportunity to restrict the number of applications received each year and prevent renewal of existing licenses, thus reducing the density of points of sale. TVL could also limit the types of vendors that can apply for licenses or forbid the sale of goods from roadside stands or kiosks.

Central Government Advisory on Tobacco Vendor Licensing

The Ministry of Health and Family Welfare, Government of India, issued an advisory on September 21, 2017, urging states to adopt Tobacco Vendor Licensing (TVL) through local municipal authorities. Through this process, local governments can maintain an inventory of all businesses selling tobacco, including the different kinds of businesses that sell tobacco and where they are located relative to schools, youth-populated areas, and each other. They can also impose additional restrictions at points of sale, such as preventing the sale of tobacco products alongside confectionery items and chocolate, chips, and candies that easily tend to lure children towards trying these products.

The Ministry of Housing and Urban Poverty Alleviation, Government of India, issued an advisory on September 25, 2018, to all states/UTs/ Urban Local Bodies, referencing the Ministry of Health and Family

Welfare's advisory dated September 21, 2017, and advising the states/UTs/Urban Local Bodies to take the following action:

i. A mechanism may be developed to provide permission/ authorization/vendor license through Urban Development Department.

ii. To ensure that the tobacco products are stored/sold only through authorized shops/retail outlets/kiosks under the municipal acts and rules which have valid TIN/PAN/GST.

iii. Through specific terms and conditions, Licensed vendors can be mandated to exclusively sell tobacco products and not non-tobacco products such as chocolates, chips, candies, etc., which are meant to attract children.

iv. State Government specific acts for regulation for retail business of Tobacco Products and State Municipal Acts to Regulate Trade in Tobacco Products.

What is already known?

- Tobacco retailer environments are important spaces for the tobacco industry to advertise, promote, and display their products.
- Tobacco is commonly sold in a variety of vendor locations including permanent structures, semi-permanent structures/ mobile vendors like pushcarts, and street vendors.
- Global studies have shown that higher tobacco vendor density is associated with increased youth experimentation and increased tobacco use.
- Tobacco retailers in proximity to schools are directly associated with the initiation of youth tobacco use.

Why Consider Tobacco Vendor Licensing'

- **Protect youth from unregulated points of sale:** A strategy to reduce the availability and accessibility of tobacco products, particularly to youth.
- Restrict the types of products that are sold alongside tobacco.
- TVL helps **denormalize tobacco use** by mapping all the tobacco retailers in the jurisdiction and creating a public database of all licensed vendors.
- **Complement enforcing other tobacco control regulations:** Leverage TVL as a tool to ensure responsible retailing behavior and public health law compliance.

TVL Benefits

- **Decreased vendor density:** Tobacco vendor licensing can limit the density of tobacco retailers in communities, especially around schools, parks, or hospitals, and restrict the types of products that are permitted to be sold alongside tobacco.
- **Promote Health:** Licensing tobacco vendors can not only help reduce the accessibility of these lethal products, but it can also help reduce youth initiation and use, especially in and around school zones and neighborhoods.
- **Funding:** TVL costs can be used to offset health initiatives or pay for enforcement. Licensed vendors are likely to comply with taxes that provide critical government revenue.
- **Improved compliance with enforcing other tobacco control regulations like COTPA 2003:** Precisely because it identifies the exact location of every tobacco vendor, TVL can help inspectors strengthen tobacco control compliance at those points of sale.

TVL being implemented globally:

Globally, preventing tobacco sales to minors has been the major focus of most tobacco retailing laws. To maximize the effect of sales to minor laws (COTPA 2003 and JJ Act 2015), there is a need for a systematic and comprehensive retailer enforcement and compliance program. Tobacco vendor licensing is perhaps a powerful tobacco control tool that can be used in a variety of different ways. By requiring a license for the sale of tobacco products, a community can then set limits on the location, number, density, and type of tobacco retailers. Many countries are implementing TVL, and some examples of this include:

Countries across World:
Hungary
Australia
Scotland
Ireland
USA
Canada
Netherland

Neighbouring countries (South East Asia Region):
Bangladesh
Thailand
Singapore
Vietnam
Pakistan
also have been implementing TVL

Initiatives by state and local government across India: Tobacco vendor licensing

More than 70+ jurisdictions across India have notified TVL to date, ranging from state regulations to district-level orders to municipal-level orders.

Given the above, the Jharkhand (Ranchi jurisdiction), leads the way.

State Legislation (1)		
Himachal Pradesh *(Prohibition of Sale of loose cigarettes & beedis, and regulation of retail business of cigarettes & other Tobacco products Act, 2016)*		
State Level Orders (8)		
Rajasthan	West Bengal	Uttar Pradesh
Uttarakhand	Assam	Jharkhand
Madhya Pradesh	Karnataka	
Municipal Corporation level Orders -ULBs (38)		
Jharkhand (15)	Bihar (1)	Rajasthan (1)
West Bengal (9)	Punjab (1)	
Uttar Pradesh (6)	Madhya Pradesh (6)	
District level Orders (24)		
West Bengal (10)	Uttar Pradesh (12)	
JK (1)	Maharashtra (1)	

State Level Orders (8)	
Rajasthan	West Bengal
Uttarakhand	Assam
Madhya Pradesh	Karnataka
Uttar Pradesh	Jharkhand

Municipal Corporation level Orders -ULBs (39)	
Jharkhand	15
West Bengal	9
Uttar Pradesh	6
Madhya Pradesh	6
Bihar	1
Punjab	1
Rajasthan	1
District level orders – 24 districts have issued TVL orders	

State Legislation (1): Himachal Pradesh (Prohibition of Sale of loose cigarettes & beedis, and regulation of retail business of cigarettes & other Tobacco products Act, 2016).

- **Jharkhand:** In Jharkhand, the Ranchi Municipal Corporation notified Tobacco Vendor Licensing (TVL) through the Jharkhand Municipal Corporation Act, 2011 in 2018 and institutionalized it by putting in place an operational guideline to issue licenses within the Ranchi jurisdiction. The authorities have received numerous license applications and have approved over 200 licenses to date. Additionally, more than 80 municipal enforcement officers have been trained to date and are successfully conducting enforcement drives to ensure that no tobacco products are sold to minors and that vendors refrain from selling tobacco products within 100 yards of educational institutions.

- **West Bengal:** Siliguri has developed and adopted operational guidelines for conducting numerous enforcement drives for Tobacco Vendor Licensing (TVL), TAPS prevention, and compliance with various sections of the COTPA.

Due to the successful implementation of Tobacco Vendor Licensing (TVL) in Ranchi, many states and jurisdictions have expressed interest in implementing TVL in their own areas.

Challenges

- **Mapping Vendors:** There is difficulty in determining the precise need for the license in areas saturated with vendors and in jurisdictions where tobacco is sold through mobile vendors or push crafts.
- **Vendor awareness:** Tobacco vendors are unaware of laws and unlikely to implement new restrictions.
- **TVL enforcement through multi-stakeholder coordination:** Vendor licensing is just the first step in the process of multi-stakeholder coordination. Multiple agencies are responsible for implementing these measures.
- **Industry interference:** The tobacco industry vehemently opposes TVL, as it prohibits tobacco product advertisements and promotion and tobacco sales incentives for retailers, as well as unregulated tobacco product sales.

Conclusion

Tobacco Vendor Licensing (TVL), is a favorable step towards effectively regulating tobacco retail outlets and de-normalizing tobacco use. In light of the available evidence, a best practice approach to tobacco retail regulation includes licensing implemented together with strong enforcement and retailer education. This approach appears to be particularly useful in decreasing sales to minors and can serve as a means of permanently removing non-compliant retailers from the market. The greatest strength of a tobacco licensing system is that it provides a more effective way to ensure retailer compliance with existing tobacco control laws. Perhaps, all states and local governments across India should consider adopting and implementing a licensing system to help ensure a responsible retailing environment in the country.

EXPERTS COMMENTS

"The answer to better implementation of tobacco control laws lies in tobacco vendor licensing. This instills fear among tobacco vendors and is an effective way to move forward. Implementing it in as many districts and states as possible is the way ahead. In every state, having at least one model city that ensures all aspects of vendor licensing is a good idea.

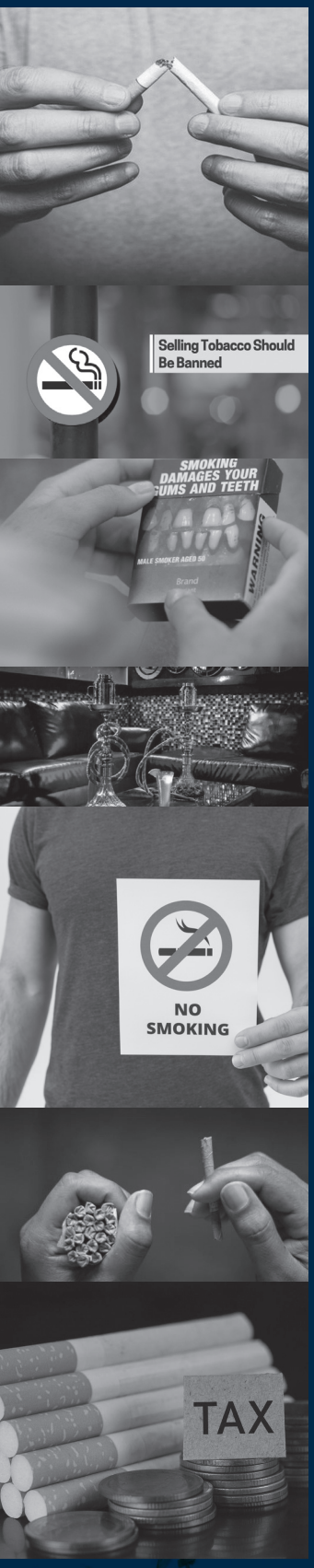
Ranjit Singh,
Legal Advisor , Supreme Court of India

"Already the laws are present in the municipal bodies, but the proper implementation is a problem. It is easy to issue a notification or form a bylaw, but the implementation is the most crucial part of the tobacco vendor licensing.

Dr. Ranjiv Pandey,
Deputy Director, U rban Development Body, Uttrakhand

"There are two main goals in tobacco control efforts: decreasing the accessibility and availability of tobacco products, and improving the implementation of tobacco legislation such as COTPA and TOEFI guidelines, as well as addressing the illicit trade of tobacco. To address the illicit trade of tobacco, it may be necessary to revise tobacco control policies. Around 8 states have implemented state-level orders and 75 districts have issued notifications for tobacco vendor licensing as a way to help achieve these goals.

Dr. Rana J Singh,
Deputy Regional Director, International Union Against Tuberculosis and Lung Disease, South East Asia



18 CHAPTER

BEEDI SMOKING: HARMFUL CONSEQUENCES, POLICY LANDSCAPE, CHALLENGES AND WAY FORWARD

BEEDI SMOKING: Harmful consequences, policy landscape, challenges and way forward

Background & Historical Aspects

Bidis (also widely recognized as beedis) are small hand-rolled cigarettes made of tobacco (0.2-0.3gm) and wrapped in tendu or temburni leaf (Diospyros melanoxylon), an Asian plant.(1) Bidis are manufactured in India and other Southeast Asian countries and exported worldwide to at least 13 countries.(2) In India, bidi are less expensive and heavily consumed than traditional commercial cigarettes. Tribes in ancient India smoked tobacco in a pipe constructed of tree leaves, from where the practice of wrapping tobacco in a leaf most likely originated. (3) Indian tobacco cultivation began in the late 17th century, and beedis were first created in Gujarat when tobacco workers took left-over tobacco and rolled it in leaves. Initially the leaf used was known as kachnar however in 1899, during the Gujarat famine, brothers Mohanlal Hargovindas Patel migrated to the Jabalpur region and discovered that the local tendu (diospyros melanoxylon) leaves were ideal for wrapping the tobacco because of their size, thickness, texture, relative thickness of midrib, lateral veins, flavour, and resistance to its decay.(4-5)

Beedi Production & Export

Bidis are treated like regular cigarettes in the United States. The Surgeon General's warning must be carried, they are subject to the same tax rates, and they must have a tax stamp.(6) Beedis are twice as popular as cigarettes in India. Beedi industry is one of the most unorganized sector in India. There are about 300 major manufacturers of branded beedis and thousands of unbranded small-scale manufacturers which account for the bulk of the beedi production.(7) Madhya Pradesh, Tamil Nadu, Andhra Pradesh, Karnataka, West Bengal, Bihar, and Odisha produce the majority of beedi in India. The majority of beedi is made in homes, with women and children accounting for a substantial share of beedi manufacturers.

Bidis, India's poor man's smoke, have become a major export item and a luxury product outside India. For example 3 Pack Set of Indian Bidis: Tajmahal Bidis in California and other parts of globe outside India costs approximately $35. The beedi export has been observed from 5.97 million (USD) to 9.81 million (USD) in 2017 but a decline to 6.07 million (USD) in 2020. (9)

Cyclic Process of Tendu Plucking and Beedi Manufacturing(8):-

Prevalence and Patterns of Beedi Consumption:-(10)

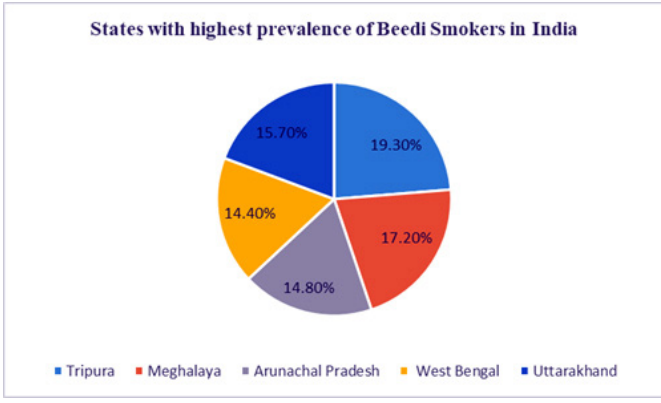
Morbidity and mortality associated with beedi consumption:
The annual deaths in India due to beedi consumption: 0.5 million & annual DALYs lost is 11,697,585 with annual loss of premature life years as 10,675,876

Uttar Pradesh(20.4%), Maharashtra (9.3%), Tamil Nadu(7.1%), Rajasthan (6.9%), Gujarat (6.6%), constitutes the states with magnitude of DALY lost.

Socio-demographic factors associated with beedi smoking:

- **Gender** – Male (OR: 17.1)
- **Education**- No formal Education (OR:6.0)
- **Age Group** – 45-46 years (OR:5.5)
- **Occupation** – Daily wage labourer (OR: 3.5)
- **Wealth Index** – Lowest quintile (OR: 2.5)
- **Residence** – Rural (OR: 1.5)

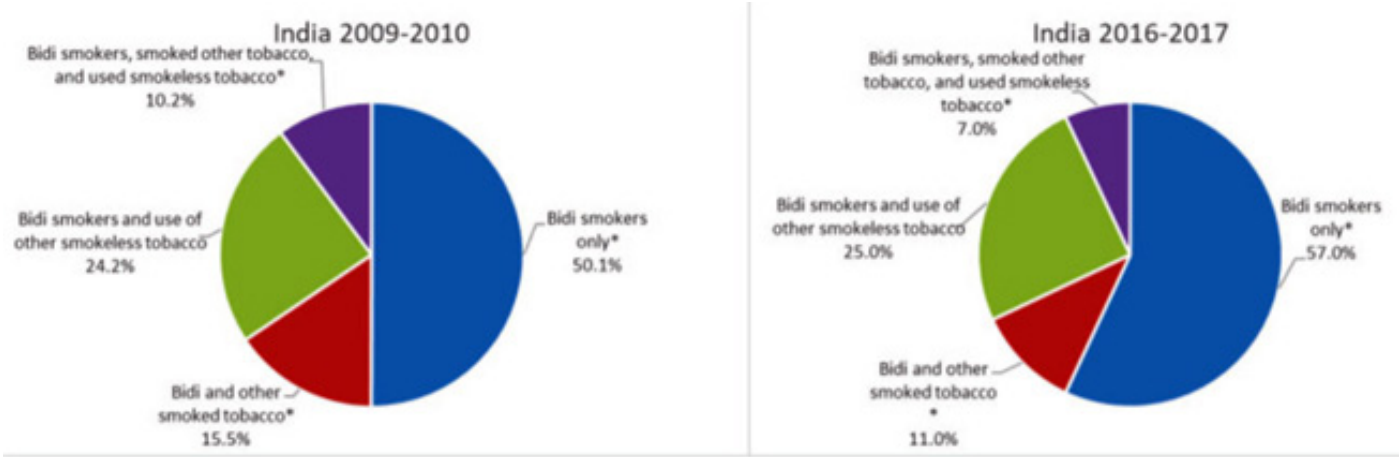
Roughly 08 Beedis are sold for every cigarette sold in India. Beedi is the second most common form of tobacco consumed after the smokeless tobacco products with a prevalence of 7.7% (Men – 14%, Women -1.2%) consumed by 72 million adults. Beedis are consumed by 7.0 A stick of beedi contains 0.15 – 0.5 g of tobacco Roughly 10.2 crore Indians consume beedis as it is cheaper and varied pricing and have poorly visible health warnings. Though the tobacco content is lesser, the concentration of nicotine is significantly high. Higher puff intensity and shorter inter-puff duration with deeper inhalations deliveries more CO and nicotine in beedi than cigarettes.



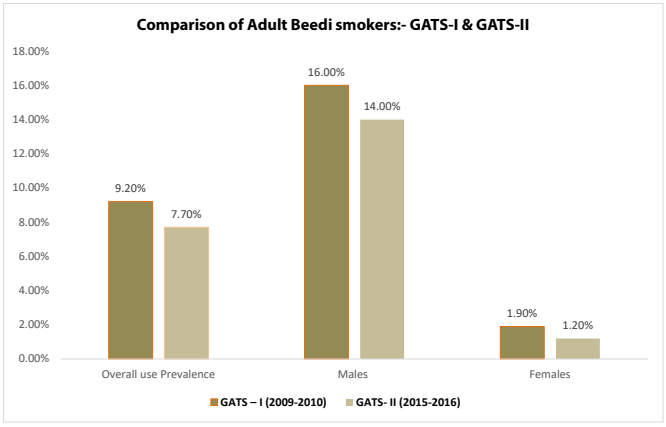
Patterns and related factors of bidi smoking in India:(7)

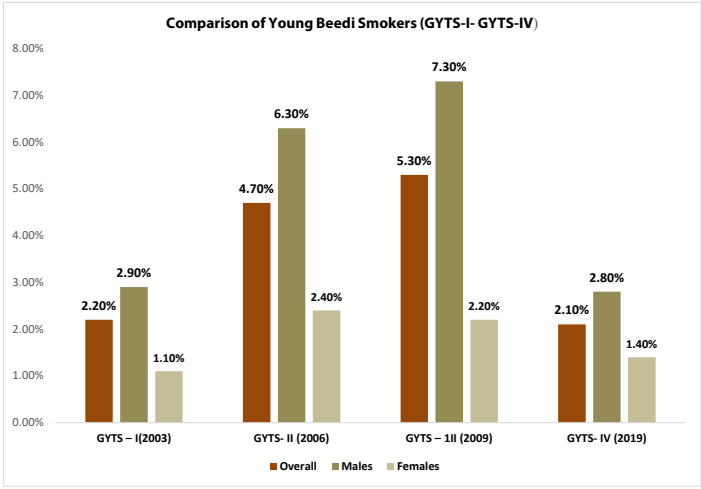
Among tobacco users in India, the proportion of adults who smoked bidis-only significantly increased from 50.1% (2009–2010) to 57.0% (2016–2017.

Figure 1:- Proportion of Tobacco users who smoke bidis, GATS India 2009–2010 and India 2016–2017



*** Indicates comparison is statistically significant at p<0.05.**



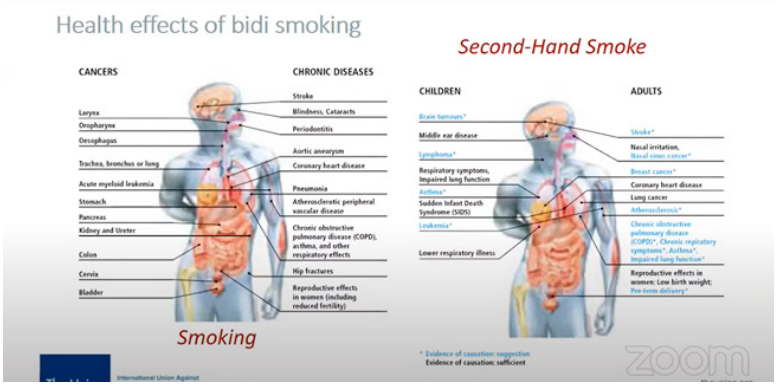


Similar to a reduction in adult beedi smoking from 9.2% (GATS-1) to 7.7% (GATS-II), a reduction in beedi among youth has also been observed from 5.3%(GYTS-III) to 2.1 % (GYTS-IV).

Health Effects of Beedi Smoking

Some Facts:

- The amount of nicotine in bidi is three to five times that of regular cigarettes.
- Compared to cigarettes, bidi cigarettes have higher levels of tar and carbon monoxide.
- Smokers must draw more frequently and forcefully on a bidi cigarette because it doesn't have chemicals added to aid in combustion. As a result, more toxins are breathed in than when using traditional cigarettes.
- Bidi smoking has been scientifically associated to adverse cardiorespiratory, all-cause, and baseline respiratory outcomes. (12)
- Bidi smoking is associated with a more than threefold increased risk for coronary heart disease and acute myocardial infarction (heart attack).(13)
- Bidi smoking increases the risk for lung cancer, oral cancer, stomach cancer, and oesophageal cancer.(13)
- The risk ratios for development of COPD (Chronic obstructive pulmonary disease) and lung cancer in particular are generally similar for cigarettes and bidis. Bidis are equally responsible for causing bronchial hyper-responsiveness, impairment of lung function and precipitation of asthma. (13)
- Bidi rolling is an occupational health hazard: Tobacco, nicotine, dust, and other particles absorbed through the skin and nasopharyngeal route endangers bidi workers' and their families' health. According to research conducted by the Factory Advisory Services and Labour Institute in Bombay, a unit of India's Labour Ministry, bidi workers have a higher incidence of tuberculosis and bronchial asthma than the general population. Bidi rolling is also identified as an occupational health hazard in a Ministry of Health and Family Welfare report.(8) Bidi rolling is making workers more prone to various diseases like musculoskeletal diseases, respiratory diseases, Cardiovascular diseases, Skin problems, Gastrointestinal diseases.
- Female workers engaged in bidi rolling were two times more likely to suffer from cervical cancer as compared to non-bidi workers.
- Infants belonging to households involved in bidi rolling activity were at 1.3 times more risk of suffering from respiratory and gastro-intestinal illnesses as compared to homes with no bidi rolling activity.



Socio-economic Impact of Beedi Smoking

Beedi Smoking has a negative impact on a person's health, as well as their financial well-being, personal life, and the health of those around them. Beedi smoking increases socio-economic costs on the poor, and other vulnerable populations as the smokers are exposed to various diseases, they will be unable to maintain a decent standard of living.

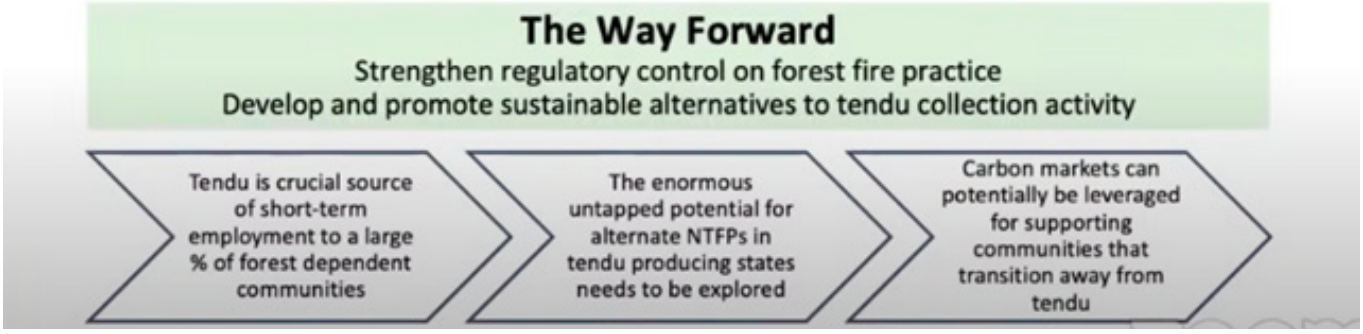
Factors impacting the decent standard of living of beedi smokers:-

Unable to acess basic resources	Lack of affordability towards better lifestyle	Decreased affordability towards Chidren Education and better healthcare
Lack of affordability towards luxury items	No good quality Food	Exposing second hand smoke to Family and friends
Decreased Productivity	Poor Oral Hygiene	Decreased Social Engagement

Environmental Impact of Beedi Production

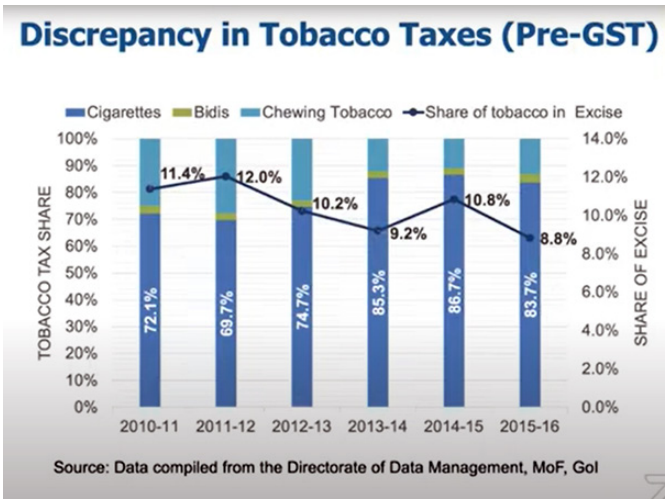
Tendu leaf collection & its Effect on Forest

Beedi manufacturing starts from collecting Tendu leaves, soaking tendu leaves in water, drying tendu leaves, cutting, rolling, filling them with uncured tobacco and packing them into vinyl packets. In this entire process Tendu leaves play the most crucial rule, so tendu leaves are exploited at large scale for beedi manufacturing. More than 2.5 lakh metric ton of tendu leaves are collected to produce 350 billion bidi sticks. Uncontrolled fires are reported in the tendu areas, as there is a traditional practice of using fires to cut back the young exposed shoots of tendu plant and to injure its roots so that they may coppice and produce fresh, green, good quality leaves for bidi rolling.



Taxation for Beedi

The impetus of bidi production in India was received from the Swasdeshi Movement (1920) and These being considered a cottage industry leading to liberal tax treatment. Economic burden of beedi smoking related diseases and deaths in India for the age group 30-69 is estimated at INR 805.5 billion (USD 12.4 billion) for the year 2017. 21 % is direct and 79% is indirect cost. Men bear 94% of the total costs. This economic cost is approximately 0.5% of India's GDP.



Source:- PowerPoint presentation from Dr. Rijo M. John during International Webinar on "Beedi Smoking: Harmful consequences, policy landscape, challenges and way forward"

Current Tax Structure (FY 2023-24)					
	GST	NCCD	Compensation Cess		Excise Tax (2019-20)
Cigarettes (length in mm)			Specific	Ad Valorem	
Non-Filter <65	28%	230	2076	5%	5
Non Filter 65-70	28%	290	3668	5%	5
Filter <65	28%	510	2076	5%	5
Filter 65-70	28%	510	2747	5%	5
Filter 70-75	28%	630	3668	5%	5
Filter 75-85	28%	850	4170	36%	10
Other	28%	850	4170	36%	10
Bidis	28%	1.02	0	0	0.05%
Smokeless Tobacco	28%	25%	0	104%	0.5%

Note: Values not in % are INR/1000 sticks of bidis/cigarettes.

Figure 2:- Tax Structure for Financial Year (2023-24) in India
From figure - 2 It can be seen that the beedi industry enjoys a larger part of the taxation exemption as compared to other tobacco products. The total tax burden (taxes as % of retail price) is 52.7% on cigarette, only 22% for beedis and 68.3% on smokeless tobacco products.

In India, the government has kept the beedi industry in a lower tax bracket because of the large number of jobs it provides in rural areas. According to government data, the tax rate on beedi leaves has been kept under the tax slab of 18%, while beedi itself is taxed at 28% without any additional cess, so beedi remains a cheaper alternative to cigarettes and other tobacco products.

Affordability of Bidis:- Bidis are affordable in India as compared to other tobacco products from a decade now, In 2017/18 a pack of 10 cigarettes sold on average for INR 56.4 while a pack of 25 bidis sold for INR 16.3. The excise tax revenue from cigarette was 42 times higher than that from bidis during the period of 2016-17 despite the fact that bidis outsell cigarettes by a ratio of 4:3:1.In 2018/19, it took 0.41% of per capita to buy 100 sticks of cigarettes while it took only 0.05% or per capita GDP to buy 100 sticks of bidis, implying that bidis were eight times more affordable than cigarettes.

Current legislation for Beedi industry

Global

WHO FCTC Article 6 Guidelines

- "All tobacco products should be taxed in a comparable way as appropriate, in particular where the risk of substitution exists."
- "Tax rated should be monitored, increased or adjusted on a regular basis, potentially annually, taking into account inflation and income growth developments in order to reduce consumption of tobacco products."
- Parties have the sovereign right to determine the level of tax rates to apply. The WHO recommends taxes should account for at least 75% of the retail prices of tobacco products.

41 countries have tobacco taxes share >75% of retail price including Sri lanka (77%) and Thailand (78.6%). 18 of them have it at >80%.

India

- The Beedi Workers Welfare Cess Act, 1976
- The Minimum Wage Act, 1948
- Beedi and Cigar Workers (Conditions of Employment) Act, 1966
- The Contract Labour (Regulation and Abolition) Act 1970
- The Equal Remuneration Act 1976
- The Maternity Benefit Act 1961
- The Cigarettes or Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act 2003 or COTPA

Recommendations:

1. State tobacco control cells, should specifically focus on local beedi industry evades government acts and harm innocent women and children violating several acts. cell.
2. Each state should have a clear cut monitoring and evaluation guidelines for Beedi industry.
3. Implement proper taxation on beedi products, the taxation should be as per the recommendation of WHO (75% of retail price).
4. Beedi products should have a specific & clean graphical health warning as per government guidelines.
5. Civil societies should create a cadre of ambassadors to mitigate the beedi industry interference.
6. The education institutions should be introducing lectures of harmful effects of beedi consumption.
7. Alternative livelihood through vocational trainings to all the beedi industry workers should be modelled in different be addressed.
8. The beedi industry interference should be addressed at all levels: political, administrative, and public.
9. Proper registration of beedi manufacturing units and licensing manufacturing, distribution and selling should be implemented.

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EXPERTS COMMENTS

There are 267 million people using tobacco in one or another form and 14% are smoking cigarettes, 27% (72 million) are the beedi smokers in the country. Beedi is consider as poor man's melody and it is well known fact that the lower economic section of the society could not find the solutions to their problems in the healthcare services due to inaccessibility. Beedi industry enjoys the lower taxation slab as compared to other tobacco products throughout the country. We need to find the Indian solution for the beedi problem.

- Dr. Leimapokpam Swasticharan,
Additional Deputy Director General of Health Services
-Directorate General of Health Services, Ministry of Health and Family Welfare, Govt. of India

Despite of nearly two decades of legislation (FCTC, NTCP), beedi control remains a challenge. The main goal is to de-normalize the beedi sector in India. People perception of beedi in India is that it is less harmful because it is ayurvedic or natural. Even though beedi is more harmful than cigarettes, integrated communication strategies play an important role in addressing this issue. The second issue is to increase the tobacco tax burden on beedi, The third issue is related to beedi trade regulation, as there is inadequate evidence on how many beedi brands exist, what the supply chain is, whether they comply with all beedi industry and trade, and what percentage of beedi manufacturers actually pay government taxes. There is an urgent need for various schemes to provide alternative income to beedi rollers and increase for taxation, regulations on beedi industry.

- Dr. Rana J Singh,
Deputy Regional Director, The Union (South-East Asia), New Delhi

From a long time, beedi control was only a concern for India, but 20 years ago, it was discovered that beedis were exported to the United Kingdom and the United States of America, and prevalence figures became sustainably high in their surveys, which sparked the CDC's interest in beedi control. A comprehensive report was created through the contributions of scientists from India and the United States of America that projected beedi smoking as a global issue. The United States and the Centers for Disease Control and Prevention handled this very carefully, but beedi smoking continues to be an extensive issue in India. Beedi manufacturing is a source of livelihood for many people in India, and that current control strategies are inefficient in beedi control due to the intricate nature of the problem.

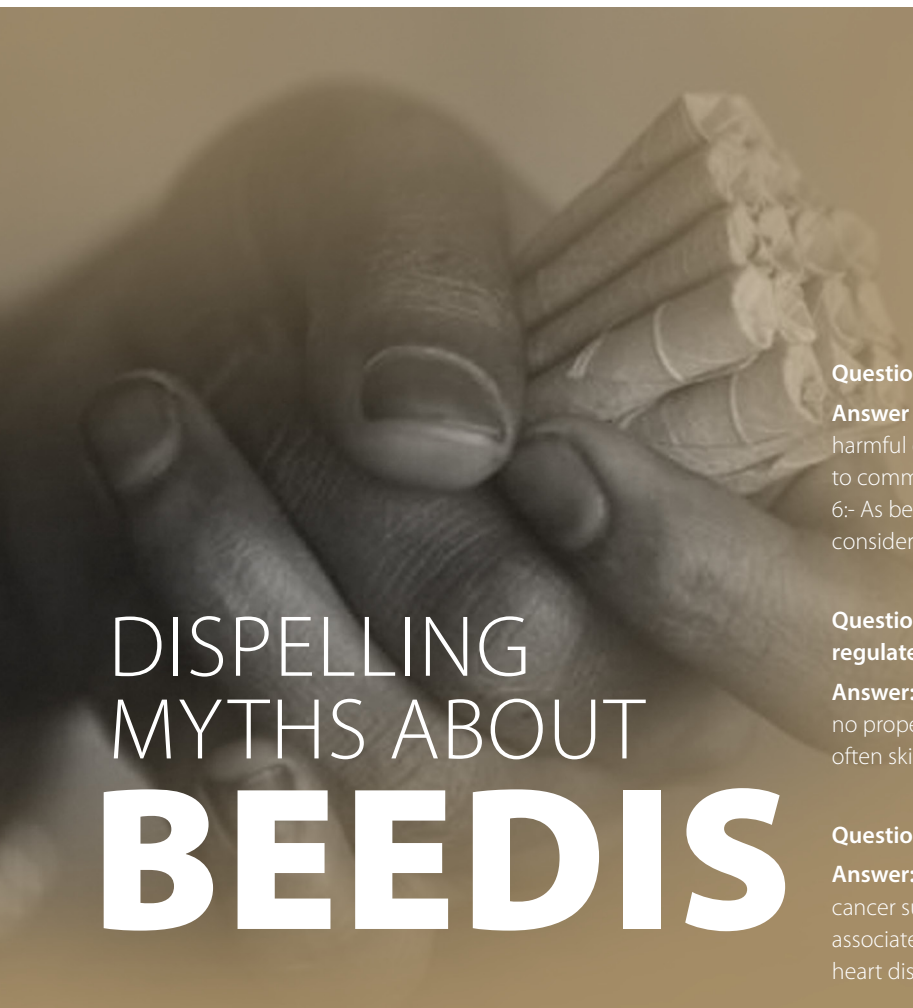
- Dr. Prakash C Gupta,
Director, Healis - Sekhsaria Institute of Public Health, Navi Mumbai

India has been dealing with a persistently high burden of beedi for decades. The gender element involved in beedi rolling, pointing out that women and children are primarily involved in beedi rolling, putting their health and lives at risk, despite the fact that beedi rolling has so many negative consequences on their health. regular health check-ups for beedi rollers are important. Taxation on the beedi industry is another critical issue that must be addressed because it is the rolling of uncured tobacco in tendu leaves and there is no count, so consumption among the community has increased.

- Dr. Suneela Garg,
Chair, Programme Advisory Committee, NIHFW and Co-Chair, MDRU, DHR

Beedis are less expensive and consumed more than cigarettes, that there are many misconceptions about harm, that they contain far more nicotine than a cigarette, that they are clearly addictive, and that there are many illnesses associated with consumption and rolling. The policy landscape, which includes 72 million adult consumers of beedis in India, which has a significant impact on both personal and public budgets. The beedi industry is given special treatment in terms of policy, as they are exempt from taxation, resulting in lower prices.

- Dr. Kevin Welding,
Associate Director of the Johns Hopkins Institute for Global Tobacco Control



DISPELLING MYTHS ABOUT BEEDIS

Question 1: Are beedis safer because they are considered to be Ayurvedic/Herbal?

Answer: No, beedis are not safer despite being considered Ayurvedic/Herbal. Beedis consist of uncured tobacco wrapped in tendu leaves, which makes them more harmful. Beedis are a combustible tobacco product and smoking them exposes users to three to five times the amount of nicotine found in a regular cigarette, increasing the risk of nicotine addiction.

Question 2: Does beedi contain less nicotine compared to cigarettes?

Answer: No, beedis actually contain five times more nicotine than cigarettes.

Question 3: Is beedi smoking lighter and less harmful?

Answer: No, beedi smoking is not lighter or less harmful compared to other forms of tobacco products. In fact, beedi smokers tend to inhale more intensely and take deeper puffs, resulting in higher levels of carbon monoxide and nicotine intake than cigarettes. Smokers often unconsciously adjust their smoking behavior, compensating for the perceived safety of beedis, which can lead to increased inhalation intensity or frequency of puffs.

Question 4: Should the beedi industry enjoy a lower tax slab since it provides livelihood to many people?

Answer : Instead of lower tax slabs, there is a need to create alternative employment and livelihood options for those who depend on the beedi industry. Beedis contain more hazardous chemicals and nicotine than cigarettes, and their combustion requires deeper and more frequent puffs to keep them lit. It is important to prioritize public health and provide support for transitioning away from harmful industries.

Question 5: Does beedi smoking help digestion?

Answer : No, beedi smoking does not help digestion. In fact, it has harmful effects on the entire digestive system and can contribute to common disorders such as heartburn and peptic ulcers.Question 6:- As beedi packet does not have pictorial warnings so beedi are considered safe for consumption?

Question 6: Is warning labeling on beedi packages properly regulated in the industry?

Answer: No, the beedi industry in India is an unregulated sector with no proper monitoring, so warning labeling on beedi packages is often skipped.

Question 7: Does beedi smoking cause cancer?

Answer: Yes, beedi smoking increases the risk of various types of cancer such as oral, lung, stomach, and esophageal cancer. It is also associated with a more than threefold increased risk for coronary heart disease and acute myocardial infarction (heart attack).

Question 8: Is beedi considered a poor man's pleasure?

Answer: There is no specific social status related to beedi smoking. In fact, outside of India, beedis are considered a luxury product, with a pack of three packs of Taj beedis costing $35.

Question 9: My grandfather smoked beedis and lived to be 100 years old, so is beedi smoking safe?

Answer: Longevity in the past was mainly due to lifestyle factors, not the consumption of beedis or tobacco. Beedi smoking has many harmful effects on a person's health and should not be considered safe.

Question 10: Does beedi smoking have any positive effects?

Answer: No, beedi smoking does not have any positive effects. The transient effect of increased dopamine in the reward center of the brain is the cause of addiction to nicotine. There is no relief from stress or tension, but rather relief from withdrawal anxiety and an increase in stress chemicals like adrenaline due to smoking can cause higher anxiety symptoms such as an increase in blood pressure, heart rate, and respiration. The other so-called positive effects on health are more due to conditioning and come with the major downside of loss of health instead of improvement.

Question 11: Is beedi rolling safe for women and children?

Answer: No, bidi rolling is an occupational health hazard. According to a WHO study, tobacco, nicotine, dust, and other particles absorbed through the skin and nasopharyngeal route endanger bidi workers' and their families' health. Research conducted by the Factory Advisory Services and Labour Institute in Bombay, a unit of India's Labor Ministry, has found that bidi workers have a higher incidence of tuberculosis and bronchial asthma than the general population.

Resource Centre for Tobacco Control (E-RCTC)

under Department of Community Medicine &
School of Public Health, PGIMER Chandigarh

To **Catalyze Tobacco Control Activities** In The Country And Facilitate In Fostering **Tobacco Control Partnerships**.

Resources Available:

Policies & Legislations, Circulars,
Advisories, Notifications, Orders, National Tobacco Control Program Publication,
IEC Material, Events

Century Publications

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